Health and Population Sector Programme 1998-2003, Bangladesh

Status of Performance Indicators 2002

A Report for the Health Programme Support Office
for the Annual Programme Review 2002
January 2003

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EXECUTIVE SUMMARY

This report is the last in a series of annual reviews[1] of the status of the performance indicators of HPSP. With planning commencing for the next national programme, it is appropriate to review the process of using an agreed set of indicators to monitor programme progress. First, a brief summary of progress throughout HPSP is presented. This will be by major topics and cross-cutting issues, in the sequence of steps to provision of health services.

Training: Due to the absence of a Personnel MIS for MOHFW, it was initially impossible to determine what training staff had already received. After four years, some progress has been made on the PMIS, which currently covers less than 10% of total staff. Implementation of the huge training requirements of HPSP, especially on ESP for field level staff, took several years to become operational. Contracting training out to the private or NGO sector, was slow and difficult, but now training by both GOB and others is progressing quickly, considering the large numbers concerned, and the diversity of courses to be arranged.

Construction: Under HPSP the major task was the ambitious plan to construct Community Clinics. This was complex due to the need to involve communities through committees, donation of land, and contracting of local construction firms. The rate of construction and handover was very slow to start but has proceeded quickly in the past two years. Functional status is more difficult to determine. There was some renovation of existing facilities at various higher levels (#c18), but relatively minor, presumably because of the focus on ESP, and community level services.

Procurement: This component has been one of the most problematic. Partly because the shift from multi-project based procurement to a system concentrated in a few sources, created a burden which fell most heavily on CMSD (10-fold increase in purchasing volume), which received little technical or other support for several years (#C20). The obligation to follow new sets of procurement regulations, introduced before systems were fully in place, created considerable confusion. An example is the absence of an international procurement agency until today. Even now, the urgently needed procurement of DDS kits for the CCs is delayed because of inconsistencies between procurement regulations and national drug policy. On numerous occasions emergency procurement, especially of essential drugs, had to be done. The past year has finally shown encouraging progress, but this exemplifies the need, in a shift from project to programme approach, for a transition plan, and phasing in of such major changes in ways of 'doing business'.

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[1] (1) ***'Performance Indicators for Sector-Wide Program Management of HAPP-5'***, PPC Report by P.K. Streatfield, February 1998, 71 pages. (Note: Original name of HPSP was HAPP-5).
(2) ***'Status of Performance Indicators'***, Annual Programme Review of HPSP, P.K. Streatfield, April 1999, 47 pages.
(3) ***'Status of Performance Indicators'***, Mid-Term Review of HPSP, P.K. Streatfield, October 2000, 58 pages.
(4) ***'Status of Performance Indicators'***, Annual Programme Review of HPSP, P.K. Streatfield, M. Hadley & N. Chakraborty, October 2001, 93 pages.

Service Delivery: Under HPSP the major service delivery issue at the community level has been the shift away from domiciliary (doorstep) services to static clinic services. This mainly affected the functioning of FWA's and HA's. Even where Community Clinics were constructed (#C15), there was widespread uncertainty amongst the (FWA/HA) staff about their roles as service providers in the CCs versus households, and in peripheral areas such as epidemiological data collection, motivation, etc. It was anticipated that a number of vital areas of the health and population programme, requiring community level services, would be negatively affected. This does not appear to have happened, although the frequency of household visits has declined steeply.

At the 'input' or 'process' indicator level, contraceptive prevalence (Indicator #B4) continued to rise at the same rate as earlier, until 2001. Immunization (both EPI for children, and TT for mothers - #B6) remained at the same levels as before HPSP. Antenatal care (#B2) appears to have increased considerably in 2001. Nationally, safe delivery (#B1) has not changed noticeably, but there is evidence that considerable progress has been made on EOC services in certain areas (#C12). Vitamin A distribution (through NIDs) has remained at high levels (#B7). TB services, particularly DOTS, have remained constant, although the persistently low case-detection rate (#B9), in the context of increasing multi-drug resistance, is of concern.

At the 'output' or 'impact' indicator level, fertility has remained stubbornly constant (#A6), but since 1991, well before HPSP started. It is possible that fertility would have declined if certain activities took place, both in awareness raising, and in improving clinical services, but it is also possible that families are having a number of children close to their desired family size. The apparent steep declines of the early 1990's in infant (#A2) and child (#A3) mortality have slowed. Maternal mortality (#A1) has shown an encouraging steady decline, partly resulting from the fertility decline, but presumably also due to the expansion of safe motherhood facilities over the past decade.

Malnutrition levels (#A5 & C38) remain high and steady, but HPSP did little outside of BINP, which was of limited coverage, to address this. HIV/AIDS remains remarkably low among high-risk groups (#B8), in the face of high STDs and widespread risk behaviours, but this cannot be attributed to an effective programme. There is no evidence that awareness of services has increased, and indeed the UBCC activities (#C23) charged with promoting awareness have not started functioning under HPSP.

One negative aspect of service delivery, not limited to the HPSP period, is growing inequity among certain important services. When the rich are many times more likely to use these services than the poor, then the system is not working as intended. This socio-economic inequity is particularly prominent where higher-level medical staff are involved.

So, in the context of major changes in service delivery, with surrounding confusion, under HPSP, many of the important indicators have not improved, most have not deteriorated. The conclusion has to be that as the health and population programme activities have matured in Bangladesh, families are less reliant on household delivery of

services. Increased mobility of women (#C11), and greater awareness of available services (#C24), has created a demand, and clients manage to obtain services from one source or another, when their customary source is removed or restricted. The fact that such a small proportion of people use ESP services should raise a warning flag that issues of poor quality of care, and uncaring staff attitudes (#C34), result in negative perceptions among potential clients (#C22). Greater attention, and research (#C26) will need to be given to clients' needs in the next programme. It should be added that a number of examples of service delivery activities that continued to improve, did so because of committed MOHFW staff, especially at LD level, and continued technical support from collaborating agencies.

Issues of payments for services, social and health insurance (#C37), retention of fees by the charging facilities (#C27), remain largely in the discussion stage, with some in small-scale pilot phase. This is not surprising, as it tends to involve changing policies which cut across other ministries, especially Finance, Establishment and Law.

Monitoring: The information requirements for monitoring HPSP are still very inadequate (#C25). The unification of the pre-existing (health and FP) MIS systems has been extremely slow, and is still contributing little towards the management or M&E needs of the program. Most of the information for annual programme reviews comes from surveys, and residual information systems from the old projects. Hopefully this situation is changing.

With a growing emphasis on poverty focused service delivery, the programme will not be able to rely totally on service statistics which cannot normally determine the economic status of service users. The programme will continue to need surveys that can identify the poor, as well as for obtaining more qualitative information on client satisfaction, etc.

Financial monitoring is part of the UMIS, but in fact operates a separate system, which has been strengthened considerably during HPSP (#C30, 39, 40, 41). While some inconsistencies between revenue and development accounting systems remain, the financial codes, and reporting mechanisms are working quite well now.

Coordination: The adoption of the programme approach contributed to a need for much greater coordination across various components of the MOHFW. Many of the new activities, particularly where integration or unification of previous functions was involved, utilized committee structures to encourage participation and inclusion in the process. Many of the areas under HPSP that have not progressed as planned, are those depending on decisions to be made by committees which have not functioned effectively, or in some cases, not at all. The creation of committees is a classic bureaucratic tactic for avoiding action on difficult issues. This appears to be the case in some of the integration issues in HPSP. In some cases there were structural reasons for non-progress. For example, several examples of activities requiring integration could not proceed because the integrated organogram were not prepared because development budget posts traditionally are not included together with revenue budget posts (#C16).

Management: There can be no doubt that a programme approach imposes a considerably greater management load on senior management than a project approach. While there were several refinements during the first years of HPSP, such as delegation of the initial highly centralized financial authority, there was little preparation of senior staff for their new roles. Most of the training was planned for lower level, service delivery staff. In a context of widespread changes in many areas, this lack of management training almost certainly contributed to problems of coordination, and allocation of responsibility. At a practical level, the selection of Line Directors from quite different levels within the Civil Service has been problematic, with some having many other responsibilities of higher priority than their line directorate.

The change to the broader allocation of responsibilities under the programme approach, rather than simply increasing the burden on senior staff, should be linked to greater decentralization of authority (#C14). This was planned down to Upazila level, and LLP made some headway on this, but without delegation of authority and resources, progress will not be made.

Policy: To an extent, HPSP is all about the introduction of new policies on how to deliver health services. It raises questions as to how to bring about change within one Ministry without compatible changes in other relevant Ministries (e.g., sector wide management). Indeed cross-sectoral progress on other factors that affect health, such as water and sanitation supply, education, did not progress far under HPSP. The programme approach was intended to minimize the duplication and inefficiencies of the project approach. The integration of the Directorates was intended to improve coordination across various levels of the MOHFW, and streamline service delivery.

While these major policy changes were incorporated from the planning of HPSP, and succeeded to varying extents, some lesser changes or pilot changes in policies, were not incorporated because they were seen as outside of HPSP. The piloting of the new IMCI strategy (#C13) has been orphaned to some extent, as has the Women Friendly Hospitals Initiative (WFHI - #C19). The revision of the National Drug Policy (#C33) has not progressed for different reasons, but reflects that for change to take place, a promoter or 'champion' is needed at senior levels within the programme. Incorporation of gender issues (#C28) has suffered a similar fate of lacking committed high level support.

There are many other policies, both inside and outside the MOHFW, which have affected the implementation of HPSP. These range from obstacles to contracting out certain activities to the private or NGO sectors, have resulted in delays or non-progress in certain areas. The customary allocation of development budget funds in quarterly 'slices', results in difficulties in funding large or longer-term activities.

In considering all these issues, this may be the time for the Government to reconsider what should be the role of the state in the health and population sector. Should it primarily be a regulator (#C36) and maker of policy, or should it mainly be a service provider. This issue is particularly relevant at Upazila and below where many alternative service providers exist, and NGOs in particular collaborate with Government in joint

service delivery activities. This is happening without any formal GOB-NGO strategy or policy being developed (#C35), although development of such a strategy was anticipated under HPSP.

Use of Indicators for Monitoring Programme Progress: The original set of performance indicators were derived from the experience of Ghana, which adopted a sector-wide approach several years before Bangladesh. There were 22 indicators in the first set, and a selection of these were dropped, added to, and modified, each year, as the Annual Programme Review teams considered their usefulness[2]. As can be seen in the text of the present document, part of the annual review of each indicator, considers whether there should be any revision to that indicator.

In the initial planning of HPSP, it was recognized that in the early phases of implementation, the majority of indicators would be of the 'input' type. Over time, this would change to 'process' indicators, then finally, 'output' and 'impact' indicators. In fact, there has been little revision of the indicators, and many are still of the 'input' or 'process' type, even though the number has almost doubled since the first year. In planning for the next three-year plan, consideration will need to be given to the additional areas of activity, such as urban health and nutrition (although that is well covered already). Some indicators cannot be shifted from inputs to outputs/impact without major developments in other areas. An example is that an impact like reduction in TB deaths requires a UMIS system that is unlikely to exist, whereas inputs like detection of TB cases, and numbers on DOTS therapy, can be measured.

New, reemerging, or simply unmonitored diseases should be considered. These include infectious diseases like dengue, malaria, kala-azar, but also chronic non-communicable diseases of adulthood, like cardiovascular, diabetes, or hypertension, which can play a major role in plunging affected families into poverty through reduced economic productivity, or through excessive costs. The appropriate approach to some of these conditions is behaviour change, for example, reducing smoking, which requires a combination of policy development (including import and production controls), effective health promotion and behaviour change communication, as well as appropriate curative services. On this issue, the focus on ESP has limited the allocation of funds to the tertiary hospital sector (#C39), and it may be here that many poor families make their largest health expenditures on curative treatments, not always effectively. Only a few pilot insurance schemes implemented by NGOs have attempted to address this problem.

The most useful indicators are not those that simply measure the existence of a service or a facility, but its functional status, and what impact it makes on the health and lives of the public. Finally, the indicator must be measurable through information gathering systems already existing, or feasible to introduce in the short term.

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[2] *'Performance Indicators for Sector-Wide Program Management of HAPP-5'*, PPC Report by P.K. Streatfield, February 1998, 71 pages. (Note: Original name of HPSP was HAPP-5).

GLOSSARY

AFP	Acute Flaccid Paralysis
AIDS	Acquired Immune Deficiency Syndrome
ALRI/ARI	Acute (Lower) Respiratory Infection
ANC	Antenatal care
APR	Annual Program Review
BBS	Bangladesh Bureau of Statistics
BCC	Behaviour Change Communication
BCG	Bacillus Calmètte Guérin (Tuberculosis Vaccine)
BINP	Bangladesh Integrated Nutrition Programme
BWHC	Bangladesh Womens' Health Coalition
CAR	Contraceptive Acceptance Rate
CAU	Chief Accountants Office
CBR	Crude Birth Rate
CC	Community Clinic
CDC	Centre for Disease Control, Atlanta, Georgia, USA.
CDR	Crude Death Rate
CIET	Community Information & Epidemiological Technologies
CMMU	Construction & Maintenance Management Unit (MOHFW)
CPR	Contraceptive Prevalence Rate
DDS	Drug and Dietary Supplement Kit
DGFP	Director-General (Family Planning)
DGHS	Director-General (Health Services)
DH	District Hospital
DHS	Demographic and Health Survey (Macro International)
DP	Development Partner
DPA	Direct Program Aid
DPM	Deputy Program Manager
DPT	Diptheria/Pertussis/Tetanus
EIS	Epidemiological Information System
ELISA	Enzyme Linked Immuno Sorbent Assay (HIV test)
EmOC	Emergency Obstetric Care
EOC (B/C)	Essential Obstetric Care (Basic/Comprehensive)
EPI	Expanded Programme on Immunization
ESP	Essential Services Package

FP	Family Planning
FPHP	Fourth Population and Health Program
FWA	Family Welfare Assistant
FWC	Family Welfare Centre
FWV	Family Welfare Visitor
FWVTI	Family Welfare Visitor Training Institute
GAVI	Global Alliance for Vaccination and Immunisation
GOB	Government of Bangladesh
HA	Health Assistant
HDS	Health and Demographic Survey (conducted by BBS)
HEU	Health Economics Unit
HIU	Health Information Unit
HIV	Human Immuno-deficiency Virus
HKI	Helen Keller International
HPSP	Health and Population Sector Program
HRD	Human Resource Development
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
IDU	Injecting Drug User
IEDCR	Institute for Epidemiology and Disease Control and Research
IMCI	Integrated Management of Childhood Illnesses
IPH	Institute for Public Health
IST	In-Service Training
IUD	Intra Uterine Device
LD	Line Director
LE	Life Expectancy
MAU	Management Accounts Unit (MOHFW)
MCWC	Maternal and Child Welfare Centre
MICS	Multiple Indicator Cluster Survey (UNICEF)
MIS (U)	Management Information System (Unified)
MMR	Maternal Mortality Ratio (No. of maternal deaths/1,000 live births)
MMRate	Maternal Mortality Rate (No. of maternal deaths/1,000 women aged 15-49 years)
MO	Medical Officer
MOHFW	Ministry of Health & Family Welfare
MOU	Memorandum of Understanding
MSM	Men who have Sex with Men
MTR	Mid Term Review

NCES	National Coverage Evaluation Survey (for EPI)
NGO	Non Governmental Organisation
NID	National Immunization Day (for polio vaccination and Vitamin A)
NIPHP	National Integrated Population and Health Program (USAID)
NNP	National Nutrition Programme
OBGYN	Obstetrics and Gynaecology
ORS/ORT	Oral Rehydration Salts/Oral Rehydration Therapy
PFC	Project Finance Cell
PIP	Program Implementation Plan
PM	Program Manager
QA	Quality Assurance
RHF	Recommended Home Fluids (to treat diarrhoea)
RIBEC	Reforms in Budgeting and Expenditure Control Project
RPA	Reimbursable Program Aid
RTI	Reproductive Tract Infection
SD	Standard Deviation
SDS	Service Delivery Survey
SM	Syndromic Management
STD	Sexually Transmitted Disease
SW	Sex Worker
TB	Tuberculosis
TBA	Traditional Birth Attendant
TFIPP	Thana Functional Improvement Pilot Project
TFR	Total Fertility Rate
THC	Thana Health Complex
UHFP	Union Health and Family Planning
UHFWC	Union Health & Family Welfare Centre
UNICEF	United Nations Childrens Fund
USAID	United States of America International Development
VA	Verbal Autopsy
VRS	Vital Registration System
WHO	World Health Organisation

C. MONITORING INDICATORS FOR HPSP IMPLEMENTATION

- ***Output Component 1*** - ESP
- ***Output Component 2*** – Reorganization of Service Delivery
- ***Output Component 3A*** – Support Services: HRD
- ***Output Component 3B*** – Support Services: Facilities
- ***Output Component 3C*** – Support Services: Procurement and Logistics
- ***Output Component 3D*** – Support Services: Quality Assurance
- ***Output Component 3E*** – Support Services:Behavioural Change Communication
- ***Output Component 3F*** – Support Services: MIS
- ***Output Component 3G*** – Support Services: Research and Development
- ***Output Component 4*** – Hospital Services
- ***Output Component 5*** – Sector wide management
- ***Output Component 6*** – Policy & Regulatory Framework
- ***Output Component 7&8***–Public Health Services, Other Health & Nutrition Services
- ***Others – Financing Aspects***

METHODOLOGY:

Almost all the performance indicators are presented with overall status, and with gender and socio-economic differentials. In past reviews, the only source of economic differentials has been the proxy variable mother's education. A number of indicators are available differentiated by maternal education, but this has not been systematically presented. This year for the first time, the analysis has been performed to present differentials by economic status for a number of key indicators, mainly relating to child survival and reproductive health.

The approach involves using a series of variables collected in the periodic Demographic and Health Surveys, such as ownership of household assets, land ownership, and household construction materials. Such variables are used to calculate a 'household asset score', based on which, households are allocated to one of five equal (20%) divisions, or quintiles, from 'poorest' to 'richest'. This approach is derived from Gwatkin et al., (2000).

Rather than burden this report with ever more tables, the economic differentials are presented as graphs showing values or levels of the indicator for each of the five economic quintiles. The levels are shown for pre-HPSP (1996-1997 DHS) and within HPSP (1999-2000 DHS), although some indicators (e.g., infant mortality rate) have a lag period which means they actually relate to an earlier period than the survey date.

Comparisons can be made across the five economic categories, and over time, pre-HPSP and during HPSP. A summary measure of equity is the ratio of the poorest to the richest households. A ratio of 1.00 indicates complete equity between these two quintiles, though not necessarily across all quintiles. If this analysis proves illuminating, it would be useful to expand it to other indicators for which data are not currently available.

Health and Population Sector Programme (HPSP) 1998-2003

Annual Programme Review 2002

As agreed at the start of HPSP, the Annual Performance Review (APR) is the main opportunity for both GOB and development partners of the health and population sector to review progress and decide how to support the sector the following year (see PIP part 1, p.50).

The process of the APR involves a review of an agreed set of performance indicators. For each indicator a table is presented here which includes the indicator name, definition, current status, and expected target at the end of HPSP. In the accompanying commentary, actual progress in the past year, or sometimes since the beginning of HPSP, will be presented, along with discussion of problems encountered, and any suggestions for revision of the indicator or target. In addition, there is a brief review of any important crosscutting issues which have emerged in the process of collecting current data on the performance indicators, but are not covered by the indicators. For quantitative indicators, the source of data is included.

It can be mentioned that a set of recommended indicators was agreed before the commencement of HPSP in August 1998[1]. At that time a list of 24 indicators was agreed, but in subsequent APRs and the Mid-Term Review (MTR), the list has been modified and expanded considerably. There are now 47 indicators, including six milestones. Since the MTR in October 2000, two milestones (Crude Birth Rate and Crude Death Rate) have been dropped, as recommended in the Status of Performance Indicators report.

The nature of the indicators was determined largely by the components of the Essential Services Package (ESP) together with several important crosscutting issues. The broad headings of the indicators are:

A. INDICATORS AND MILESTONES FOR MONITORING HPSP GOALS

B. MONITORING INDICATORS FOR HEALTH & POPULATION SECTOR PERFORMANCE

From the ESP:

- ***Reproductive Health Care,***
- ***Child Health Care,***
- ***Communicable Disease Control,***

[1] 'Performance Indicators for Sector-Wide Program Management of HAPP-5', PPC Report by P.K. Streatfield, February 1998, 71 pages. (Note: Original name of HPSP was HAPP-5).

A. INDICATORS AND MILESTONES FOR MONITORING HPSP GOALS

1. Maternal Mortality Ratio (MMR) per 1,000 live births

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003 **
1. Maternal Mortality Ratio (MMR) (per 1,000 live births)	Number of maternal deaths in a year due to pregnancy related causes during pregnancy or within 42 days of childbirth, per 1000 live births in same year. Disaggregated by socio-economic status.	4.1 per 1000 live births (HDS, BBS 1998)	3.2 per 1000 live births (Verbal autopsy, BMMS 2001 *	2.8 per 1000 live births.

* Current Status: see below for various estimates based on different approaches.
** Note: The PIP does not specify a precise target of 2.8 /1000 live births, but rather "under 3/1000".

Actual progress:

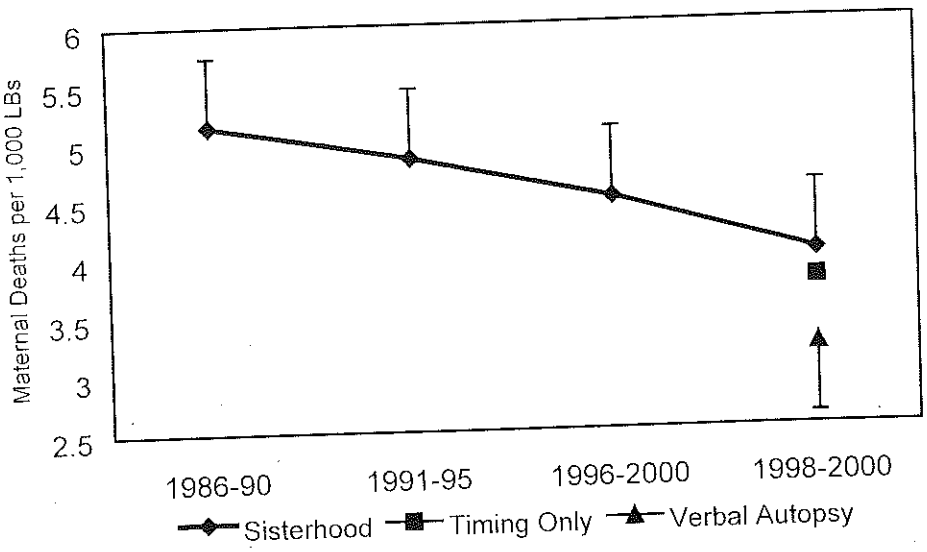
For the first time there is a nationally representative estimate of maternal mortality. The preliminary report of the Bangladesh Maternal Mortality Survey 2001, with national estimates, was released in March 2002. The final report, including more detailed analyses and differentials, is expected in early 2003. The survey interviewed 103,796 eligible women respondents in 99,202 households between January and June 2001[2].

Three approaches were used to estimate the current level (1998-2000) of maternal mortality, and three different estimates were produced. Respondents were asked a series of questions[3] about any deaths of household members since April 1997. If the deceased was a woman aged 13-49 years at time of death, three additional questions were asked about timing of death[4]. Also a verbal autopsy was conducted to determine whether or not the death was a true maternal death. In addition, all ever married female household members aged 13-49 were asked about the survival status of their (biological) sisters[5]. This approach produces historical estimates and thus trends for pregnancy related deaths (ie. not limited to true maternal deaths).

[2] The sample size for this survey was some ten times larger than the DHS, as maternal mortality is a relatively rare event. The high fieldwork cost means that frequent surveys are unlikely, although UNICEF are planning to conduct a survey in 2003.
[3] Name, sex, age at death, month and year of death, cause of death.
[4] Whether the woman died while she was pregnant, giving birth, or within two months of the end of the pregnancy. This allows an estimate of 'pregnancy related deaths'.
[5] Name, sex, survival, age if still alive, age at and years ago if dead, for all sisters. For any sisters who died at age 12 or older, the time of death relative to pregnancy, childbirth, and the first two months after end of pregnancy was also ascertained.

Trends: The five year period estimates of MMR from the deaths of sisters show a steady decline from 5.14 per 1,000 live births in 1986-1990, to 4.85 in 1991-1995 (5.6% decline in 5 years), to 4.48 in 1996-2000 (7.6% decline in 5 years). For the three years before the survey (1998-2000) the estimate is 4.00 (22.2% decline in 11 years, and possibly a 10% decline between mid 1998 and mid 1999 - see Figure 1.1 for estimates with 95% confidence intervals). This latter figure is quite consistent with the estimate of 3.92 for the year 2000 (HDS) reported last year.

Figure A1.1: Trend in Maternal Mortality Ratio



Note: the confidence intervals around the first three estimates are +/- 12%, and the latest three estimates (1998-2000) are +/- 16%.

Current Estimates: As mentioned, the direct sisterhood method identifies pregnancy related deaths, and so may include accidental deaths to pregnant women (i.e., not true maternal deaths). There may also be certain small biases in that households with no surviving women of reproductive age will not be included in the estimate. The household survey also provides an estimate of pregnancy related deaths based on timing of deaths during the same three-year period (1998-2000). This MMR figure is 3.77 per 1,000 live (5.7% lower than the sisterhood estimate). If only the 'true' maternal deaths are included, based on the verbal autopsy, the estimate is 3.20 per 1,000 live births. This is 15% lower than the estimate of pregnancy related deaths based on timing of deaths. It suggests that up to one in six reported deaths are pregnancy related but not true maternal deaths. The proportion is higher among older women, consistent with other (non-maternal) causes of death during pregnancy being more common in the past.

The estimate of 3.2 implies a total annual number of maternal deaths in Bangladesh of around 11,000-12,000. It is possible that some of the reported 'accidental' deaths excluded from the verbal autopsy may not have been completely coincidental and should have been classified as 'maternal'. Further analysis is underway, and if this is the case, it could result in slightly increased estimates.

Problems encountered:

Last year the problem was that no direct reliable source of the indicator was available. That is no longer the case.

Revisions to indicator:

The indicator should be retained, but with awareness that such large scale surveys may not be (financially) feasible on a regular basis. The BMMS 2001 should be used to examine which proxy indicators collectable at lower cost might be used in future reviews. Global experience suggests that no single proxy indicator, such as use of antenatal care, would provide a sensitive guide to maternal mortality, so some combination of proxies would be necessary.

Amendment to target:

The target of "less than 3 per 1,000 live births" for 2003 is attainable, according to the verbal autopsy estimate of 3.20 for 1998-2000. The assessment of a suitable target, however, is problematic. The WHO document listing global MMR estimates for 1990 included some unacceptable figures, such as 8.5 per 1,000 for Bangladesh. The authors admit the methodology (for category E countries such as Bangladesh) was defective, and have been working on revised estimates. The WHO global estimates based on a regression approach (category E considered only general fertility rate and proportion of births delivered with skilled attendants), are no longer relevant and should not be used.

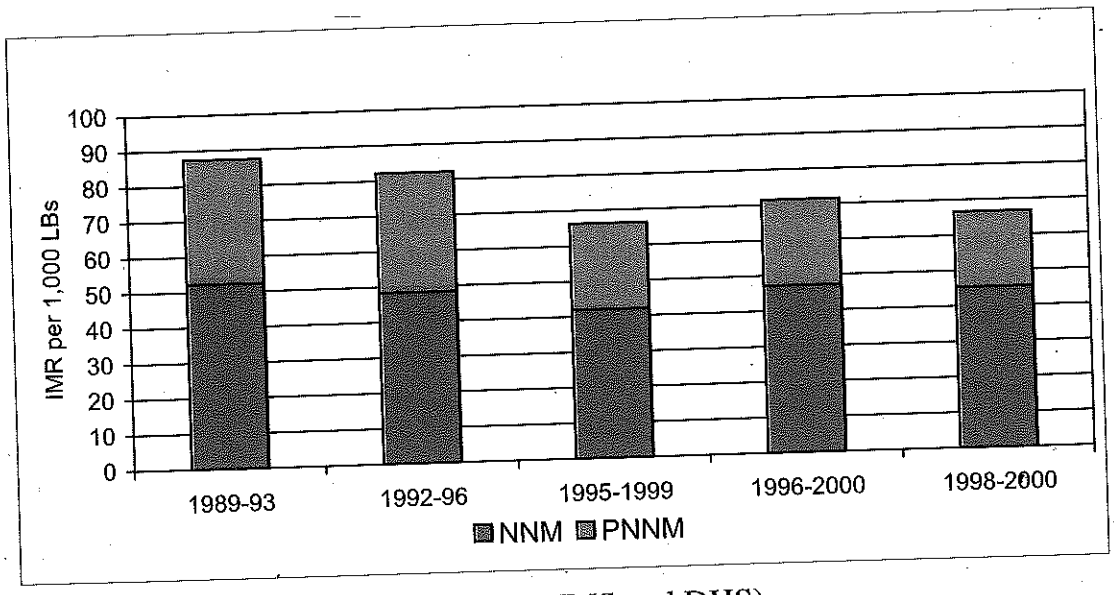
2. Infant Mortality Rate (IMR) per 1,000 live births

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Infant Mortality Rate (IMR) (per 1000 live births	Number of deaths in a year of children under 1 year of age, per 1000 live births in same year. Disaggregated by gender and socio-economic status.	57 per 1000 live births (BBS, 1998)	62 per 1000 live births (HDS, 2000); 71.5 for past 5 years; 66.7 for past 2 years (BMMS 2001).	50 per 1000 live births.

Actual progress:

Infant mortality rates by source: The BMMS 2001 has a preliminary estimate of infant mortality of 71.5 per 1,000 live births for the five years before 2001 (i.e., mid point is late 1998), and 66.7 for the two years before the survey (i.e. mid point is early 2000). The latter estimate is virtually identical to the DHS 1999/2000 estimate of 66.3, but relates to an earlier period (1995-99). The higher figure of 71.5 is more comparable in terms of time period.

Figure A2.1: Trend in Infant Mortality



(Sources: BMMS and DHS)

A number of child health experts expressed doubts about the dramatic decline of almost 20% in IMR between the 1996/97 and 1999/2000 DHS surveys. There was little evidence of programmatic changes that could account for it. EPI remained static, there were only minor changes in childhood ARI and diarrhoea, and no improvements in institutional deliveries. So, it is possible that the figure of 66.3 presented last year was a slight underestimate. The 95% confidence interval (CI) around that estimate was +/- 6.8, or about 10%, so the new higher estimate is still within the CI. It is true that the HDS gave a lower figure last year, but there has been no new figure from that source. Incidentally, the ICDDR,B's Matlab GoB service area showed a decline in IMR of 10% for the same period.

Neonatal (first month of life) mortality currently accounts for about two thirds of infant deaths (45.4 out of 66.7). This proportion is increasing slowly, as post neonatal mortality is declining faster. Neonatal morality now accounts for over half of the deaths at ages under 5 years (45.4 out of 84.6/1,000 live births), an increase of 40% compared with a decade ago.

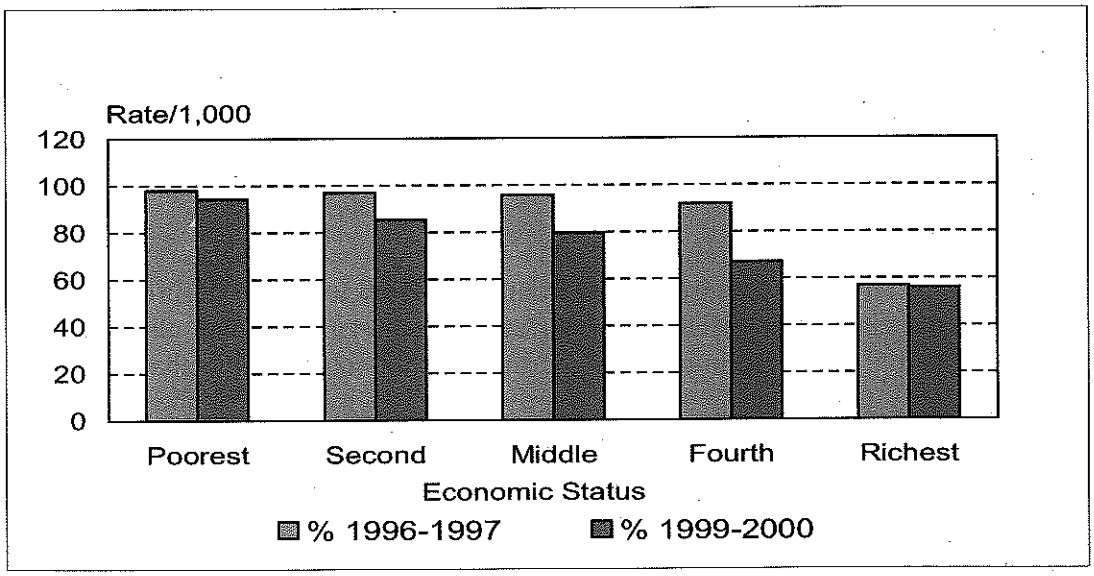
This is a classical trend in infant mortality, where the infectious diseases of the second half of infancy can be overcome (diarrhoeal disease more easily than pneumonia), while the non-infectious causes become relatively more important. There have been no Government programs specifically directed towards neonatal mortality, except components of IMCI (see indicator 13). These include temperature control of the premature/underweight baby, aspiration of the baby with breathing difficulties. All of which require a rapid response available primarily through institutional deliveries.

This imbalance or skew towards mortality in the early part of infancy, is also seen within neonatal mortality where more than half the deaths in this first month of life actually occur in the first week, up to half on the first day of life. This points very clearly to the vital importance safe delivery, in addition to early childhood interventions to improve child survival.
The differentials by gender and socio-economic status are shown below. Due to sample size limitations the data relate to a longer period, and averages will not equal the above total figures.

Gender differentials: From the BMMS 2001, females have lower infant mortality (67.3/1,000) than males (75.4/1,000). As usually observed, females have lower neonatal mortality (i.e., in the first month of life) (41.7 versus 52.4 for males), but higher post-neonatal mortality (in the following 11 months of the first year) (25.7 vs. 23.0 for males). None of these differences are statistically significant, but this is when parental behaviour favouring males in terms of feeding and health care seeking start to play a greater role.

Economic status differentials: This breakdown by economic status (see graph) was presented last year. The analysis using DHS 1999/2000 data shows considerable inequity with IMR being 68% higher among the poorest quintile than among the richest. In comparison with data from the DHS 1996/97, when the poorest had an IMR 72% higher, there has been little change in equity (IMR among the poorest and richest changed little), although there have been substantial improvements among the middle three quintiles.

Figure A2.2: Infant Mortality Rate by Economic Status



Poorest/Richest Ratio: 1996/1997 = 1.72; 1999/2000 = 1.68.

The poorest/richest ratio indicates that the infant mortality rate among the poorest households is about 68% higher than among the richest households, a slight decline from 72% higher pre-HPSP. This indicates a minor shift towards greater equity. The change is basically a result of IMR among the richest households remaining virtually unchanged, while IMR among the poorest households declined slightly. The decline has been greater among the second, middle and fourth quintiles. Further analysis might throw light on the mechanisms for this differential decline.

Social differentials: Traditionally there has been a differential between children of women with no education versus those with primary education. Children of women with secondary education have an IMR almost half (56%) that of children of mothers with no education.

Geographic differentials: Sylhet remains exceptional with IMR one third higher than the national average – in fact neonatal, post neonatal and under 5 mortality are all at this elevated level. Somewhat surprisingly, Chittagong has the lowest levels of infant mortality (neonatal, but not post neonatal). However, overall Khulna Division ranks best on these indicators. Rural areas have about 10-12% higher infant mortality than urban areas, although other (older) evidence suggests that IMR in urban slum populations can be up to twice the rate for urban areas overall.

Problems encountered:

In past years, the time lag built into estimates meant that they applied to a period before HPSP. With the large sample size of the BMMS 2001, that limitation does not apply to the same extent, and the estimate refers to the year 2000, well into HPSP.

Revision to indicator:

This is a standard indicator for national and international comparisons, and should be retained.

Amendment to target:

Target by end of HPSP was revised down from 55 in 2000 to 50 per 1,000 live births in 2001 (almost the same as the MDG target for 2015). Achieving this will almost certainly require a substantial reduction in neonatal mortality, as the interventions that reduce post-neonatal mortality (EPI, management of diarrhoea, ARI, etc.) are not showing signs of expanding in the near future. If implementation of the IMCI strategy accelerates, there may be some reduction in neonatal deaths.

3. Under 5 Mortality Rate per 1,000 live births for Males and Females

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Under 5 Mortality Rate (per 1000 live births), Male/Female	Number of deaths in a year of children under 5 years of age per 1000 live births. Disaggregated by gender and socio-economic status	96 per 1000 live births (BBS) 115.7 per 1000 (DHS, 1996/97)	83 per 1000 (HDS 2000); 95.2 per 1000 (past 5 years); 84.6 per 1000 (past 2 years) (BMMS 2001)	70 per 1000 live births.

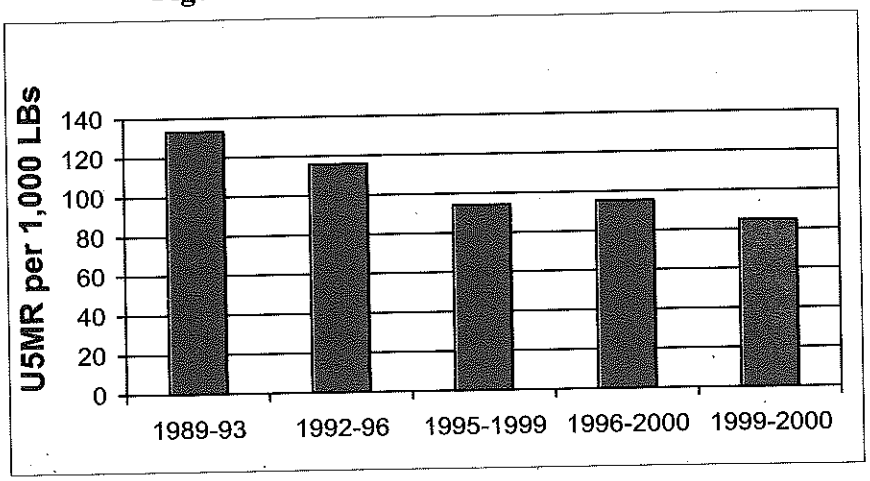
Actual progress:

Overall U5MR: The under 5 mortality rates (U5MR) were also given in the previous report, but not dis-aggregated by gender or socio-economic status. These data are now available. The BMMS 2001 shows two estimates (as with IMR), one of 95.2 per 1,000 live births referring to the 5 years before the survey (mid point late 1998), the other of 84.6 referring to the 2 years before the survey (mid point early 2000). The HDS 2000 figure of 83 per 1,000 live births appears to refer to the reference year 2000. This is consistent with the BMMS estimate for early 2000.

As a number of child survival programs have been implemented in the past two decades, deaths to children between 1st and 5th birthdays now account for only one quarter or less of the deaths to under 5 children. This points to future improvements in U5MR having to be focused in infancy, especially the neonatal period.

In the previous report there was some discussion about the causes of the U5MR decline in the 1990s, such as a decline in diarrhoeal disease incidence, combined with increased use of ORT. Data on ARI was less clear, and needs to be monitored in future.

