GOVERNMENT OF THE PEOPLE'S REPUBLIC OF BANGLADESH
MINISTRY OF HEALTH & FAMILLY WELFARE

OPERATIONAL PLAN

ESSENTIAL SERVICE DELIVERY

July 2011-June 2016

HEALTH, POPULATION AND NUTRITION SECTOR DEVELOPMENT PROGRAMME **(HPNSDP)**

DIRECTORATE GENERAL HEALTH SERVICES
Mohakhali, Dhaka-1212

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9. Description

9.a)Background information, current situation and its relevance to National Policies, Sectoral policy, MDG, Vision 2021, Sixth five year plan, MTBF etc.

Background Information:

Bangladesh is a signatory to the declaration in the International Conference on Primary Health Care (PHC) held at Alma Ata in 1978, where the concept of primary health care (PHC) as the strategy for achieving the goal of health for all (HFA) was laid. Bangladesh started with pilot projects in 6 Upazilas in

the year 1979-80 in the light of which subsequently PHC Program started in Bangladesh in 1980. The basis of the policy of the government was to provide health care to the un-served and underserved population as far as possible, at their door steps, at an affordable cost. Since then, considerable progress has been made in this sector, but due to lack of adequate investment the full potential of PHC services is yet to be realized.

Since the inception, PHC services in Bangladesh have been rendered in terms of 8 elements: health education, nutrition, adequate and safe water and sanitation, maternal and child health, immunization, prevention and control of endemic diseases, treatment of common ailments and injuries and provision of essential drugs. In the Health and Population Sector Program (HPSP), these services were remodeled as the Essential Service Package (ESP) with prioritization of some of the PHC activities. The redesigned PHC approach already in place, includes: (a) Child health care, safe motherhood, family planning, MR, post abortion care, and management of sexually transmitted infections; (b) Communicable diseases (including TB, Malaria, others); (c) emerging non-communicable diseases (Diabetes, Mental health, Cardio-vascular diseases); and (d) Limited curative care and behavior change communication (BCC). The current Health, Nutrition and Population Sector Program (HNPSP) has included nutrition into the service package of PHC and renamed the same as the essential service delivery (ESD) program.

The basic pillars of the primary health care approach (universal coverage, equity in health, inter-sectoral collaboration and community participation, use of appropriate technology) remain valid even today. A careful, wider application of these principles in the upcoming program to strengthen health system in Bangladesh is necessary. With the changing political, socio-cultural, economic and epidemiological scenario, the concept of primary health care would continue to strengthen community-based public health interventions and the next sector program would deliver primary health care through the Community Clinics as it is considered cost-effective and appropriate tool for achieving the objectives of the Sixth Five Year Plan and the Millennium Development Goals. The primary health care service provision operates at three tiers, i.e., upazila, union and the community linking them with the districts as part of the public sector health service.

Over the decades Bangladesh has made considerable progress in improving the health status of its population. Life expectancy has increased while mortality, morbidity and fertility have decreased. Nevertheless, many challenges remain to be addressed. The basis of the policy of the Government was to provide health care to the un-served and underserved population as far as possible, at their door steps, at an affordable cost. With this motto, to give health care, the package named ESD (Essential Service Delivery) had been incorporated in HNPSP. Essential Service Delivery under the Directorate General of Health Services, which will be continued to address LCC (Limited Curative Care), SS&C (Support

Services & Coordination), MWM (Medical Waste Management), Urban Health, Mental health and autism, Tribal Health, Strengthening Upazila Health System under the ESD of HPNSDP. The vital component of health services delivery i.e. maternal; child and adolescent health have been shifted under the Maternal, Neonatal, Child and Adolescent Health (MNCAH) of DGHS, a new OP under HPNSDP.

Description of Components of OP

Components of ESD:

1. Support Services & Coordination
2. Limited Curative Care
3. Urban Health Services
4. Medical Waste Management
5. Mental Health and autism
6. Tribal Health
7. Strengthening Upazila Health System & Referral System

Component 1: Support Services & Coordination

Support Services & Coordination is one of the key components of ESD. This component acts as a link between the different components of ESD as well as between the Line Director of ESD and other Line Directors.