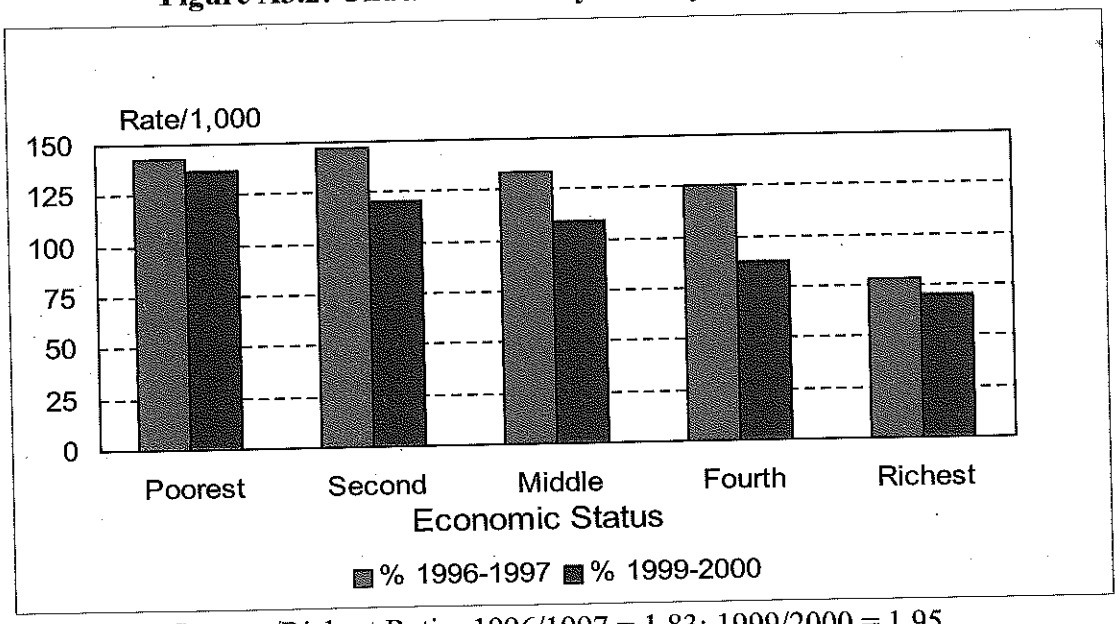
Figure A3.1: Trend in Under 5 Mortality



Gender differentials: The 30% higher mortality rate for females between 1st and 5th birthdays outweighs the favourable IMR for girls. The U5MR is slightly higher for girls (111.7/1,000) than for boys (108.3/1,000).

Economic status differentials: An acceptable indicator is now available, and shows a slight decrease in equity for U5MR among socio-economic groups. According to the 1996/97 DHS, children in the poorest quintile households suffered 83% higher mortality than children in the richest households. In the 1999/2000 DHS this inequity had risen to 95% higher mortality among the poorest households, even though the overall U5MR had fallen by 14%. As shown in Figure 3.2, there were encouraging falls in U5MR among the middle three quintiles. It should be remembered, however, that the latest survey estimate is backdated to a period before HPSP, so this figure, and the infant mortality rates, do not actually reflect the situation during HPSP.

Figure A3.2: Under 5 Mortality Rate by Economic Status



Poorest/Richest Ratio: 1996/1997 = 1.83; 1999/2000 = 1.95.

Problems encountered:

As for previous indicator, IMR.

Revisions to indicator:

Like infant mortality, this is used for both national and international comparisons and should be retained. As it includes infant deaths, which now account for almost 80% of all under 5 deaths, substantial reduction in this mortality indicator will require reduction in infant mortality. There are some mortality causes, however, such as drowning, that are particularly concentrated in the childhood years (1-4) in Bangladesh[6]. There are currently no interventions in place, and little attention has been paid to these accidental ('unintentional injury') causes.

Amendment to target:

The target remains unchanged since last year.

4. Life Expectancy at Birth (Male/Female)

Indicators by Program Area or Type	Definition	Base status (pre-HPSP)	Current Status	Targets for 2003
Life Expectancy at Birth (Males and Females)	The average number of years of life that a newborn infant is expected to live under current mortality rates.	Males: 60.7 years; Females: 60.5 years	Males: 68 Females: 69 years (HDS, BBS 2000)	Males: 62 Females: 62.5 years

Actual progress:

No new data are available since last year. The HDS 2000 gave figures for life expectancy of 68 years for males and 69 years for females, which would be an extraordinary increase over the past few years (see baseline figures). This BBS survey is really the only national source for this indicator. As the DHS only studies women of reproductive age in detail, it cannot provide this figure.

However, 'model' life tables for South Asia (United Nations) indicate that for current levels of infant mortality, a life expectancy of around 65-66 years would be expected. The accurate ICDDR,B Matlab data show life expectancy of 66 years for males and 69 years for females for 2000, which tends to support the HDS estimate. It is sometimes suggested that mortality levels are somewhat lower in Matlab than nationwide. However, the age specific mortality rates from the BMMS 2001, match almost exactly with the rates for the Matlab site, suggesting that it is nationally representative.

[6] In the ICDDR,B fieldsite of Matlab, Chandpur district, drowning is now the leading cause of death for children aged 1 to 4 years – more important than diarrhoea or ARI.

Problems encountered:

Life expectancy is difficult to calculate accurately because it requires reliable data on age at death for all people who die during the reference year. As Bangladesh does not yet have a comprehensive vital registration system monitoring the million or so deaths annually, it has to be estimated from surveys such as HDS, or from the sample registration system. Both sources have problems producing this indicator reliably.

Saving the life of an infant theoretically contributes a full lifetime of years (say, 60 or 65 years) to life expectancy[7]. So, compared to saving the life of an adult that may contribute only 10 or 20 years, improvement in child survival contributes much more to improvements in life expectancy. Bangladesh has seen a solid improvement in child survival in the 1990s, so it is conceivable that life expectancy has increased substantially. Whether it has actually reached the reported figures of close to 70 years is another question.

Revision to indicator:

This is a widely accepted indicator of the health of national populations. Its usefulness, however, is conditional on having full confidence in the data upon which it is calculated. Secondly, the interpretation of improvements in life expectancy requires a careful examination of where in the age range of the population the improvements have occurred.

Amendment to target:

The target has already been surpassed, according to the available estimates, which suggest it should be set at a higher level. However, in view of the above caution about the accuracy of the estimate, it would not wise to raise the target above 70 years.

5. Malnutrition, Moderate and Severe Underweight

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Malnutrition, moderate and severe underweight	Percentage of children 0-59 months of age: moderately malnourished (between –2.00 and –2.99 WAZ), and severely malnourished (below –3.00 WAZ) from NCHS/WHO reference standards. Disaggregated by gender and socio-economic status.	Moderate: 35.7%; Severe: 20.6% DHS 1996/97	Moderate 34.8%; Severe: 12.9% DHS 1999/00	Moderate: 35%; Severe: 8%.

[7] Of course the life of a particular child may be saved in infancy but lost later in childhood, but for the calculation of life expectancy, it is treated as a full lifetime saved.

Actual progress:

There are several sources of nutritional status data, but no new data since last year. Sources include the 1999/2000 DHS, which was available in the previous report, and data from Helen Keller International. A new source is the national Child Nutrition Survey of Bangladesh (CNSB) 2000 conducted by BBS and UNICEF.

There are some differences to note. DHS uses the age range 0-59 months[8], HKI uses 6-59 months, and the CNSB 2000 uses 6-71 months. However, adjustments can usually be made. Another note of caution is that the DHS presents 'moderate' malnutrition as % children less than –2 standard deviations (SD) below median which includes the severely malnourished children below –3 SDs. The APR indicator (correctly) includes only children between –2 SD and –2.99 SD as moderately malnourished, excluding the severely malnourished children below –3 SDs. The CNSB 2000 uses the range –2.01 to –3.00 SD for 'moderate' malnutrition, which again is slightly different from the APR indicator, though unlikely to seriously affect the results.

The revised list of indicators shows the level of malnutrition as measured by 'wasting' (which is weight-for-height), but the definition states weight-for-age, or 'underweight'. The latter indicator, W/A, will be reported here, as in past reviews. There is a concern that in communities with widespread stunting, weight-for-height ('wasting') may underestimate malnutrition.

Levels of 'moderate' and 'severe' malnutrition: According to the DHS 1999/2000 survey 34.8% of children 0-59 months were moderately malnourished (between –2 and –2.99 S.D. W/A), and 12.9% were severely underweight (<-3 S.D. W/A). This is almost the same as three years earlier for moderate malnutrition (35.7%), but reflects a substantial (one-third) decline in severe malnutrition from 20.6% earlier.

The CNSB 2000 shows very similar levels of 38.5% moderate and 12.6% severe malnutrition (total 51.1% underweight), among children aged 6-71 months.[9] The data for this latter source was gathered over 12 months (2/2000-2/2001) whereas the DHS was gathered over 3-4 months (11/1999-3/2000) so there may be seasonal fluctuations as well as a timing difference with poorer harvests in 2001 than 2000. The HKI data show a similar level of 49.1% of children malnourished (< -2 SDs W/A) in the year 2000.

Gender differentials: According to DHS 1999/2000, girls are more likely to suffer severe (14.4% vs 11.4% for boys) malnutrition, but about equally likely to be moderately (35.2% vs 34.4%) malnourished. According to CNSB 2000 the pattern is similar to DHS for severe malnutrition (girls 13.9% vs 11.5% for boys), but boys are more likely to be moderately malnourished (39.9% vs 37.0% for girls). The overall rate of malnutrition (below –2 SD W/A) was almost the same (50.9% for girls and 51.4% for boys). These

[8] As malnutrition is not usually a problem in the first 6 months of life, the inclusion of this age group tends to slightly reduce apparent levels of malnutrition overall, compared to the 6-59 mth age group.

[9] The inclusion of the age group 60-71 months does not change the overall level much as for each measure the 60-71 mth. average is very close to the 6-59 mth. average.

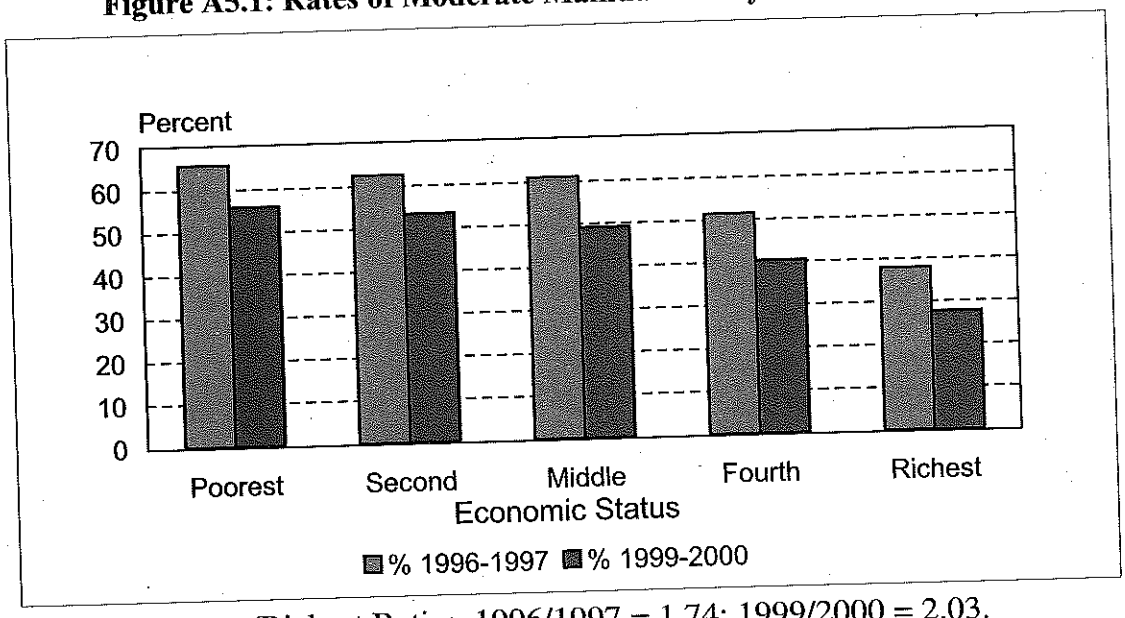
CNSB estimates of overall malnutrition are somewhat higher than the DHS 1999/2000, at least for boys (45.8%), if not for girls (49.6%).

Economic status differentials: Economic differentials are now available for this report for the first time. The data show a wide inequity in malnutrition with children in the poorest households being twice (2.03) as likely to be moderately malnourished, and four time (4.2) as likely to be severely malnourished as children in the richest homes. This poorest/richest ratio appears to have worsened since the previous DHS survey (1.74 and 2.5 moderate and severe, respectively), but in fact malnutrition has declined in all economic quintiles, but faster among the richest quintile.

The measures of equity for both moderate and severe malnutrition, suggest that equity has deteriorated in both. For moderate malnutrition, the ratio has increased from an excess among the poorest households of 74% in 1996/1997, to an excess of 103% in 1999/2000. Similarly, for severe malnutrition, the excess for the poorest households has increased from 147% (P/R ratio =2.470) in 1996/97, to 320% (P/R ratio = 4.200) in 1999/2000. It should be noted that the actual levels of moderate and severe malnutrition have declined in all of the five quintiles over this period. This suggests that nutritional status has improved overall, but more among the richest households than among the poorest.

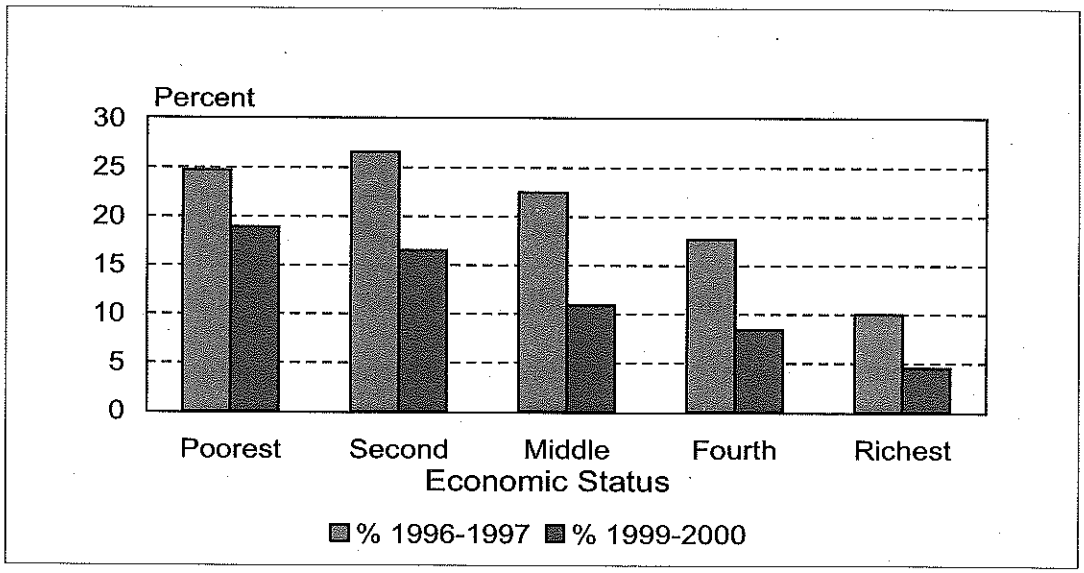
Social differentials: Using mother's education as an indirect proxy for economic status, the ratio of malnutrition for children of illiterate mothers compared with children of mothers with secondary education is considerably worse (1.73 in 1999/2000). This ratio has worsened slightly since 1996/97 (1.65), even though, as for economic status, malnutrition levels have improved in every maternal education category.

Figure A5.1: Rates of Moderate Malnutrition by Economic Status



Poorest/Richest Ratio: 1996/1997 = 1.74; 1999/2000 = 2.03.

Figure A5.2: Rates of Severe Malnutrition by Economic Status



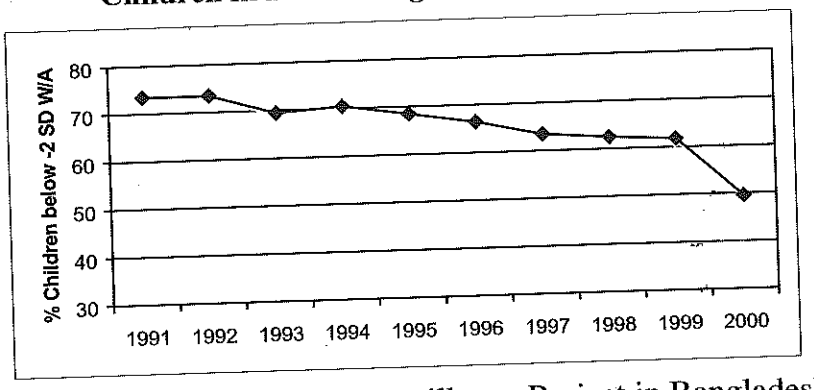
Poorest/Richest Ratio: 1996/1997 = 2.47; 1999/2000 = 4.20.

Geographic differentials: According to DHS 1999/2000, rural children were much more likely than urban children to be both moderately (35.6% vs 30.8%), or severely malnourished (13.6% vs 9.0%). The CNSB 2000 found slightly higher levels of moderate malnutrition (rural=39.6% vs urban=32.6%) and severe malnutrition (rural=13.2% vs urban=9.6%).

By administrative division, children in Sylhet division were most likely to suffer moderate (38.6%) and severe (18.2%) malnutrition. Children in Khulna were least likely to be moderately (32.2%) or severely (9.5%) malnourished.

The Nutritional Surveillance Project (NSP) of the Institute of Public Health Nutrition, MOHFW, in collaboration with HKI, has collected nutrition data from over 7,200 children aged 0-59 months (6-59 months until 2/2000) throughout Bangladesh every two months for a decade. Since 1991 a steady decline in the number of children underweight for weight has been reported.

Figure A5.3: Rates for Moderately and Severely Underweight Children in Rural Bangladesh from 1991-2000



(Source: IPHN/HKI Nutritional Surveillance Project in Bangladesh in 1999)

From a programme perspective the targeting of moderate malnutrition will have the largest impact and could automatically reduce severe malnutrition cases.

Problems encountered:

The different age ranges used by different sources can make comparisons difficult, especially for the differentials. The slight variations in the way 'moderate' malnutrition is defined and expressed across different sources, e.g., less than –2 SD, between –2.00 and –2.99 SD, and between –2.01 and –3.00 SD, can complicate comparisons.

Revision of indicator:

A more comprehensive view of the nutritional state of children in this age group will include rates of stunting, measured by height-for-age (H/A), which measures chronic malnutrition. Stunted children will not always be picked up in programmes aimed at underweight children.

Amendment to target:

The target of 35% moderately and 8% severely malnourished children for the year 2003 is ambitious when the trend from 1991-1999 is taken into account. However, if the apparent decline between 1999 and 2000 continues, the target could be reached.

It should be noted that as nutritional status of children of these age groups improves there will be a general shift of the normalized distribution of z scores for weight for age. This will mean an increase in moderately malnourished children as children from the severely malnourished category move up into the moderate category.

6. Total Fertility Rate (TFR) per woman aged 15-49 years

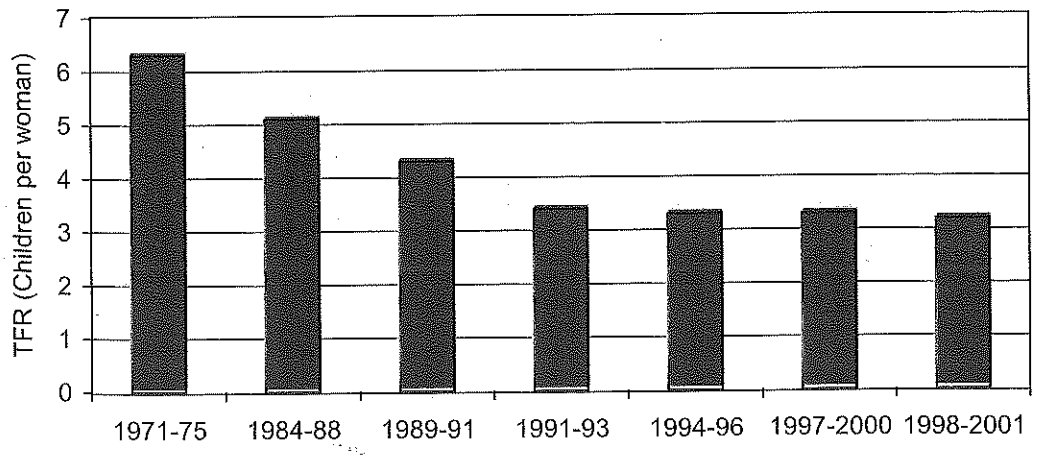
Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Total Fertility Rate (TFR) per woman aged 15-49 years,	The average number of children that would be born to a woman during her reproductive lifetime under current age-specific fertility rates. Disaggregated by socio-economic status.	3.3 (DHS 1996/97)	2.9 (HDS,2000); 3.22 (BMMS 2001)	TFR reduced to 2.5

Actual progress:

Overall level: The estimate for TFR of 3.22 from the BMMS 2001 is slightly lower than last year's figure of 3.31 from DHS 1999/2000. The new estimate relates to a period around mid-1999, one year into HPSP. This figure confirms the stagnation of fertility at about one child above replacement level (TFR=2.2) since early in the 1990's (Figure 6.1).

There is an estimated TFR of 2.9 from the HDS 2000 which is lower than the DHS estimates, and if correct, it should reassure that the fertility decline of the 1980s has not stalled indefinitely. A breakdown of the HDS figure by age, shows a pattern of age specific fertility rates of younger women (15 to 30 years) being lower in HDS than DHS, but ASFRs are higher in HDS for older women (30 plus years). In fact the entire difference between the two estimates can be accounted for by the difference in teenage fertility (15-19 years). The HDS figure (at 48/1,000) for teenage women is 96 per 1,000 lower than the DHS figure (144/1,000). This is far lower than the trend in earlier surveys would suggest. The new BMMS 2001 survey also found the ASFR for teenage women (15-19), at 134, was close to previous DHS surveys.

Figure A6.1: Trend in Total Fertility Rate



It is the case that teenage fertility is quite sensitive to social changes such as rising age at marriage, or adoption of family planning after marriage to postpone first births, but there is little evidence of major changes having taken place in the past several years. Median age at first marriage for women 20-24 years is still a disturbingly low 16.1 years (two years below the legal minimum), even though the proportion of these women who have never (not yet) married has increased gradually to 18.5%, up from 12% in the early 1990s.

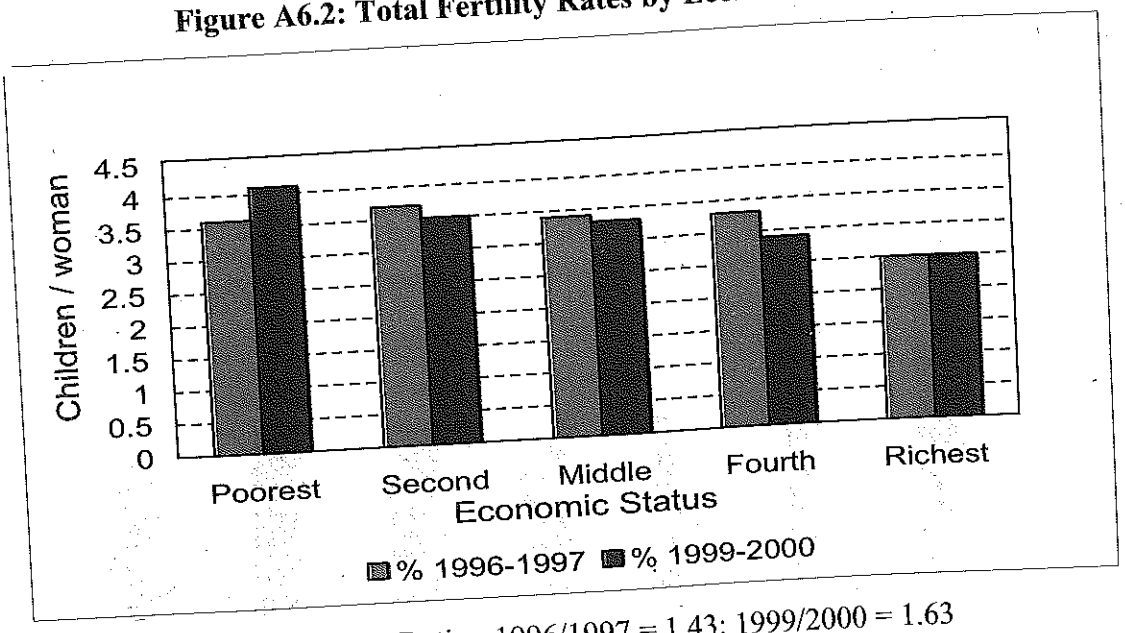
With the recent important increases in secondary schooling enrolments (and retention rates), and in employment opportunities for young unmarried women, such social changes resulting in delayed marriage can be expected.

Further analysis is needed to check if sample selection was similar in each survey, or if some other explanation for the difference can be found. For example, the difference lies entirely in the rural areas, urban estimates are the same for both surveys, even though there have been recent changes in urban definitions and boundaries.

Geographic differentials: Urban fertility (2.69) is now about two-thirds of a child less than rural fertility (3.36), a shrinking difference. Khulna (2.61) and Rajshahi (2.85) Divisions are the only ones with fertility below 3 children. Syhlet remains highest at 4.27, showing a resistance to change in childbearing, as in many other indicators.

Socioeconomic differentials: All fertility surveys show higher fertility among less educated women, so it is not surprising that poorer households exhibit higher fertility. Even the richest households have a fertility level above replacement, despite having 1.5 children fewer than in the poorest households.

Figure A6.2: Total Fertility Rates by Economic Status



Poorest/Richest Ratio: 1996/1997 = 1.43; 1999/2000 = 1.63

Problems encountered:

The lag period for estimates is a weakness of this indicator, but unavoidable with samples of the size of the DHS as several years of data have to be aggregated.

Revisions to indicator:

This is a vital indicator, and must be retained.

Amendment to target:

If the HDS 2000 estimate for TFR of 2.9 is correct, the trend in the 1990s suggests that the target of 2.5 is attainable. If the DHS and BMMS estimates are correct, then further analysis is required to determine the likelihood of resumption of the fertility decline.

B. MONITORING INDICATORS FOR HEALTH AND POPULATION SECTOR PERFORMANCE

Reproductive Health Care

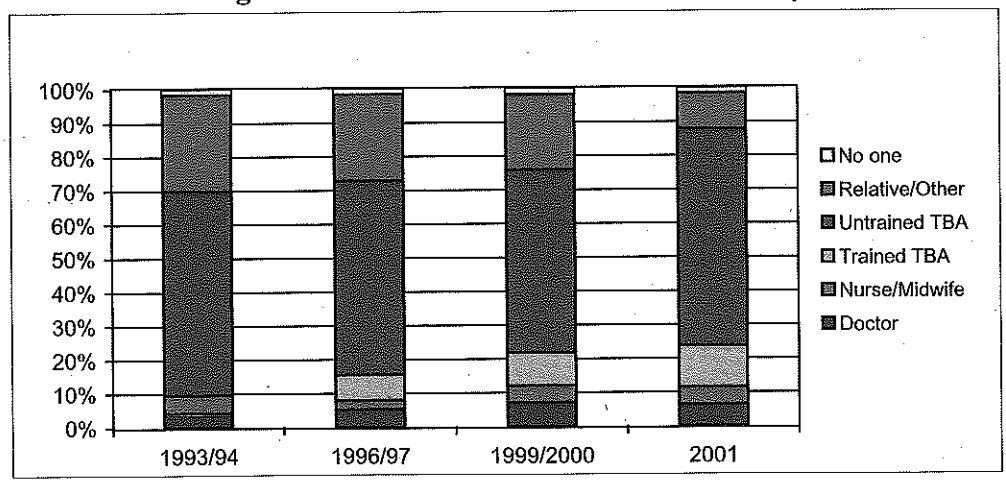
1. Conduct of deliveries by skilled personnel (in home or in facility)

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Conduct of deliveries by skilled personnel (in home or in health facility)	Percentage of deliveries of target population conducted by skilled personnel (excluding TBAs) during the last one year. Disaggregated by socio-economic status.	8.0% (5.2% Doctor + 2.8% Nurse or Trained Midwife) (DHS 1996/97)	11.6% (BMMS 2001); 12.7% (HDS 2000); 15% (SDS 2000).	30%

Actual progress:

The proportion of deliveries attended by a medically trained person has stabilized at the end of the 1990s. According to BMMS 2001, only about one in eight deliveries (11.6%) in the past three years was performed by a medically trained person. This includes doctor (6.5%) or nurse/midwife, FWV, SACMO or MA (5.1%). This is similar to the figure of 12.1% in DHS 1999/2000, a small increase over 8.0% in the DHS 1996/97, and 9.5% in DHS 1993/94, but still unacceptably low by international standards. The HDS 2000 gave a very similar figure of 12.7% of births attended by a medically trained person: a doctor (5.8%), or nurse/midwife, FWV auxiliary (6.9%). This appears to refer to births in the 12 months before the survey. The SDS 2000 found a slightly higher figure, 15% of deliveries attended by a trained person (doctor, nurse/midwife or FWV).

Figure 1.1: Trend in Attendance at Delivery

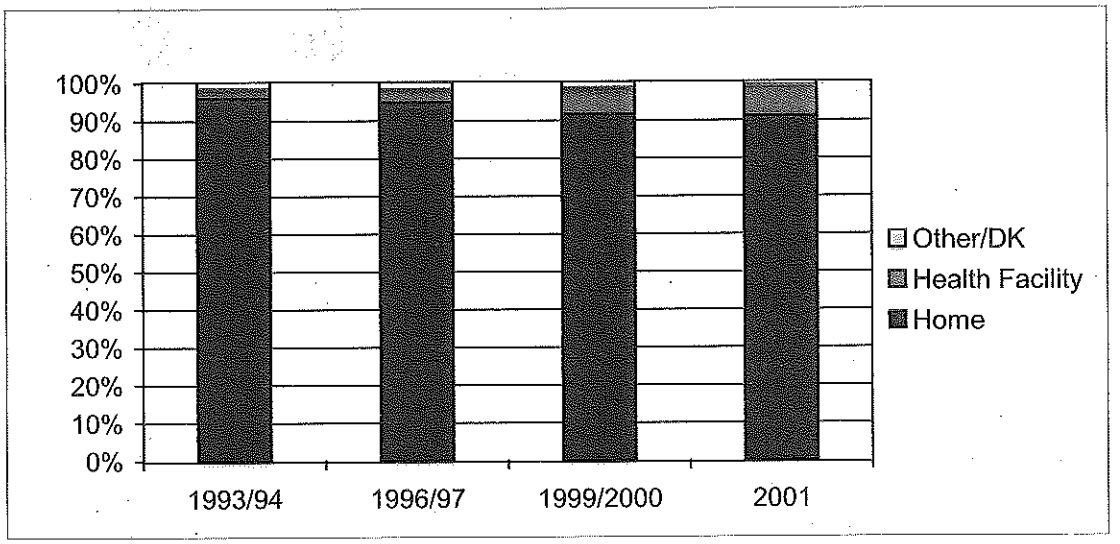


[Note: in DHS 1993/94 TBA's not separated into Trained & Untrained]

The proportion of births delivered by untrained TBAs has increased considerably (from 54.0% to 63.7%), and this counterbalanced a decrease in those delivered by relatives/others (down from 22.4% to 10.8%). About one in eight (11.9%) were delivered by trained TBA, up slightly from DHS 1999/2000 (9.7%).

This indicator incorporates two different elements: (i) deliveries by skilled person, and (ii) place of delivery. In Bangladesh nine out of ten births still occur at home (BMMS 2001 = 91.2%, HDS = 89.7%). The rest occur at a health facility (BMMS 2001 = 5.5% for GoB plus 3.1% for private/NGO facility; HDS 2000 = 9.7%).

Figure 1.2: Trend in Place of Delivery

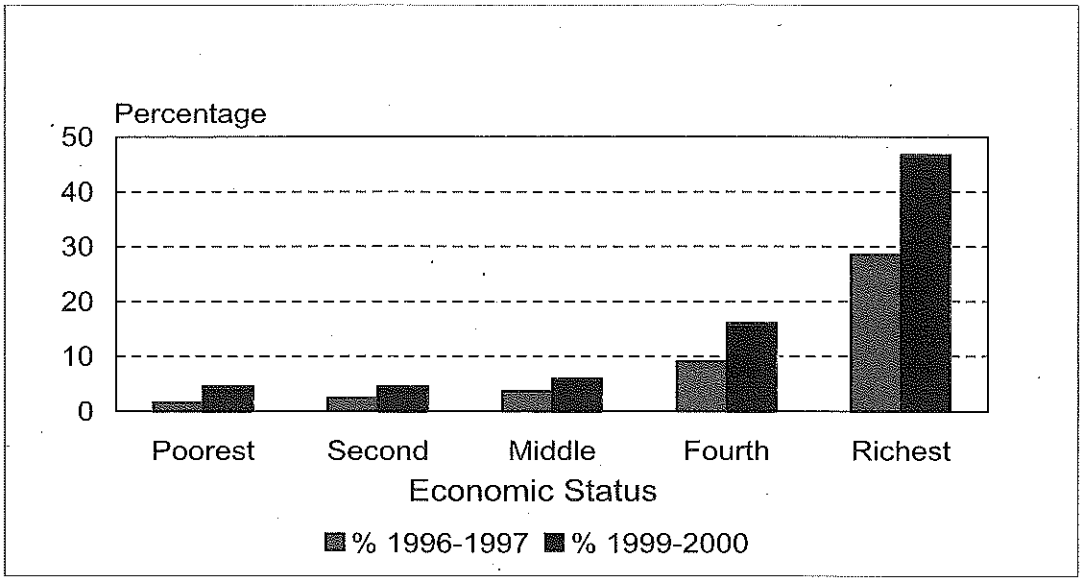


The breakdown of who attended deliveries at the various locations is not available from the reports. However, it can be assumed that virtually all deliveries by a doctor occur in a health facility, and all other deliveries occur at home attended by a person other than a doctor.

Economic differentials: Gender differentials are not relevant for this indicator. However, data on economic differentials are now available, and these are quite striking. In DHS 1999/2000 deliveries from the poorest households are one tenth (probability=0.096) as likely to be attended by a medically trained person (4.5% vs 46.7%) as those from the richest households. Deliveries from poorest households are 52% (probability=1.520) more likely to take place at home (97.0% vs 63.8%).

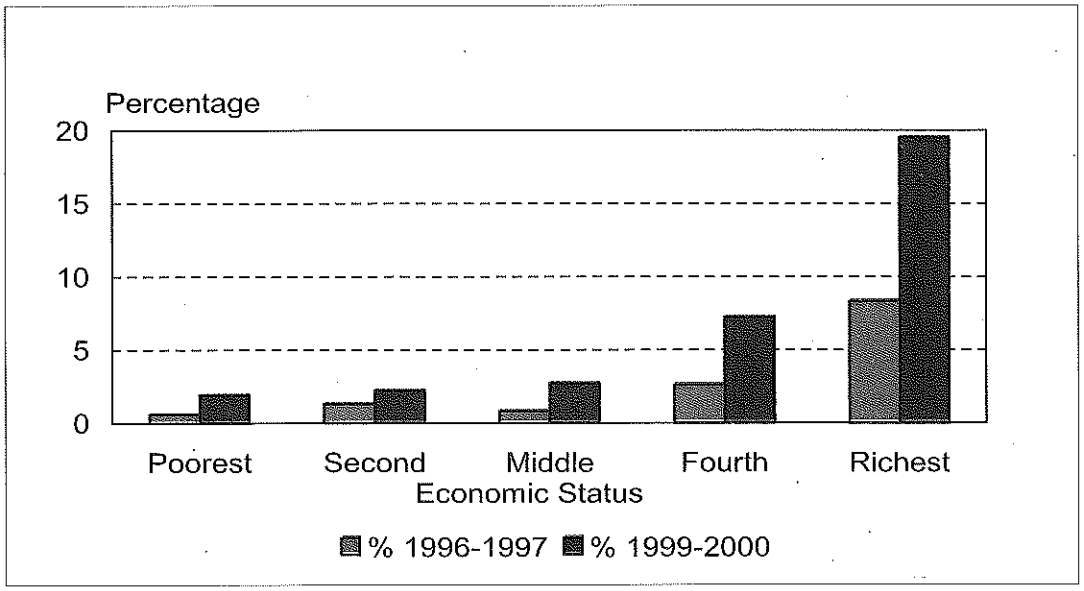
In the context of the overall rise in use of skilled attendants, this is slightly better than in DHS 1996/97, when only one in twenty deliveries (probability=0.056) of the poorest households used such attendants (1.6%) compared to the richest households (28.5%). While among the poorest, the proportion delivered at home has remained unchanged since 1996/97 (98.4%), it has fallen among the richest households (from 81.2%). The poorest/richest ratio has increased from 1.212 to 1.520, an apparent rise in inequity due to differential improvement.

Figure 1.3: Deliveries Attended by Medically Trained Person by Economic Status



Poorest/Richest Ratio: 1996/1997 = 0.06; 1999/2000 = 0.10

Figure 1.4: Deliveries in a Public Facility by Economic Status



Poorest/Richest Ratio: 1996/1997 = 0.07; 1999/2000 = 0.10.

In looking at the type of health facility in which deliveries take place, it is useful to invert the poorest/richest ratio. The richest group are ten times more likely than the poorest to deliver in a public facility (19.5% vs 1.9%), and thirty times more likely to deliver in a private facility (16.0% vs 0.5%), the private facilities being where many of the C-sections

take place. These highly inequitable ratios have not really changed since 1996/97, even though the overall proportions delivering in such facilities have increased somewhat.

Social differentials: As a comparable social indicator (and indirect proxy for economic status), mothers with secondary plus education are seven times more likely than illiterate mothers to deliver at a health facility (21.4% vs 3.1%), and six times more likely to be medically attended (30.4% vs 5.4%).

Geographic differentials: Although almost all babies are delivered at home there are differentials. According to DHS 1999/2000, use of health facilities for delivery in urban areas is five times more common (25.1%) than in rural areas (4.6%), and they are four times more likely to be attended by a medically trained person (33.0% vs 8.0%).

In rural areas a woman is more likely to deliver in a health facility if she is younger than 30 years old and not from a remote upazila. There is a variation between divisions with only 3% deliveries in Barisal being conducted at a health facility compared with 16% in Khulna division (SDS 2001). These patterns suggest that the women most at risk are not attending health facilities for delivery.

Giving birth in a health facility does not ensure that a trained medical person assists the mother during delivery (Leppard 2000). Focus group discussions revealed that half the participants (50% of males and 43% of females) consider that there is no advantage to delivering at a health facility. Disadvantages were cited as having to pay service providers, lack of medicines, bad behaviour of service providers and unnecessary interventions. Those focus groups that did see advantages, mentioned the availability of good doctors and rapid help in case of emergency.

SDS revealed that only 4% of deliveries conducted at home were assisted by a trained worker (4.4% according to HDS 2000). A woman is more likely to be assisted by a trained medical person if she has one or more of the following characteristics: primagravida, young, from an urban area, has four or more antenatal visits, secondary education, or lives in Khulna division. Similarly, of those mothers who had no antenatal care, 4% of births were assisted by a trained medical person, compared with 55% of mothers who had more than four antenatal visits. Again, with the exception of young primagravida mothers, those most at risk are less likely to be assisted by a trained medical person during delivery.

The main reasons for not having a trained person to assist at delivery was given by focus groups as non-availability of a trained person in or near the community. When a trained person was available, money was expected and the very poor were refused help.

Decision making as to where the woman should deliver was mainly by the husband alone, or with the mother in law. A woman who took part in the decision making with another person is three times as likely to be assisted during the delivery by a skilled person than a woman who was not involved in the decision-making.

Problems encountered:

The usual recurring problem with this indicator is the definition of a skilled person. A TBA may have received training but if she does very few deliveries she may not maintain a good skill level.

When the UMIS is fully functioning it is planned to provide more information on deliveries, including whether the women who deliver with a skilled attendant are those who need special attention, i.e., women with a potentially complicated delivery.

Revision to indicator:

Normal deliveries will not cause mortality or morbidity even if a skilled attendant is not present, although neonatal morbidity and mortality may be reduced by a skilled attendant being present at delivery. However, 15% of births carry a potentially life threatening complication. In order to have an impact on maternal mortality and morbidity it is necessary to increase the number of complicated births attended by a skilled attendant. If a sub-indicator could be added to reflect the number of complicated births attended by a skilled attendant, it would be most useful.

Amendment to target:

If the indicator is not revised, the target should take into account the trend towards low risk women being assisted at birth by a skilled attendant/ in a health facility. This would entail a target for the number/proportion of complicated births assisted by a skilled attendant.

2. Antenatal care

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Antenatal care	Percentage of pregnant women that sought ANC. Disaggregated by socio-economic status.	26.4% (1+ visits); 28.6% (DHS 1996/97)	47.5% (1+ visits) (BMMS 2001)	65% of pregnant women made 1+ visits

Actual progress:

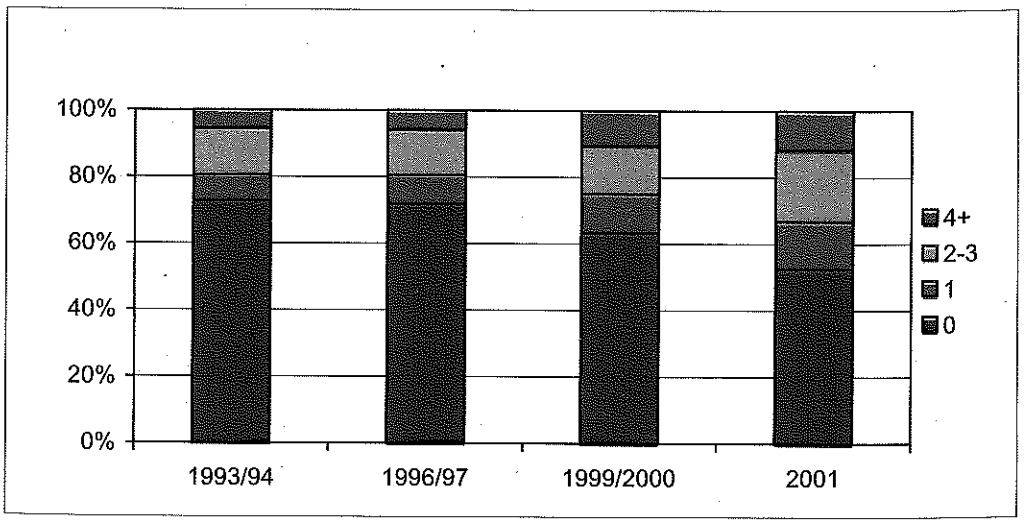
Number of ANC visits: The BMMS 2001 reports that almost half (47.5%) of women made one or more antenatal visits during their pregnancies in the past three years. This is a dramatic increase since the DHS 1999/2000 which showed an ANC visit for just over

one in three (37.0%) pregnancies[10]. This represents almost a doubling of ANC coverage since the early 1990s (26.4% in DHS 1996/97, 25.7% in 1993/94). However, it is still disturbing that of all women in the survey who had had a pregnancy, half had received no antenatal care whatever.

The increase in ANC use was mainly among Nurse/midwife/FWV/SACMO/MA providers (9.6% in DHS 1999/2000 up to 15.7% in BMMS 2001), which could partly be due to the expansion of providers in this category. There was virtually no increase in doctors providing ANC (24.4% in 2001). A small proportion (around 3%) of the providers were not medically trained, as in previous surveys.

The HDS 2000 shows a different pattern with 77% of women reported as consulting some provider, although only two out of three were trained providers. This suggests that half of all women received care from a trained provider – a level far above the one in three reported by DHS. SDS 2000 did not present data on ANC.

Figure 2.1: Proportion of ANC Visits by Number



Younger women, lower parity women, urban women, and well educated women are considerably more likely to use ANC (as expected), and to make multiple visits, than others. Geographic differences are small, except for Barisal which ranks poorly on all ANC scores.

The BMMS 2001 reports on the content of ANC visits. It is surprising how many women reported having physical checks: weight/height (31.1%), blood pressure tested (35.1%), abdomen examined (35.6%), and a substantial number had urine (17.7%) and blood (14.3%) tested. Very few had internal examination (5.9%), and some had sonogram

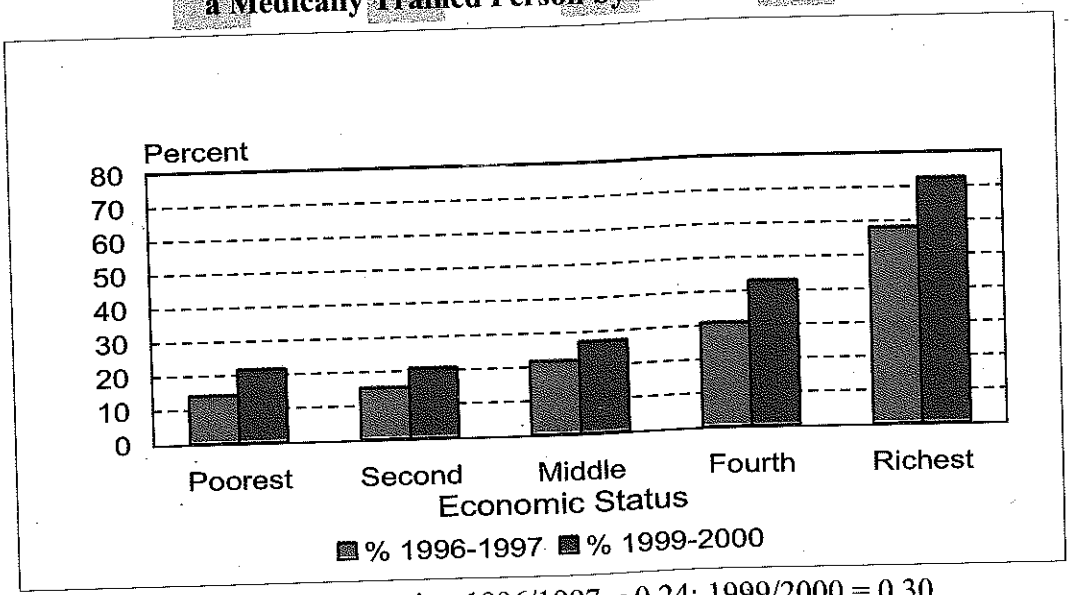
[10] Visits to health services for tetanus toxoid vaccinations during pregnancy are not included here as ANC. According to DHS 1999/2000, in past 5 years, four out of five women got TT (17.5% had 1 dose; 63.7% had 2+ doses). HDS 2000 shows 69.9% (number of doses not stated).

(7.8%), an increasingly popular procedure in the private sector. These checks and tests were more common among younger, lower parity, urban, well educated, and economically better of women.

The BMMS 2001 revealed that there is little advance planning for delivery. Two thirds of women (64.3%) did not discuss who would assist their delivery during their pregnancy. Among the one third who did discuss this important issue, the majority (21.7%) planned to call upon an untrained TBA, with small numbers planning to call a trained TBA (4.9%), a doctor (4.4%), a relative (3.1%), and a few would call a nurse/midwife (1.6%). This pattern resembles the actual distribution of delivery assistance, but it is disturbing that so few women plan for their delivery. There is surprisingly little difference in the likelihood of planning across age, parity, education, geographic, or economic status categories. However, the wealthy and well educated women who do plan in advance, are substantially more likely to nominate a doctor than other providers.

Economic differentials: Levels of ANC by economic status show a highly inequitable situation, with the poorest being one third (ratio=0.3) as likely as the richest to utilize the services of a medically trained person (Doctor or Nurse/Midwife) (21.5% vs 72.4%). The poorest are also one fifth (prob.=0.218) as likely as the richest to make two or more ANC visits (13.9% vs 63.7%). As shown in the graphs, the relation between ANC and economic status is not linear, as the poorer three quintile behave very much alike, and only the richer two quintiles show much higher levels of ANC use, particularly the richest. This overall increase in use of ANC incorporates a reduction in inequity (or increasing equity) as the poorest only one fourth (prob.=0.242) as likely to use ANC according to the DHS 1996/97 (14.0% vs 57.9%).

Figure 2.2: Proportion of Women Receiving ANC from a Medically Trained Person by Economic Status



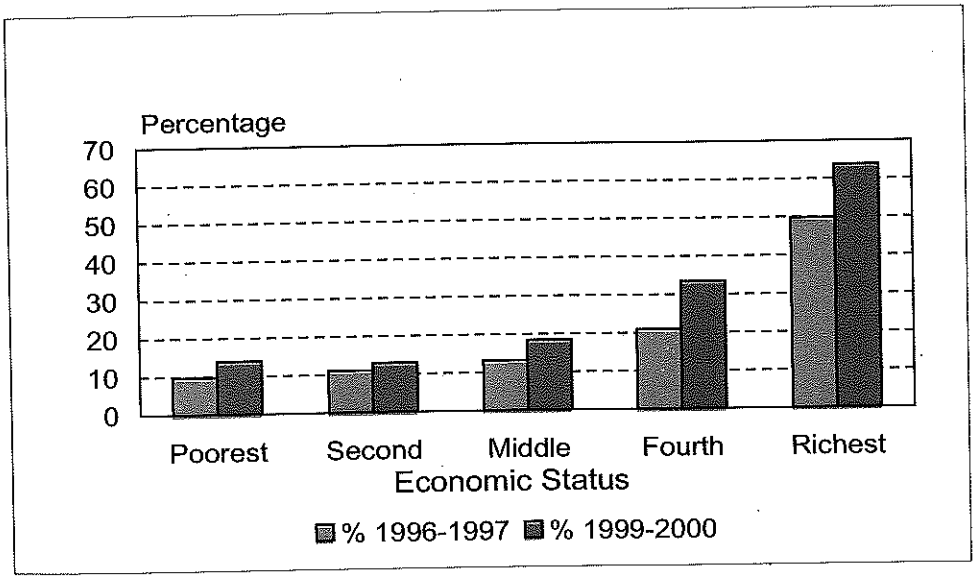
Poorest/Richest Ratio: 1996/1997 = 0.24; 1999/2000 = 0.30.

Social differentials: The DHS 1999/2000 presents patterns of ANC by the level of education of the mother. A woman with secondary plus education is three times more likely to receive ANC from a medically trained person than an illiterate mother (60.0% vs 20.0%).

In addition a mother is less likely to receive any antenatal care during a pregnancy if she is over 35 years (21.7%), has more than four children (23%) and lives in a rural area (31.7%).

The services provided and timing of antenatal visits is important to the relative impact on maternal or/and infant mortality. For example, a single antenatal visit by a mother who only receives TT and no other services will have more impact on the mortality of the newborn infant, (protection against neonatal tetanus), than on the mortality and morbidity of the mother. The DHS figure of 37.0% of women making an ANC visit does not include women who only received TT injection. While the coverage of two or more TT vaccinations in pregnant women is very high, at 63.7%, it appears that there is a missed opportunity for ANC to be included during the TT visit.

Figure 2.3: Proportion of Women Making 2+ ANC Visits by Economic Status



Poorest/Richest Ratio: 1996/1997 = 0.20; 1999/2000 = 0.22.

A breakdown of the components of antenatal care according to social characteristics shows that the higher the education status of the mother the more information she is given regarding her pregnancy (29.4% compared with 8% in those mothers with no education) and the more services she is likely to receive. This indicates that comprehensive antenatal care is not being given to those who are in most need. Furthermore, women from rural areas are less likely to receive iron tablets than women from urban areas (50.0% v. 33.5%).

The recommended number of antenatal visits is 12-13, depending on the actual date of delivery. However, the DHS shows that the median number of antenatal visits was 1.8 (among those who visit), and 23% made the visit before the sixth month of gestation.

Problems encountered:

It would be extremely useful if the UMIS reported on whether women at high risk of complications were being detected and referred/managed during their visits.

Revision to indicator:

It would be useful to define antenatal care as being a visit to a health facility where a skilled person performs a limited number of activities, e.g. takes BP, weight, tests urine, etc., as detailed in the DHS 1999/2000. Visits during pregnancy where only TT is given should be reported separately, since the impact of these visits will be reflected on neonatal, not maternal, mortality.

Amendment to target:

The target of 65% women receiving one or more antenatal check-ups during each pregnancy is in line with the number of pregnant women who are known to attend health facilities during a pregnancy to receive TT vaccine. As this represents a missed opportunity, the target should be attainable. However, with the present low level and slow increase over recent years, the target seems optimistic, unless the system is strengthened to provide antenatal check-ups when TT is given.

3. Discontinuation rate of contraception

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Discontinuation rate of contraception	Percentage of eligible couples aged 15-49 years who discontinued use of (modern) contraceptive methods.	46.9% (DHS 1996/97)	48.6% (DHS 1999/00)	< 25%

Actual progress:

There has been no new source of data on this indicator since the DHS 1999/2000 results presented in last year's report. At that time, data were presented showing that the first-year discontinuation rate of any method of contraception was almost 50%. It had barely changed since DHS 1996/97 (46.9%) or even earlier in DHS 1993/94 (47.8%). The rate from the DHS 1999/2000 (48.6%) was composed of 19.2% due to side effects or health concerns, 7.7% to become pregnant, and 4.3% due to method failure. Other reasons account for the remaining 17.4%. It can be noted that although these levels of

discontinuation appear high, they are not substantially different from levels in many other developing countries.

Among specific methods, it is noteworthy that the IUD, while not widely used, showed no cases of method failure. Oral pills showed 3.0% discontinuation due to method failure, similar to the level of 2.9% three years earlier. Injectables showed a rate of only 1.3% in both surveys. The traditional methods, periodic abstinence (8.6%) and withdrawal (9.7%), showed higher failure rates, as expected. Conversely, the traditional methods showed much lower discontinuation rates due to side effects than hormonal methods like pills (22.1%) and injectables (36.6%). These levels have remained unchanged reflecting a lack of response to management of side effects.

The shift from home based visits by FWAs and HAs, to static clinic (CC) based services does not appear to have resulted in more women discontinuing FP use, because of lack of reassurance or counseling about side effects. The proportion of women visited by a FP fieldworker in the 6 months before the survey has declined dramatically, from 35.3% in DHS 1996/97 to 21.2% (19.0% by GoB, and 2.2% by an NGO fieldworker (78.6% had no visit) in DHS 1999/2000. It can be noted that 16.3% were visited by a fieldworker for health services (15.0% GoB, and 1.2% NGO). Overall, 69.6% were visited by a fieldworker for one or the other reason.

Problems encountered:

The key problem is that the 'all-method continuation rate' is not available in the report. The single-method discontinuation rates suggest major inefficiencies in FP use, but the all-method rate would indicate what proportion of FP users are simply switching methods, but remaining protected from unwanted pregnancy. This all-method rate could be calculated from the dataset.

Revision to indicator:

No revision is provided at this time, although it would be helpful to provide the rates, especially failure rates, according to specific methods.

Amendment to target:

As mentioned in last year's report, the target of less than 25% discontinuation in the first year, is unlikely to be achieved by end of HPSP. Method failures are unlikely to fall much below the current 4.3%. The proportion of women stopping to become pregnant will only fall if fertility declines dramatically, which is unlikely. So the key is to reduce the high proportion of women who stop using due to side effects or health concerns. Some reduction can be achieved through improved quality of care and counseling of clients at the time of method adoption.

4. Contraceptive Prevalence Rate (CPR) with proportions for method mix

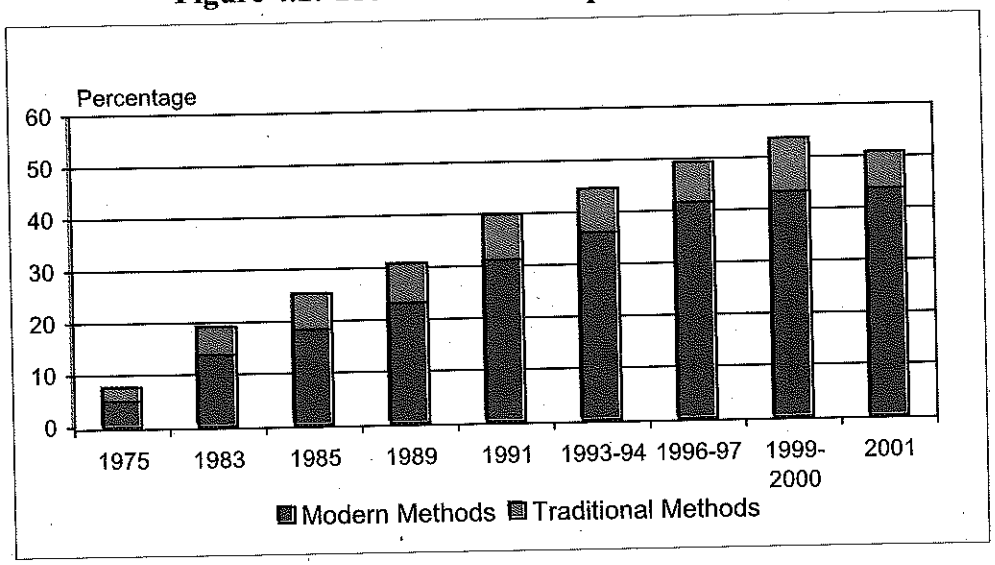
Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
CPR, with proportions for method mix	Percentage of currently married couples aged 15-49 years who are currently using contraception (specified by method)	49.2% (41.6% modern + 7.7% traditional) (DHS 1996/97)	50.8% (44.5% modern + 6.3% traditional) (BMMS 2001)	60% using any method (of that 20% is traditional methods)

Actual progress:

The Contraceptive Prevalence Rate (CPR) has been monitored more closely than any other indicator over the years. Since the mid 70's, the CPR has climbed steadily from 7.7% (1975) to the present level of half of couples (50.8%, BMMS 2001; 53.8%, DHS 1999/2000; 53.8%, HDS 2000). Modern method use accounts for more than four out of five users, with traditional methods declining from the usual one in five users, even as overall prevalence has increased.

Method mix: Oral pills still account for about half of modern method use – higher than is really desirable. Use of an alternative form of hormonal contraceptive, injectables, is increasing rapidly (from 0.2% in 1983 to 7.9% in 2001 – BMMS; or 9.1% - HDS, 2000). Rather than replacing oral pills, it appears to be compensating for the disturbing decline in clinical methods. Sterilization is steadily declining, with 0.5% males, and 5.3% of females sterilized, according to BMMS (0.4% and 5.1% respectively – HDS). As mentioned last year, this is partly due to the passing out of the reproductive age group of the mid-1980s acceptors (500,000 in each of 1983 & 1984 – 5 times the annual average before and after). However, it also due to a lack of promotion of the method, possibly combined with concern about invasive surgical procedures of any kind.

Figure 4.1: Trend in Contraceptive Prevalence

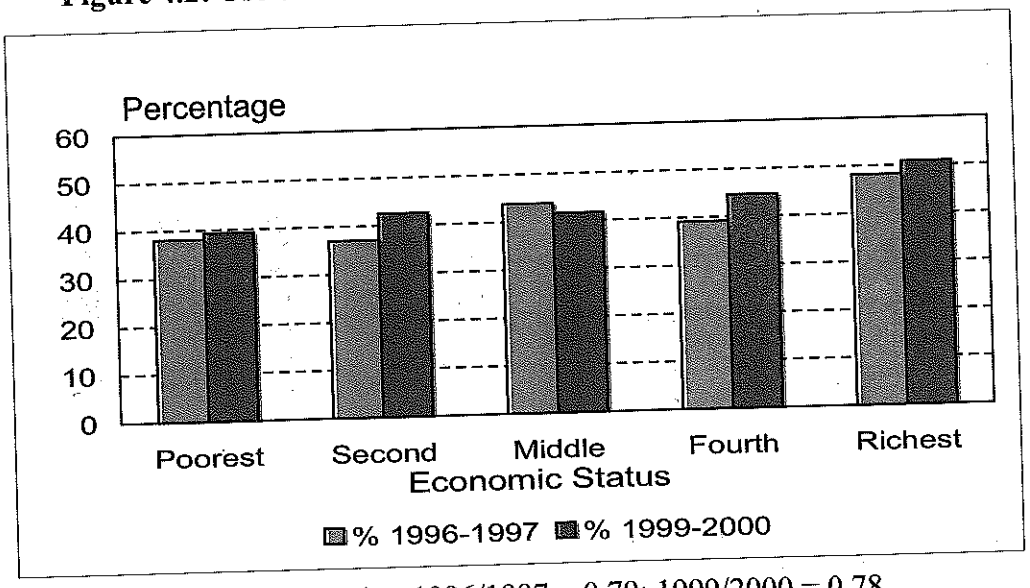


CPR differentials: Surprisingly there is little urban/rural differential, except for higher condom use (6.9% vs 2.3%) in the cities. Sylhet (28.6%) retains the dubious distinction of having a CPR half that of Khulna (61.9%) or Dhaka (57.2%). The deficit is across all hormonal and clinical methods, but especially pills. CPR at District level is available in the BMMS 2001 for the first time. The range is from 25.2% in Sylhet District to 66.5% in Chuadanga District in Khulna Division.

Method differences across educational and economic status are mainly in sterilization, where tubectomy is less used by the better educated and economically better off. This pattern also holds for injectables, and implants to some degree. The reverse is true for pills and, unexpectedly, for condoms, both more popular among the better off.

Equity: The equity ratio (Poorest/Richest Ratio) indicates that contraceptive use is quite equitable in Bangladesh, more so than other services. It has remained fairly unchanged, with use among the poorest households being about three quarters that among the richest households. However, in 2001, the P/R ratio was 0.87, more equitable than in 1999/2000. Interestingly, the methods vary, with sterilization being primarily a method of the poor (P/R=1.4 for female sterilisation; 4 for male sterilisation; injectables (Depo) 1.9; Norplant 1.5), while other methods are favoured by the economically better off (pill 0.7; IUD 0.5; condom 0.1; abstinence 0.6; withdrawal 0.3.

Figure 4.2: Use of Modern Contraception by Economic Status



Poorest/Richest Ratio: 1996/1997 = 0.79; 1999/2000 = 0.78.

Problems encountered:

As mentioned in the previous indicator, there has been a major decline in the numbers of household visits by GoB or NGO fieldworkers in the late 1990s. From over one third (35.2%) of households visited in the past 6 months (DHS 1996/97) to 21.2% (DHS 1999/2000). While part of this decline has been compensated for by increased use of the private sector as a source of supply, it would be hoped that users would also make greater use of static clinics. However, this does not seem to be happening. While the proportion of respondents reporting a clinic in their community remained effectively unchanged (69.6% DHS 1996/97 v. 67.7% DHS 1999/2000), the proportion using or visiting a clinic in communities where one existed, fell from 56.7% (DHS 1996/97) to 35.4% (DHS 1999/2000).

Revision to indicator:

This is an important indicator and should be retained. It can be expected to be a sensitive reflector of the functioning of the Community Clinics, as well as of outreach activities. The method mix component should reflect, to some degree, the attitude of the population to clinical FP services, and their concerns about quality of care.

Amendment to target:

While a CPR of 60% would be desirable, it is still below the level required to achieve replacement fertility by the GoB target of 2005. If CPR increases at 2% per year (a little above the long-term rate of 1.7% per year), then 60% could be achieved in 2003. It is still extremely doubtful that 20% of users on traditional methods should be a target (that would be 12% of eligible couples at a CPR of 60%). Although it is the case that some

countries achieve high CPR this way (e.g., Vietnam with 20%, and Philippines with 18% of users on traditional methods), it should not be a preference where female education levels are low.

Child Health Care

5. Incidence of polio (polio eradication)

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Incidence of polio (Polio eradication)	Total number of Polio cases during the last year	10 (1998) 29 (1999)	0 cases since August 2000 (1 case in 26/08/2000)	Reduced to 0 (3 years with no cases reported)

Actual progress:

Definitions and numbers of cases: Possible polio cases are initially detected by the presence of paralysis, but acute flaccid paralysis (AFP) can also be caused by a number of other non-polio viruses[11]. Cases of AFP are first checked clinically and may be confirmed. From the confirmed cases, laboratory confirmation is required before the number of cases caused by wild polio virus (as opposed to resulting from vaccination) can be determined. For example, in 1999, there were 761 AFP cases of which 322 were clinically confirmed, but of these only 29 were laboratory confirmed wild polio virus. In 2000, there was only one laboratory confirmed case nationwide (a young girl named 'Dolly' in Dhaka city). There have been no subsequent confirmed cases.

Surveillance: The number of reported cases of polio alone is not an indicator of the true polio incidence. The surveillance system must be sensitive enough to detect a new case of polio. As an indicator of the country's ability to detect polio, at least one case of AFP per 100,000 children aged 15 years or below, should be detected even in the absence of polio. The non polio AFP rate in children age 15 years or below in Bangladesh has exceeded 1 for two consecutive years (Table 5.1).

The classification for confirmed polio cases has been changed as from January 2001. Confirmed polio cases prior to January 2001 were either:

1. Laboratory confirmed wild polio virus
2. Acute Flaccid Paralysis (AFP) cases with residual weakness after 60 days
3. AFP cases that had subsequently died, or
4. AFP cases that had been lost to follow up.

[11] Causes of AFP may be traumatic neuritis, transverse myelitis, echovirus, other enteroviruses, Guillain-Barre syndrome and Coxsackie virus as well as poliovirus

Due to the more sensitive surveillance system, confirmed cases are now classified as those confirmed through laboratory isolation of wild poliovirus only.

Previous cases of isolated wild poliovirus were 10 in 1998, 29 in 1999, 1 in 2000, 0 in 2001, and 0 in 2002 (to 30/09/2002) (Table 5.1). The present figure of 0 in 2002 is the most accurate indicator of true polio incidence in Bangladesh due to more specific classification *and* improved surveillance system.

Table 5.1: Annual Non-polio AFP rate in children <15 years, and AFP cases with isolation of wild poliovirus

Year	1998	1999	2000	2001	2002
Isolated wild polio virus	10	29	1	0	0
AFP Rate/100,000 children < 15 years	0.33	0.87	1.82	1.87	2.59*
Expected Annual Number of non-polio AFP cases (per 100,000 < 15 years)	495	505	515	533	549

(*up until 30 September 2002)

As a result of the changed definition, caution must be used in comparing past and present figures of confirmed polio cases.

The number of AFP cases is estimated to be 549 in Bangladesh for 2002, giving an AFP rate of 2.59, about triple the 1999 figure, and reflecting a great improvement in the surveillance. This figure relates to a global incidence of 1/100,000 in children under 15 years and is based on an estimated national population at all ages of 134,271,000. The AFP figures have exceeded the expected number in the last two years, being almost double in 2000. The high rate could be due to high population density and favourable climatic and environmental conditions facilitating the spread of non polio entero-virus. A surveillance system that is based on an accurate AFP estimate is essential before it can be established that polio has been eradicated.

Problems encountered:

The challenges for the eradication of polio in Bangladesh are twofold. Firstly, there is the delay in initial reporting of a case of AFP. This reflects the health seeking behaviour of the population. In the year 2001, only 78% of confirmed AFP cases had 2 stool specimens tested within 15 days of the onset of paralysis. This results from delay in initial presentation at a health care provider. If clinical cases are no longer included in the classification of confirmed polio, then the cases presenting later than 14 days will not be included as polio cases. Surveys of health-seeking behaviour show that the first contact for the majority of rural population is the private informal health system, usually the local traditional healer. In 2001, 40% of AFP cases were notified by the community and 60% by formal, government health facilities. It is possible that in Bangladesh a few cases of AFP will never be reported to a health care provider.

The second challenge to the eradication of polio in Bangladesh is the difficulty in operating the eradication programme in some areas of Bangladesh. There are pockets in the country, for example Chittagong Hill Tracts, in which coverage during the NIDs in 2001 fell far below the national average (IPN/HKI 2001). The GAVI Program offers an incentive of $20 per child brought into the EPI Program, this is may result in inflation of field-based EPI figures, so it should be monitored carefully. Serious consideration should be given to whether such incentive approaches are useful, or counterproductive, in the long term.

Actions taken:

The National Public Health Laboratory in Dhaka has been accredited for poliovirus isolation since May 2001 but differentiation cannot be made between vaccine induced and wild poliovirus – this situation continued in 2002 and will indefinitely. Samples isolating poliovirus, therefore, continue to be sent to the Centre for Disease Control in Atlanta. Accreditation of the laboratory has resulted in a fall in the interval between the onset of paralysis and the intralyptic differential results, from 398 days in 1998 to 49 in the first half of 2001. Non polio AFP cases take an average of 41 days to process.

Considerable extra resources have been channeled into the polio eradication programme since 1998. World Health Organization (WHO) has hired 33 surveillance medical officers to up to May 2002, and 6 Divisional Coordinators. A National Surveillance Officer, a Data Management Analyst, and a GAVI staff member have been added to the GAVI Support Team.

Revisions to indicator:

The indicator of 0 cases of polio for three years has not been reached yet since one case was identified in August 2000. However, continued absence of polio until August 2003 is not be an unreasonable target.

The indicator should, however, include evidence of surveillance, such as an AFP rate of > 1 per 100,000 in children aged 15 or below, to indicate that the surveillance system is sensitive enough to detect polio cases if they were to arise.

Amendment to target:

The current target of zero cases for three years cannot be achieved by July 2003 since a case of wild polio was isolated in August 2000, but it could be very close. No additional cases have been found, in spite of the outbreak in Eastern India. This is a realistic target considering the improved surveillance system and reporting of only laboratory isolated wild poliovirus

6. Percentage of fully immunized children

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Percentage of fully immunized children	Percentage of children fully immunized against 6 diseases within first year of life. Disaggregated by gender and socio-economic status	46.9% at 12 months; 54.1% at 12-23 months (crude coverage: DHS 1996/97)	56% at 12 months (valid doses only); 76% at 12-23 months (crude coverage) (EPI Coverage Survey 6/2002); 52.8% at 12 months; 62.1% at 12-23 months (DHS 1999/2000)	> 80%

Actual progress:

In the 2002 National EPI Coverage Evaluation Survey a different methodology was used. In past surveys, 30 cluster (210 households) samples were used in 6 divisions, all 88 municipalities and 4 city corporations. This year the 30 cluster surveys were done in all 64 districts (13,440 households), enlarging the rural sample. Overall the rates look reasonable, although some areas show unexpected rates (e.g., Rangamati much higher than expected).

Fully immunized within one year (i.e., by first birthday) includes one dose of BCG (95%), three doses each of DPT and Oral Polio (70%), and one dose of Measles (65%) vaccine. There are specific recommendations for initial doses and intervals for DPT and Polio, and for the Measles vaccine. The EPI Coverage Survey uses the concept of valid doses and invalid doses, the latter referring to doses taken outside the recommended ages or intervals. The coverage for children aged 12-23 months is 'crude' because it includes both valid and invalid. The crude rates at 12-23 months were: BCG (95%), DPT1/OPV1 (94%), DPT3/OPV3 (85%), and Measles (77%).

Urban rates for fully immunized children at 12 months are somewhat higher than rural rates (66% v. 54% for valid doses), and also for crude doses (12-23 months: 84% v. 74%).

The EPI Coverage Survey does not give data disaggregated by gender or socio economic status. Other surveys, such as DHS, do not distinguish between valid and invalid doses, so the DHS 'crude' rates (valid and invalid doses) may show higher coverage rates than EPI valid rates.

The EPI Program has benefited from an influx of funds from the GAVI program (US$1.7 million in 2002) and the same amount is expected in 2003. Much of these funds have been used to reduce the dropout rate. The dropout rate (DPT1-DPT3) has declined to 10.5% from 11.3% in 2001, and 14.6% in 2000. The dropout rate (DPT1-Measles) has declined very slightly to 18.5% from 19.0% in 2001 and 24.9% in 2000.

There is a plan to switch from reuseable, sterilizable syringes and needles to single-use auto-destruct (AD) syringes with GAVI support. This will involve the purchase of 30 million syringes annually (see indicator on polio) over the next three years. This also requires the purchase of 'Safety Boxes' wherein the used syringes (100 plus at a time) are burned. Unfortunately in Bangladesh this does not guarantee complete disposal, so burial of the burned syringe residue is contemplated. This is another challenge. The total number of syringes required is also affected by the availability of Hepatitis B vaccine in combination with DPT3 vaccine. This combined tetravalent vaccine is preferred to minimize pilferage, as there is a high premium on the open market for Hepatitis B vaccine for adults (less so for the combined vaccine).

Three improvements have been reported since 2000: 1) a rise in the number of fully vaccinated children reflecting improved coverage/access; 2) a fall in drop-out rates; and 3) a fall in the number of abscesses (reported by mothers) as a result of vaccinations.

The trends over the last ten years, taken from the National EPI Coverage Survey show little change in the proportion of fully vaccinated children given valid doses. There has been a general improvement in crude rates of about 10% for most vaccines: BCG, from 86% in 1991 to 95% in 2002; DPT1, from 69% in 1991 to 94% in 2002; Measles, from 62% in 1991 to 77% in 2002.

The BCG coverage rate of 95% indicates there is very good access to EPI services, although over 90% of babies are born at home (BMMS, 2001) and EPI services are not given on a house to house basis. The National EPI Coverage Survey 2000 shows that the most frequent place for DPT vaccination is the outreach clinic (70%). Urban areas report use of outreach clinic in 38% cases compared to 79% in rural areas. In one division, Sylhet, 92% of DPT 1 vaccinations took place in the outreach clinics. This has implications for the implementation of community clinics where two outreach clinics combine at clinic level and still require 4 outreach clinics to be carried out by HA or FWA in the first two years, thereafter this approach is being gradually phased out.

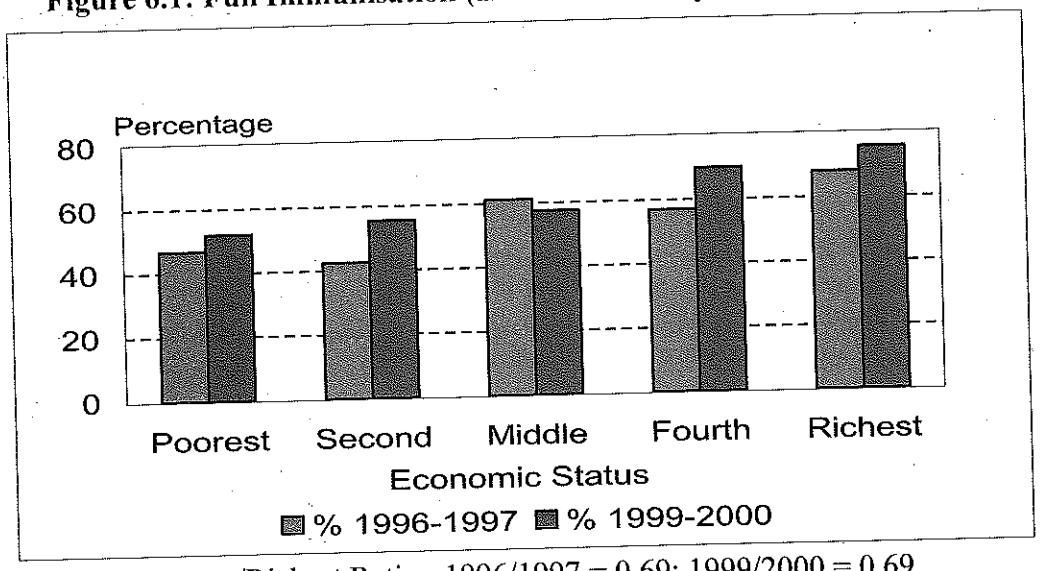
The dropout rate relates to the number of children who received the first DPT vaccine but did not receive DPT3 or measles. The dropout rates have decreased and qualitative studies indicate there is further room for improvement through focused service provision. The National EPI Coverage Survey found the most frequently reported reason for dropping out was a lack of knowledge that further vaccinations were required (27% of total drop-outs). This reflects a deficit in service provision, for example a lack of communication between the health staff at the EPI clinic and the mother, and/or absence of EPI cards that are used as reminder of due date for subsequent vaccine. Other reasons given were fear of side effects (12%), not vaccinating sick children (11%), distance to vaccination site (11%), lack of vaccine or vaccinator (9%), and excessive crowding at the vaccination site (8%).

Reasons for not attending clinics include fear of side effects. Abscesses are reported in 2.8% (1.9% in 2001; 2.8% in 2000) children vaccinated. Although no causal relationship has been proven, this coincides with a new emphasis on the central sterilization system. Syringes and needles are packed and sterilized at the Upazila Health Complex rather than

boiling them at the field site immediately before a vaccination session. The latter system entailed sterilizing equipment to be carried by the vaccinators in addition to the vaccines, supplies and equipment required for conducting the session. This procedure varies from place to place across the country.

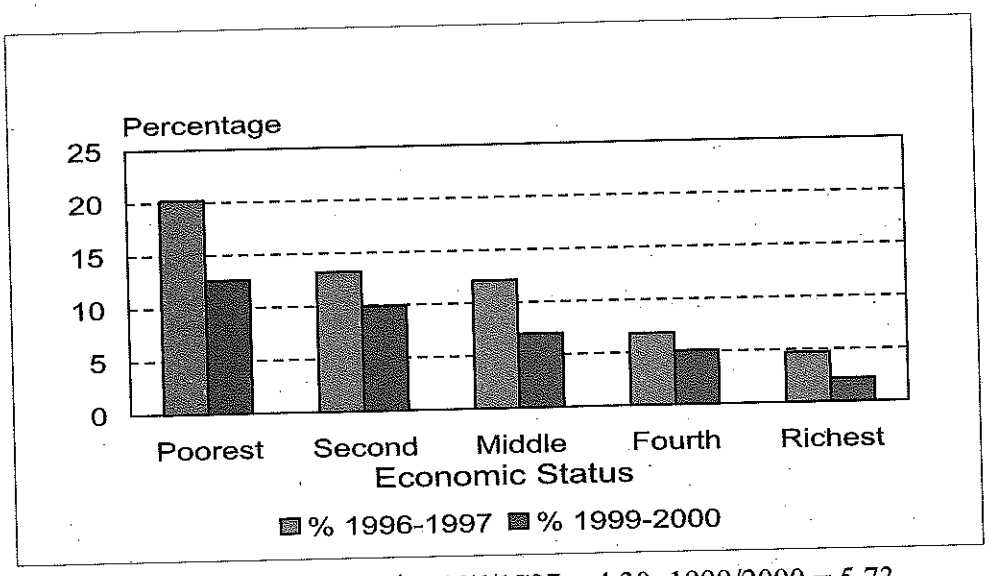
Economic differentials: The EPI Program is a good example of a potentially equitable preventive health service. However, children in the poorest economic quintile were less likely than those from the richest quintile to be fully immunized, the ratio of poorest to richest was 0.687 (Figure 6.1). The ratio for measles was higher (0.723) and for DPT3 (0.738). The ratio for children receiving no immunization was highly inequitable (5.727), so the poorest children were almost six times more likely not to be immunized (Figure 6.2).

Figure 6.1: Full Immunisation (12-23 months) by Economic Status



Poorest/Richest Ratio: 1996/1997 = 0.69; 1999/2000 = 0.69.

Figure 6.2: Children with No Immunisation (12-23 months) by Economic Status



Poorest/Richest Ratio: 1996/1997 = 4.30; 1999/2000 = 5.73.

Social differentials: The rate for fully immunized children (12-23 mths) with illiterate mothers was 53.7% compared with 72.5% for those with mothers who had secondary plus education.

Gender differentials: From the same DHS survey, the crude immunisation rate in 1999-2000 for children aged 12-23 months was 60.4% (males 63.4%, females 57.0%). This differential between girls and boys has persisted since 1993/4.

Problems encountered:

The GAVI funds have been beneficial, but several obstacles have arisen in financial transfers and establishing signing authority (see ICC). Hopefully this has been overcome, and will not delay future transfers. The GAVI requirement that outreach sites (e.g. satellite clinics) will still be conducted for the next two years, remains.

The introduction of Hep B vaccine was planned for July this year (see last year's report). This has been delayed because of the polio outbreak in Eastern India: 1,200 cases (5 times the 2001 figure) and 40 in West Bengal. The Bangladesh response was immediate with campaigns to protect the western borders of Bangladesh. However, the Hep B campaign is still planned to start in January 2003, with TOT at District level complete, and TOT for Upazila level trainers ending in December 2002. Previously it was planned to start with 6 districts, now the plan is that Rajshahi City Corporation will be added.

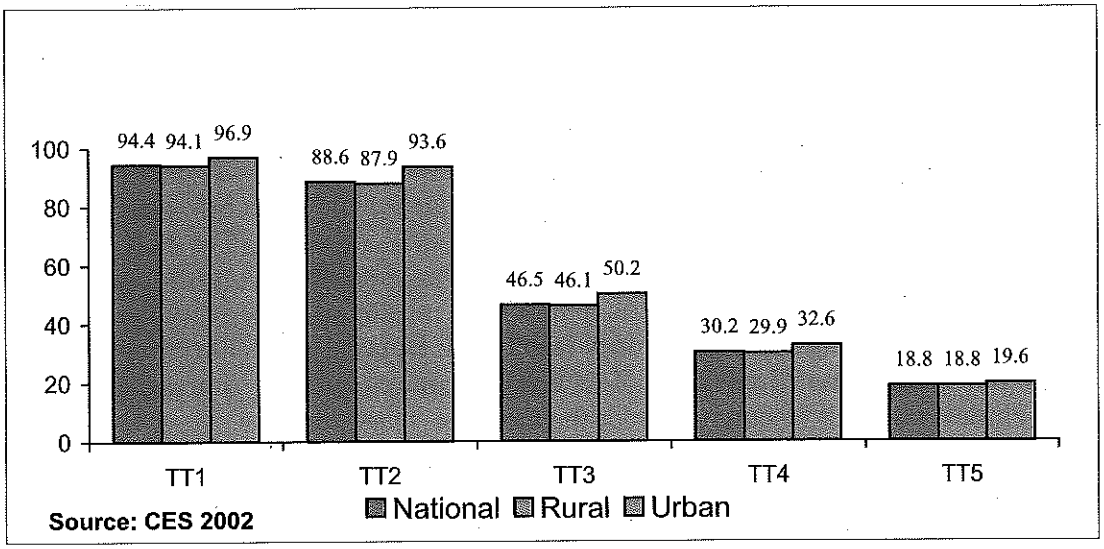
The EPI Coverage Survey does not provide breakdown by gender or any socio-economic variable. The DHS does provide these breakdowns but only for children aged 12-23 months, not under one year.

The methodologies used by the EPI survey and other surveys are very different. The EPI survey uses the WHO cluster approach covering 210 households in each of eleven surveys. The sample is from rural, minor municipalities, major municipalities, and urban areas. The weighting factors are based on estimated populations but may differ from those used in other surveys.

The main issues that prevent Bangladesh from achieving routine EPI coverage goals are inappropriate timing of some vaccine doses resulting in invalid doses (5.7% for DTP1, 5.0% for measles), geographical differences in coverage (varying from 38% to 92% coverage of DTP3), and high drop out rates. In addition, overall urban EPI coverage is similar to that in rural areas, although coverage in slum areas is as low as 22%, less than half the rate for non-slum areas.

There has long been something of a paradox in that about nine out of ten mothers obtain one or even two doses of tetanus Toxoid vaccine during pregnancy (see Figure 6.3), although a much lower proportion of their children receive full vaccination. This is also surprising as many pregnant women do not receive any other kind of antenatal care, so TT vaccination is being selectively sought. It may be worthwhile to consider what motivates women to seek one type of vaccination more than others.

Figure 6.3: TT Coverage (card + history) for Mothers Aged 15-49 with Children Under 1 Year Old



Action taken:

It is quite feasible for surveys such as DHS to produce the appropriate disaggregation by gender and various socio-economic variables, specifically for children under one year of age. This would require secondary data analysis but could be requested.

Revisions to indicator:

As mentioned previously, not all components of the coverage are available for children aged under one year, so the choices are to change the age range from under 12 months to 12-23 months, to drop the dis-aggregation, or to specifically request the dis-aggregation. As many of the EPI Program staff are cautious about changing to 12-23 months, the preferred option seems to be to request specific dis-aggregations for gender and socio-economic indicators, provided the sample size is adequate (for DHS it is).

It is expected that Hepatitis B vaccine will be introduced as an addition to the EPI vaccination schedule, in six districts and Rajshahi Community Clinics from January 2003 for the first 18 months and then expanded to all districts. From 2004 a combined DPT/Hep B vaccine is expected to be introduced and become fully available in all districts by 2005. This timetable can only operate if two conditions being stipulated by GAVI are met. Firstly, that outreach clinics will continue for 2 more years and be discontinued gradually. Secondly, that the coverage rate of DPT3 is known, as this will also reflect the proportion of children receiving the Hep-B vaccine (if tetravalent vaccine is used). When introduced, consideration should be given to including this indicator (DPT3 coverage) as well as the existing one.

Amendment to target:

The current target of >85% is unlikely to be reached by 2003. The trend does not indicate such a rapid increase, and barriers to children becoming fully vaccinated are related to cultural factors as well as health service provision. This is evident with geographical and gender differentials in coverage. In addition, the target population of children under one year is totally refreshed every year by 3-3.5 million new births. To achieve the target in the current population would require an additional 1 million infants to be immunized.

7. Vitamin A coverage

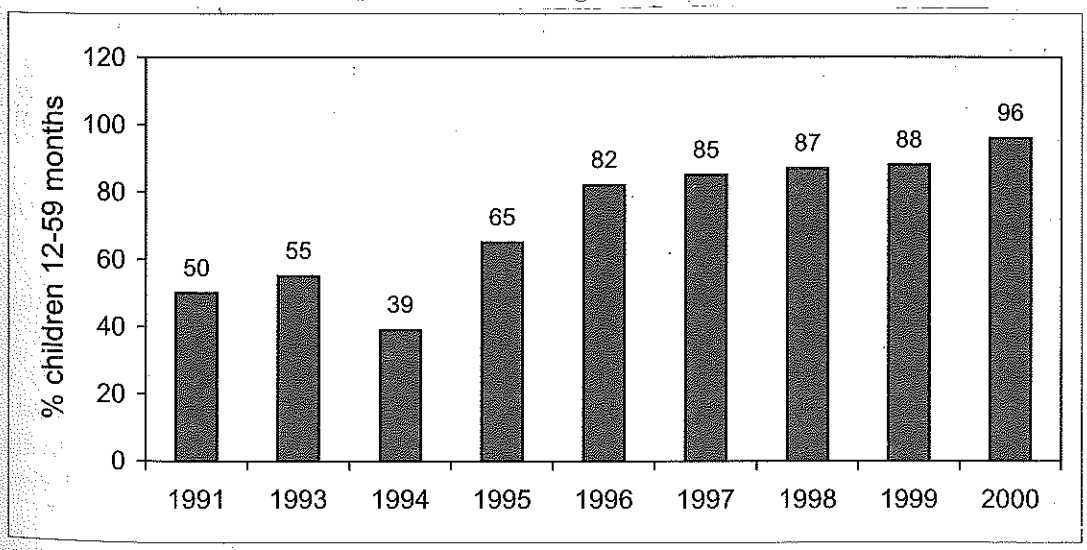
Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Vitamin A coverage	Proportion of children 9 to 59 months receiving Vitamin A capsules twice a year	85% (IPHN/HKI 1997); 66.8% (DHS 1996/97*)	84.1% (NCES 2002*); 80% (DHS 1999/2000*)	> 90%

* The national EPI Coverage Evaluation Survey 2002 figures, and the DHS figures are for children 12-59 months, not 9-59 months, as in the indicator definition.

Actual progress:

The expansion of Vitamin A coverage has been impressive over the past ten years, rising from 50 % in 1991 to over 90% in 2000 in rural Bangladesh (Figure 7.1).

Figure 7.1: Percentage of Children Aged 12-59 Months Reported to Have Received a Vitamin A Capsule Within the Previous 6 Months in Rural Bangladesh, 1991-1999



Source: reproduced from IPHN/HKI 2001 (Figure 1.3)

According to the national EPI Coverage Evaluation Survey 2002, among children aged 12-59 months, 84.1% received one or more Vitamin A capsules within the past six months. In rural areas the figure was 84.2%, and almost the same in urban areas at 83.9%.

Distribution of Vitamin A capsules has been conducted during the National Immunization Days for polio eradication since 1998 on an annual basis. The 'Vitamin A weeks' were held six months after the NIDS to provide six monthly coverage. However, conducting NIDS every six months has had a positive impact on the coverage for Vitamin A capsules. In 2002, the 10th round of NIDs was conducted on 29 January and 10 March.

Dose policy: There has been a change in policy in the past year. The previous policy was that infants should be given 25,000 IU doses of DPT1/OPV1 (at around 6 weeks), again with DPT3/OPV3 (2 months later), and again with Measles vaccine (at 9 months). WHO had abandoned that recommendation some time ago following reports of swollen fontanelle in some infants given Vitamin A. The MOHFW policy is now in line with WHO, and children receive their first dose of 100,000 IU at 9 months (see Problems encountered section below).

However, to ensure that young infants still maintain a satisfactory level of Vitamin A, it is recommended that mothers are given a standard 200,000 IU dose during the post partum period, so that the breastfed infant receives the vitamin from the mother. As very few mothers deliver in institutions such as hospitals or clinics (see indicator B1), a certain level of domiciliary visits should be made to recently delivered mothers.

Differentials (gender, education, geographic): To complete the picture on vitamin A, several sources must be used. Differentials on gender, for example, can only be taken from surveys such as DHS, as data are not collected in the CES surveys.

There is virtually no gender difference in Vitamin A distribution, very small differences by education of mother, urban-rural residence, and geographic Division. However, it is thought that some areas of Bangladesh, particularly in the Chittagong Hill Tracts, have significantly lower coverage.

There has been a fall in the reported cases of night blindness, associated with Vitamin A deficiency, from 3.6% in 1983 to 0.6% in 1997 and a further decrease to 0.33% in 1999 (IPHN/HKI 2001).

Problems encountered:

Records kept during the NIDS are not very detailed, so coverage rates must be determined by surveys. National figures do not give information about areas of low uptake. Coverage for polio vaccine (associated with Vitamin A distribution) during NIDS in Chittagong Division increased from 64.4% to 87.2% between 1998 and 1999. Chittagong Hill Tracts also achieved a coverage of polio vaccine of 80% during the first round of NIDS in May 2000. However, there are pockets in this area where coverage of

polio vaccine is reported to be as low as 43% (Nutritional Surveillance Project, Bulletin No 2).

In 1999 coverage was reported to be 85.0% during Vitamin A weeks compared to 89.6% during NIDS (Nutritional Surveillance Project, 2001). Since NIDs will be discontinued once polio has been eradicated there is some concern that Vitamin A coverage will fall as a consequence.

While night blindness has fallen dramatically it is now believed that sub clinical Vitamin A deficiency, without any deterioration in sight, causes higher morbidity and mortality in children and their mothers due to common infectious diseases. The National Vitamin A survey estimated the prevalence of sub-clinical Vitamin A deficiency in children 6-59 months to be 25% (through serum testing). The age group 12-23 months showed the highest prevalence of sub clinical Vitamin A deficiency. Since almost half of pregnant and lactating mothers have been found to be Vitamin A deficient it may be necessary to include them in distribution campaigns in order to raise the vitamin A status of their infants.

There appears to have been some confusion in ordering Vitamin A capsules this year, possibly resulting from the dosage policy change mentioned above. Instead of the standard 200,000 IU caps for children aged 12 months or more, 100,000 IU caps were ordered. Although the caps are different colours (red and blue) the service providers apparently distributed a single cap, and thus half the expected dose.

There was a shortage of routine EPI forms, and GoB funds were not available for printing. An alternative WHO source was used.\

Revisions to indicator:

In order to ensure that sub-clinical Vitamin A deficiency in infants declines it would be necessary to add pregnant and lactating women to the indicator. Due to the sub-clinical nature of vitamin A deficiency and the related increase in morbidity and mortality in children and their mothers the present input indicator is the most relevant. Measuring Vitamin A deficiency in relation to morbidity and mortality of common infectious diseases is not a feasible alternative due to the number of confounding factors.

Amendment to target:

The target of over 90% coverage may be achievable by 2003, particularly with the doubling of the frequency of NIDS. The challenge will be to maintain this level once NIDs have been discontinued.

Communicable Diseases Control

8. STD prevalence among selected groups

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
STD prevalence among selected groups	Percentage of syphilis cases among targeted groups: sex workers, MSM, truck drivers, and ANC seekers	Syphilis: SW (41%); MSM (12%); Truck drivers (8%); ANC seekers (0.6%)	Syphilis: SW (36.2%); MSM (10.9%); IDU (12.9%); STD clients (0.1%); Migrant workers-returnees (0.5%); Truck drivers (0.0%)	30% reduction in syphilis in all groups

Actual progress:

There was considerable delay in starting the fourth round of the National STD/AIDS sero-surveillance due to a lengthy process for GoB to contract ICDDR,B following IDA guidelines. Although round-4 has been completed, the Technical Committee of the National AIDS Committee (TC-NAC) has not reviewed the data, so they are not yet publicly available. Until the round-4 data are released (possibly in February 2003), the only data available are those from round-3, some of which were reported last year. Table 8.1 shows the summary of results from rounds 1-3 of sero-surveillance. In addition, data from round-3 of the behavioural surveillance, which were not available at the time of the last report, are referred to below.

Sero-surveillance: In 2000/01, the rates of syphilis infection were very high among street-based sex workers (42.7%) and brothel-based sex workers (34.1%). The other main vulnerable groups also had relatively high rates: injecting drug users - IDUs (12.9%) and men who have sex with men - MSMs (10.9%). However, among the potential 'bridging populations' of truck drivers, dock workers and rickshaw pullers, the rates were much lower (4-7%). [12]

As expected, street based sex workers (SW) have higher syphilis rates than brothel based SWs, most likely because health education, awareness raising on condom use, and clinic based treatment for STDs are more easily provided and accessed in the brothel setting. Syphilis rates were about the same in round-2 and round-3, and somewhat lower than in round-1. Rates among IDUs and MSMs have remained about the same level (10-12%). The rates for MSMs might have been higher given that over half had bought sex in the past week and consistent condom use was less than 3%.

[12] Note the same caution as in earlier reports, that syphilis testing can show up as positive even several years after the patient has been fully cured, so some overestimation of prevalence may occur.

Table 8.1: Rates of HIV and syphilis among vulnerable and bridging groups: third round of national aids/std sentinel surveillance

Study Populations	HIV Positive			Syphilis Positive		
	1998/99	1999/00	2000/01	1998/99	1999/00	2000/01
Vulnerable populations						
IDUs (Clinic based) (n=1010)	2.5%	0.2%	0.7%	12.9%	10.4%	12.9%
Brothel Sex Workers (1313)	0.0%	0.0%	0.3%	45.7%	32.3%	34.1%
Street Sex Workers (female) (419)	0.0%	0.2%	0.5%	56.8%	42.8%	42.7%
STD Patients (1184)	0.3%	0.3%	0.1%	15.9%	8.2%	6.0%
MSM (709)	0.2%	0.0%	0.0%	12.0%	12.6%	10.9%
Migrant Workers (Returnee) (401)	na	na	0.3%	na	na	0.5%
Bridging populations						
Truckers (829)	na	Na	0.0%	na	na	6.2%
Dock Workers (793)	na	Na	0.0%	na	na	7.3%
Rickshaw pullers (801)	na	Na	0.0%	na	na	4.1%
TOTAL (7459)	0.4%	0.2%	0.3%	na	18.4%	20.8%

(na = not available in earlier rounds)

While syphilis rates remained high, HIV rates remained consistently low in the first three rounds of surveillance. With the exception of IDUs (2.5%) in 1998/99, no group had HIV prevalence greater than 1%. However, HIV positive cases have been found in all the vulnerable populations. This is cause for considerable concern in view of the continuing prevalence of high risk behaviours and the experience of neighbouring countries which experienced similar patterns before an epidemic.

A pattern of low HIV prevalence in successive years among IDUs has been observed in neighbouring countries prior to a dramatic increase in prevalence (eg. Kathmandu/Nepal, Manipur/India, and Haiphong/Vietnam where prevalence increased from 0% to 60% in 2 years). Behavioural data suggest that this is mainly due to frequent needle-syringe sharing. However, a high level of unprotected sex, including buying sex, is reported by IDUs in Bangladesh.

There is considerable overlap between the vulnerable populations which increases the chances of an epidemic. IDUs are not an isolated population among which HIV transmission could be self-limiting. The round-3 data show that 40-54% of IDUs were married, 16-29% bought sex last month without using a condom, 28-35% sold blood last year, and 4-10% had sex with another male in the last year (rates are for central and north-western regions, respectively).

Given this inter-connectedness of vulnerable populations and the particular vulnerability of IDUs to HIV transmission through sharing needles, a major requirement for HIV/AIDS prevention in Bangladesh is to extend the coverage and completeness of needle exchange programmes. Needle sharing is still common practice, despite successful needle exchange programmes implemented by NGOs. In north-western Bangladesh, those who got clean needles from an NGO programme were far less likely to share, but in

round-3, 51% reported some sharing, compared with 85% of IDUs not attending needle exchange. In central Bangladesh, over 90% of IDUs (n=500) reported some sharing in the last week, although only one-third had access to a needle exchange programme.

Among the vulnerable populations in Bangladesh, knowledge about HIV/AIDS and transmission is relatively poor. For example, in the south-east region, 90% of street-based SWs could not correctly name two ways of contracting AIDS. With an average of about 19 clients a week, female sex workers in Bangladesh brothels have the highest rate in Asia. Hotel-based sex workers average 44 clients per week. Virtually all sex workers reported some sex without a condom. Hijras and other males also sell sex to a wide range of clients and engage in non-commercial sex with men. Two-thirds of men buying sex from men never use a condom.

Most men reported that they did not use condoms when they bought sex. For example, 82.3% of truckers and 85.9% of rickshaw pullers in central Bangladesh never used a condom when they bought sex. The scale of the potential problem, and risk to those not themselves engaged in risk behaviour, such as housewives, was also clear from round-3. The majority of married male respondents reported unprotected sex with a sex worker, a street girl, a hijra (transgender), or another man in the past month, although almost all had sex with their wives.

Risk behaviours in Bangladesh are at least as prevalent as in Asian countries that have experienced an HIV epidemic. HIV cases among IDUs are a particular concern in view of the dramatic increase in prevalence in this group in other Asian countries. The experience of HIV/AIDS in Indonesia, a predominantly Muslim Asian country also indicates the need to avoid complacency in Bangladesh. The proportion of sex workers and clients reporting that they always used a condom remained low (<15%) for some years (1996-2000). HIV prevalence among sex workers also remained low (<5%) from 1994-1997, but then increased dramatically to 8% in 2000. Similarly in West Bengal, HIV prevalence among sex workers has risen to 6% and prevalence among STD clinic attenders increased from 0.6% in 1998 to 2.0% in 2000.

Problems encountered:

There is a particular methodological problem for the sero-surveillance, in that access to the vulnerable populations for testing is through existing interventions. It would be difficult and unethical to test those who do not have access to preventive and curative (STD) interventions, although these populations may have higher prevalence for that reason. As mentioned last year, many of the populations for surveillance are contacted through attendance at clinics or treatment centres, so they may not be representative of the particular vulnerable population. However, this means that the surveillance results are unlikely to underestimate the prevalence of STDs and HIV infection.

Revisions to indicator:

As mentioned previously, there is a problem because of persisting markers for syphilis among patients who have been cured. Testing for current syphilis will overcome this problem. The indicator has so far focused on syphilis and HIV rates, largely due to concerns about costs and logistic problems involved in testing for other STDs, such as gonorrhoea and chlamydia. With the recent development of simple and relatively low cost PCR tests for these diseases[13], it may be worth considering whether these tests could be added to the surveillance. This would also overcome the problem of syphilis prevalence rates being affected by past infection.

Although the base status shows a prevalence rate for seekers of antenatal care, representing the general (low risk) population, this group is not routinely included in the sentinel surveillance. There is evidence from studies by ICDDR,B and other sources, that STDs are low in the general population, particularly in rural areas. WHO advises that until any particular vulnerable population has an HIV prevalence of 5% or more, there is no need to include less vulnerable populations. Even so, several populations not in the original definition of the indicator, but thought to be vulnerable in Bangladesh, have been included in the sero-surveillance, such as IDUs, migrant workers, and transport workers.

Amendment to target:

As mentioned in previous years, the problem of persisting positive syphilis markers even after cure, means that this indicator is not ideal to demonstrate short term decreases in prevalence as a result of interventions. In the third round, few populations experienced a statistically significant decline in syphilis prevalence, although prevalence among sex workers and STD clients did fall considerably between round-1 and round-3.

Continuingly low HIV prevalence is no cause for complacency given similar patterns of STD prevalence and behaviour in other Asian countries prior to an epidemic. Behaviour with a high risk of contracting and transmitting HIV is highly prevalent in Bangladesh. The populations most vulnerable to HIV overlap, in terms of shared risk behaviours, and HIV cases have been found in all of them.

9. Detection of smear positive TB cases

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Detection of smear positive TB cases	Annual TB case detection rate of smear positive incidence cases. Disaggregated by gender and socio-economic status	31.0% (1998) see Graph	31.4% (2001)	70% of incidence cases by year 2005

[13] The PCR (Polymerase Chain Reaction) combined test for gonorrhoea and chlamydia costs about US$8 or $9, and requires only a urine sample (no blood sample required), and can be transported in ice.

Actual progress:

Case detection rate: The number of pulmonary TB smear positive (PTB+ve) cases has been increasing, and the population under surveillance has increased, with the rapid expansion of the National TB Programme (NTP)[14]. As a result, the case detection rate in NTP areas has gradually declined from 1995 to 1999 (Figure 9.1). Since then the PTB+ve case detection rate within the NTP area has increased slightly to 31.4% for 2001, still well below the WHO target of >70%.

There is a wide range in the case notification rate at District level, from 10%-65%. NGOs often perform better and develop innovative ways of implementing DOTS, such as incentives for community health workers. The Government collaboration with NGOs under NTP is considered a success and more are being brought into the programme. An additional 67 Upazilas have been handed over to two major NGOs and GOB now has 207 upazilas (45%) and NGOs have 253 (55%).

An MOU has been signed with DCC and Urban Primary Health Care Project and the NSDP (former Urban Family Health Partnership funded by USAID) to expand DOTS in the metropolitan cities and major municipalities, and some Leprosy NGOs have agreed to add TB to their activities. Recently CIDA agreed to provide financial support for further expansion of DOTS.

Up to now, personnel of 5 zones out of 10 under Dhaka City Corporation have been trained on DOTS, and the rest, including the other metropolitan areas, will be trained soon. In fact, DOTS expansion in metropolitan areas is yet to be made fully functional, so population coverage at the end of 2001 was about 95%.

Treatment completion rate: Overall, the NTP treatment completion rate for new PTB+ve cases in 2001 was 83.5%, only just below the WHO target (>85%)[15] and very close to the rate for previous years (see Figure 9.1).

Multiple drug resistance (MDR): The treatment failure rate is very low at 0.8%, which suggests that MDR-TB is not a major public health problem. However there has been no national survey on drug resistance. A study in 1994-5 in one rural area found <1% primary MDR-TB, but the rate of 4.9% found in a study in Dhaka in 1997-98 is of more concern. Currently a number of patients attending the Institute of Diseases of the Chest Hospital have been clinically diagnosed as MDR-TB. The NTP needs to establish collaboration with the main tertiary hospitals to address this problem. ICDDRB is strengthening the capacity of Shyamoli Chest Clinic for culture and sensitivity testing which offers the prospect of establishing national TB drug resistance surveillance. ICDDR,B has established TB surveillance in urban Dhaka and rural Matlab to

[14] The NTP started in 1993 in 4 thanas, expanded rapidly to 40 by end 1994, then to 460 by 1998.

[15] Cure rate applies to cases that are laboratory confirmed sputum negative on completion of treatment. Treatment completion rate applies to those patients who completed the full course of treatment but for one reason or another did not have a sputum sample laboratory tested, on completion of treatment. The figure is, therefore, not identical with that in the WHO Global TB Control 2000 report (p.22).

characterize the epidemiology of TB and drug resistance patterns. Up to October 2002, ICDDR,B had tested 161 *M. tuberculosis* isolates for drug susceptibility. MDR (defined as resistance to both isoniazid and rifampicin) was observed in 6.8%. MDR was particularly common among patients who had relapsing or persistent disease after receiving at least one month of anti-tuberculosis therapy (15.5%). Currently some 20 patients are receiving treatment (at $3,000 per course) at the TB Hospital, Mohakhali.

Numbers of cases and deaths: As TB can spread from a PTB+ve case by droplet infection, the NTP focuses on identifying and treating these infectious cases. The total number of TB cases in 2002 was estimated at 306,509 and almost half were PTB+ve cases (137,929 cases at 105/100,000 population). The remainder of cases (168,580 at 129/100,000) were sputum negative pulmonary and extra-pulmonary TB cases. The total number of old and new PTB+ve cases for 2002 was estimated at 275,858, about double the estimated number of new cases in the year. The number of TB deaths in 2002 was estimated at 68,926, the majority being among PTB+ve cases (48,275). On the basis of these estimates, Bangladesh ranks fifth in the world for TB disease burden.

Drug supplies: All NTP implementing units, including NGOs with an MOU, receive TB drugs free. NTP estimates the requirement for the year based on population and case detection rates, with an added buffer stock for 12 months. The CMSD procurement plan is now expanded to provide an 18-month buffer stock beyond the end of HPSP.

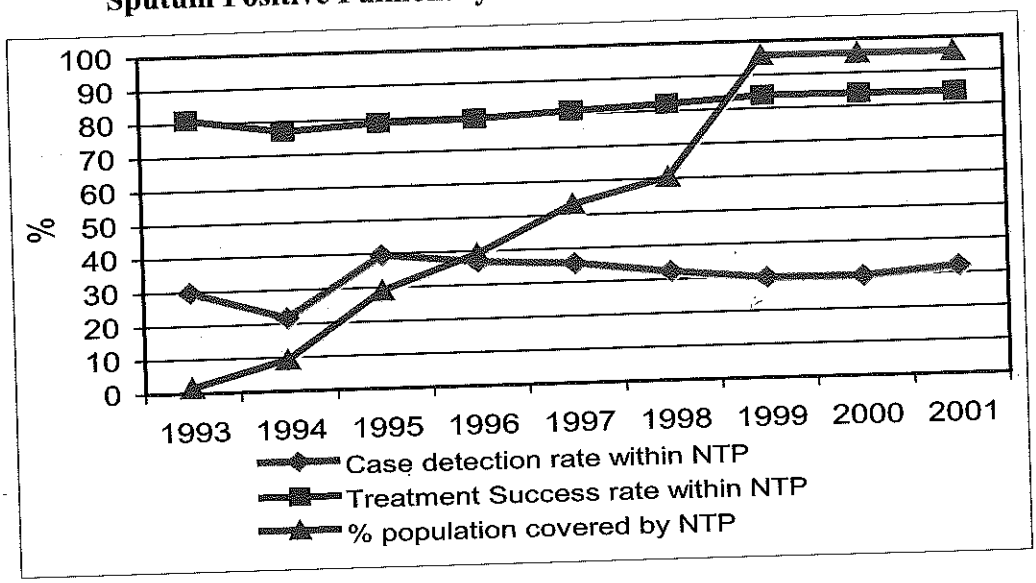
Although there has been an improvement in levels of stocks at central level, the situation regarding drugs and diagnostic supplies for the NTP remains a concern. There is no longer a shortage of slides, sputum containers or drugs. And at present there is about 12 months stock of most of the Anti-TB drugs.

According to the strategic plan 2001-2005, the new regime is supposed to be introduced from Jan 2003 as recommended by the NTP Review in July 2001. Some of the drugs from the Global Drug Fund (GDF) under a new regime (Ethambutol, INH) are in the pipeline, but 4FDC (four fixed drug combination) is yet to get registration from the drug authority of Bangladesh, as no such combination is available in Bangladesh. The proposal includes the prescription of an increased dose of Rifampicin, and the discontinuation of Thioacetazone. So it is assumed that it is not possible to introduce new regime of DOTS from Jan 2003.

Bangladesh is one of two Asian countries that have received preliminary selection for the Global Fund for AIDS, TB and Malaria (GFATM).

Gender differentials: The incidence ratio of new pulmonary TB smear positive incidence cases for females to males is 0.4 (or 2.5 males per female). This has raised the question of equity in access to treatment. However, a prevalence survey in rural areas in 2000 found smear-positive cases in the same ratio.

Figure 9.1: Case Detection Rate and Treatment Success Rates for New Sputum Positive Pulmonary TB in the NTP Area, 1993-2001



Problems encountered:

Procurement of more anti TB drugs is in progress (initial stage) and if not done within the next 6 months, there may stock-out requiring emergency procurement.

No National Consultants except one have been in post since June 2001, and it is assumed that all other posts at Division level and central level will not be filled by June 2003. There was no Expatriate consultant from Sept 2002, but recently WHO has appointed an expatriate consultant under regular budget who is likely to join very soon.

A significant number of smear positive TB cases are still being treated by private practitioners, and at hospitals. These are not included in the NTP reporting, nor is there information on whether or not DOTS was followed in treating these cases.

It is assumed that to increase the Case Detection Rate to meet the WHO target (> 70%) is hard or impossible without the involvement of the private sector and the secondary and tertiary level care providers, and without the urban TB control programme being fully functional.

Revisions to indicator:

The Case Detection (CD) Rate indicator is required. However, as mentioned last year, for international comparisons it is necessary to know the Treatment Success (TS) Rate. This is currently around 80%, and the WHO global target is > 85%. For true program effectiveness, this TS target must be attained together with a CD rate of 70% or more.

Amendment to target:

The target has been moved back to 2005, but is still unrealistic.

10. Leprosy Prevalence Rate per 10,000 population

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Leprosy Prevalence Rate per 10,000 popn.	Estimated leprosy prevalence per 10,000 population. Disaggregated by gender and socio-economic status	0.96 / 10,000 (1998); 1.05 / 10,000 (1997)	0.62 per 10,000 (June 2002)	<1 per 10,000 population by 2000

Actual progress:

Bangladesh has been detecting about 11,000 cases every year, and has the 4th highest leprosy burden after India, Brazil and Indonesia if annual detection is considered. The National Leprosy Elimination Program (NLEP) of Bangladesh has already been integrated into general health services and it has involved different NGOs in Leprosy Elimination activities. GO-NGO collaboration in NLEP is functioning well and there is scope to further strengthen this.

The target for elimination of leprosy is less than 1 case per 10,000 population. This has been achieved nationally in Bangladesh since 1998. However, in June 2002 there were 12 Districts/Metros which had a prevalence rate above the target: Nilphamari (3.38), Urban Dhaka (3.33), Urban Chittagong (2.43), Gaibandha (2.08), Lalmonirhat (2.03), Khagrachari (1.76), Dinajpur (1.55), Joypurhat (1.52), Rangpur (1.37), Rural Chittagong (1.07), Kurigram (1.06), Bandarban (1.04) and Rangamati (>1). Sylhet is at 1. The Leprosy Elimination Program (LEP) is focusing on these districts to achieve elimination. Other encouraging indications are the reduction in the Grade II Deformity rate among new cases, from 9.0% in 1998 to 6.5% in 2002, and the reduction in the proportion of children appearing among new cases, down from 18.3% in 1998 to 11.7% in 2002.

Case definition for clinical diagnosis is the presence of a skin patch with absence of sensory loss. However, there has been a change in the recommendation for starting treatment, which may reduce the number of false positives and hence the number of registered new cases. Health workers are now instructed to wait three months before starting treatment from the time the patient first presents at the health facility. During this time, other skin conditions resembling leprosy may have self-resolved, e.g. fungal infections or seasonal vitamin deficiencies. This change in policy may reduce the number of new registered cases of leprosy, as fewer false positives are included.

LEP provides drugs and cards, and the programme has not experienced any shortages. Novartis is committed to provide multiple drug therapy (MDT) drugs from 2000-2005. Unlike TB drugs, the leprosy drugs are specific to the disease which reduces the incentive for pilferage. Side effects are rare, and drug resistance is not a public health problem. It has been suggested that other health programmes are considering bypassing central procurement in order to ensure constant supply of drugs.

Eight NGOs are assisting the Government in leprosy control in 29 endemic districts with 231 Upazilas which contribute over 80% of caseload. This has created an exemplary partnership where the Government and NGOs are pooled and optimally utilized. NGOs are following National Guidelines and submit reports and returns in standard formats. In addition to case finding, case holding and referral, the NGOs operate the leprosy clinic in some UHCs. The aim eventually is to transfer responsibility to Government staff. The key to prevention of leprosy deformity is early detection and this is now a focus of activities to develop community participation. NGOs are working through religious leaders, scouts, community leaders, private practitioners and former patients to raise awareness and identify cases. As far as possible, the emphasis is on treatment of uncomplicated cases in the community. NGOs are also responsible for vocational training and Community Based Rehabilitation (CBR).

Leprosy Elimination Monitoring was carried out by an independent organization in Bangladesh during the period 21 January to 15 February as per WHO guidelines for validated elimination status.

Patients with multi-bacillary (MB) leprosy (6 or more skin lesions) require a regime of drugs for 12 months. Compliance for this group is low, at 90% compared with 95% for those cases with 2 to 5 lesions that required treatment for six months. For those a 3-months supply of drugs is now given. Compared with Tuberculosis side effects of these drugs are rare and drug resistance is not a public health problem.

Gender differentials: Leprosy prevalence is higher in males than females, with a ratio of 1.32:1 for new cases, 1.46:1 for cured cases and 1.74:1 for MDT cases. The reason for this difference is not known. One hypothesis is that women have a more efficient immune system to protect them against leprosy. However, the difference does raise a question about equal access to treatment.

Problems encountered:

The prevalence indicator is based on registered cases but there are currently estimated to be 15,000 undetected cases nationwide. A standard formula suggests that the number of cases may be 2.5 times higher than the registered number. For every index case, 20 new cases are infected. The long incubation period (2-5 years) means that complete eradication may take some years with new cases appearing each year.

In the Government sector, clinical diagnosis of leprosy is mainly by clinical examination, although in suspected cases slit skin smear for laboratory confirmation has been done. However, almost all NGOs involved in LEP take slit skin smears for diagnosis. This invasive procedure requires trained health workers and experienced laboratory technicians. While government health workers have had training in how to recognize suspect cases and when to refer these to the UHC for diagnosis and treatment, private MBBS doctors often misdiagnose leprosy. No training has been available for this group of service providers.

Although stigma is not a major problem, it is still a problem for some groups, particularly women. In 10% of cases, women have faced divorce on diagnosis of leprosy. Reluctance of educated people to accept diagnosis and start treatment is also a concern. There are currently no data available to disaggregate prevalence by socio economic status.

The proportion of deformity cases among newly diagnosed cases declined to 6.5%. Although the number of such cases is falling, it still reflects continuing delay in seeking help, or misdiagnosis by health service providers. A key element of leprosy eradication is community awareness. In 1999, a widespread campaign was organized by the LEP to promote awareness. In one month shortly afterwards 2,500 new cases were registered. A mop-up programme in highly endemic districts has recently been undertaken.

UMIS does not collect data on the deformity rate in children, and LEP continues to use its own MIS forms.

Revision to indicator:

The present indicator is accepted globally and should be retained, with the same target. The Deformity Rate (Grade II) among new cases could be considered for inclusion as an additional indicator.

Amendment to target:

No change is required.

C. MONITORING INDICATORS FOR HPSP IMPLEMENTATION

Output Component 1 – ESP

11. Increased access to ESP services at thana level and below to women, children and poor

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Use of ESP services (curative only) at Thana level and below, at public and NGO facilities, by sick population especially women, children and poor.	Percentage of total population that use or access one or more ESP services. Disaggregated by gender and socio-economic status.	13% at public facilities	14% at public facilities	80% for public facilities

Actual progress:

There are no new data since last year.

General access: To measure the accessibility of ESP services, the DHS presents data relating to whether children under five years with ARI are taken to a health facility. Data was obtained from mothers reporting on their children's illness in the two weeks prior to the interview. In 1999/2000, 27.2% took their children to a health facility compared with 33% in 1996-1997. This suggests that there is no major improvement in access to ESP services. The Service Delivery Survey data shows that 22 % households reported at least one member who was ill in the last month and did not seek care from any source. From the same sample, 14% of households had at least one member of the household who visited a government facility for any purpose in the last month, 11% as a result of illness. This represents an increase of 1% on 1999.

Economic differentials: According to the SDS there is a positive relationship between poverty and unmet need for health care. Of households with a sick person, 14% of very poor households compared with 10% of less poor households did not have any contact with a health provider in the past month, and fewer very poor households were using government health facilities than poor households.

Social differentials: DHS reports a positive correlation between education level of the mother and taking the child to a health facility (23.4% of those with no education v. 39.3% with secondary+ education). However, SDS did not find a relationship between literacy of the household head and use of a government facility.

During Focus Groups Discussions reasons given for very poor people not accessing government health facilities related to perceived discrimination against the very poor and

bad behaviour of health staff towards them, rather than purely economic reasons.(more reasons in section 22; CIET).

Gender differentials: The DHS shows that boys are more likely than girls to be taken to a health facility when they are ill (29.6% v. 24.6%). This was confirmed in the SDS in which more females than males of all ages, except under 9 months, were reported as not seeking care for illness. This was most pronounced in the 20-29 year old age group (SDS Figure 10). From a cohort of 10,544 women interviewed, DHS report that 87.5% women report specific big problems in accessing health care for themselves (Table 11.1). However DHS reports no difference between use of government health facilities for treatment of illness among women and men.

Table 11.1: Problems reported by women in accessing health care for themselves.

Problem	% Women Reporting
No facility nearby	79.0
Difficulty in getting money needed for treatment	71.4
Did not know where to go	63.2
Lack of confidence in source of services	54.0
Going to the health center	49.6
Difficulty finding someone to accompany them	49.2
Difficulty in getting permission to go	44.0

SDS 2001

Violence against women is a recognized problem in Bangladesh. SDS found that of women who suffered injury requiring treatment in the last year 26% did not seek treatment. There was a large difference by geographical location. In rural areas in Chittagong, 93% of injured women sought care whereas in Barisal only 58% sought care. In metropolitan areas 78% women sought treatment. Of the women from rural areas who did seek treatment 49% went to unqualified practitioners, 34% to a government facility and 17% to a private facility. In urban areas 29% sought treatment from unqualified practitioners, 24% from government health facilities and 27% attended private facilities (SDS Figure 25). Focus groups describing the experience of women who sought treatment for injuries due to violence are not encouraging. Often payment, sometimes large amounts had to be made to receive treatment (SDS 2001 p49).

Home visits by health workers: SDS shows that 9% of households interviewed from a sample of 25,459 had at least one government health or family planning worker visit their homes to provide services in the last month. Of these visits 8% were to provide curative care.

Problems encountered:

No specific problems mentioned.

Revision to indicator:

Access to health care for curative treatment in time of illness is determined, not only by physical distance, but by many other factors such as culture, society, economic status, and knowledge. The indicator needs to measure access in relation to uptake of services in times of illness, on the basis of the number of people requiring treatment who actually access it. An estimation of this is provided in the SDS community based survey but this needs to be more specific to allow comparison over time. An example might be the number of children with ARI and the number of women who have suffered injury who are taken to a health facility.

Amendment to target:

No need to consider revising the 80% target by 2003 until further consideration has been given to the indicator itself (see above).

12. Met need of EOC (incorporating 'availability of basic EOC and of comprehensive EOC')

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Target for 2003
Met need for EOC	Proportion of women estimated with obstetric complications treated at facilities	5.1%	26.5% (1999) higher in 2002	30%

Actual progress:

Bangladesh is the only country in the region implementing a strategy for Comprehensive Essential Obstetric Care (C-EOC), which combines both Basic EOC (B-EOC)[16] and Emergency Obstetric Care (EmOC). The Government would like B-EOC services to be available at all Union FWCs. All 13 Medical College Hospitals and all 59 District hospitals, as well as 64 Maternal and Child Welfare Centres (MCWCs), and 40 Upazila Health Complexes (UHCs) should offer C-EOC.

The target by end of HPSP is that every 500,000 population should have four facilities offering B-EOC, and 1 facility offering C-EOC (this implies around 1,000 B-EOC facilities, and 250 C-EOC facilities nationwide). In 1994 the actual number of facilities per 500,000 offering EOC was 0.41 for B-EOC and 0.14 for C-EOC. By 1999, these ratios had increased to 0.60 for B-EOC and 0.27 for C-EOC.

[16] A B-EOC facility is one able to: administer parenteral antibiotics, oxytocics, sedatives and anticonvulsants; perform manual removal of placenta and retained products of conception, and perform assisted delivery. EmOC comprises surgical obstetrics, anaesthesia and blood replacement.

A survey conducted in 1999 by ACPR for UNICEF reviewed the status of 710 EOC facilities. Table 12.1 shows the status of 726 facilities. Figures are based on the ACPR survey plus data from August 2001 for 59 DH and 120 UHC (including 16 UHCs in addition to the 104 in the 1999 ACPR survey).

Table 12.1: Levels of EOC services according to type of institution

Service Level	Medical College Hospital	District Hospital	Upazila Health Complex	MCWC	Private	Total
Comp EOC	13 (100%)	48 (81.4%)	22 (18.3%)	17 (27.4%)	197 (41.7%)	297 (40.9%)
Basic EOC	-	4 (6.8%)	31 (25.8%)	12 (19.4%)	27 (5.7%)	74 (10.2%)
No EOC	-	7 (11.9%)	67 (55.8%)	33 (53.2)%	248 (52.5%)	355 (48.9%)
Total Facilities	13	59	120	62	472	726

The GOB C-EOC facilities are mainly at division and district levels, while B-EOC services are at district as well as lower levels (UHC and MCWC). The private clinics offering C-EOC tend to be concentrated in the four big cities: Dhaka, Chittagong, Rajshahi and Khulna.

Upgrading plan: The MOHFW has a plan to ensure 179 facilities (59 District Hospitals plus 120 Upazila Health Complexes) are equipped to offer EOC. By August 2002, there were 69 offering C-EOC, including 58 able to perform C-sections. Full functionality requires the presence of a Consultant MO-Obstetrics (n=104), and a Consultant MO-Anaesthesia (n=84), plus equipped operating theatre.

Monitoring: The above describes the necessary inputs, but in terms of outputs, the UMIS with UNICEF inputs, is monitoring some 123 facilities (District Hospitals and Upazila Health Complexes) for EOC activities. An improvement in the system for processing the EOC data has been reported for the second half of 2002. Registration and reporting forms and software have been developed. Reports are received from 49 District Hospitals and half of the UHCs. Nurses are completing the forms, with UNICEF staff checking them.

Met need for EOC: Last year's report indicated an impressive rise in met need for EOC from 5.1% in 1994 to 26.5% in 1999. The latter figure calculated from the 72,505 complicated deliveries in GOB facilities plus 27,275 in private facilities, amounting to about one quarter of the estimated 376,498 complicated births nationwide. It is not possible to calculate met need for 2002, as the 123 facilities being monitored include only DHs and UHCs, not Medical College Hospitals, MCWCs, or private facilities.

However, there is evidence to suggest significant increases since 1999. Among the facilities monitored, there has been a 25.3% increase in births, an 88.3% increase in admissions of complications, and a 43.8% increase in c-sections. The increases have been more dramatic within the EmOC facilities with births up by 34.1%, and complicated deliveries up by 98.6%. UNICEF plan to repeat their maternal mortality survey in late 2003, so a revised measure of met need should be available after that.

Training: Competency-based training in EOC is to be conducted for MOs and nurse midwives. These are complete (not refresher) courses: 1 year on EOC and anaesthetics for MOs; and 4 months on EOC for nurses. Training of trainers will be conducted by January 2003. About 5,000 FWVs will be trained as Community Midwives.

Problems encountered:

In the past there have been problems with supplies. Facilities had to collect equipment procured by CMSD and get reimbursement for transport costs. GOB has now appointed an agent (HAMA/BOC) which clears goods at the port and delivers them. JICA is providing hardware (e.g., computers; OT equipment) in support of EOC services.

Revision to indicator:

As with some of the other indicators, it would be useful in future reviews to have an indicator on met need for EOC, but in the text some indication should be given of progress in upgrading facilities for basic and comprehensive EOC services.

Since private clinics conduct more than half of all C-sections, and those facilities are concentrated in urban areas, the met need indicator could usefully be divided into GoB and private facilities, and possibly urban-rural. Otherwise a substantial increase in met need may be apparent, but it may be reflecting improvements largely among economically better-off, urban populations.

Amendment to target:

The figure for met need in last year's report was 26.5%, based on the 1999 survey. Since substantial improvements appear to have occurred between mid 1999 and mid 2002, it is likely that the present (unknown) level is quite close to the 2003 target of 30%.

13. Integrated management of childhood illness (IMCI) strategy

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Target for 2003
IMCI strategy	Percentage of Upazila/Thana (UHC/THCs) that have adopted and introduced IMCI strategy		1 % (pilot in 3 thanas	30% of total thanas

Actual progress:

As described in the previous report, the IMCI Strategy is a global strategy to which Bangladesh has committed. Eligibility of 14 Upazilas was reviewed using set criteria to select 5 for pilot implementation. However, the pilot was started in only 3 Upazilas.
The National Work Plan was completed in August 2000. Generic IMCI modules were adapted with technical assistance from WHO and ICDDR,B, and the finally approved version of the training modules and materials, in English, was produced with assistance from UNICEF. A Bangla version of the training modules and materials for nurses and paramedics has been prepared by GoB with assistance from ICDDR,B and will be printed next year.

Eight National 11-Day Clinical Training Courses and three Facilitator workshops have been conducted in 2002. The participants included Senior Managers from MOHFW, Upazila and District managers, paediatricians, clinical staff from Medical College Hospitals, and staff from partner organizations. Three of the 11-Day Clinical Training Courses were conducted for paramedics. At least six doctors have been trained from each of the pilot Upazilas.

The 11-day National Clinical Training Courses are used to train staff from Medical College level down to Union facility level. The training courses for Basic Health Workers (Health Assistants, Family Welfare Assistants and similar staff) down to the level of Community Clinics, are intended to start from 2003. Training for doctors, nurses and paramedics in the three pilot Upazilas have been completed. The recording and reporting forms and formats are already supplied to the pilot Upazilas. A number of NGO staff have also been trained in IMCI and NSDP is currently implementing IMCI from 15 of its urban clinics.

IMCI training covers two areas: 1) clinical skills training for service providers; and 2) community level activities. So far, IMCI trainings have been restricted mainly to clinical skills.

The implementation of IMCI requires large numbers of staff at various levels of the MOHFW to be trained. Significant progress has been made in IMCI training with all staff in pilot upazilas being trained. Adequate staff from 3 institutions in Dhaka have been trained to enable them to conduct trainings. In addition, some staff from 3 institutions outside Dhaka have been trained as part of a plan to establish other training sites.

With regard to special requirements for the facilities in the IMCI Upazilas, there are some drugs required to continue 5 days treatment (eg. injectable antibiotics) which are not normally available at these facilities. The Civil Surgeon is expected to use his/her flexible funds, which seem to be meager, to procure these drugs locally. This could be a potential problem if there are competing demands for these flexible funds.

There has been a decision to form an Upazila Core Committee for IMCI, but these committees are not fully functional yet.

Bangladesh is collaborating with WHO in the Multi-Country Evaluation (MCE) of IMCI. The study is being implemented by GoB and ICDDR,B in Matlab, a pilot IMCI Upazila. After some delays in 2001, significant progress has been made in this activity in 2002.

Problems encountered:

The selection of pilot Upazilas was very slow, even though guidelines for selection, based on patient flow, distance from other facilities, drug availability, presence of committed staff, were all fulfilled much earlier.

Many aspects of the IMCI implementation require the approval of the National Steering Committee, but this committee has not met since its formation (10 April 2001). The Core Committee has met on three occasions but all its resolutions are awaiting formal approval from the Steering Committee.

One obstacle to implementation of IMCI has been the lack of status within HPSP, leaving it as a somewhat peripheral issue. Consequently, adequate resources have not been available for IMCI implementation. Additionally, authority has not been delegated to the levels actually responsible for day-to-day activities, and obtaining approvals from the higher authorities has proved to be a time consuming process.

Amendment to target:

As mentioned last year, it remains optimistic to expect that 30% of Upazilas (i.e., 150 Upazilas) will have trained their staff and implemented IMCI in less than one year (by end of HPSP). The target needs to be revised in line with revised IMCI implementation plans. Collaborative effort with the NGO sector could contribute towards the achievement of the target. NSDP now has 278 clinics operational and IMCI is already implemented in 15. It is expected to be implemented in another 55 clinics in 2003.

Output Component 2 – Reorganization of Service Delivery

14. Decentralization and local management of services

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Decentral-ization and local management of services	Number of Districts and Thanas (THCs) with (a) decentralized planning, financing and human resource management authority (b) Upazila plan incorporated in AOP.	Not applicable.	0 (see text)	12 Thanas

Actual progress:

In common with most Ministries in Bangladesh, the management of the health sector is highly centralized. The problems with this are well recognized. The potential benefits of decentralization are also well recognized.

The long-term vision for the health sector as set out in the Programme Implementation Plan (PIP) for HPSP described roles, responsibilities and functions at the different levels within the MOHFW. The vision assumed a unified service approach and supported the GOB's policy of decentralisation and reform within sector wide management.

In order to achieve decentralisation, the aim was to delegate power as well as responsibility to the level at which health care is provided, i.e. the upazila level[17]. The new role of the Secretariat was articulated as policy, strategy formulation, regulation and legislation, whilst the Directorate would move from service delivery towards standard setting, performance review, agreeing plans and budgets, supporting districts and hospitals, and overseeing major capital projects. Greater involvement of NGOs and other organisations was also proposed in addition to greater community involvement in the health services.

The aim of decentralisation is to strengthen the capacity of the public health sector to deliver high quality curative and preventive services itself. Also to contract with other providers such as NGOs and the private sector to do like wise. Given that a significant proportion of health care in Bangladesh is purchased directly by households from the private sector, decentralisation must strengthen the capacity of the public health sector to ensure households get value for money for this expenditure through regulation and other mechanisms.

However, till now the most used and recognized option is the delegation of power to the lower levels. Following that option of delegation of powers, the MOHFW increased financial powers under the development budget by issuing an order on 29.12.98. MCU prepared a proposal for sub-delegation of financial powers under revenue head and sent it to the MOHFW on 29/10/1998. It is still under consideration. In the meantime, in March 2000 the Ministry of Finance enhanced the financial delegation of powers for all Ministries. This order was aimed at speeding business, and updating the levels of financial delegation to Ministries.

MOHFW obtained two reports (one from local consultants, Centre for Development Research of Bangladesh (CDRB) and the other from foreign consultants, Dr. Ken Grant, et al.). The consultants submitted the report and the MOHFW constituted a committee headed by the Joint Secretary (Administration) to analyse the reports and submit recommendations. The committee after several meetings and a workshop, submitted an action plan for consideration of the MOHFW. The proposed action plan was submitted for consideration of the High Level Inter Ministerial Committee (HLIC). HLIC

[17] See 'Decentralization in the Bangladesh Health Sector: Main report' (draft), prepared by MCU for the MOHFW, (2001).

considered the matter in its meeting held on 7/7/2002 and decided to constitute a sub-committee headed by the Secretary, MOHFW. A sub-committee was constituted which has so far held two meetings and finalised the recommendations in respect of HRM&D and delegation of financial powers under revenue head. The sub-committee needs to hold further meetings to finalise the recommendations in respect of other components namely planning, procurement, BCC/health promotion, MIS/performance monitoring and evaluation, hospitals, public private partnership.

MCU/RCT prepared a proposal for enhancement of financial power under development head. The proposal was sent it 3/12/1998 to the MOHFW for consideration. MOHFW held meetings and ultimately issued GO on 29/12/1998 enhancing financial powers under development head.

MCU/RCT also prepared proposal of sub-delegation of financial powers under revenue head and sent to the MOHFW on 22/3/1999. The MOHFW took up the proposal with the Ministry of Finance. The Ministry of Finance did not agree to make the proposed enhancement for a particular Ministry but assured enhancing existing financial powers under revenue head in general and accordingly the Ministry of Finance has issued an order on 7/3/2000. Inspite of the order of the Ministry of Finance it was felt that enhancement of financial power under revenue head in respect of some specific items such as maintenance/repair of ambulances, equipments etc. to ensure better service delivery is necessary. Accordingly the committee headed by the Secretary, MOHFW to finalise the action plan on decentralisation already recommended for enhancement of financial powers under revenue head for some items which is to be considered by HLIC.

Decentralized planning:

Local level planning (LLP): A decentralized system of planning named LLP was introduced with the aim to build capacity on planning based upon a situation analysis and local priorities, participation of the community in the planning process, effective utilization of available resources and reflecting local needs in the National Plans so that national plans become more realistic and meet the local needs of different areas or Upazila. Further decentralization would include equipping Upazila managers and staff, introducing user fees and local utilization, and team building among the Upazila managers and staff after unification of Health and Family Planning at the Upazila level. Other important objectives are self-analysis of own situation, and prioritization of interventions within available resources. LLP will act as a monitoring tool for Upazila managers and as well as District managers. Medium-term objectives are 'pull method for further decentralization', shifting current resource allocation system, which is now facility based, towards population and disease burden. And long-term objective is overall decentralized planning, management, user-oriented needs-based and effective service delivery, monitoring and evaluation jointly by the providers and users.

First phase of Local Level Planning (LLP): Support had been provided to develop LLP Toolkit (planning formats, guidelines etc.) and implementation process. LLP was introduced to 39 Upazilas of 5 Districts in 2000-2001. Important activities were

incorporated in the AOP of ESP (Reproductive Health). MCU conducted an independent review of the first phase LLP that presented options for the subsequent roll out of LLP within the life of HPSP. The initial phase of LLP appears to have been welcomed by the Upazilas, districts, Directorate, MOHFW and DPs.

Second phase of LLP (National roll out, 64 District and 460 Upazilas): Revised LLP Toolkit developed and implementing process formulated as per the LLP review. A Core LLP Cell (CLC) under the direct supervision of LD-SWM, DGHS was established at the DGHS staffed by GoB officials from both the FP and Health directorate for greater ownership and sustainability. During 2001-2002, LLP has been developed in all the 460 Upazilas with GoB fund. Compilation of relevant portions was done for incorporation in the relevant AOPs of 2002-2003 (UBCC, IST, ESP-RH and ESP-Other than RH). A national LLP information base was developed at the CLC. A draft monitoring and feedback process and mechanism for LLP has already been drafted. The overall LLP documentation process is in progress.

Third phase of LLP (continuing phase): Necessary preparation is on going.

Hospital planning: Under the Hospital Improvement Initiative (HII), hospital level plans have also been developed (see indicator 27). These locally developed plans were subsequently fed into relevant line director's AOPs for FY 2000-2001 and FY 2001-02 planning cycle (bottom up planning).

Human resource management and development (HRM/D): HRM/D relates to decentralization in two ways. First, the kind of activities (e.g., ESP training) that are required to support overall health sector reform and decentralization. Second, the decentralization of responsibilities and authorities for HRM/D tasks, many of which are currently held in a number of central institutions like the Public Service Commission.

A number of HRD/M activities have taken place to support overall decentralization. These include clarifying existing levels of HRM/D authority at all levels, piloting individual performance management systems at 60 Upazilas, further development of personnel information systems, review of incentive systems and career structures, and to some extent HR strategic planning. A HR strategy was finalised. The HR strategy contains HR priority areas such as: organisation of HR, its planning, information system, performance management (supervision monitoring and evaluation), disciplining, recruitment, career planning etc. The strategy has recently been approved by the MOHFW. Now the approved strategy will be published and distributed for action.

The PRU/Human Resource Development Unit has been established to improve overall HRM/D capacity. In addition, a gender equity strategy has been developed.

Problems encountered:

According to the decentralization review, "under HPSP to date, little actual decentralization of these functions has occurred. Indeed, experience to date suggests that

decentralization of HRM/D functions is often unwanted by many stakeholders who choose not to exercise their authority. Taking certain financial responsibilities, for example, may leave one open to some amount of risk (e.g., of accusations of financial impropriety)" (page 8). This 'responsibility risk' is believed to underlie some other areas of inaction.

Another obstacle is that the structure and processes for HRM/D functions in the health sector are linked to broader Civil Service structure and processes, and are therefore not amenable to change in a single sector. The review concludes: "without fairly radical change, e.g., broader civil service reform or creation of health authorities/ boards, HRM/D decentralization in the health sector is likely to take at least as long as unification with at least as much difficulty".

There was a need to take a longer term view of decentralisation and to have a vision of what decentralisation might look like by the end of Health and Population Sector Programme. The vision could be developed by building upon the basic principles that were established within the original PIP, and by realising the potential roles at upazila and district levels. Upazilas have always been recognised as key service delivery units for the delivery of ESP services. Districts are being increasingly recognised as being pivotal health service management units throughout the country. It is felt that the districts will be of prime importance in support and performance management of the upazilas.

Problem encountered for LLP:

A. At the upazila level: Capacity for proper planning is not up to the mark. There is room for capacity building. An intention has been observed that planning means getting extra resources. Over the period of time this paradigm needs shifting to effective utilisation of available resources, rather than extra resources.

B. At the district level: Capacity to assist Upazila for planning is not satisfactory, supportive supervision is quite weak, and there is less sound understanding of the overall objectives of LLP. District managers are not using individual LLP as a monitoring tool. Further assistance is required.

C. Directorate level: There was inadequate effort by the relevant LDs for incorporation of centrally prioritised issues of LLP in the relevant AOPs. Fund disbursement was not efficient (not timely and without guidelines). The relevant LDs need to be proactive especially the ESP. Policy agreement is required.

D. Ministry level: Planning is a time-bound activity. Delay in fund release caused hectic implementation of planning processes in the District and Upazila. MOHFW can utilise LLP information base for policy and other issues, such as personnel (vacancies) disease prevalence, performance, community voice of 460 Upazila regarding health and family planning services. LLP necessitates nourishment and support by the MOHFW for

LLP to flourish. Within 2-3 years it can be a routine process out of which MOHFW can easily decide or modify policy or regulatory issues.

Revision to indicator:

An indicator that focuses more on inputs may be more useful at this stage.

Amendment to target:

The target of 12 thanas/Upazilas by end of HPSP is not consistent with the present activity where all the 460 Upazilas are included in the LLP pilot. This should be reviewed.

15. Implementation of community clinic concept

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Implementation of Community Clinic concept	Number of Community Clinics established and functional.	0	8,598 handed over	10,833

Background to development of community clinics:

To ensure community participation in health and family planning services in rural areas under HPSP, Community Clinics (CC) have been established at village/ward level for delivery of the Essential Services Package (ESP) from a static clinic. One CC serves a population of about 6000 people, except in metropolitan and municipal areas. Under the Government plan, CCs were to be the first level, one-stop site for delivery of a standard package of integrated health and family welfare services (ESP) free of cost. The intention was to continue domiciliary visits on one day a week for some special groups of clients (e.g., post-natal cases, advanced pregnancy, drop-outs) and at regular intervals to those living at distant places.

Under the former Thana Functional Improvement Pilot Project (TFIPP) of the MOHFW, operations research was conducted from June 1998 to April 1999, during piloting of alternative CC models, in 6 Unions of 4 Districts. A number of organisations (Red Crescent Society, GTZ) carried out similar research and the Operation Research Project of ICDDR,B also conducted research on different systems of delivery. The experiences of these research activities contributed to the development of Community Clinic program by the MOHFW. MOHFW issued guidelines on establishment of CCs in April 1999. A transitional plan and guidelines for changes in the service delivery system from domiciliary to static services were developed after discussion with different stakeholders, and submitted to the MOHFW for consideration on 26/2/2002 by MCU.

Detailed guidelines exist for operation, management and maintenance of the CCs, following article 7 of the 'Guidelines on Establishment of Community Clinics' circulated down to Community level in April 1999. The CCs are to operate through joint management of the Government and the local people. The Union Council (UC) and representatives of the local community will participate, together with officials and staff of the MOHFW working at local level. In addition to the existing government systems of monitoring and supervision, the community are to participate in supervision of service delivery from the CC through a Community Group (CG) of representatives of the local community. Provision was made for involvement of the CGs in establishing the CCs and in their management, maintenance and security. CGs are constituted for 2 years, with 9-11 members, including a Chairman, Vice-Chairman, Treasurer and Member-secretary. Special consideration was to be given to representation by women, poor, landless and low-income groups of population. Either the Chairman or Vice-chairman should be a woman.

GoB is responsible for deployment of staff, supply of medicines, equipment and furniture to make the clinics functional. Selection of site, transfer of required donated land to the government, supervision of construction, day to day cleanliness, maintenance and security, is the responsibility of the local community through the CG. Participation of the local community is considered essential at all stages. CGs are expected to demand quality of care once they have understood their rights and had training.

Actual progress:

Under the CC programme, GoB planned to complete construction of CCs through one-time allocation of funds. A total of nearly 18,000 Community Clinics was planned for the whole country (13,799 CCs to be newly constructed; and services to be provided from about 460 Upazila Health Complexes (UHC) and 4,040 Union Health and Family Welfare Centres (UHFWC), some existing and some to be constructed). A policy guideline for site selection of CCs was formulated and approved by the MOHFW.

About 13,364 sites have been selected and CMMU report that by December 2002, 9,413 CCs had been constructed, of which 8,598 had been handed over for operationalisation, with furniture, equipment, medicines and trained manpower provided. It was expected that the target of 10,833 CCs would be constructed by the end of 2002 (3,858 by CMMU and 6,975 by LGED). However, the figure of 10,820 CCs for which money has been allocated suggests that slightly fewer might be completed. Figures from the Line Director by Division (Table 15.1) indicate that a total of 10,722 CCs were either constructed (7,768) or under construction (3,094) by the beginning of December 2002. However, there is a lag in information being transferred to Line Director as CCs are handed over to the Upazila Chairman who informs the THFPO, who then informs the LD. The data from CMMU indicating that 9,413 CCs have been constructed and 8,598 handed over, are more up-to-date.

Table 15.1: Progress in establishment of community clinics by division

District	Number of Proposed CCs	Number of sites selected	Number of sites not selected	Number of CCs under construc-tion	Number of CCs constructed	Number of CCs handed over	Number of CCs operating
Dhaka	3888	3646	242	1036	1824	1645	1547
Barisal	1042	1040	02	330	485	408	340
Raj-shahi	3625	3584	41	457	2751	2493	2474
Khulna	1599	1591	08	302	1108	1046	887
Chittagong	2709	2591	118	679	1241	1192	1103
Sylhet	936	912	24	290	269	399	355
Sub-Total	**13799**	**13364**	**435**	**3094**	**7678**	**7183**	**6706**

* Source: Line Director, ESP, DGHS, Mohakhali - up to 2 December 2002

Training (21 days) on ESP for existing staff (FWAs, HAs) has been conducted: a total of 41,310 FWAs and HAs, and supervisory staff (AHI, FPI, HI, SI) have been trained so far. Priority was given to those already assigned to CCs. It is expected that by June 2003 a total of 55,000 staff will have been trained. Training and orientation (2-3 days) has been carried out for Community Groups on management of a CC, initially in 20 Upazilas and recently covering 80 Districts. Orientation involves decisions regarding opening hours, drug availability, staffing issues, and cleanliness. At CCs where CGs were heavily involved from the beginning of construction, there has been more lasting involvement.

Problems:

(See also section 18 on construction of facilities). Supervision is problematic and largely dependent on the quality of the UHFPO and transport, which is a problem. Involvement of Line Directors in monitoring CCs through personal visits could increase quality of care and proper functioning of CCs, which to date has not been possible due to lack of supplies. Procurement of equipment has been de-centralized to district level (via the civil surgeon). A core team at district level (all 64) has been trained on IDA procurement, including tendering and expressions of interest. Procurement has taken place in 60 districts. It was suggested that DDS kits, similar to those given out to Union level health facilities should be supplied for CCs, to prevent favouritism in supplying individual clinics (see also indicator 20).

Revision to indicator:

The indicator of number of Community Clinics 'established' should be defined as those constructed, equipped, supplied with medicines, staffed with suitably trained and supervised FWA and HA's.

Amendment to target:

Not required at this time.

16. Unification of support services BCC; MIS and logistics

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Unification of support services: - BCC; - MIS; - Logistics;	SRO notified	Not applicable	0 (see text, awaiting SRO)	All (BCC, MIS, Logistics) support services unified and integrated (by 2001) at all levels

Actual progress:

This indicator is almost unchanged since last year's APR/MTR.

BCC unification: The unification of BCC involves the merging of the Bureau of Health Education (BHE), which falls under the DG (Health Services), with the Bureau of Information, Education and Motivation (IEM), which falls under the DG (Family Planning). According to Section 4 of the Services (Reorganization and Conditions) Act 1975, the approval of the Prime Minister is required. This step, while not expected to delay the process, adds to the complexity. The development of the organogram has proved problematic because normally no development budget posts are explicitly included in such an organogram. Many of the posts under DG (FP) are on the development budget.

The report of Research Evaluation Associates for Development (READ), Bangladesh about UBCC was examined. The proposal of SRO for UBCC was prepared by MCU and sent to the MOHFW on 24/12/1998. The proposed Organogram of UBCC was prepared in the light of the decision of the meeting held on 24/10/1999 under the Chairmanship of the Secretary, MOHFW. It was sent to the MOHFW on 14/11/1999 by MCU. The proposed organogram of UBCC was cleared by the Ministry of Establishment on 22/11/2000. Both the proposals of SRO and organogram are still under consideration by MOHFW.

The MCU facilitated the Line Director, UBCC, to prepare a paper outlining a methodology for designing a nationwide Communications Strategy for Service Providers in June-July 2000. During the process, the impact of reforms already in place was analyzed, and reforms that were planned were studied and discussed with staff at various levels. The prevailing communication efforts and the main groups affected by the reforms at each level within the MOHFW, as well as other government and non-government staff, were examined.

During October–December 2000, the MCU facilitated the process to prepare and finalise the Communications Strategy for Service Providers on HPSP Reforms, to sensitize service providers to the reforms taking place under the programme and develop a favourable environment towards the HPSP. During the process, numerous interviews and

discussions were held with staff of all levels of government, and with representatives *of* both the Health and FP wings. The resulting document, the Communications Strategy for Service Providers on HPSP Reforms, was presented to the UBCCU in December, 2000.

As a follow–up to the development of the Communications Strategy, an Implementation Plan was formulated. This document offers detailed information to guide implementation of the communication interventions put forward in the strategy. The document was prepared following review of the Communications Strategy, discussions with the MCU, Programme Co-ordination Cell (PCC) and the UBCCU. The Implementation Plan recommended that the UBCCU serves as the MOHFW agency responsible for managing the implementation of the Communications Strategy. No GO has yet been issued in this regard.

Seventeen issues of the Newsletter "Nabadiganta" (New Horizon) for all officials and MOHFW staff (about 1,50,000 per issue) have been published in Bangla and distributed.

MIS unification: The report of Programme for Introduction of Appropriate Contraception Technologies (PIACT), Bangladesh, about UMIS was examined. The proposal of SRO for UMIS was prepared by MCU and sent to the MOHFW on 28/7/1999. The proposed Organogram of UMIS was prepared. The proposal was sent to the MOHFW on 27/7/1999. The Ministry of Establishment on 22/11/2000 cleared the proposed organogram. Both the proposals of SRO and Organogram are still under consideration of MOHFW.

Logistics and procurement unification: The report of Associates for Community and Population Research (ACPR), Bangladesh, on Unified Procurement and Logistics was examined. The proposal of SRO of Unified Logistics was prepared by MCU and sent to MOHFW on 15/1/2000. The particulars of posts were collected from the DGHS and the DGFP. The proposed Organogram of Unified Logistics was then prepared and sent to MOHFW on 15/2/2001. Both the proposals of SRO and organogram are still under consideration of MOHFW.

The issue has gone back and forth to the Ministries of Establishment, Finance, and Law, Justice and Parliamentary Affairs, three or four times, and is still awaiting final approval. This delay is quite disturbing, and is certainly hindering the development of these important services.

Problems encountered:

Problems revolve around settling the organogram structure to the satisfaction of the MoE, and other Ministries.

Revision to indicator:

Two years ago it was suggested that some intermediate steps be considered for the indicator. These might include approval of the SRO, implementation of the new organograms, and production of unified OP's. This suggestion still holds.

Output Component 3A – Support Services: HRD

17. Trained personnel to deliver ESP, improved hospital management and other support services

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Trained personnel to deliver: ESP; Improved Hospital Management; Other Support Services	Numbers of different categories of personnel trained on ESP/ IHM/ OSS, by level of service. Disaggregated by local and foreign.	Not applicable	See table below	Total assessment on yearly basis

Actual progress:

A. Capacity development at central level: Since July 1999 much of the groundwork has been completed to strengthen in-service (IST) capacity at the central level. The National Curriculum Committee, ESP Training Working Group and several sub-working groups were formed to strengthen and support central level capacity in the preparation of training curricula, training standards, guidelines, and monitoring and evaluation. To date, the following key elements of a standardized, quality national IST program have been developed: National In-service Training Policies and Standards, in-service training guidelines on Basic ESP course for field service providers and Action Plan for training monitoring and follow-up. In addition, a Training Management Information Systems (TMIS) has been established to increase the capacity of policy makers and program managers to plan, monitor and assess training activities, including preparation of training calendars, development of an expansion plan, and generating routine and special progress reports. The Curriculum Development Sub-working Group, based on the findings of a Training Needs Assessment, developed 20 training curricula including Advanced ESP Skill Curricula (Reproductive Health, Child Health, Communicable Disease Control). In addition, Basic ESP Curricula have undergone further review and revision, based on recommendations from the Annual Performance Review and from stakeholder workshops and the results of pilot testing.

B. Capacity development at LTO: Lead Training Organization (LTOs), as the key providers of training under the Strategy, received a great deal of input to increase their capacity. In addition to core support for their personnel and activities, a Performance Need Assessment (PNA) was conducted for all LTOs to identify areas that needed strengthening with respect to training, clinical and management capacity. The majority of the interventions based on PNA are planned for implementation during FY 2002-2003. LTO trainers received Master Trainer training, and were oriented on training monitoring and evaluation. They are also actively utilizing the TMIS for documentation and reporting on training implementation, monitoring and follow-up.

C. Capacity development at district level: The district has been developed as a local level training planning, coordination, monitoring and follow-up agency. A five-member District Training Coordination Committee (DTCC) headed by Civil Surgeon is now functioning in each district. The DTCC members once oriented to their roles and responsibilities, which include training monitoring, supervision, documentation and reporting were reinforced through refresher orientation during the 2001-2002 period. In addition, in order to foster among them the performance perspective, PNA was conducted in 32 districts during the February-June 2002 period. Emphasis has been given to replicate in the remaining 32 districts during the FY 2002-2003. Along with PNA and TMIS replication, development of Supportive Supervision System (SSS) will be one of the important interventions toward improving performance feedback of the providers during the same period. It is expected that the DMIS would be completed in 64 districts during the current fiscal year.

D. Capacity development at upazila: The upazila has been designated as the principal venue for training, particularly for the Basic ESP Training for field service providers. A District/Upazila Training Team (DUTT) is functioning in each upazila to provide training to the field service providers and to conduct follow-up of the trainees at their work sites. The members of the DUTT received training of trainers (TOT) provided by the LTOs. They were further oriented to the roles and responsibilities as trainers at district level meetings conducted by the DTCCs. Training guidelines and the training monitoring and follow-up plans are now available in each upazila. Following the LTOs strengthening through PNA, during the period 2002-2003, a plan has been developed to conduct PNA of the providers working at upazila and below to foster performance. Support for trained providers at the work site by DUTT members will be linked to existing supervisory system in order to develop a sustainable system of provider's feedback.

E. Training: Several training courses implemented during the reporting period are categorized as Training on ESP Delivery, Complementary Training to ESP Delivery, and Specialized Skill Training on ESP Delivery. To date, 967 doctors and 8073 paramedics have been oriented to ESP, 2488 DUTT members received Training of Trainers (TOT) on Basic ESP Training for field service providers, and 41310 field service providers working in the community clinics have been trained using the Basic ESP training curriculum.

F. Gender issues: Efforts have been taken to address the gender issues in the arena of in-service training. For example, provision was made to foster team training where almost 50% of trainees in the 21 day Basic ESP training were Family Welfare Assistants (FWAs). Provision was also made for training of Family Welfare Visitors and Nurses. In addition, in order to make Representative Health Curriculum gender sensitive, gender sensitivity testing has been conducted. Training on "Services for women and girls subject to violence" during the FY 2002-2003 will be another new initiative under IST.

A list of trainings conducted through IST against their target since initiation of HPSP is shown in Tables 17.1.

Hospital Improvement Initiative

The Line director, Hospital services, held a large number of workshops and seminars. A list of which is shown in Table 17.2.

Other Support Services

Progress on other support services is shown in Table 17.3.

Problems encountered:

- The Training MIS (TMIS) is not yet fully functional. Information regarding persons trained and courses conducted is not coming from the Upazila to the District and to the central PMIS in a complete and timely form. Information is not being updated regularly at the central location i.e., TTU.
- Completed forms are being hand carried from District level.
- There exits no single information centre either in the MOHFW, or in DGHS or in DGFP, where the total number of trainings/workshops, both local as well as external, conducted in a given year through MOHFW could be retrieved. Like the previous years, *ad hoc* arrangements are being pursued in collecting, collating and recording of the TMIS. Although the responsibility in this regards lies with the TTU, however, the TTU has so far been failed to achieve those. At the same time there is no coordination with TTU and other Line Directorates in matters related to IST.
- In many occasions the Ministry itself directly selects and sends persons for external long or short courses, of whom mostly are ministry officials, but the TMIS at TTU are not being provided with any information.
- Procedures for contracting training to NGOs are very complicated. At best it takes 9 months to contract an NGO for this purpose. This is in relation to accessing IDA funds. Also the upper 20% limit for advances from Project Finance Cell (PFC) hinders the funding of training courses.

Revision to indicator:

Now that a large number of trainers have received their TOT, the completion of training courses is speeding up. Although some training is still behind schedule, the numbers of staff trained on ESP/IHM/OSS, appears to be reasonable for this indicator, with prospects of the numbers increasing steadily in the next year.

Amendment to target:

The targets are provided for each category of staff, and these appear to be feasible at this time.

Table 17.1: Training Progress Report (July 1999 - June 2002)

Sl. No.	Name of Training	Duration	1999-2000		2000-2001		2001-2002		Cumulative 07/1999-12/2002
			Target (Number)	Achievement (Number)	Target (Number)	Achievement (Number)	Target (Number)	Achievement (Number)	Achievement (Number)
1	Basic ESP Training for Field Service Providers (AHI, FPI, HA, FWA, HI, SI)	21 days	3800	853	24300	12704	20000	27753	45035
2	Management Development Program for Upazila Managers	11 days	360	332	1152	594	800	280	1258
3	Basic Training on Clinical CSD RTI/STD Case Management	20 days	450	129	450	450	300	216	795
4	Basic Computer Training for MOHFW, DGHS and DGFP, NIPORT, NICVD, MCH, CSO, DDFO, TB Lep., NIKDU, MC Personnel	28 days & 15 days	20	20	56	56	238	238	635
5	Comprehensive EOC Training for Senior Staff Nurse	4 months & 12 wks	0	0	100	37	71	62	99
6	Comprehensive EOC Training on Safe Blood Transfusion for Medical Technologists	2 weeks	0	0	50	0	30	65	65
7	Comprehensive EOC Training on Gynacology and Obstetrics for Medical Officer	1 year	0	12	120	16	20	19	47
8	Comprehensive EOC on Anesthesia for Medical Officers	1 year	0	15	120	16	20	10	41
9	Training on Basic Service Management for Newly Recruited Doctors	5 days	270	0	288	0	300	40	40
10	Midwifery Skilled Practice Training for FWVs	12 weeks & 6 month	100	0	500	0	130	28	28
11	Training on UMIS Recording and Reporting for Field Personnel (AHI, FPI, HA, FWA, FWV)	2 days	500	0	1080	0	30000	20127	20127
12	ESP Orientation for Paramedics (i.e. SACMO, MA, FWV, SN, Lab, Tech, etc.)	5 days	7520	343	4000	3814	10000	3916	8073
13	Orientation of Divisional, District and Upazila Managers on ESP Training Guidelines	1 day	0	0	1240	1240	1700	1700	2940
14	TOT on Basic ESP Training for Field Service Providers (UHFPO, RMO, UFPO, MOMCH, DCS, MOCS, MOCC, ADCC, RTC/FWVTI.	5 days	1176	984	1779	790	500	714	2488
15	Quality Assurance Training for Hospital Staff	3 days	0	0	3784	0	4000	2000	2000
16	ESP Orientation for Medical Graduates (MOs)	5 days	1728	281	500	190	456	496	967

Sl. No.	Name of Training	Duration	1999-2000		2000-2001		2001-2002		Cumulative 07/1999-12/2002
			Target (Number)	Achievement (Number)	Target (Number)	Achievement (Number)	Target (Number)	Achievement (Number)	Achievement (Number)
17	TOT on ESP Orientation for Clinical Service Providers (RMO, MOMCH, MOs)	5 days	1320	413	1500	447	456	78	938
18	Basic Training Clinical CSD RTI/STD Case Management for Nurses	10 days	150	0	226	226	226	635	861
19	Orientation of District and Upazila Managers on District Management Information System	1 day	0	0	0	0	630	630	630
20	Essential Newborn Care Training for Doctors	1 week	300	55	300	243	0	0	298
21	Orientation Training for Imam	1 day	0	0	0	0	4000	232	232
22	Basic Training on Clinical CSD RTI/STD Case Management for Medical Technologists	5 days	60	0	89	89	89	106	195
23	TOT on Quality Assurance for UHFPO, RMO, Mos	3 days	750	0	200	135	400	26	161
24	Breast Feeding Counseling Course for Doctor, Nurses, Nutritionist, Health Educators	5 days	150	0	144	145	105	14	159
25	TOT for FWVs on Midwifery	5 days	100	62	0	0	100	78	140
26	TOT on Sputum Microscopic Test on TB for Doctors	6 days	0	0	0	0	200	102	102
27	Comprehensive EOC Training for UHFPO & RMOs	1 week	0	0	60	60	0	0	60
28	Training on Sputum Microscopic Test on TB for Laboratory Technologists	6 days	0	0	0	0	100	41	41
29	Training on Prevention and Control of STD/AIDS for Doctors, EPI Supervisors, EPI Technicians and Sr. FWVs	3 days	0	0	0	0	200	40	40
30	Training on Research Methodology for MOHFW, DGHS, DGFP Personnel	5 days	0	0	0	0	40	36	36
31	Training on training Methodology, Management, Monitoring, Supervision and Follow-up (Sr. FWV, AHI, FPI, SI, HI)	6 days	0	0	0	0	25	18	18
32	Voluntary Sterlization Certification Course for Doctors	3 days	150	80	150	60	150	126	266
33	Training on Nutrition for Obs & Gyn Specialists	15 days	270	48	270	97	0	0	145
34	Health Education, Communication, Community based Clinical Practice Course for Doctors	1 week	0	0	20	17	0	0	17

Sl. No.	Name of Training	Duration	1999-2000		2000-2001		2001-2002		Cumulative 07/1999-12/2002
			Target (Number)	Achievement (Number)	Target (Number)	Achievement (Number)	Target (Number)	Achievement (Number)	Achievement (Number)
35	Training on HIV Testing and Quality Control for Laboratory Technician	1week	90	11	45	25	0	0	36
36	Community Based MCH Training for B.Sc Nursing Students	15 days	0	0	112	26	0	0	26
37	Training on Laboratory Diagnosis of Public Health Importance for MOs and Lab. Tech.	1 week	10	9	30	9	0	0	18
38	Midwifery Training Course for Senior Staff Nurses	12 weeks	0	0	0	0	30	30	30
	Total Achievement	22	19274	3647	42665	21486	75286	59826	89087

(Note: No Training was conducted in 1998-1999)

Table 17.2: Training / Seminar/ Workshops on Hospital Improvement Initiative

Workshop / Seminar	For / with	Date	Venue
Nurses Assertiveness Training Workshop	Nurses from 5 Pilot Hospitals	12 April 2001	Sylhet MAG Medical College Hospital
Launching Ceremony – QA Standards	Hobigonj District Hospital	09 May 2001	Hobigonj Hospital
Management Development Workshop	Committee Members	14-17 July, 2001	DFID Guest House Srimangal & Parjatan Hotel, Sylhet
Management Development Workshop	Committee Members	09, 11 August and 13-14 August 2001	DFID Guest House Srimangal & Hotel Holy Side, Sylhet
QA dissemination workshop (Basic and Refresher)	Committee Members - MAG Osmani M.C. Hospital, SSA Hospital, Sumangonj, Hobigonj and Moulvibazar district hospitals	Oct, Nov and Dec, 2001 3 days each	MAG Osmani M.C. Hospital, SSA Hospital, Sumangonj Hospital, Hobigonj Hospital & Moulvibazar district hospitals
Workshop on developing Job Description and Concept of	Committee Members - MAG Osmani M.C.H, SSA Hospital, Sumangonj,	05 and 06 Nov' 2001	Conf. room_ Holy Side Hotel, Sylhet

Workshop / Seminar	For / with	Date	Venue
Performance Management	Hobigonj and Moulvibazar dhs		
Management Development Workshop	Committee Members	10 Nov' 2001	DFID Guest House Srimangal
Management Development Workshop	Committee Members	12 and 13 Nov' 2001	Hotel Holy Side, Sylhet
Workshop on QA Standards Monitoring	Sr. Doctors and Consultants of MAG Osmani M.C Hospital and SSA Hospital, Sylhet	14 Nov' 2001	Hotel Holy Side, Sylhet
Presentation and Finalization of draft 'HAOP" under HII	Sr. Staff Members - MAG Osmani M.C. Hospital, SSA Hospital, Sumangonj, Hobigonj and Moulvibazar dh	2~6 January 2002	Hobigonj, Moulvibazar, Sunamgonj, MAG Osmani MCH and Shahed Samsuddin Ahmed Hospital
QA dissemination workshop (Basic and Refresher) under HII	Committee Members Moulvibazar district hospitals	03 January 2002	Moulvibazar district hospitals
Workshop on Management Development under HII	HMC Committee Members - MAG Osmani M.C. Hospital, SSA Hospital, Hobigonj, Moulvibazar and Sumangonj district hospitals	16~17 and 19~20 January 2002	Hobigonj DH, Moulvibazar DH, Sunamgonj DH, MAG Osmani MCH and Shahed Samsuddin Ahmed Hospital
Workshop on BCC Strategy _ HII	Hospital Staff Members - MAG Osmani M.C.H, SSA Hospital, Sumangonj, Hobigonj and Moulvibazar dh	17 January 2002	Conf. room_ MAG Osmani Medical College Hospital, Sylhet
Workshop on Hospital Level Planning	HMC Committee Memebers - MAG Osmani M.C.H, SSA Hospital, Hobigonj, Moulvibazar and Sumangonj district hospitals	21~22 and 23~24 January 2002	DFID Guest House-Srimangal and Hotel Holy Side, Sylhet
Workshop on Hospital Level Planning	Line Directors of DGHS	17 January 2002	DGHS Conference room
Workshop to formulate Job	Hospital Staff - MAG Osmani M.C.	7, 9~10	Conf. Room- MAG Osmani Medical College

Workshop / Seminar	For / with	Date	Venue
description for Hospital Staff	Hospital. SSA Hospital. Hobigonj. Moulvibazar and Sumangonj district hospitals	March 2002	Hospital
Workshop on TOT Infection Prevention SoP and QA Monitoring with HMC Members in 5 Hospitals, Sylhet	QA Members HMC Members -MAG Osmani M.C. Hospital, SSA Hospital, Hobigonj, Moulvibazar and Sumangonj district hospitals	22~24 April, 2002	Hotel Holy Side conf. Room
Training on Cleaners of 5 Hospitals, Sylhet	Clearners - MAG Osmani M.C. Hospital. SSA Hospital. Hobigonj. Moulvibazar and Sumangonj district hospitals	4~6 May, 2002	Sylhet
Workshop on Hospital Management Committee with HMC Committee Members of 5 Hospitals, Sylhet	HMC Members - MAG Osmani M.C. Hospital. SSA Hospital. Hobigonj. Moulvibazar and Sumangonj district hospitals	10~11 July, 2002 13~14 July, 2002	DFID Guest House, Srimongal and Hotel Holy Side Conf. Room. Sylhet

Table 17.3: Training Provided to Other Support Services System

Name of training	1999-2003				
	Category of Staff	Target numbers	Achievements by July '02	Achievement rate	Remarks/ information source
Training of Support Services on Logistics and Procurement					
6 days training on store management by Deliver Bangladesh	hana Storekeepers (designated)	150	150	100%	Deliver
2 days for	H&FPO/TFPO/MOMCH	450	435		
21 days (on 3 different module)	Selected officials of MOHFW	70	75	107%	Deliver

Name of training	1999-2003				
	Category of Staff	Target numbers	Achievements by July '02	Achievement rate	Remarks/ information source
Training on Procurement of goods and services (Deliver Bangladesh with USAID fund)	M/DPM/ Desk officers of CMSD/ &S (DGFP) ESP both, UBCC, MIS, Drug.A				
One day orientation training on IDA guidelines for procurement by Deliver	olicy level and decision making ersonnel of MOHFW, DGFP. DFP		100	100%	Deliver
Basic Computer training for CMSD staff by Deliver		20	20	100%	Deliver
Basic Computer training for officials/staff of MOHFW/DGHS/DGFP/NIPORT/NICVD etc	28/15 days Mid level and Desk fficers, POs, DA/ LDA, CS and DD ffice officer and staff	314 by TTU	314	100%	IST/ TTU report
Training of Support Services on UMIS					
TOT on UMIS forms etc MIS by UMIS	H&FPO,RMO TFPO, MOMCHFP		All thanas of 64 districts		UMIS
2 days Training on UMIS recording and Reporting for field personnel by UMIS	HI,FPI,HA, WA,FWV	31580	20127		IST/TTU report
Training on newly designed LMIS forms for pre-testing by Deliver and UMIS	ll concerned staff of 31 Upozilla			100%	Deliver

Activities	Target/No. of activities	Achieve-ment (%)	Outcome
Training of Support Services on BCC			
Delayed marriage Campaign	Campaign in 64 district HQ and 50 Upazila HQ	100%	Campaign organized in Dhaka City as well as 63 dist. HQ and 50 UZ. HQs. Urban/semi urban population of these areas became aware of deleterious effect of early marriage.
Campaign on improvement of continuous rates of contraceptives in low performing 50 Upazilas	Campaign in 50 low performing Upazilas HQs	100%	Campaign organized in low performing these areas became aware of disadvantages of the use of contraceptives as well as influenced about the benefits of the development of small family norms by the continuos use of contraceptives.
Orientation on safe motherhood and social mobilization for service providers and community leaders.	Pilot testign in 2 Upazila under Bagerhat Dist.	100%	Communication materials on safe motherhood pretested among the field workers/community leaders in two pilot areas namely Fakirhat & Mongla Upazila under Bagerhat district.
Orientation on HIV/AIDS for tea garden workers and port workers	24	71%	About 850 workers of tea garden (Sreemongol) and port areas (Chittagong) becam eaware of danger effects of HIV/AIDS.
BCC workshop for Journalists	2	50%	Arranged 1 workshop in one District HQ. 30 local Jounalist of different news agencies attended the workshop. They were oriented about HPSP/ESP/BCC/Gender issues an dshared/exchanged ideas and views in order to high light these issues in different news media and augment the process of behaviour change of the people through mass media.
Advocacy for community group through mass motivational meeting	44	100%	44 mass motivational meeting held at the Upazila/Community level. About 2200 target population become aware of reproductive health. gender issues and HIV/AIDS.
Orientation on Gender Issues	1	100%	35 BCC officials (HQ) participated in the orientation course and shared

Activities	Target/No. of activities	Achieve-ment (%)	Outcome
for BCC personnel			ideas about modalities: how to address this issues among the target population particularly on H&FP issues.
Intersectoral Population Project (IPP) workshop	1	100%	The national level IPP workshop arranged at Comilla BARD. Representatives of nice (9) ministries and 3 NGOs attended the workshop. Each of the projects of the ministries and NGOs has FP-MCH based IEC/BCC programmes. 44 participants form the aforesaid agencies shared their experiences. Promoted BCC in support of H&FP.
Population Information Network (POPIN)	1	100%	The workshop was arranged a the national level with a view to strengthen and improving the utilizaiton of population information data network through strengthening linkage with the members in the country. 32 participants form different allied agencies attended the workshop. The workshop. The workshop helped the net work member to understand the need and importance of establishing a National Population Information Network in the country as well as in the Asia and Pacific.
School Health Education promotion/BCC sessions	35	100%	Arranged 35 school health promotion orientation sessions for the school teachers at the Dst./UZ level. About 1400 hundred school teachers were oriented about different aspects of health promotion such as disease control, school health, FP, adolescent health, gender issues. Relevant H&FP messages are supposed to be addressed by the teachers among the students during the course of teaching - learning sessions in schools.
Observance of different days	10	100%	Observed 10 International and National days related to health and family welfare. These days were observed at the national/divisional/district/upazila level. Rallies, Seminars, TV discussions, Radio discussions News paper supplements and distribution of 30 lacs IEC printed materials and other relevant activities were under taken and implemented in order to foster the theme of the days and strengthened public awareness on promotion of health and family planning on particular national and international issues.
Film show	1050	70%	Involved about 4 lacs people in the film show programme a the community

Activities	Target/No. of activities	Achieve-ment (%)	Outcome
			level and made them aware of FP-MCH. nutrition, disease control and services provided at the service centres.
Video show	460	75%	Involved about 60 thousand people in the video show programmes arranged at the upazila level and made them aware of disease control, nutrition FP-MCH/ESP.
Media Exhibition	64	70%	Media exhibition arranged at the national/division/district/upazila level. Strengthened mass awareness on population control /reproductive health/disease control/nutrition.
Production and distribution of IEC/BCC materials		100000	Produced and distributed different BCC/IEC materials at different levels. Strengthened public awareness on health & family planning and nutrition and relevant issues.
Publication: Parikrama	3600	18800	Produced and distributed Parikrama (Bengali monthly news letter) at he national/division/district/upazila level in which BCC activities highlighted and service providers/stake holders have had necessary informations about current BCC programmes.
Support to Population Health and Nutrition Cell of Bangladesh Betar			Broadcasted 10 programmes per day on reproductive health including adolescent reproductive health, control of communicable diseased including ARI, and FPI, nutrition including breast feeding, gender issues, & arsenicosis. Health & FP messages disseminated regularly. Fostered relevant messages at the grass root level through 9 radio stations.
Support to BTV for Health & Family Planning communication programme	288	100%	Telecasted 6 programmes per week on reproductive health including adolescent reproductive health, control of communicable diseased including ARI, and EPI, nutrition including breast feeding, gender issues, and arsenicosis. Health & FP messages disseminated regularly. Fostered relevant messages a the grass root level through BTV.
1-day BCC Orientation Training of Imam (community leaders)	4000	232	

Table 17.4: List of Participants Attended Overseas Seminar/Study Tour/Fellowship/Training Under in-Service Training (Period: June 1998 – November 2002)

Sl.No.	Year	Organization	No. of Participants
1	1998-1999	DGHS including CS Office, Medical Colleges and UHC	08
		CMMU	03
	1998-1999 Total		**11**
2	1999-2000	MOHFW	11
		DGHS including CS Office, Medical Colleges and UHC	25
		DGFP including DDFP Office and UHC	07
		CMMU	03
		NIPORT	01
		ICMH	01
	1999-2000 Total		**48**
3	2000-2001	DGHS including CS Office, Medical Colleges and UHC	11
	2000-2001 Total		**11**
4	2001-2002	MOHFW	05
		DGHS including CS Office, Medical Colleges, NEMEW and UHC	17
		DGFP including DDFP Office and UHC	08
	2001-2002 Total		**30**
5	2002-2003	MOHFW	10
		DGHS: ➢ From Central ➢ From Districts ➢ From Upazila	 17 06 06
		DGHS: ➢ From Central ➢ From Districts ➢ From Upazila	 01 00 02
		Medical College and Hospitals	63
	2002-2003 Total		**105**
	Grand Total		**205**

Output Component 3B – Support Services: Facilities

18. Adequate physical state of facilities

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Adequate physical state of facilities	Number of facilities upgraded and maintained to provide ESP services (a) physical; (b) functional.	Not applicable	(See text)	CC; UHFWC; THC; District and National by FY

Actual progress:

At the level of Upazila and below, there has been a slowdown in upgrading activities in past three years, reportedly due to funding constraints. But the statement of expenditure for last two years revealed that funds allocated for construction and maintenance could not be fully utilized. From the AOPs of the last 2 years, it appears that a new activities plan of work has been undertaken without completing the ongoing work. This is particularly in the case with CMMU. As a result, completion of construction of a facility and making it functional takes longer and the cost of construction increases and needs revision. As a result, scarcity of funds remains a problem for CMMU. This is illustratedby the following review of progress by level and facility:

Upazila level: There were 402 UHCs (467 upazilas), mostly with 31-bed hospitals prior to HPSP. In 64 sadar Upazilas, District Hospitals and MCWCs (55 functioning in District HQ) are providing the required services. There were plans for:

1) New construction: Construction of 4 new 31-bed Hospitals at Upazila level was planned. From financial expenditure incurred by June 2002, it appears that none of these have been completed (see Table 18.1). Only 5% of works may have been completed so far.

2) Upgradation of 31-bed UHCs: It was planned to upgrade 29 UHC's bed capacity from 31 to 50 bed. It is reported by CMMU that 25 have been completed, although it was not clearly recorded in the AOP 2001-2002. However, from the financial statement of expenditure it appears that 10% of works had been completed by June 2002.

3) EOC in UHCs: It was planned to remodel 35 UHC for EOC service provision. The remodeling/upgrading has involved mainly renovation of the Operating Theatres and creating more facilities for EOC services. About 76% of the estimated cost has been incurred, but the number of UHCs completed and functioning has not been recorded. However, CMMU reported that 31 UHCs had been completed.

Union level: There was a plan to construct 200 new Union Health & Family Welfare Centres (UHFWC). There are 4,470 unions in the country. UHFWCs were planned for those unions where other facilities such as UHC, MCWC, RHC are not established or

functioning at all. Up until June 1998 (pre-HPSP), there were 3,176 constructed UHFWCs (2,595 + 581 upgraded RDs). It should be clarified that before HPSP, Family Welfare Centers (renamed as UHFWC) were constructed and made functional under the control of the Directorate of Family Planning, in those unions where no physical facilities were available. At that time 1,249 Rural Dispensaries (RD) had been functioning under the control of DGHS throughout the country, 750 of which were in GOB owned houses (most were old tin-shed small houses with 2-3 rooms), and 499 were in hired houses. Rural Dispensaries were transformed into UHFWCs through new construction of FWC-type buildings, within the same campus as the RD. CMMU termed the work as up-gradation of RDs. So, in respect of facilities, there is virtually no difference between UHFWCs and upgraded RDs. Prior to HPSP, 581 RDs were upgraded as UHFWC.

During HPSP it was planned to construct 200 new UHFWCs (in 176 unions without any facilities) and to upgrade 24 RDs (with similar construction). Up to June 2002, construction of 152 UHFWCs (including 20 upgraded RDs) had been completed. Among the 750 GOB owned RD houses, 601 (581 before HPSP +20) have been transformed into UHFWC through new construction. Of the remaining 149 RDs, 63 have been tendered and are under process of evaluation as reported by CMMU. In view of the above, it can be concluded that union level facilities have increased from 3,176 to 3,304 UHFWCs during last four years of HPSP.

Community level: At community level, there were no physical facilities or plans to construct facilities prior to HPSP. PIP for HPSP planned for construction of a Community Clinic for every 6,000 people, to provide one-stop service delivery of ESP nearer to the community, where no other physical facility was available

According to the AOP of 2002-2003, it appears that 6,000 CCs were undertaken for construction in 1999/00, 4833 in 2000/01 and 560 in 2001/02. As of now, out of 10,820 CCs planned for construction, 9,413 have been completed (by June 2002) and 8,598 have been handed over for operationalization. It has also been reported that no further CCs will be constructed other than those that are under construction. The number of CCs that are currently functioning is not known.

Where RDs have been upgraded into UHFWCs and the old houses remain unutilized, it was thought that they could be utilized as CCs for the surrounding 6,000 population. It was planned that a CC could function within the same building as a UHFWC. On this basis, the total number of CCs planned was about 18,000.

Overview of progress:

For the purpose of health service delivery, development of facilities (new construction, renovation, up-gradation, maintenance of existing facilities) under HPSP, a yearly operational plan is prpepared every year for 'Construction, Repair and Maintenance'. From the Annual Operation Plan (AOP) of 2002-2003, it appears that only 7 out of 62 activities of different types are directly related to ESP delivery at the Upazila level and below.

The status of implementation in a matrix, with data sheet containing information on cumulative physical and financial progress of the work completed, is supposed to be included in the AOP. However, the AOP for the year 2002/03 contained only the cumulative financial expenditure. From the financial statement, it appears that only 46% of the total expenditure of CMMU has been for facility development for ESP delivery at Upazila level and below. The AOP does not contain any clear statement of completion of work previously planned. However, the AOP and verbal reports from CMMU form the basis of the information in Tables 18.1 and 18.2.

Table 18.1: Progress on facility development for ESP

Location and type of facility	Baseline July 1998	Target up to 2002	Achievement by June 2002	% of work completed
Community Clinic at community level for 6,000 population	Nil	10,820 taken up for construction	9,413 constructed 8,598 handed over; number functional not known	87% 91%
Construction of UHFWC /up-gradation of RDs at union level	2676 +581	176+24	132+20=152 completed	76%
Doctors Quarters at union level; facilities	Nil	200	100	50%
31-bed Hospitals at Upazila level	402	4 new	Work started	5% of work done so far
Up-gradation of UHC from 31-bed to 50-bed		29 + 31 planned	Work started	10% of work done so far
EOC in UHCs		35	Work on going	70% of work done so far
MCWCs in district HQ	55 in districts	9	Work on going	25 %
MCWCs/ Rural Health Center at Union level	23 + 8	-	-	No plan

Table 18.2: Activities planned and cumulative expenditure up to June 2002 according to AOP 2002-2003 (page 226-231)

SL	SL No. with Level of Code of AOP	Name of Activity Ongoing	Estimated Cost (lac taka)	Cumulative Expenditure to June 2002 (lac taka)	Progress %
1	1-A/9362	Construction of 200 UHFWC and RD up-gradation	7000.00	5287.19	76%
2	2/9363	Construction of 35 EOCs in 35 UHCs	1400.00	1077.53	76%
3	4/9368	Construction of 1,760 CCs by CMMU	5170.00	4430.00	86%
4	5/9372	Construction of 8 MCWCS	1260.00	338.25	27%
5	9/9363	Up-gradation of 29 UHC from 31-bed to 50-bed	8820.00	837.00	9%
6	10/9363	Construction of 4 new 31-bed Hospitals at Upazila level	1950.00	89.05	5%
7	18/ 9364	Up-gradation and repairing of existing UHFWC	8417.00	500.00	6%
		All above activities	27017.00	7271.83	27%
	Total	**Estimated Cost for all on going work by CMMU**	**49497.00**	**15715.51**	**32%**
8	61/9368	Construction of 2,500 CCs by LGED	7100.00	6175.00	87%
9	62/9368	Construction of 560 CCs by LGED	1582.00	750.00	47%
	Sub total	LGED	8682.00	6925.00	

Revision of indicator:

This is a compound indicator, with many components and it is not easy to summarize. However, it remains useful while CC construction is underway. After the CC construction has been completed, it may be reviewed and made more focused.

Amendment of target:

This indicator does not have a specific target in the sense of most other indicators. It will never be possible to give a single figure summarizing the adequacy of all physical facilities. An overall impression of the status and of progress in construction is the best that can be provided.

19. Availability of hospitals certified as women friendly

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Target for 2003
Availability of hospitals certified as 'Women-friendly'	Number of facilities assessed and accredited according to WFHI criteria on quality of care, mother-baby package of service, management of violence against women, and gender equity.	Not applicable	No facilities yet accredited and no accrediting agency identified	40 %

Actual progress:

The definition given in the protocol of a woman friendly hospital is one in which: 1) women are treated with respect, dignity and equity; 2) women receive adequate and appropriate care that is timely and affordable; 3) a woman is respected as the person to receive the necessary information to decide about her own treatment, and can voice her opinion and be heard; 4) women as care providers are enabled to make a full and appropriate contribution to service provision.

The women-friendly hospitals initiative was established to address two reasons for female mortality and morbidity in Bangladesh, pregnancy related conditions and death and injury due to violence. To this end, proposed improvements in hospitals include:

- provision of EOC services;
- establishment of protocol for mother baby friendly services, and for the management of violence against women;
- training of care providers and provision of female care providers;
- establishment of a legal framework so the evidence of specially trained care providers is legally binding.

- to ensure appropriate distribution of resources to eliminate discrimination against women;
- develop good management procedures to improve quality of care for women.

Particularly for dealing with violence, multiple Ministries are involved. For example, in rape cases cooperation is required between the Police, the Civil Surgeon and the relevant examining Medical Officer. DANIDA has been supporting the development of this multisectoral aspect.

A multisectoral committee is needed for setting standards, and for certification of WF hospitals. UNICEF has been involved in training hospital staff on dealing with cases of violence – not so much the physical aspects, but psychological aspects like lost self esteem. The initial focus is on staff of hospitals offering EOC services, as these should be the first to be accredited as WF.

Part of the problem for lack of progress with the WFHI is structural, within the MOHFW. The most likely hospitals to be accredited are the Azimpur Maternity Hospital, and four MCWCs (Pabna, Jessore, Bogra and Comilla), with Pabna the most likely. These come under Directorate of FP. The DG (HS) is, however, responsible for identifying the accreditation agency. This responsibility was proposed for LD (Primary Health Care) under whom the WFHI was originally placed. But the LD (PHC) is responsible only for Upazila Health Complexes, and the WFHI is intended to operate in MOHFW facilities like Medical College Hospitals, District Hospitals, UHCs; in autonomous facilities like ICMH; in City Corporation facilities in several cities, and in NGO hospitals like LAMB.

One proposed solution was to shift the responsibility to the Director (Hospitals), but that was not well received, and passed onto the Quality Assurance Cell in DG(HS), which claimed it was understaffed, and not equipped to fulfill the task (possibly correctly).

One possible solution, already suggested, is that some kind of body independent of the two Directorates should do the accreditation. Such a body might be the Obstetrics and Gynaecology Society of Bangladesh (OGSB), a professional body, which has shown a genuine commitment to the wellbeing of women, and indeed took a strong stand on the need to include violence as part of the WFHI on the grounds that many women present with gynaecological problems as a direct or indirect result of violence.

Women Friendly Hospitals must also be Baby Friendly, and the Bangladesh Breastfeeding Foundation has proved effective in accrediting Baby Friendly Hospitals. So the task is achievable but requires a decision on who should do the accreditation. It is still not clear who in the MOHFW has the authority or responsibility to take such a decision, as the WFHI is not in the annual work plans of any LD.

Once the accreditation system is eventually established, the issue arises of which hospitals are likely to meet the standards. As mentioned above, there are several possibilities, but they all need some strengthening in various areas. It has been proposed that a phased accreditation, using Bronze, Silver or Gold levels, be considered as a means

of getting started. Something analogous to basic and comprehensive EOC facilities, where different degrees of capacity are accepted.

Problems encountered:

Since no accreditation body has been identified no institutions have been accredited as Women Friendly. Staff once trained, are moved on to other posts.

A further constraint on developing a cadre of trained staff is that a substantial number of the doctors do not attend the training, even when they have been nominated. The WFH program has little authority over them, so training is proceeding more slowly than was hoped.

Revision to indicator:

This indicator is satisfactory provided an accreditation body is identified as soon as possible.

Amendment to target:

No amendment required.

Output Component 3C – Support Services: Procurement and Logistics

20. Unified logistics and procurement management

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Unified Logistics and Procurement Management	Proportion of goods and services procured and distributed within FY to Upazila level and below, against APIP	a)Goods: 0 b)Services: 0		a) 80% b) 80%

Actual progress:

In the second and third year APR/MTR report, attention was drawn to a number of issues surrounding this indicator:

(1) "Services" are a very minor part of procurement and could easily be dropped from the definition in the cause of greater simplicity.

(2) CMSD receives procurement requests from other LDs, and when the goods are procured they are disbursed according to the distribution plan/list provided by the relevant LDs. In CMSD, the system of supplying goods is complex. At first, CMSD

informed the concerned LDs about the receipt of goods in the CMSD's store. The concerned LDs provided a list or distribution plan to CMSD and to the user authority. The users had to send an authorized person with the authorization and requisition papers. After processing a requisition, delivery of goods was permitted and the concerned party had to manage the transportation of goods. Carrying cost was a major constraint at the initial stage As a result, distribution delays occurred in most cases, particularly for district and Upazila level goods. In the fourth year, CMSD contracted a carrying agency and the situation has improved. However, it is very difficult for CMSD to track whether the goods are going to Thana level or below, except for large items such as X-Ray machines that are likely to go to higher levels hospitals, although possibly to UHCs. Thus, some system of tracking incoming goods procured at Upazila and below is needed (see more discussion below).

(3) Even with a system at Upazila level and below for tracking incoming goods, it may be very difficult to know if those particular goods, which are received during a particular financial year, were actually ordered during the same financial year.

(4) CMSD does not have linked databases for matching orders received or procured, and goods dispersed. This must be carried out manually, and should be computerized with linked databases.

As suggested above, a system is needed at Upazila level and below to track whether or not goods ordered have been received. A reporting format has now been developed by UMIS together with the LDs (ESP-Reproductive Health and Non-Reproductive Health), with assistance from the Deliver Project. This will track the disbursement of kits to these various levels. The form will cover 29 items for Thana/Upazila level, 7-8 items for UHFWC level, and 4 items for Community Clinic level.

LMIS formats containing critical items of both health and FP goods have been developed and pre-tested in 31 Upazilas for several months and are now finalized. These have been sent to MOHFW for approval, but feedback has not yet been received and the format is not in use. Hence, the collection of information on distribution status of health goods up to the client level has not been made functional.

LMIS report on FP items such as Contraceptives and DDS kits are collected from the Upazila and other store levels, including information on distribution to user level, and this is published regularly. However, currently at least 30% of Upazilas remain unreported when the information is published. The number of non reporting Upazailas increased by 25%. (only 5% at the beginning of HPSP). Comparison of earlier and current LMIS reports will show this.

It was widely known that there have been delays in procurement due to lack of familiarity with procurement procedures following IDA guidelines. To alleviate this situation, three full-time USAID-funded consultants have been deployed, one for CMSD, one for DGFP logistics unit and services procurement, and a third for procurement of construction – this continues. KFW have provided 4 full time local- and 1 full time expatriate consultant,

and another two part time equipment specification specialists from July 2001 to December 2002, for CMSD only. In order to build capacity within GOB, extensive training has been provided to personnel of CMSD and other procurement related officials under different line management, on procurement guidelines for goods and services - up to 150 staff involved in procurement (see HRD support services for training). At the same time three operation manuals (one for goods, one for services and one for reference) have been developed, tested, used during training, and widely circulated by Deliver for those who are working on procurement. As a result, the situation had improved to a great extent by the third and fourth year of HPSP implementation.

Since logistics and procurement of both DGHS and DGFP are not unified as planned, the procurement of goods and logistics management are done separately by the logistics unit of DGFP and CMSD under DGHS, following their own previous management system. The only change occurred as an interim arraignment that all goods for Reproductive Health (except EOC equipment) are procured by DGFP, and others are procured by CMSD. As a result, CMSD has been overburdened with a numerous types of items such as furniture, office equipment (eg. computers and accessories, photocopiers, fax machines, printing materials for UMIS and EPI office). It has had to remain engaged with constant pressure from different line managements for those items which are not directly related to service provision. Consequently most of the items related to provision of services are unattended. Procurement planning, packaging, specification and prioritization were also major constraints for CMSD, although it has overcome many of the problems and made much progress in the last year.

Status of procurement:

In 2001-2002, CMSD executed 65 packages (some of which included more sub-packages). During the HPSP period, out of 257 packages planned by the CMSD, goods for 123 have already been received, and 27 packages are under process of contract execution.

The status of Package contracted and executed by CMSD is shown in Tables 20.1 and 20.2. CMSD improved its performance over the years. In the first year (1998-1999) it made contracts against only 15 bidding packages, all national shopping (NS) packages. However, in the fourth year (2001-2002) it made contracts against 47 bidding packages. In the first year (1998-1999) CMSD executed only 15 procurement contracts, but in the fourth year (2001-2002) executed 65 (each bidding package may have one or more contracts).

Figure 20.1: Number of CMSD Packages Contracted, 1998/99-2001/02

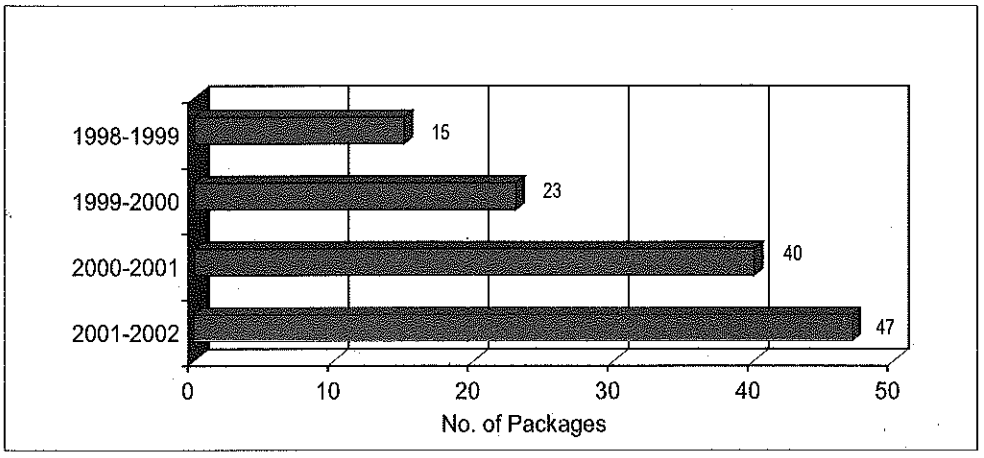
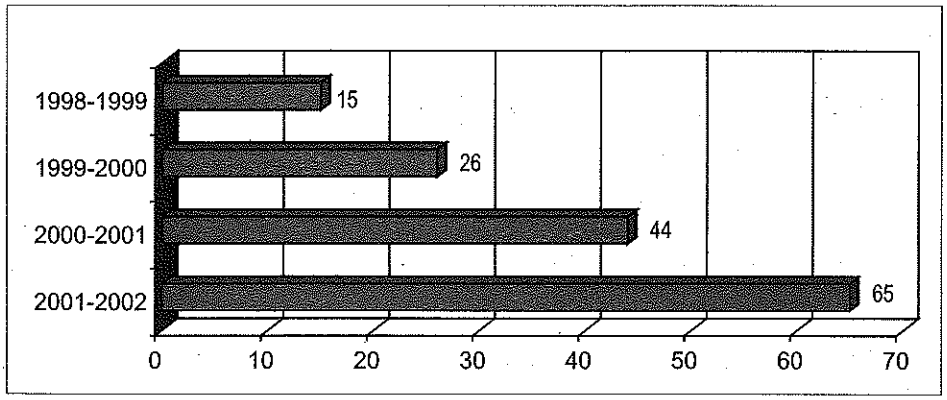


Figure 20.2: Number of CMSD Contracts, 1998/99-2001/02



Status of storage, inventory control, supply and distribution in CMSD:

As reported by the authority/ concerned official, 80% of goods received till now have been distributed to:

i) All goods of specialized hospitals, X-ray machine, ambulance and large equipment, instruments directly to thanas and center where it will be using, as per distribution list provided by the line management.

ii) Drugs and other small but bulk instruments for ESP services have been sent to CS offices/ DRS/ Stores through CMSD's contracted private carrier.

iii) CMSD informed that goods procured during 4th project and some which were lying in CMSD has been supplied 100%

iv) TB/Leprosy and other drugs 100%

v) Furniture, office equipment, forms registers –100%

vi) CC goods and equipment to CS Store /DRS –100%

vii) Instrument for EOC (RH) – not done because of proper distribution plan and carrier problem (one carrier cannot be sent for only a few items to a Upazila)

viii) Out of 53 X-ray machines, 51 distributed.

ix) Out of 63 Ambulance received, 43 distributed.

Overall, 80% of goods received against 123 packages are supplied and distributed from CMSD. Whether the of goods (drugs/equipment etc) that were supplied to District H/Q has been distributed to service center, or not, is not known to them. CMSD has no mechanism to get feedback on the distribution of goods at the service outlets. A system needs to be developed to collect information on the distribution of goods from District stores to service outlet through a reporting format like the LMIS report on FP goods. Currently this can be done manually and later through a computerized inventory control management system which is going to be established by Deliver / JSI in CMSD.

Status of procurement and distribution of RH goods from FGFP:

Logistics unit of the DGFP prepared a thee year rolling procurement plan for 25 packages (increased to 36 for sub-packages) for mainly contraceptives, DDS kits for CCs and H& FWCs and MSR for reproductive health services in 2000-2001. As of now, they have completed procurement of 6 packages containing 18,200 sarees , 10,200 lungis , 60,000 ampoules of injection pathedine for surgical contraception, 119,600 bottles of Povidone Iodine solution. Procurement postponed/ dropped for 16 packages/sub-packages. Table 20.1 shows the status on other drugs and contraceptives.

Table 20.1: Status of procurement of drugs and contraceptives

Item	Quantity	Status
Condom	4440,000,000 piece	6 – Contract signed by November 2002
Low dose Oral pill	50,000,000 cycles	Tender floated
Injectables	31,000,000 vial	Contract signed on Sept. 2001. Out of 31 million 25.5 million already received
IUD/Copper-T	165,000 piece	Contract signed by November 2002
Norplant	253,000 set	Under the process of Bid evaluation
NSV kits	5000 set	Bid evaluated and decision taken for procurement
MR kits	37,000 set	Under process of Bid evaluation
DDS kits for CC	121,500 box	IFB could not be issued for want of clearance from Drug Administration
DDS kits for UHFWC	84,075 box	Same as above

Problems encountered:

Procurement of Drug kits for CC and UHFWC will be delayed because of some legal issues in respect of procurement of drugs outside from the country. On the other hand IDA guidelines require International Bidding for such large scale procurement. Stocks of DDS kits are already existed. There will be acute crisis of those essential drugs supplied through kits particularly at the union and community level.

Stocks of contraceptive items and distribution of those items through Family Planning distribution system are quite satisfactory. Monthly LMIS reports reflect the distribution status of contraceptives regularly.

Unified logistics management at upazila level:

Until now the unified logistics system at upazila level has not been fully (100%) functional. Deliver Bangladesh has been working on this problem for last two years. According to Deliver, only 94 of the 464 Upazilas are operating a fully unified system (management, storekeeper, goods supplied from both health and FP in one store). In 194 upazilas, unified management, designated store keeper are functional , but the store is in two separate location/rooms. In 73 Upazilas, there is unified management, but 2 storekeepers and 2 separate stores in separate locations. The rest are yet to be unified in any way and in 25 cases there are two managers, two store keepers, and goods are in two different stores, as before HPSP. The status of 111 Upazilas is unknown.

Status of procurement of services:

Services Procurement: This is the most grey area of implementation of HPSP. Procurement of services such as hiring individual consultants or consulting firms/ agencies for technical assistance, studies or surveys is problematic. Selection of NGOs for providing certain specific services using IDA funds, requires that IDA procedures are followed. These are very simple in the case of hiring individual consultants. However, most of the line managers have complicated the process with GOB procedures and have not been able to procure consultants. For example, line management of ESP (DGHS), L&S DGFP, UMIS, R&D, SWM, HRM, FM could not complete the process and procure individual consultant for TA under their AOPs, and ultimately dropped this. Some of the study/survey TA services proposed in the selection plan could not be implemented by Drug Administration (2), CMSD (3) , L&S DGFP-2, IST (2), Intersectoral Multusectoral (1), Policy Regulation (3), SWM (2) and the packages were ultimately dropped from the plan. Most of the TA has been procured under bilateral funding on the initiative of concerned DPs or UN agencies. Training provided on service procurement to a few desk officials of important line management like ESP (both Health and FP), UBCC, UMIS, L&S of DGFP, CMSD, SWM of DGHS, MOHFW by Deliver Bangladesh improved the situation. UBCC executed 3 contracts, IST 1 contract, ESP (RH) ultimately contracted (with a delay of 2 years) NGOs for 3 service packages. Line management of IST , and Intersectoral and Multi-Sectoral collaboration could not completed the process of contracting two service packages as planned in 2001-2002 and dropped this at the end of the process. LD-ESP did not contract out any package on HIV/AIDS to NGOs during the

period. The HIV/AIDS office processed 17 service packages of different types for contracting out to NGOs. However, the process has been very slow and for two EOI published in August 2002, short listing has not been completed. Another 15 EOI have been requested, but it will be difficult to complete the process in 2003 because of shortage of skilled manpower in the HIV/AIDS office .

Revision to indicator:

As mentioned above, consideration could be given to three aspects of the indicator. (1) in the interest of simplicity, 'goods' be retained, but 'services' be dropped, as they are a very minor component of procurement, and a component that is difficult to monitor; (2) dispersal of goods procured to the level of Thana and below can only effectively be monitored by a system that records and reports incoming goods at those lower levels. Such a system under development, but will take time to function; (3) even with a functioning system reporting receipt of goods at Thana level and below, it will be problematic for that system to know if the incoming goods were ordered in the same financial year as they were received. Maybe that timing criterion could be modified or dropped, although some measure of timing is certainly needed to monitor delays.

Amendment to target:

A great many improvements have to be put in place in the procurement system before there is any chance of the target of 80% of goods and services being procured and distributed within the FY.

21. Reduction of system losses

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Reduction of system losses	Proportion of commodities (contraceptives, X-ray films, vaccines, etc.) distributed by CMSD and DGFP versus received by service delivery institutions		10% (estimated for commodities)	5%

Actual progress:

This definition covers system losses between the CMSD, DGHS (for non-FP commodities), DG(FP) Central Warehouse (for FP commodities), and the peripheral storage warehouses, and stores of NGOs involved in the distribution of GoB commodities (FP contraceptives, some TB, leprosy drugs, etc.). The definition does not cover system losses between the service delivery institutions and the users (see below).

Until now there has been no formal Logistics MIS system in place that could recognize and measure system losses in the health sector. In the absence of a functional MIS, Deliver Project, Bangladesh, maintained its own MIS. It continues to give technical and logistic support to UMIS. Activities currently underway are the development of a delivery form to trace supplies from central stores to health facilities. 29 items will be included at Upazila level, 7-8 at UHFWC level and 4 at Community Clinic level.

Sources of information on systems loss are almost non-existent. Physical Inventory/ Continuous Physical Inventory , Commodity Audit and Monitoring of inventory and storage management which were proposed in the PIP as well as in the operational plan were not implemented at all during HPSP period. No systematic information is available both at CMSD and Logistics DFP to assess the system losses. So it is difficult to assess the current status of systems loss. The Central Warehouse authority claimed that systems loss has been reduced during the HPSP period. The reasons stated were that occurrence of theft in the stores/DRSs have been reduced considerably because various precautionary measures have been taken by the authority and there is better inventory management by the trained personnel at all levels. The estimate was that systems loss had been reduced from 30% (1997) to 10%.

Indicator for measuring system loss may be able to identify and assess systems loss in the following manner:

i) Quantity of goods and equipments pilferage during shipping/ carrying, distribution or at storage level with cost involvement

ii) Quantity of goods losses by theft cases occurs and cost involvement of those theft items

iii) Items and quantity of goods become unusable for expiry of dates and other mismanagement and the cost

iv) Delay in supply and distribution etc.

Establishment of a monitoring cell and proper utilization of existing 4 Logistics Monitoring Officers of UMIS through regular field visits and systematic monitoring of logistics will be highly cost efficient in reduction of further reduction of system loss. Yearly commodity audit, continuous physical inventory on sampling basis, and computerization of inventory management at all level will help a lot in minimizing the system loss to the desired level/

Even when fully functional the MIS will not take into account losses from service provider to client. This could, potentially, be quite high for certain items, and will require audits; surveys or strict supervision of service providers at all levels.

Contraceptives are an example of commodities believed to have high levels of system losses. There have been rumours of up to 50 million condoms, and 20 million oral pill cycles being unaccounted for, or going astray, in the recent past. There have been a number of investigations of this problem (see READ). With so many outlets it is difficult to track usage all the way to the consumer or user. For example, Social Marketing

Company (SMC) has 150,000 outlets used for delivery of condoms and pills. There are some assumptions on usage that may affect apparent system loss. The actual number of condoms required was recently increased from 150 to 200 condoms per person per year. Such a change has a substantial impact on the estimation of system losses. A detailed study of systems loss for all contraceptives is proposed, to be conducted sometime in the future, possibly in 2003 (FPLM). This may throw some light on this perennial problem.

Several actions were taken to reduce these losses that were expected to occur both within and outside the country. Service providers were made aware of the suspected losses, program supervisors were trained and the Minister of Home Affairs collaborated with an awareness exercise among border officials to hopefully reduce losses to markets in neighboring countries.

Problems encountered:

It is generally agreed that systems losses cannot be tracked through the conventional MIS statistics. Rather special surveys or audits are required. There have been quarterly audits over the past couple of years, but these have been discontinued for reasons unknown. A recent audit by a private sector firm throws some light on the extent of the problem (See PIACT Report).

A change in supply delivery system to Kits has slowed down the progress made in preparing a reporting form for use in tracking supplies from Central to peripheral level. Even when fully functional the MIS will not be able to detect losses from the service provider to the client.

Revision to indicator:

This indicator is appropriate until 2003. Thereafter revision will be required to ensure delivery from service provider to clients.

One approach is a dual measurement estimating demand by users, and comparing with commodities dispersed. For example, this would theoretically be possible by estimating the number of condoms required for the households using them as a contraceptive method as estimated by survey. Supplies from service provider to clients should match this number or at least follow the trend in usage. It is probably not practical however, to use this approach on a large scale for a wide range of commodities including drugs.

Amendment to target:

No change at this time.

Output Component 3D – Support Services: Quality Assurance

22. Client satisfaction

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Client satisfaction	Client Satisfaction Index. Disaggregated by gender and socio-economic status.	53%	Among users, 62% were satisfied with GoB services, and 88% with NGO/private services.	80%

Actual progress:

Fieldwork for the Service Delivery Survey (2001) was actually conducted in October 2000. The annual SDS was not conducted in 2001 for 2002, and thus there are no new national level data on client satisfaction. The SDS 2001 survey obtained data from 25,429 households (users and non-users) regarding satisfaction with government health and family planning services. Among all respondents (users and non-users of Government services), 10% considered the Government health and FP services were good, 48% neither good nor bad, and 41% thought services were bad. This was a reduction from 1999 when 37% of all respondents thought Government services were good. However, among the users of Government services, 62% were satisfied with the overall service they received, compared with only 53% in 1999.

As reported last year, the most commonly reported problems in Government Health and Family Planning Services were lack/poor quality of medicines (58%). Other commonly reported problems were poor service and staff attitude, difficult to reach, having to pay, expensive medicines, lack of doctors/nurses/specialists, lack of services, dirty and poor quality equipment, doctors not available, extra payments to doctors/workers, too few beds/lack of facilities. A similar pattern of problems was reported by men and women and by different socio economic groups.

In comparison with 10% of respondents reporting that Government services were good, 25% rated NGO/private services as good, with a slightly higher proportion among very poor households (28%). NGO/private services were rated as neither good nor bad by 62%, while 10% rated them as bad. There were no gender differences in opinion in this respect. Satisfaction among users of services was much higher compared with Government service users. Among those who reported using health services in the last month, 88% reported satisfaction with NGO/private services overall.

Commonly identified problems of private and NGO health care services were having to pay/expensive medicines (41% v 17% for Government services); bad service, lack of doctors/nurses/specialists; lack of different services; lack/poor quality of medicines; extra payments to doctors/workers; difficult to reach; dirty and poor equipment/facility; too

few beds, lack of facilities; and bad staff attitude (6% for NGO v. 25% for GOB services). There was no difference in responses by gender or socio-economic status.

Revision to indicator:

Client satisfaction is a demand-side indicator that is valuable in itself, but is only a proxy indicator for quality of services. An additional supply-side indicator might be considered, with a composite index being based on a set of quality assurance (QA) indicators. The index could be compiled on the basis of observation/data collection rounds on a random sample of locations and facilities. However, in the public sector, DG Health, the Line Director responsible for QA, currently does not have any structure for systematic QA monitoring. In the NGO sector, monitoring systems are well developed among some of the larger NGO programmes, such as NSDP, BPHC and BRAC. For example, data on 8 quality of service indicators were collected in 3 observation rounds under the NIPHP project and a report on this has been compiled by Engender Health.

Amendment to target:

No change.

Output Component 3E- Support Services: Behavioural Change Communication

23. UBCC strategy functional

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
UBCC strategy functional	a) % of population aware of: danger signs of pregnancy and childbirth; disaggregated by gender. b) % of caretakers aware of fast/difficult breathing and chest indrawing as danger signs of pneumonia, disaggregated by gender. c) % of children who received ORT for the most recent bout of diarrhoea, disaggregated by gender. d) % high risk group aware of how to protect themselves from HIV/AIDS	Not applicable	See text	a) 70% b) 70% c) 95% d) 60%

Actual progress:

The "Integrated Behaviour Change Communication Strategy for the Health and Population Sector" has been drafted. A stakeholder workshop on finalization of the BCC strategy was held, and the draft strategy finalized. It was sent to the MOHFW which met on 16 Sept. 2001 and suggested revisions, resubmitted on 11 March 2002,

further revised, and is now awaiting approval. It is, therefore still not functional. As stated in Indicator 16 on unification, progress in UBCC has been very slow. There is a unified AOP, offices in the same building, but still no finalized job description by the (former) MCU, the SRO has not been issued, and staff are still paid from separate budgets (HEB from revenue, and IEM from development budget). In the field, the TFPO, who has BCC training, reports on BCC activities to the MO-MCH who has not been trained. Some materials for use in the CCs have been produced and supplied.

Sub-indicator (a): The DHS 1999/2000 found that only 16-19% of pregnant women had received advice on danger signs in pregnancy. The national Maternal Health Strategy, which has been approved by government, details a BCC strategy. BINP could strengthen their own BCC on warning signs in pregnancy, labour and delivery, and share with others.

A campaign is underway on warning signs in pregnancy and childbirth (developed by 'Expressions', and funded by UNICEF – it will be scaled up by UBCC. In various pilot test areas with NGOs and donors, there have been efforts to increase awareness (eg. CARE, BRAC, GTZ), and BINP has made progress which could be scaled up.

Sub-indicator (b): The DHS 1999/2000 found a slight increase in ARI incidence in children, but a significant reduction from 36% taken for treatment, to 27% (29.6% for males, 24.6% for females). UBCC needs to address this gender gap in treatment. UNICEF found (reported in Progotir Pathey) that awareness by mothers of danger signs had increased from 67% in 1998 to 76% in 2000. UNICEF is working with field level ARI treatment providers, and district health educators to develop an approach.

Sub-indicator (c): No new data since last year's report. According to the DHS 1999/2000, the percentage of children under 5 years who had diarrhoea in the two weeks preceding the survey was 6.1% (6.4% for male and 5.8% for female children). The data on ORT is somewhat complicated as it distinguishes between oral rehydration solution (ORS) in packets produced commercially, or recommended home fluids (RHF), or either one or the other, or simply increased fluids. Other options for diarrhoea management include: 'taken to a health facility'; 'no ORS/RHF/Increased fluids'; 'various other treatments'; or 'no treatment'.

For this indicator, 'increased fluids' is not regarded as relevant to the functioning of the ESP, whereas taking RHF is relevant. Therefore the percentage of children with diarrhoea receiving either ORS or RHF is presented. This percentage is high at three out of four (73.6%), primarily ORS (61.4%), with RHF 24.7% (there is clearly some overlap with use of both types).

Gender differentials: Female children are more likely to receive either ORS or RHF than male children (76.7% vs 71.0%, respectively).

Economic differentials: Use of either ORS or RHF is very equitable, ranging from 67.9% among children in the poorest households to 78.4% among children in the richest households – a poorest/richest ratio of 0.866.

Social differences: There is remarkably little difference across maternal education categories, with 71.6% of children of illiterate mothers using either ORS or RHF compared with 78.2% of children of mothers with secondary education or more.

Sub-indicator (d): This sub-indicator refers to awareness among high-risk groups, but the DHS 1999/2000 presents levels of awareness among married couples, both men and women. Only 30.8% of (ever-married) women, and 50.2% of (currently married) men have ever heard of AIDS. The sources of such information were TV, radio, and friends/relatives, in that order.

About one in ten believed that there is no way to avoid AIDS, but it is encouraging that this percentage has declined since the 1996/97 DHS from 41% to 12% for women, and from 27% to 11% for men. The most frequently cited way to avoid AIDS was avoiding sex with sex workers. More than 10% of men and women said that having only one sexual partner was also effective. Seven percent of women and 18 percent of men knew of two or more valid ways to avoid AIDS. This knowledge was strongly positively associated with educational level.

For awareness among high risk groups, the behavioural component of the third round of the national AIDS/STD surveillance[18] provides information. The findings suggest that even some high risk groups have similar levels of ignorance about HIV/AIDS to the general population. Among street-based sex workers in south-eastern Bangladesh, 90.7% could not name two correct ways to avoid AIDS – fortunately in central Bangladesh the proportion was much lower, at 31.2%. Among drug injectors, about three quarters could name two ways. This appears to partly reflect the HIV prevention activities of the National AIDS/STD programme and its partners aimed at increasing people's ability to protect themselves against the virus in the better-informed populations. Knowledge of correct modes of HIV transmission is very low among rickshaw pullers (2.8% in Central and 6.7% in South-eastern Bangladesh). Some other groups are also very uninformed (see section 8 on STD prevalence).

Problems encountered:

A fundamental problem is that four years into HPSP, the UBCC strategy has not yet been implemented. As reported last year, a very professional and useful document, 'Integrated Behaviour Change Communication Strategy for Health and Population Sector' has been drafted, and revised, with the involvement of experts in the BCC field. It has been awaiting distribution for two years – supposedly due to lack of funds for printing. This seems extraordinary, considering that producing even a small number of copies for the LDs would be a useful start, so that the LDs can begin considering what their BCC needs are.

There is a structural issue that possibly underlies the lack of implementation. The production of effective BCC materials involves a number of steps. (1) Analysis of the

[18] Although the third round was conducted before last year's report, the findings were not available until November 2001. This year the fourth round has been conducted and findings written up, but as the report has not been approved by the TAC, they cannot be made available in this review.

problem, issues of behaviours to be modified. This requires capacity to conduct research and develop analytical insights. (2) Strategic design of BCC materials, based on the preceding analysis. This requires not only graphic design skills, but a sensitivity to the issues, the audience, and the outlets through which the message will be transmitted. (3) Pretesting of the materials, refinement and production. (4) Implementation and monitoring. (5) Impact evaluation.

Many of these steps in the process of effective BCC material production require creative skills functioning within a flexible system. The UBCC has evolved from two earlier units, the Health Education Bureau of DG(HS), and the Information, Education and Communication unit of DG(FP), both of which served their purpose, but maybe have not kept pace with the developments in the communication field. For example, when HPSP was being planned, there was only one TV station and one radio station – now there are many such stations, and many choices for consumers. The new UBCC unit is presently designed to provide resources in all the above five areas. Government agencies anywhere in the world are limited in their flexibility, and their capacity to foster creative activities. Consideration could be given to focusing the energy of the UBCC unit on the steps that Governments are best suited to. That is the physical production (printing materials in large volumes), and the implementation of the communication, through whatever media is most suitable (print, radio, TV, workshops, etc.). The creative aspects of background research, material design and pre-testing, and possibly impact evaluation, could be contracted to technical assistance agencies with the flexibility, expertise and experience to carry this out.

To some degree the need for flexibility has been recognized. A centre for BCC (CBCC) was proposed some five years ago. It was planned to be autonomous, but under the control of the MOHFW Coordinating Committee for BCC, and the BCC Technical Committee. This is a kind of pseudo-autonomy, which does not guarantee creativity. For example, BCC work can be contracted out, but under GoB guidelines, the technical proposals from bidders are reviewed on merit, but the financial proposals tend to be selected on lowest cost, which does not always coincide with technical excellence. Some structure is needed that allows the UBCC to do what it does best (material production and dissemination), and allows it to contract out what other agencies do best (research, design, and possibly impact evaluation).

Revision to indicator:

It could be argued that the indicator is too far removed from the activities of the UBCC unit. For example, awareness of many of the components in the indicator are being influenced by the activities of many agencies – GoB, NGO, private. Even when positive changes in awareness become apparent, it will be quite difficult to determine how much of that positive change is due to the activities of the UBCC, and its strategy.

It is proposed that, at least initially, that the indicator focuses more on the mechanics of implementing the UBCC strategy. That includes production and dissemination of the document, evidence that concerned LDs are aware of it, and have given thought to requesting the UBCC unit to produce materials relevant to their areas (e.g., STD/AIDS;

CDD; TB/Leprosy; FP; Safe Motherhood, etc.). Possibly some measures of impact of the said specific materials, could be included.

Amendment to target:

The idea that a single target (especially a target of 100%) can be achieved for such different issues as safe motherhood, ARI, diarrhoea, and HIV, is unrealistic. Bangladesh is far ahead of many developing countries in awareness of the signs of dehydration due to diarrhoea. It is behind many other countries in awareness of HIV because this is not yet a visible public health problem. The target must be simplified or subdivided in some way – not because it is not desirable for 100% of the population to be aware of these matters, but because priority must be given in UBCC to the separate issues, according to their importance.

24. Awareness of selected ESP interventions

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Awareness of selected ESP interventions	Proportion of the population who are aware of availability of ESP services at community clinic level, including the referral system up to thana level, disaggregated by gender and socio-economic status.	Not available		100%

Actual progress:

The original intention was that the Service Delivery Survey (SDS) conducted by CIET, would provide this information on an annual basis, or at least until awareness became widespread. However, construction of the Community Clinics was slower than expected (currently 9,413 constructed of the 13,799 planned). The awareness indicator would be quite complicated to explain. For example, it would only be relevant to estimate the proportion of the population aware of ESP services in those areas where services are offered.

The awareness raising is also a responsibility of the UBCC line directorate, but that has also been slow in starting its activities, so the indicator would reflect pre-existing awareness of services such as family planning and EPI. These services are virtually universally known in Bangladesh, in terms of proportion of the population who have heard of them in a general sense.

Under these circumstances, it is probably more realistic to wait another year before examining this indicator closely. It will be useful for CIET to ensure the appropriate

questions are included in the third round of the SDS, assuming that takes place before the next APR, and is not delayed as was the second round.

Problems encountered:

The second round of the SDS did not collect the necessary information, although there were sound reasons for this, as explained above. Other sources, such as DHS routinely collect information on awareness of family planning services, although not the source, which is the intention of this indicator. The HDS 2000 of BBS also did not collect information that could be used for this indicator.

Revision to indicator:

As a range of services are expected to be made available at CC level, when functional, the indicator will have to take into account that some respondents may be aware of certain services, but not others. For example, people without young children may be unaware of EPI services as they are not relevant, but they may be aware of curative services for adult conditions.

Also "awareness of availability of services" must be clear as to whether it includes awareness of when services are available, or only where. Eventually the indicator may need to be expanded to incorporate some aspects of whether the respondent has a positive attitude to such services, and would actually use them. That would involve some measure of perceptions of quality of care at CCs.

Amendment to target:

The achievement of this target requires several steps to be made. One is the construction and operationalizing of all planned CCs, and the second is the conduct of awareness raising activities. If these can be completed in the near future, then this indicator becomes relevant. If not then the target for this indicator must be modified to deal with the reality that not all communities have a functioning CC.

Output Component 3F – Support Services: MIS

25. UMIS operational and functional

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Target for 2003
UMIS operational and functional	Monthly reports of service statistics by thanas and districts received by 15th of the following month, and feedback given by end of month.	Not applicable	Not yet in operation	100%

Actual progress:

To an extent the MIS has been unified in that the MIS (Family Planning) and the MIS (Health) are now both located together. They are sharing computer and database equipment, and data management staff. The Ministry of Establishment has still not approved the organogram.

With regard to data collection, over the past two years recording and reporting forms have been developed which will feed both FP and health data into the unified MIS system. This development was carried out with support from the Operation Research Project (ORP) of ICDDR, B, and full-scale implementation of the new system was done first as a pilot in all Upazilas of Chittagong and Jessore district in February 2000.

There are thirty-one forms and registers, including family health cards just for routine service statistics (SMIS), not including PMIS, FMIS and LMIS. During 2001-2002, the UMIS printed and distributed 23 million Family Health Cards (FHC), 252,350 copies of different registers, 35,000 copies of reporting formats, and 55,000 copies of forms to be used at the different tiers of Upazila level and below.

All district and specialized hospitals are continuing with the previous system. The disease profile part at the UHC is compiled with the district and specialized hospitals at the office of Civil Surgeon (CS) and then sent to Dhaka. Disease profiles are still being collected using old forms and registers. Data on disease profile from district and specialized hospitals are received and a publication entitled "Bangladesh Health Bulletin" is published infrequently. The computerization of service statistics from the Upazila level and below began from May 2002, and customized software has been developed. Retrospective data entry is underway.

WHO is supporting the piloting of the International Classification of Diseases at Gazipur. A list of the most common 500 diseases is being used for the purpose and piloting may take one year.

The deadline for receiving reports from Upazila level is the first week of each month, but the system is not fully operational. There is no official publication of service statistics in a compiled form. With assistance from WHO, an analysis of data from the yearly Geographic Reconnaissance (GR) round of 2001 from 40 selected Upazilas has been published in the form of a flyer. Necessary feedback has been provided to all Upazilas. The UMIS unit plans to do similar analysis of GR data in 2003 for one Upazila of each District. The coverage of immunization and Vitamin A is yet to become a part of the UMIS, and is planned for the next phase. Family planning information continues to go to MIS(FP). The performance of Family Planning, similar to that of the former FP-MIS, is not published yet. The performance on institutional deliveries and of caesarean section at different EOC facilities and levels, is operational. The system has been introduced in collaboration with UNICEF in all district hospitals, MCWCs and 120 selected Upazilas. The reports are coming for computerization at the UMIS unit. A compilation on the status of institutional deliveries and caesarean section will be published soon.

Personnel MIS: 14,000 forms are distributed among the medical professionals, and 9643 forms have been entered into the computer, and detailed analysis is in progress.
All the officers of the Upazilas are fully trained for filling up of the forms and in the reporting system of the UMIS.

A batch of 60 new computers has already been distributed among the officers of MOHFW, Directorates and UMIS. The monitoring of the utilization of those computers is yet to develop by UMIS.

Logistics MIS: The full-scale implementation of LMIS with training of the user and adequate formats at the Upazila level and below officially started in the later part of 2001 in the all Upazilas of Chittagong, Cox's Bazar and Khagrachari district. The previous system is continuing nationwide for recording and reporting the status of family planning logistics. Storekeeper manuals have been printed and distributed, and staff in Cox's Bazaar, Khagrachari and Chittagong districts are trained.

The UMIS is in discussion with concerned officials of the City Corporation and UNFPA to set up a uniform system for the urban areas.

Problems encountered:

The major problem remains the delay in printing the forms and registers. The required form and registers for the year 2002-2003 are in the process of printing.

There are some programs that are still using their previous forms. UMIS still need some time to develop software to satisfy the requirement of individual programs. For example, the EPI and TB Programs are doing this, but they are concerned that when the new UMIS forms come into operation the new forms and registers will not collect all needed data for those Programs. In fact, some of the new forms will not collect data required for annual performance monitoring (APR) in terms of gender and socio-economic status. This should be reviewed in light of the emphasis on equitable service provision.

It is expected that staff below Thana level will require 5 days to complete the forms, a further working week will be required to send these to Thana level where a further week will be required before the forms have arrived, by post, to the central UMIS.

While unification has occurred at Community Clinic Level, UFWC and Thana level, at district, regional and divisional level unification has not taken place. As a result a uniform reporting system has not been followed. Some Upazilas are sending their reports as per UMIS system, while some are not and prefer to send them to the districts.

Development of database software has been contracted out to a private company, and is reported to be complete. When forms start to come in, the question is whether the capacity of the UMIS unit will be sufficient to cope with the data entry to provide quick up to date information on which to develop and change policy, and to monitor progress.

Revision to indicator:

Should be a full month allowed for forms to be completed and arrive at MIS, Dhaka.

Amendment to target:

The target of 100% of Upazilas and Districts reporting by end of following month appears very optimistic at this time. Upazila and districts may be allowed minimum four weeks time for their collection and compilation.

Output Component 3G – Research and Development

26. Research and development (R&D) activities focused on HPSP priorities

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
R & D activities focused on HPSP priorities	Proportion of research information used at policy and implementation level, out of total completed research conducted during the previous fiscal year.		See text	TBD

Actual progress:

Administration of R&D: Last year it was reported that since July 2001 the Director-General (FP) is the sole LD[19]. The current single LD position, being at a senior level, has some consequences with a wider range of other, non-research responsibilities. This means that research does not always receive the attention it deserves. There could be an argument that LD's should be, where possible, at a similar level within the MOHFW, say around Additional Secretary or Director level, to permit them sufficient time to carry out the LD duties. On a different issue, the single Operational Plan still suffers a little from two different formats used by the Directorates (DGHS and DGFP).

Regulation of research: The Research Coordination Committee (RCC), chaired by the Secretary, met on 16 April 2002, and decided to revive NASCOPOR[20]. This is a high level committee, chaired by the Secretary[21], which will prioritize research topics,

[19] Prior to that, there were two LD positions: LD-DGHS (Director, Planning & Research) and LD-DGFP (Director, Planning).

[20] The previous NASCOPOR had ceased to function partly because in order to carry out its technical and supervisory role, it insisted that a proportion of each research budget be allocated to it. Researchers and donors, by and large, were not willing to cooperate with that charge, and bypassed it.

[21] Members include: Member-Secretary – Director, Research NIPORT; DG's NIPORT and FP (the LD); Jt. Chief (Planning); Directors IPGMR, BIDS, BMRC; Deputy Sec (Programs); plus from non-GoB sectors: Directors BIRPERHT, H&R BRAC, and ICDDR,B; Prof. B. e-Khuda (Economics, Dhaka University); CD Population Council.

particularly in population and family planning. It will provide some guidelines for research, and utilize and disseminate research findings. It is encouraging that the committee met on 8 August 2002, and plans to meet again in January 2003.

Funding: There is a proposal to receive a lump sum grant directly from the Ministry of Finance to fund research. Research will be funded by open, transparent peer-reviewed bidding from individuals and institutions, based on a Ministry of Science and Technology model. The LD has received Tk. 350,000 to conduct a workshop on research priorities. However, by mid December, none of the allocated Tk. 2,600,000 funds to actually conduct research have been released. Thus, just as in the past two years, annual funds are not available until half the year has passed, making it impossible to complete any projects of reasonable duration. Indeed there are studies that were funded till June 2002 that have only collected data, but had no funds to computerize and analyze the data, write a report, and disseminate the findings.

As reported last year, the annual procedure for developing the Operational Plans (AOP), and approving them through the Secretarial Committee, then Ministerial Committee, is such that delays in fund release are inevitable. Activities can continue beyond the AOP but need approval, usually an MOU between the LD and the concerned institution, even NIPORT. Based on the signed MOU, the Project Financing Cell can release up to 20% of funds, and can reimburse bills submitted.

A system for contracting out research is functioning, but needs further expansion. There are precedents with research funded through UBCC, and this mechanism has worked quite smoothly. Admittedly they used IDA (WB) funds through PFC, and thus could approve studies longer than one year. There is a TAPP mechanism where UNFPA is supporting policy and planning research in NIPORT on fertility trends, population projections, and sector specific research. NIPORT continues to manage to support studies that reach completion, but a number of these, such as the Demographic and Health Surveys, and the Bangladesh Maternal Mortality Survey 2002, are funded through a different, more direct, mechanism. See 'NIPORT's Research Experience: Lessons Learned, Volume II' (Dr. Ahmed Al-Sabir, 2002).

Problems encountered:

To repeat last year's comments, the delays inherent in fund release, point to the usefulness of Operational Plans of longer than one-year duration, or at least no cost extensions from the previous annual OP. Also rolling work plans would then be needed under this scheme.

The Directorates – DGHS and DGFP do not have trained specialized research staff. Only NIPORT has a Research Director. This results in low priority or neglect of research in the Directorates of Health and FP.

It should not be the role of the LD (Research) to disseminate findings of the research funded. That should be built into the funded proposals.

Revision to indicator:

With the delays in fund release there are few, if any, studies completed and disseminated this year which could have contributed to policy or program implementation. Last year it was stated "Hopefully this same situation will not occur next year", but unfortunately it has. Maybe NASCOPOR will remedy this situation.

Amendment to target:

No target has been decided yet, and it is difficult to see how a target could be set until procedures are in place. Measurement of "proportion of research information used" (as in the indicator definition) is a challenge to quantify. Further consideration should be given to the feasibility of measuring this indicator.

Output Component 4 – Hospital Services

27. Improved hospital management

Indicators by Program Area or Type	Definition	Current Status	Targets for 2003
Improved Hospital Management	Number of hospitals at district and above that 1) are managed by (local) boards; 2) have greater delegated administrative and financial authority	1 Tertiary Hospital; 4 District Hospitals	8 district hospitals, 1 General Hospital, and 2 tertiary hospitals

The Hospital Improvement Initiative (HII) is a component of HPSP with DFID support. It includes specialist technical assistance; management development and training; building works and equipment; systems development, computerization, financial and management information systems; and quality assurance and planning.

The improvement of public sector hospitals has been planned in five district hospitals and one medical college hospital through devolution of greater management authority combined with local accountability. However, instead of five district hospitals, the initiative was launched in four in Sylhet Division: Sunamgonj, Moulvibazar, Hobigonj, and Sylhet Shamsuddin Sadar Hospital; and in Sylhet MAG Osmany Medical College Hospital, from 15th December 1998. Actual implementation started in 1999, following the GO identifying the hospitals (issued by the MOHFW on 27/8/2000). The inputs include improvement of physical facilities with particular emphasis on women-, baby- and disabled-friendly environment, supply of laboratory and other equipment, and comprehensive emergency obstetric care. A decision was taken to allocate 70% of beds for women and children in all new and renovated hospitals.

HII was based on the idea that 'Efficient management of hospitals was not possible without sufficient autonomy, local accountability and decentralization of administrative and financial powers and authority to hospital managers'.

The three main strands of the Hospital Improvement Initiative are:

1) Management capacity building
2) Development of Management Systems
3) Decentralization of greater financial and administrative authority

In the first four years HII has prepared hospital managers in the 5 pilot hospitals in Sylhet for the proposed greater authority, by building their capacity and developing improved hospital systems (strands 1 and 2). It has also provided support to assist with policy development in strand 3 - decentralization of greater financial and administrative authority and retention and application of user fees at the institution. The latter strand is subject to high-level policy formulation.

According to the PIP of HPSP the status of the selected hospitals should be autonomous, but in the initial stages of implementation there was non-cooperation and resistance among the employees of the hospitals. As a result, the programme of granting autonomy to HII hospitals could not proceed. Instead, steps were taken to constitute a management and advisory committee for the HII hospitals, for improving management and service delivery, while keeping their existing government status. However, the MCU/RCT later formulated the draft Hospital Autonomy Bill and handed it to Line Director, RCT on 19/12/2001.

Actual progress:

Considerable progress has been made on the HII. The major interventions and activities undertaken include:

- Formation of National Hospital Improvement Committee with DG Health Services as its convener.
- Formation of Core Cell at MOHFW with Joint Secretary (Hospital Services) as its convener to oversee the activities of HII.
- Formation of Hospital Management (Senior Administrators, Professors / Consultants and Senior Nurses) and Hospital Advisory Committees (stakeholder representatives)
- Formation of Quality Assurance Teams (cross section of clinical and support staff)
- Implementation of work based management development programme, training for hospital management committee members (Vision, Strategy, Quality, Planning, Team Building, Conflict Resolution, Individual and Team Effectiveness and Communication).
- Development of Communication / consultation strategy / Stakeholder Participation (joint planning seminars at all participating hospitals)
- Completion of Building and Equipment Programme at all 5 Hospitals – working initially with JS-Coordination, Hospitals, HMCs, Executive Engineers and PWD to determine works, and with HMCs to implement works focussing on services for women and children (improvements to delivery suites, renovation of wards, bathrooms and toilets) and emergency, surgical and waiting facilities.

- Introduction of Gynaecological Services and Emergency Obstetrics Care at Sunamganj District Hospital after over 5 years without such services
- MIS – Established UMIS Working Group chaired by LD-UMIS (Other stakeholders NIPSOM / UNICEF) to develop and improve existing service, financial and personnel information systems.
- Financial Management training and Financial System Development (FMU/FMIS/HII) initiated including development of monthly reports and orientation of Hospital Managers and Supporting accounting staff on the use of information and basic information technology (IT training).
- Commencing plans for the introduction of computerization in payroll and inventory, and stores management at MAG Osmani Medical College Hospital – currently procuring hardware (FMU/FMIS/HII).
- Currently finalizing proposed new Service Delivery information registers and reporting formats ready for trailing in early 2003 (UMIS/HII).
- FMU / RCT / HII proposing further work on User Fees within Hospitals via proposal for FMU led working group.
- Introduced Hospital Planning in all 5 Hospitals using a hospital planning toolkit linked to LLP process for ease of replication. The process has been developed with Directorates of Planning and Hospitals and 5 Pilot hospitals, with Advisory Committee inputs, and is replicable by DGHS
- Implemented new Quality Assurance Programmes and teams with – LD QA, PM QA and QA Cell
- Developed draft Job Descriptions under ambit of JS-A, Directorates Administration and Hospitals and HMCs.

Key achievements:

Strand (1) Capacity building:

Hospital Managers and Hospital Management Committees increased capacity indicated by:

- Conducting regular meetings (Management and District Hospital Advisory Committees).
- Preparation of Annual Hospital Plans 2001-2 and 2002-3
- Implementation of Quality Assurance and Waste Management Systems
- Development and use of QA monitoring tools
- Planning, coordination, implementation and monitoring of building and equipment programmes
- Local procurement of QA materials and Repair of Equipment

- Regular communication/consultation with doctors, nurses and 3rd /4th class employees according to set communication strategy.
- Improved communication and consultation with stakeholders
- Inputs into user fee and decentralization policy support documents and high level participation on National Hospital Improvement Committee (NHIC), NHIC Sub-Committee on decentralization and presentations to Higher Authorities on HII
- Readiness/willingness to seek additional local responsibility and powers.

Strand (2) System development:

- Development of hospital planning process
- Development of QA and Hospital Waste Management Systems
- Developing Financial System reporting, inventory and pay roll computerization
- Developing MIS (Service and PMIS) reports and formats
- Draft Job Description of agreed categories of Hospital staffs has been prepared and submitted for consideration. A subcommittee was constituted by MOHFW to examine the draft and place for approval by MOHFW.

Strand (3) Policy support:

- Options paper setting out three main options for Hospital Autonomy Decentralization / Greater Authority
- Draft Decentralization Plan (Hospital section)
- Draft Hospital Autonomy Bill consisting Administrative, Financial, and Planning issues has been prepared and submitted for consideration of the appropriate authority on 19.12.2001.
- A GO on collection of user fees and its use in the five HII hospitals was issued on November 2001. However, the modalities were not being cleared through the same GO. To functionalise the GO a supplementary order was considered essential. A revised proposal was developed and submitted to the JS (FM and D), MOHFW, recommending a working group be formed, with members drawn from MOHFW, Finance Division of MOF and other relevant Ministries to work out the modalities for its implementation. The supplementary order for introducing user fees and retention of funds in HII pilot hospitals was also drafted and submitted for consideration by MOHFW.

HII was designed as a pilot to allow phased rollout to other hospitals based on lessons learnt during the first four years. In view of the experiences to date, and to prepare more hospital managers for increased responsibility, the national Hospital Improvement Committee in its last meeting on 15th September 2002 decided to roll out the following components of HII in six more hospitals:

- Management Committee
- Management development programme
- System development: Hospital level planning, Waste management, Quality assurance and Improved financial management system.

A GO has been issued on November 2002 to add six new hospitals to the improvement initiative:

- Chittagong Medical College Hospital
- Chittagong General Hospital
- Feni District Hospital
- Noakhali District Hospital
- Comilla District Hospital
- Coxs Bazar District Hospital

Problems encountered:

The main problem has been non-meeting of the Advisory Committee and non-effectiveness of the Management Committees due to lack of authority. The process of devolution of administrative and financial authorities at the functional level has not taken place leading to virtually non-functional Advisory and Management Committees.

Revision to indicator:

At this stage the revision to this indicator would not be realistic. It could be suggested that MOHFW take effective steps towards decentratization at the targeted HII hospitals. At the same time, concrete functional modalities have to be devised and put into operation for user fee collection, retention and use at the local level.

Output Component 5 – Sector-wide Management

28. Improve gender awareness across the MOHFW through adoption of gender strategy and institutionalization amongst line management

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Improve gender awareness across the MOHFW through adoption of gender strategy, and institutionalization amongst Line Management	Gender strategy for HPSP in place and main-streamed in Line Management			GIO and GNSP operational 100% of AWP of all LD are gender oriented

Actual progress:

The Gender Equity Strategy (GES) is a Strategic Plan developed by the MOHFW, to integrate gender aspects into HPSP. Ten Line Directors are identified to incorporate gender activities in their respective operational plans to mainstream gender in HPSP.

The Gender Desk of the GNSP (Gender, NGO and Stakeholder Participation Unit) and the Gender Issue Office (GIO) have been functionally united. GNSP is part of the Health Economics Unit (HEU), and henceforth the Gender desk will be responsible for planning work and GIO will be responsible for monitoring the implementation status of the plans.

GIO has recently submitted the Gender Strategy to the thematic groups so as to ensure integration of the main elements of the strategy paper into the MOHFW's three-year "Conceptual Framework".

A Gender Equity Mainstreaming project in the MOHFW, with proposed technical assistance from the Royal Netherlands Embassy, is currently under review by the ERD and the Planning wing of the MOHFW has been urged at the recently held Gender Advisory Committee (GAC) meeting (August and September 2002) to expedite the approval process.

The GIO held a workshop with the Line Director (LD), BCC where the LD agreed on incorporating the gender related issues raised. However, no documentation or feedback has yet been received. LD, UMIS has come up with a strong database, which is gender-disaggregated, for health services, and allows provision for information sharing through a server network with the Ministry. Apart from this, LD, HRM (Human Resource Management) has developed a Human Resource Strategy that is in its finalization stage, and has also done a study on "Sexual Harassment in the Workplace".

A committee has been formed, namely Organizational Management Committee (OMC), to monitor implementation of the GES, and is headed by the Additional Secretary of the ministry. In pursuit of this monitoring, the GIO has taken a number of initiatives. It has developed a format to monitor implementation status of different operational plans (OP), and concerned LDs have been asked to report to the GIO on a monthly basis according to that format. However, feedback has been poor. Furthermore, updated information needed by the GIO for reviewing progress and implementation status of the National Action Plan for the Advancement of Women is not forthcoming. The GAC, in its recent meeting, decided that a letter will be sent "to the concerned LDs under the signature of the Secretary MOHFW for implementation of the Gender Equity Strategy" and to initiate feedback to the GIO.

Each LD has been asked to nominate a working level official to work as focal point with GIO. However, only 4 out of 15 LDs responded.

The GIO facilitated one in-house workshop undertaken by the DGFP to "motivate and integrate the GES objectives in the OP 2002-2003". It also facilitated training workshops for the DGHS (in Chittagong and Dhaka) to motivate the health service providers to

implement the GES objectives. GIO has further facilitated a Strategic Planning Workshop on the National Action Plan, organized jointly with the Minsitry of Women and Childrens Affairs (MOWCA) and Local Consultative Working Group of DPs. A workshop was also arranged by the Nursing Wing of the MOHFW for sensitization of nurses, and a similar one is to be held in the next few weeks.

The GIO has also worked on incorporating gender-related elements into the "inspection form" being developed by the MOHFW. This initiative is hoped to serve as a means to monitor the status of implementation of plans.

Problems encountered:

After the Gender Strategy was produced, workshops were facilitated by an external consultant to help translate the strategies into the AOPs of Line Directors. However, these were poorly attended and ownership of the process of implementing the strategy appears to be lacking. A workshop was arranged early February this year, and the GIO invited the LDs to come and formally express their experience, needs and concerns. However, only one Line Director- LD, Nursing, attended. Except from HRM, no other LDs sent effective representatives who were responsible or involved in preparation of the OP. Each workshop had an estimated number of twenty to twenty-five participants.

There have been numerous constraints in the implementation of the Gender Equity Strategy. Coordination among LDs, adequate resources for implementation, awareness and ownership of the issue, all central to the success of gender equity mainstreaming. One of the main impediments faced by the GIO is that it has no separate Operational Plan: its activities are included in the OP of the Line Director, HEU (PRU). Furthermore, it lacks adequate funding, logistic support and equipments.

An inherent functional problem, that of the policy of job rotation, creates further impediments. Re-posting of LDs who are oriented on the issue hampers progress. The current GIO Senior Assistant Secretary is highly committed to addressing gender issues, but may at any time be transferred to another ministry/post. The GIO is currently severely constrained by the lack of technical support and resources (eg. for workshops and travel).

Revision to indicator:

Not necessary at this time.

Amendment to target:

Line Directors should be oriented and in post long enough to initiate changes.

29. HPSP collaboration by/with other ministries

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Target for 2003
HPSP collaboration by other Ministries	Time needed for issue-wise major policy decisions of National Steering Committee to obtain required concurrence from other Ministries.		TBD	TBD

Actual progress:

MCU sent a proposal to MOHFW for formulating a High Level Inter-Ministerial Committee (HLIC) for Health and Population Sector on 6/9/2000 and prepared a draft summary for approval of the Honourable Prime Minister. After completing all the necessary steps, MOHFW issued a GO on 14/12/2000 on the formation of the HLIC. The composition of the HLIC is shown in Table 29.1

Table 29.1: Composition of the HLIC

Honourable Minister for Health and Family Welfare	Chairman
Honourable Minister of State for Health and Family Welfare	Vice Chairman
Secretary, Ministry of Establishment	Member
Secretary, Finance Division, Ministry of Finance	Member
Secretary, ERD, Ministry of Finance	Member
Secretary, Ministry of Health & Family Welfare	Member
Secretary, IMED	Member
Secretary, Ministry of Law, Justice and Parliamentary Affairs	Member
Secretary, Local Government Division, Ministry of LGRD	Member
Member, SEI, Planning Commission	Member
Chief Advisor, MCU/RCT, MOHFW	Member
Team Leader, PCC, MOHFW	Member
Joint Secretary, MOHFW	Member Secretary

The purpose of the Committee is to discuss, coordinate and take appropriate decisions on issues that require Inter-Ministerial involvement, for timely implementation of HPSP. Fourteen items have been listed in the GO under the purview of the committee, including cost recovery with safety nets, HRM/HRD related to reforms and reorganisation, decentralisation, local level accountability, unification, HR planning, management and development.

As per TOR, four meetings of the HLIC are to be held each year. The first meeting was held on 07/07/02, which was chaired by the Honourable Minister for Health and Family

Welfare. In that meeting a total of seven agenda items were submitted. All the agenda items could not be discussed in the meeting because of shortage of time. Only agenda item 1 (Action plan on decentralization) and 2 (Transfer of FP employee from development to revenue) were discussed.

Problems encountered:

Meetings of the HLIC could not be held on time.

30. Financial sector planning

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Financial Sector Planning	Proportion of detailed plans and budgets (APIP) done by June for next FY		Most submitted on time in 2002	100% by the year 2000

Actual progress:

The annual operational plans (AOPs) for the FY 2002-2003 and budgets were received largely on time this year. The Annual Program Implementation Plan (APIP) for the fiscal year 2002-2003 was drafted by the PCC and shared during May-June 2002 APR. After being reviewed in the APR all the OPs were detailed incorporating the recommendations made in the APR. Most of the OPs were submitted to the Planning Wing of MOHFW before July 2002.

The National Steering Committee meeting held on 17th August 2002 decided to restructure and rationalize functions of six OPs (Reorganization of Service Delivery: MCU, Sector Wide Management, Human Resource Management, Policy Research Unit, Inter-Sectoral & Multi-Sectoral Collaboration and Regulation). After this, the OP of SWM was restructured incorporating the activities/functions of Reorganization of Service Delivery: MCU and Policy Research Unit. The NGO and Stakeholder Participation activities of GNSP previously under PRU were brought under the OP of SWM. The activities of the HRD Unit under PRU were brought under the OP of HRM. The activities of Inter-Sectoral & Multi-Sectoral Collaboration were merged with the OP of Research & Development and the activities of the OP of Regulation were merged with the OP of BCC. The OP of Policy Research Unit only contained the activities of the Health Economics Unit.

As a result, the total number of Operational Plans for the FY 2002/03 was brought down to 22, from 25 the previous year. The whole process took much time and all the OPs were not approved by the National Steering Committee until 6 October 2002.

The ADP allocation for the FY 2002/03 is shown in the following Table 30.1, with the total cost of all the 22 OPs as approved by the National Steering Committee.

Table 30.1: ADP allocation for 2002/03

(Million Tk.)

	GOB Development	Project Aid
ADP allocation for FY 2002-2003	Tk. 4060.00	Tk. 11780.00
Total Budget approved by the NSC	Tk. 4060.00	Tk.14090.00
Difference	-	**+ Tk. 2310.00**

Problems encountered:

Although this is the last year of HPSP, in order to restructure/reorganize the OPs of HPSP, a considerable delay has been occurred in approving them. This delay affects the overall procurement process in the last year of the programme. A huge number of packages are in the pipeline for procurement and these will possibly be delayed due to non-release of funds, leading to delayed opening of LC.

An amount of Tk.2310.00 million has been over budgeted in the Project Aid component which would require revision of the current year's ADP. As of now, this revision has not been requested by MOHFW and is not being done by the Planning Commission.

Revision to indicator:

This is not necessary as this is the last year of HPSP.

31. Cost of service use per user

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Unofficial payment for services	Proportion of clients that incur unofficial out-of-pocket expenditure at and by facility level (who didn't receive receipt), disaggregated by gender and socio-economic status		Unofficial = 13%	Unofficial =0%

Actual progress:

There has been no new information in 2002.

Payments: The ticket is the official payment for government health services at hospital level and in some urban facilities. The SDS 2001 shows that about a quarter of people

who used Government health services paid ticket charges (50% in hospitals; 16% in UHC; 20% in UHFWC; and 27% at EPI/Satellite clinic). The mean payment was Tk 7 which is the official charge, indicating that there is overcharging. Charging at UHC level and below is unofficial.

Medicines were paid for by nearly two thirds of people visiting government health facilities, 55% are paying for medicines outside the facility and 8% paying inside the facility. There is a grey area surrounding the terms official and unofficial regarding payment for medicine. For example, if medicines are not available in the facility because they are considered too sophisticated a prescription is made out to the patient who purchase, out of pocket, at a private pharmacy. This can be categorized as 'official' payment since there is a limit to the number of drugs a health facility stocks. If the drug is not available because stocks have run out, this may also be placed in the category of 'official' payments, however, the term 'official' comes into doubt when medicines are purposefully withheld from patients and prescriptions are given in their place. Medicines purchased in the facility, where medicines should be given out without charge, would clearly be 'unofficial'.

In addition to payments for ticket and medicines, payments were made by some people for services, or to obtain a prescription. This amounts to 22% of people who paid on average 54 taka. Moreover, although it is known to be 'unofficial', 20% of people reported having to pay an unexplained amount to a service provider, usually doctors (19%). The average amount was 53.5 taka.

Gender differentials: There was no gender difference in paying for tickets but more male adult service users than females paid for service charges and for medicines outside the government health facility. Males were also found to pay higher service charges (65 taka compared with 46 taka for females) and service provider charges (59 taka compared with 47 taka).

Economic differentials: Very poor people were only half as likely to pay for a ticket compared with less poor people. Although very poor people are as likely as less poor people to pay for medicines they pay lower actual amounts (44.5 taka compared with 93 taka) This applies equally for service or prescription charges and payments to service providers. Although the frequency of payment was similar, amounts paid by the very poor were lower on average compared with the less poor for service charges (41.1 v. 58.9 taka) and for service provider charges (41.3 v. 55.5 taka).

For private service providers, all costs were more frequently required, and average payments in all areas were higher. Therefore, while the public generally feel that 'unofficial' payments are wrong, they realize it is cheaper to pay the provider in the government facility than to pay the same provider in their private chambers.

Total payments related to household income: The Public Expenditure Review published in February 2001 also provides some information on the issue of expenditure on health and FP services. Although there is no segregation of official and unofficial payments, it is interesting to note that for outpatient services the survey suggested that on average people

in different groups make similar payments, a total of about 16 taka per visit and 40 taka for inpatient services . Just under a third of patients reported making a payment. Equal payments by income groups imply unequal proportionate spending, from 4% of per capita household income for richest quartile to 19% for poorest household for out patient services, (2% and 13% respectively for inpatient services). If only those who made a payment are included the proportion rises to around 49% of per capita household income for the poorest household.

Gender distribution of total payments: In the PER survey men were also found to pay more than women for treatment at both outpatient level (22 taka v. 9.5 taka) and inpatient (51 taka v. 17 taka).

It is of concern that the largest payments were for communicable diseases (average: 73 taka). And more so that the highest payments for communicable diseases and limited curative care were reported in the low and low middle income groups. However, lower payments were made for maternal care and family planning (less than 12 taka). This was consistent with the SDS report which showed that less than 5% of people made payments in government facilities for preventative services.

Problems encountered:

The definition of unofficial as being out-of-pocket expenditure without a receipt is problematic. It does not include indirect unofficial charging as discussed in the case of prescribed medicines.

Revision to indicator:

There is no reason to revise the indicator at this time.

Amendment to target:

The target of zero percent unofficial charges is admirable. Whether or not it is achievable is another question. But as a long-term goal it should remain.

Output Component 6 – Policy & Regulatory Framework

32. Pro-women orientation of service pattern in MOHFW

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Target for 2003
Pro-women orientation of service pattern in MOHFW.	Proportion of women on stakeholder committees and management committees.		TBD	Mini-mum 30%

Actual progress:

During implementation of HPSP provision has been made for involvement of the policy makers, local community, personalities, and local government representatives in decision-making, management, supervision, maintenance and other activities related to delivery of services. To date, several stakeholders committees have been formed. To have womens' representation on these committees, having mandatory women members has been suggested. Associated notification and GOs have been issued in this regard. Some of the committees where womens' representation is reflected are listed below:

1. Community clinic

Eleven members which must include:

a) A minimum of 3 women living in the locality will be members of this group (including the women members mentioned in b, c, and d). If a female member of a Union Council is residing within the catchment area of a Community Clinic, she must be a member of the Group by virtue of her position in the Council.

b) One member of the Group should represent the teachers (an experienced social work minded teacher of an educational institution within the area) and another from the local socio-cultural groups. At least one of them should be a female.

c) Two of the members should be included from among the poor/landless and low-income groups living in the locality. It is desirable that one of them should be a female.

d) Two Health and Family Planning service providers (A Health Assistant and a Family Welfare Assistant) should be included as members of the Group without any right to vote. The FWA is a female and in some instances HA's are female.

It was also considered desirable that either the Chairman or Vice-chairman, should be a female.

2. Union health, nutrition and population activities coordination committee

Twelve categories of members which must include:

a) Female members of the Union Council
b) Family Welfare Visitors
c) Headmistress/Headmaster of High School
d) President/Secretary of local Women's Association

3. Upazila health, nutrition and population activities coordination committee

Twenty-five categories of members which must include:

a) Principle of Women's College
b) Head Mistress of Girl's School
c) President/Secretary of Upazila Women's Association

4. District health, nutrition and population activities coordination committee

Twenty-two categories of members which must include:

a) Principle of Women's College
b) President/Secretary of Upazila Women's Association
c) One female NGO representative

However, so far, except for Community Groups, none of the committees has been formed. Also, no data are currently available centrally on how many community groups have been formed, or how many are functional.

Pro-women orientation of service pattern in MOHFW:

There are currently two women working as Line Directors: Line Director (HRM) and Line Director (Nursing). A gender-disaggregated database for the Health Directorate staff has been developed by the UMIS. The database includes information such as, where a certain staff is posted, when a particular staff joined, what training she/he has received. The computerized database will be available to the ministry through a server network and this initiative is hoped to enhance information sharing.

Problems encountered:

The main problem is that no basic unit of the MOHFW or the DG-HS/FP has been given the responsibility to establish and monitor a computerized data system for stakeholder committees.

Revision to indicator:

Indicator has been revised and is appropriate.

33. National drug policy/ordinance revised

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
National Drug Policy revised	The National Drug Policy is revised with widespread stakeholder involvement		0	Revision completed

Actual progress:

There was a need to create a new Drug Policy Committee following legal action protesting the lack of representation of the alternative medicine sector in the previous committee. Subsequently the new committee titled "Drug Policy Review Committee" headed by the Honourable Minister for Health and Family Welfare was formed in

February 2001 to review the existing Drug Control Ordinance 1982 and to recommend necessary amendments to the Ordinance.

In the first meeting of the committee four sub-committees were formed, namely, Allopathic, Unani, Ayurvedic and Homeopathic. All the four committees have submitted their recommendations to the MOHFW. A meeting to discuss the reports and recommendations by the sub-committee on Unany, Ayurbedic and Homeopathic was held on 18/12/2002 under the Chairmanship of the Secretary, MOHFW. The Line Director, Drug Administration expressed the view that it would be possible to complete the process by June 2003.

In the Performance Indicator review for 2000, it was stated that the first steps in the revision of the NDP had been taken in that advertisement had been made for 'expressions of interest' (EOI), and six firms were short-listed. Progress in the subsequent months was minimal. The timing of the advertisement was such that only 26 days remained before submission of bids (4 less that the required 30 days), thus the advertisement had to be resubmitted. This was done, and again six firms were short listed, including three from overseas. The RFPs were sent and proposals were received. An allocation of Tk.3.42 crore has also been kept for consultation on improving Drug Policy. However, in view of the above experience this was dropped by the National Steering Committee in its last meeting.

A major issue that the NDP will have to confront is the globally relevant matter of price control of essential drugs. The original policy of 1982 was designed partly to foster the national production of drugs to be made available to the public at reasonable prices. This has in fact happened, and 117 essential drugs currently have their prices controlled at low levels by international standards. However, there is growing pressure from national pharmaceutical manufacturers to lift controls and free up prices. This issue will have to be addressed in the context of a growing drug/medication export industry in Bangladesh, not only by multinationals based here, but also local firms. Possibly some kind of multi-tiered pricing structure may result.

Problems encountered:

The delays in advertising for the consultant firms to carry out the revision of the NDP are the major problem. The lesson from this is that advertisements for consultants or services should have an eligibility period (say, 30 days) starting from the date of appearance of the advertisement in the press, and not from the date of preparation of the advertisement, or the date of submission to the press, or MOI.

Licensing of pharmaceutical firms appears to need strengthening. There are currently 44 inspectors nationwide. They are expected to visit and renew licences every two years. There should be at least one inspector for each of the 64 districts, or some ratio of inspectors:factories. UNICEF also provides inspectors for drug factory certification, and they have been asked to assist in training new Drug Administration Inspectors.

Revision to indicator:

Little or no progress has been made in the past year. However, there is some prospect of progress next year. The issue of widespread stakeholder participation has been partially addressed by the creation of a new committee.

34. Client charter of rights designed and promulgated

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Client charter of rights designed and promulgated	Percentage of THC and CC that display charter publicly	Not applicable	UHC =100% CC=100%(?)	UHC=100% CC = 100%

Actual progress:

The MOHFW developed mechanisms for participation of stakeholders at both local and national level through the National Stakeholder Committee (NSC). The objectives of the NSC were to facilitate the incorporation of the community's voice into the health programmes to establish their rights to transparency, and to build a foundation for programme accountability. At the local level, the stakeholder committees consist of users of ESP, primarily the poor and women, and include members of civil society to play and advocacy role on health issues. They were initially introduced in nine Upazilas and 16 unions.

An evaluation carried out by ICDDR, B reveals at least two-thirds of the committee members understood and agreed on the purpose of the committees and their role in the committees. Most meetings were held as planned (90%) and were well attended (90%) and facilitated.

The benefits of the NSC were two-fold. First, it provided a forum to raise awareness of availability of health services, including NIDs and cultural practices that were detrimental to healthy life-styles. Second, it empowered committees to address issues to improve health services, reported improvements in cleanliness, waiting arrangement, waiting time, and service providing hours.

Considering the short period of operation of the stakeholder committees, it is too early to expect any significant change in terms of quality of services, transparency, and accountability. However, the committees successfully addressed the commonly discussed barriers to quality of care, such as negative attitudes/behavior of service providers, poor interactions between clients and service providers, and lack of essential drugs and supplies in the facilities. This background is provided here as these activities complement the client's Charter of Rights.

The clients' Charter of Rights was listed in the original PIP (annex 11) as 'Patient's Charter of Rights'. There was also a 'Health-Care Providers' Charter of Rights, each with ten points, but the latter charter is not included in this indicator.

The English version of the Patients' Charter was prepared before last year's APR, and had been translated into Bengali. Around May 2001, the Bengali version was printed in large numbers - 20,000 according to UBCC, from their own press. These were distributed by Policy Research Unit (PRU) of MOHFW to all Divisions around the country with instructions to distribute them down to Upazila Health Complex level, and then to the Community Clinics.

Although there was no major opposition from the service providers, the Upazila-level managers of the MOHFW were reluctant to cooperate with the committees. The stakeholder committees did not follow any standard procedure in implementing their activities. Absence of monitoring by the NSC, and lack of necessary funds, affected the implementation of the committee activities.

Problems encountered:

The Charter was printed at large poster size, and there have been some problems in finding sufficient wall space to display it in the smaller facilities. Also there was not sufficient budget to permit lamination of the posters, so the life of these may be limited. In future print runs, the charter may be produced at smaller size, and laminated or attached to poster board for longer life.

No study has been designed to assess availability and impact of Client's Charters of Rights.

Revision to indicator:

Once this Charter has been distributed, as has happened, it is doubtful that this 'input' indicator is needed in its present form. Some process or output indicator of client's awareness of the Charter, or even use of such knowledge to improve services, should be considered.

Amendment to target:

It is not relevant to amend the target if the indicator is to be dropped. Some output type indicator which monitors signs of growing awareness and implementation of the Charter, either at the individual client, or at the stakeholder committee level, would be useful.

35. Consultative mechanism for private sector and NGOs established

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Consultative mechanism for private sector and NGOs established	Number of consultative meetings between public and private sector stakeholders, and between the public and NGOs, on policy and programmatic issues		No regular meetings at national level	Regular biannual consulta-tive meetings

Actual progress:

The process to delineate the Government-NGO collaboration mechanism was started in March 1999, at a workshop in which the findings and recommendations of the HPSP Consortium Working Group were presented. By November 2000 five consultative meetings had been held to prepare for the formulation of an issue paper on the Role of NGOs in Delivery of Essential Services Package by the Policy Research Unit (PRU) of the MOHFW. This was developed with technical assistance (see below) and presented at a workshop in November 2000.

A unit within PRU was formed for establishing policy consultation between NGO, private and public sector stakeholders: the Gender, NGO and Stakeholder Participation Unit (GNSP), which consisted of three sub-units for these areas. Although the unit was included in the 1999-2000 Operational Plan it only became functional in 2000-2001. The Unit comprised three staff members, a joint secretary and two junior officers. No technical assistance was available within the department, although external support was offered on gender and NGO collaboration. The overall budget allocation for 1998-2001 was 82.88 lakh taka, of which 15.59 lakh taka was spent. The gender and stakeholder participation units were instrumental in the formation of the Gender Equity Strategy prepared by the GIO and the draft Stakeholder Participation Strategy document. However, there has been little progress towards finalizing a strategy for Government-NGO collaboration.

Several consultancies have mapped out the background for development of an NGO strategy and mechanisms for GO-NGO collaboration in the health sector. A draft policy paper was prepared by the GNSP officer for NGO unit taking into account: 1) a study of the activities of 56 NGOs on Essential Service Package (ESP), prepared by a local consultant in June 2001; 2) Government-NGO collaboration on HPSP (HPSP Consortium Working Group) March 1999 and; 3) An Issues Paper on the role of NGOs in Delivery of Essential Service Package, prepared by a committee comprising of members of the Policy Research Unit, consultants from Dhaka University and a USAID representative, in November 2000. The lack of progress on developing the strategy and mechanisms for

national level consultation with NGOs has been attributed to lack of manpower and technical expertise in the PRU.

Initial steps were taken to form an Advisory Committee for guiding formulation of strategy on Government-NGO collaboration. The proposed committee was to consist of 20 members, including Dhaka University, MOH-DG/MOH-FP, USAID, DFID and World Bank representatives, a member of civil society and 2-3 NGO representatives selected from ADAB. Given the recent controversies within ADAB, the latter would not be problematic. Under the guidance of the Advisory Committee and in the light of principles laid down in the PIP, the TWG was to formulate the GO-NGO Collaboration strategy. BPHC, as managing agency of the Public NGO Partnership (PNP) provided assistance to PRU in the form of a framework for the strategy and a process for developing it. However, that process was not taken forward before the PRU was disbanded in mid-2002.

NGOs were involved in the Working Group developing HPSP, but since its implementation there has been no ongoing mechanism for policy dialogue between NGOs and the Government. Generally, it is at the national strategy/policy level that progress on NGO consultation and collaboration has been lacking. However, mechanisms have been established for consultation and collaboration on implementation of ESP. For example, under the Public NGO Partnership (PNP), BPHC has 28 partner NGOs which it contracted under an open bidding process to provide ESP services on behalf of the MOHFW. There is a formal channel for consultation with the Line Director ESP-RH and the NGOs have established mechanisms for collaboration with local MOHFW managers and staff. PNP has established a workable model for GO-NGO collaboration on ESP delivery, with mechanisms for transparent contracting, collaboration at local level, and effective delivery of quality ESP services. The scale and coverage of large NGO programmes for ESP delivery, such as BPHC/PNP and the NGO Service Delivery Program (NSDP) funded by USAID, which serve several million clients each year, call into question the data from the Service Delivery Survey which found that only 1% of health services used in the last month were provided by NGOs.

As mentioned elsewhere in this report, mechanisms also exist for consultation and collaboration between Government and NGOs on particular components of ESP. For example, under the national TB and leprosy control programmes there is a well-defined and significant role for NGOs, and there are mechanisms for consultation on implementation and development of policy. However, the role of NGOs in the overall sectoral programme has not been clearly defined in an official strategy document and there is no mechanism for GO-NGO policy dialogue on ESP in general. This will need to be done in the context of Government defining its own role in the sector, in terms of regulatory and service delivery functions.

With regard to initiatives involving different stakeholders in health care delivery, the Public-Private Partnership (PPP) has developed approaches for involving communities, NGOs, private sector and Government in delivery of ESP. A pilot has been developed in three unions of Brahmanpara Upazila, Comilla district. Three different models have been used: 1) based on the government Community Clinic model; 2) a Community Scheme

initiative in which services are hired in an area where no Community Clinic has been established; and 3) where a clinic is established within an existing UHFWC run by local government. As yet, there has been no evaluation of the effectiveness of these models in improving access to services for the poor. Consideration is being given to testing the feasibility of NGOs implementing the approaches in other areas, with a view to possible scaling up.

Problems encountered:

There are a number of NGOs working in various parts of the country that have experience in organizing or mobilizing local populations into groups to achieve various development objectives. Many of them do not have experience in delivering health services which needs to be taken into account in selection of the NGOs for different roles in the development of local health services, such as community mobilization, developing community participation, and actual delivery of services.

Records are kept by some NGOs of meetings with local health managers and staff, but not all meetings held between public and NGO/private sector stakeholders are documented. There is no systematic recording of the number, composition and outcome of meetings involving the different stakeholders at national level on discussion of policy and programmatic issues.

Revision to indicator:

A more suitable indicator might relate to the Government policies and strategies developed; the programmatic issues discussed at different levels on different components of ESP, with private sector, NGO and community participation in formal committees, advisory-, steering- and working groups. Later, consideration might be given to an indicator reflecting the outcome of consultations, in terms of key decisions affected by participation of stakeholders in a consultative process.

Amendment to target:

The target is vague and does not refer to the significance of outcomes of consultative meetings. If the indicator reflected the above revision, the target could be 100% for strategies developed and for involvement of stakeholders in policy and programme development.

36. Regulatory framework for a range of safety standards, including occupational health, food, cosmetic and road safety is updated

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Regulatory framework for a range of safety standards, including occupational health, food, cosmetics and road safety, is updated	Important health and safety standards updated			All

Actual progress:

The former Policy Research Unit (PRU) took responsibility for developing the regulatory framework. This is being done with the assistance of the Institute of Health Economics (IHE) at Dhaka University. The IHE organized a conference in July 2001, on regulation, and invited participants from the MOHFW as well as speakers from elsewhere within and outside the country.

Much of the focus of that conference was on drug regulation, and related issues, rather than on setting safety standards for occupational health, or the other safety aspects listed in the indicator. A report has been prepared by IHE, which was expected to be available in October 2001.

Problems encountered:

The problem is that other aspects of regulation have been focused on, before getting onto establishing the types of safety standards listed in this indicator.

Revision to indicator:

It may be useful to consider expanding the list of types of standards to be included in this indicator. It could be argued that drug regulation is a very important aspect of a regulatory framework.

Amendment to target:

It appears to be rather ambitious to fix a target of all standards to be covered by a regulatory framework by end of HPSP, but it may be decided to retain this target for another year to highlight the urgency of making progress.

37. Social/rural insurance scheme

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Social/Rural Insurance scheme	Percentage of Thana implementing social/rural health insurance schemes that fit into the GOB approved regulatory formalities		Some NGO schemes	10%

Actual progress:

There are a number of NGOs operating health insurance schemes in Bangladesh, but as yet there is no government social insurance scheme. In 1996, five leading NGOs in Bangladesh were experimenting with different models of community financing, some dating back to the early 1970s. These were reportedly covering about 12.5 million people. A variety of financing schemes are being operated ranging from flat user fees to insurance schemes with sliding scales for prices. Health services being covered range from Mother and Child Health and Family Planning services, to fully comprehensive and integrated health and family planning services. Recovery rates are generally higher for community-level care than for first level referral care. It has also been found that if additional revenue is generated, 100% of recurrent costs can be covered. However, schemes that aim at 100% cost recovery have more difficulty serving the destitute.

A recent example of an effective programme is that supported by ILO, and implemented in 7 Districts by two NGO partners, Grameen Kalyan and BRAC. Grameen began its programme in 1997 and at the end of 2002 had about 45,000 families enrolled (target 60,000 by 2004). The scheme is linked with service provision at Satellite Clinics and 17 Health Centres. The annual premium is Tk120-150 for Grameen members and Tk150 for non-members. BRAC began its insurance scheme in the area served by two of its Health Centres in July 2001 and entered partnership with ILO in November 2001. It has about 3,600 families enrolled (target 12,000). The scheme is similar to that of Grameen with slightly higher charges for BRAC non-members. Enrolled families are entitled to consultation (Tk5), medicines at reduced prices, and high cost services (e.g. facility delivery) at reduced fee. There is exemption from premium and a free card for ultra poor families (target: 5% of families exempt). Cost recovery is currently 78% of service costs for Grameen, and 50-60% in the more recent BRAC scheme. It is anticipated that full cost recovery will be achieved within 5 years, and replication could follow a satisfactory evaluation.

Problems encountered:

It is not clear what the GOB approved regulatory framework is, or indeed, if it exists.

Revision to indicator:

The indicator needs to distinguish between GoB run schemes and NGO run schemes.

Output Component 7&8 - Public Health Services, Other Health & Nutrition Services

38. Nutritional status of children and women

Indicators by Program Area or Type	Definition	Base Status	Current Status	Targets for 2003
Nutritional status of children and women	Prevalence of women with Body Mass Index (BMI) less than 18.5	70%	45.4% (DHS 2000); 38.6% (HKI 2001)	60%

Actual progress:

The Nutritional Surveillance Project (NSP) of HKI and IPHN found that 38.5%[22] of non-pregnant mothers in rural areas were wasted (BMI <18.5), in 2001. This is somewhat lower than the DHS figure of 45.4% for 1999/2000. The HKI/IPHN data show seasonal variation from a low of 35% in August-September to a peak of 41% in December-January, the time of the DHS fieldwork. The prevalence of more than 40% adult wasting indicates a 'critical' food security situation.

Differentials:

The HKI/IPHN data are not dis-aggregated, but the most recent DHS found the following differentials for wasting among mothers with children under 5 years in 1999/2000:

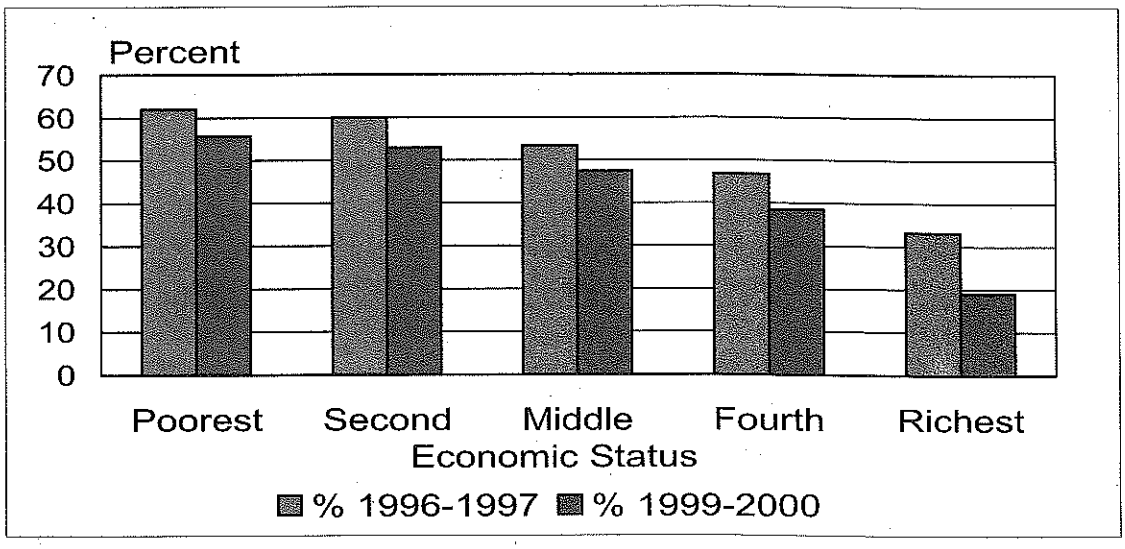
Maternal age: The proportion wasted was 50.5% at ages 15-19 years, 40.6%-44.4% at ages 20-34, and 53.9% in the 35-49 age group.

Geographic: Rural women were more likely to have low BMI (<18.5): 48.7% compared with 29.9% of those living in urban areas. Sylhet division had the highest proportion of women with BMI <18.5 (55.4%) and Chittagong had the lowest proportion (40.3%), as I the HKI/IPHN survey.

Economic status: There is a substantial differential across economic status quintiles, with women from the poorest quintile being almost three times (2.93) more likely to be wasted than women from the richest quintile in 1999-2000. This reflects an increase in inequity from a poorest/richest ratio of 1:87 in 1996-97 (Figure 38.1). However, a positive finding is that malnutrition fell among all quintiles, although less so among the poor. It would be interesting to examine these differentials in BINP areas, to see if this intervention program is having an impact which shows up in nationally representative surveys. However, the samples are likely to be very small as BINP covers only a small part of the country.

[22] The figure of 38.5% is an unweighted average of six measurements during the year 2001.

Figure 38.1: Prevalence of Malnutrition (BMI<18.5) Among Women with Children Under 5 by Economic Status



Poorest/Richest Ratio: 1996/1997 = 1.87; 1999/2000 = 2.93.

Social: Women with no education were more likely to have BMI <18.5 (52.1%) than women with secondary/higher education (30.1%).

Mothers with BMI <18.5 were almost twice as likely to have children who were wasted (Weight for Height below –2SD from the median of the NCHS/CDC/WHO international reference population.).

Problems encountered:

Data are only available for mothers of children under 5 years, not for other categories of women such as mothers without children and those with children 5 years and over. However, BMI is more of a public health issue for women of childbearing age, so the data that are available are appropriate to indicate the general nutritional status of women.

Revision to indicator:

If the indicator were changed to include only mothers with children under 5 years this would be a good indicator of maternal nutrition.

The indicator refers only to women in rural areas, but in the next three year plan, the nutritional status of urban women should be considered. The HKI/IPHN data indicate that levels of wasting are lower (about half) among urban slum women than rural women. Levels in Dhaka are lower than in Chittagong and Khulna throughout the year.

The name of the indicator should not include 'children' as their nutritional status is reviewed elsewhere – milestone 5.

Amendment to target:

No amendment is required at this time.

Others – Financing Aspects

39. Budget allocation for ESP

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status 2001-2002	Targets for 2003
Budget allocation for ESP	Percent of total MOHFW budget reserves applied to ESP delivery annually	60% (1998-99)	72% (including overhead).	65% of Public Sector Expenditure

Actual progress:

Actual MOHFW budget utilization during the FY 1998-99 to 2001-2002 (4 years) was Tk 407,780 lac for revenue (non-development) and Tk 420,150 lac for development, a total expenditure of Tk. 827,930 lac (49.3 % revenue and 50.7% development). Table 39.1 also shows actual budget utilization from FY 1998-99 to 2001-2002, FY 2001-2002 separately, and the estimated budget for FY 2002-2003. The final column is the HPSP total–1998-2003.

Table 39.1: Contribution of GOB and development partners to HPSP expenditure

(Lac Taka; 1 Lac = 100,000)

Sources of Funds		Actual Utilization			Estimated Budget	Total Budget
		1998/01	2001/02	Total 1998-02	2002/03	1998-2003
GOB	Revenue	287,150	120,630	407,780	132,540	540,320
	Development	91,670	26,780	118,450	40,600	159,050
	Total GOB	**378,810**	**147,420**	**526,230**	**173,140**	**699,370**
	% of Grand Total	63%	66%	64%	55%	61%
DPs	**Develop. Partners**	**225,090**	**76,610**	**301,700**	**140,840**	**442,540**
	% of Grand Total	37%	34%	36%	45%	39%
Grand Total		**603,900**	**224,030**	**827,930**	**313,980**	**1,141,910**

The GOB contribution has been consistently around two-thirds of the total expenditure during the first four years of HPSP, with the remainder coming from the Development Partners. The estimated budget for the current financial year indicates a somewhat higher DP contribution, reflecting an absolute increase (almost doubling) from the previous annual average of Tk. 7.5 billion to Tk 14.1 billion , while the GOB contribution increases slightly from an annual average of Tk. 13 billion to Tk 17.3 billion.

Three quarters of the GOB contribution has been from the revenue budget. This points to an important issue of obstacles to spending the GOB development budget allocations (see Indicator 41 for more discussion). The proposed development budget for FY 2002/03 (Table 41.2) amounts to Tk. 181,430.92 lac (GOB, Tk 40,600.00 lac; DP, Tk 140,839.20 lac). GOB development and DP's contribution (almost double) is much higher than the utilization rate of previous years.

In previous years, the indicator was presented in two ways, including and excluding overhead for ESP activities. ESP 'overhead' refers to items such as ESP training, which falls under LD (IST) rather than LD (ESP). This year only the proportion including overhead is presented as this is more realistic than an indicator without overhead.

Last year the proportion of the total MOHFW expenditure spent on ESP delivery was 79%. However, as shown in Table 39.2, the 4-year average for 1998-2002 was 73%. This is projected to fall somewhat (to 63%) in FY 2002-2003, but the total for the whole HPSP period should be around 70%. Last year, overhead contributed 17% to the total of 79% for ESP, but that was unusual and it is unlikely to occur again in the remaining year of HPSP (see 2001 Report, p.85).

Table 39.2: Expenditure on ESP and non-ESP from revenue and development budgets

(Lac Taka; 1 Lac = 100,000)

Sources of Funds		Actual Utilization			Estimated Budget	Total Budget
		1998/01	**2001/02**	**Total 1998/02**	**2002/03**	**1998/03**
ESP	Revenue	184,770	78,750	263,520	75,190	338,710
	Development	257,710	83,150	340,860	122,39	463,250
	Total ESP	**442,480**	**161,900**	**604,380**	**197,580**	**801,960**
	% of Grand Total	73%	72%	73%	63%	70%
Non-ESP	Revenue	102,380	41,880	144,260	57,350	201,610
	Development	59,050	20,250	79,300	59,050	138,340
	Total Non-ESP	**161,420**	**62,130**	**223,550**	**116,400**	**339,950**
	% of Grand Total	27%	28%	27%	37%	30%
Grand Total		**603,900**	**224,030**	**827,930**	**313,980**	**1,141,910**

Problems encountered:

Expenditure reports from CMMU on construction have been late coming in, so some figures may be revised later. Construction though, appears to have been progressing according to plan. Over 91% of the budgeted amount (Tk. 1.422 billion) for construction of Community Clinics has been spent (Tk. 1.299 billion).

In previous years a notable cause of delay in financial reporting was the provision of information by the Development Partners. This proved problematic for the then MAU. This year the reporting by DPs has been more timely and the totals are available.

Revision to indicator:

No need to revise this indicator. The indicator should specify that only one figure should now be presented - that including overhead.

Amendment to target:

The target has been achieved or surpassed for the two previous years, assuming the original target was intended to include overhead. There is no strong reason to modify the proportion at this time. In planning the level for the next plan, the need for ESP training should be considered as this is a major component of the overhead.

If there are philosophical changes to the distribution of resources, for example, to improve the neglected state of the tertiary hospitals, the proportion will need to be reconsidered.

40. Functional budget allocation

Indicators by Program Area or Type	Definition	Base Status	Current Status	Targets for 2003
Functional Budget allocation	Proportion of health sector expenditure for recurrent (salary versus non-salary) expenditure	75%	89.4%	80%

The economic codes used for estimating capital expenditure are shown in Table 40.1.

Table 40.1: Economic codes for estimating capital expenditure

(Lac Taka; 1Lac =100,000)

Code	Category	Expenditure
6800	Acquisition of assets	3844.1
7000	Construction and works	15974.4
7900	Import duty and VAT	3995.0
Total		23813.4

Actual progress:

Capital expenditure in 2001-2002 (Tk. 23,813.4 lac) amounts to 10.63% of total expenditure (Tk. 224029 lac), which is slightly down from last year's 12%, mainly due to the decreased activity in construction of Community Clinics. The recurrent expenditure for 2001-2002 amounts to 89.37% of total expenditure, exceeding the target of 80% by end of HPSP.

Table 40.2: Capital and recurrent expenditure by budget source

(Lac Taka; 1 Lac = 100,000)

Sources of Funds		Actual Utilization			Estimated Budget	Total Budget
		1998-2001	2001-2002	Total 1998-2002	2002-2003	1998-2003
Recurrent	Revenue	284,270.09	120,457.29	404,727.38	132,347.32	537,074.70
	Development	253,718.23	79,758.42	333,476.65	132,874.93	466,351.58
	Total	**537,988.32**	**200,215.71**	**738,204.03**	**265,222.25**	**1,003,426.28**
	% of G Total	89.09	89.37	89.16	84.47	87.87
Capital	Revenue	2,876.85	175.71	3,052.56	193.28	3,245.84
	Development	63,037.04	2,637.69	86,674.73	4,8564.22	135,238.95
	Total	**65,913.89**	**23,813.40**	**89,727.29**	**48,757.50**	**138,484.79**
	% of G Total	10.91	10.63	10.84	15.53	12.13
Grand Total		**603,902.21**	**224,029.11**	**82,7931.32**	**313,979.75**	**1,141,911.07**

The definition of this indicator mentions the salary and non-salary components of the recurrent budget. This is not given in table 40.2, but about half recurrent expenditure, Tk. 99,550.01 lac (49.7% of the total Tk. 200,215.71 lac) is on salary costs and half on non-salary costs.

This equal division of recurrent expenditure between salary and non-salary costs has been fairly consistent throughout HPSP: 52.3% salary in 1998/99, 48.4% in 1999/2000, 49.5% in 2000/01, and 47.8% is projected for the whole HPSP period, 1998-2003.

Problems encountered:

No major problems encountered here.

Revision to indicator:

There is no need to revise this indicator at this time. Once the major construction activities have been completed, it might be the figure of 80% on recurrent expenditure is too low. This past year has seen considerable CC construction, plus substantial

expenditure on repair and renovation of various MOHFW facilities, but still the capital component only reached about 12%. It is difficult to see how it can reach 20% in a normal year.

Amendment to target:

The achievement of 89.4% on recurrent expenditure is heading in the right direction as construction picks up. It is down slightly from 90.4% last year, and is on the preferred side (ie. above) the 80% target.

41. Diversification in health sector financing

Indicators by Program Area or Type	Definition	Base Status (pre-HPSP)	Current Status	Targets for 2003
Diversification in Health Sector Financing	Proportion of health sector financing by source		See Table below	GOB; DP; User fees; Health Insurance and Private Sector

Actual progress:

The total health sector expenditure for 2001-2002 was Tk. 22.4 billion. Of this, 53.8% (Tk. 12.1 billion) was from the revenue budget, and 46.2% (Tk. 10.3 billion) was from the development budget[23] (Table 41.1).

Table 41.1: HPSP expenditure for FY 2000/01 by source of funds

(Billion Taka)

Source of Funds	Expenditure (2000/01)	% of Total Expenditure
Revenue Budget	12.063	53.8%
Development Budget	10.340	46.2%
Government of Bangladesh	*2.678*	*19.9%*
Development Partners	*7.661*	*26.4%*
Total	**22.403**	**100%**

[23] Note: these figures are estimates, and may be subject to some later revision.

The total health budget was up by 5.7% this year, but the distribution shows a change in terms of GOB versus other sources. The amount budgeted for next year (2002-2003) represents a 40% increase on the current year, and is thus unlikely to be achieved. Any shortfall in next year's expenditure will obviously result in a reduced grand total figure (1998-2003).

The GOB contributes through the Revenue budget and the GOB component of the Development budget. The GOB proportion tends to be around two-thirds of the total. Last year the GOB provided 63.2% of the total, but this year (2001/02) GOB provided 65.8% of the total from its revenue and development budgets, reflecting an increase in revenue with a decrease in development expenditure. The remaining 34.2% came from Development Partners.

In Table 41.2, the figures in the right-hand column (Total 1998-2003), represent the estimated expenditures from the second revision of the PIP[24]. For planning the next Programme it is informative to compare each of these (sub) categories with the estimates from the original PIP. The Total (Tk. 114.2 billion) is 25.4% lower than the original estimate; the Revenue component (Tk. 54.0 billion) is 1.6% lower and the Development component (Tk. 60.2 billion) is 38.7% lower. The GOB sub-component (Tk. 15.9 billion) is 68.4% lower and the Development Partner sub-component (Tk. 44.3 billion) is 7.7% lower.

Table 41.2: HPSP annual expenditure (actual, estimated and budget)

(Lac Taka; 1 Lac = 100,000)

Major Inputs	Actual Expenditure			Estimated	Budget	Total
	1998/99	1999/00	2000/01	2001/02	2002/03	1998-2003
Revenue	**87695.0** (48.3%)	**95767.8** (45.5%)	**103684.2** (48.9%)	**120633.0** (53.8%)	**132540.6** (42.2%)	**540320.5** (47.3%)
Development	**93763.6** (51.7%)	**114753.5** (54.5%)	**108238.2** (51.1%)	**103396.1** (46.2%)	**181439.2** (57.8%)	**601590.5** (52.7%)
GOB	*31019.0 (17.1%)*	*30426.5 (14.4%)*	*30220.5 (14.3%)*	*26784.3 (12.0%)*	*40600.0 (12.9%)*	*159050.3 (13.9%)*
Project Aid	*62744.58 (34.6%)*	*84327.0 (40.1%)*	*78017.7 (36.8%)*	*76611.8 (34.2%)*	*1408392 (44.9%)*	*442540.3 (38.8%)*
Total	**181458.6**	**210521.2**	**211922.4**	**224029.1**	**313979.8**	**1141911.1**

Note: The rows 'GOB' and 'Project Aid' are sub-categories of the Development budget. 'Project Aid' includes 'Reimbuseable Project Aid' plus 'Direct Project Aid'.

[24] The original PIP budget for HPSP was US$3.2 billion, but based on the first four years expenditure, this was revised in August 2002 down to US$2.153 billion.

Problems encountered:

From the above table, a clear picture emerges with Revenue and Project Aid components spending approximately as originally planned, but the GOB Development component being substantially under spent. There are some practical reasons for this, including the quarterly fund release approach which creates major difficulties for large semi-annual or annual expenditure.

The previously mentioned problem of lack of consistency between the budget codes for the development and revenue budgets resulting in difficulties in merging financial data from both sources, seems to have been largely overcome. Data are readily available this year.

Revisions to indicator:

No revision is required at this time.

Amendment to target:

No target is given, so no amendment is required at this time. As mentioned last year, no specific proportions have been stated, but it is believed that it was originally planned that the Development Partners would provide not more than 42% of the total. Last year some 36.8% came from the DPs and this year that proportion is down to 34.2%.

In the original PIP it was estimated that the DPs contribution would be around $1 billion. On the basis of LDs' last four years SOEs, the total contribution of the DPs is expected to be $819.72 million (Tk. 442540 lac), some $180.28 million less. This revised estimate includes some $63.55 million that was carried over for incomplete projects[25] from the fourth five-year plan, so actually $756.17 million came from the DPs.

[25] EU for TFIPP; ADB for H&FP services; SFD for hospital construction; IDA for BINP.

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