The three OPs under DGHS such as MNCAH, ESD and CBHC focus on delivery of the primary health care services particularly at the Upazila and below level. This in fact divides the PHC implementation within three separate OPs and the related LDs responsibilities where coordination during implementation will be critical. Through the establishment of home for ESD under the Director-PHC, DGHS, the gap between MNCAH and ESD –OP during implementation will be minimized. To synchronize the inter-OP operation and maximize coordination, Director-PHC will be made LD of MNCAH and a senior level DD may be posted as DD (PHC) under Director (PHC), DGHS will be given responsibility of the LD for the ESD-OP thus ensuring these two OPs' implementation under the Director (PHC). The coordination of CBHC with these two OPs will be ensured through Upazila Health System, with referral linkages to service delivery issues such as BCC, Nutrition etc. A technical committee including representatives from concerned sector of Planning Commission and IMED will be formed to guide coordination among these OPs with defined TORs to improve coordination in this regard.

Objectives/Targets: To provide all necessary support and coordination to ensure health care services at Upazila and below levels for the most vulnerable and underserved especially children, women, persons with disability (PwD), elderly and the poor.

Strategies:

1. Provide essential health care services at grass roots level by ensuring manpower, furniture, equipments, logistics, vehicle etc for newly constructed & upgraded facilities at the level of Upazila & below;
2. Holding of quarterly M&E Sessions at each district level.
3. Strengthening of Laboratory facilities.

Activities:

1. Procurement and supply of furniture, equipment, logistics support for facilities
2. Workshop, meeting to develop checklist for monitoring & supervision and Format for evaluation & reporting
3. Procurement and supply of laboratory equipments e.g Colorometer, Analyzer etc to strengthen Laboratory facilities.

Component 2. Limited Curative Care

Limited Curative Care is to meet the basic health need of the people especially children, women and the poor by providing treatment of medical emergencies.

Objectives/Targets:

To meet the basic health need of the people by providing treatment of medical emergencies, common diseases including asthma and to provide First aid for common injuries.

Strategies:

1. To meet the basic health need of the people especially children, women and the poor providing treatment of medical emergencies including asthma
2. To provide First aid for common injuries like burn, snakebite, drowning, accidents including road traffic accident.
3. To treat common diseases of skin, eye, ear and dental problems.
4. Establishment of reporting of patients under Limited curative care.

Activities:

1. Procure and supply medicine & MSR for medical emergencies including asthma
2. Procure and supply First Aid essential materials (First Aid Kit boxes, medicine & MSR) for common injuries like burn, snakebite, drowning, accidents including road traffic accident.

3. Procure and supply medicine & MSR for treatment of common diseases of skin, eye, ear and dental problems.
4. Workshop, meeting to develop training module on medical emergencies including asthma, common injuries like burn, snakebite, drowning, accidents including road traffic accident and common diseases of skin, eye, ear and dental problems
5. Training/orientation of health personnel on LCC e.g. doctors, nurses, paramedics, (HAs, HIs, AHIs, CHCPs) etc.
6. Workshop, meeting to develop IEC materials (electronics and printing) on issues under LCC for awareness raising .

Component 3. Urban Health Services

Bangladesh is going through significant social and demographic changes, including rapid urbanization (at an estimated rate of 6%), expanding industrialization, rising incomes and increase in non-communicable diseases. At present about 27% people of Bangladesh lives in urban areas. Population growth in urban areas is 2.5% whereas the national population growth rate is less than 1.4%. The biggest city, Dhaka alone accounts for 40% urban population. The other five divisional cities account for 29%, while 309 municipality towns have 31% urban population. Rapid influx of migrants and increased numbers of people living in urban slums in large cities are creating continuous pressure on urban health care service. Urban health services are the responsibility of the Ministry of Local Government, Rural Development & Cooperatives (MOLGRDC). The Municipal Administration Ordinance of 1960, the Pourashova Ordinance of 1977, the City Corporation Ordinance of 1983 and the Local Government (Pourashova) Act 2009, clearly assigned the provision of preventive health and of limited curative care as a responsibility of the city corporations and municipalities. But due to their limited resources and manpower, public-sector health services have not kept up with needs. Private health care providers are the main source for delivery of curative care, including tertiary and specialized services to the urban people, but private providers seldom provide preventive and promotional health services. On the other hand, MOHFW is tasked with setting technical standards, packaging services, strategies and policies of the country‟s health sector. The urban areas provide a contrasting picture of availability of different facilities and services for secondary and tertiary level health care, while primary health care facilities and services for the urban population at large and the urban poor in particular are inadequate. With the implementation of two urban primary health care projects (UPHCPs) since 1998, services have been delivered by

the city corporations and municipalities through contracted NGOs under MOLGRDC in the project‟s areas. The project provides free services to 22% (as per household survey 2007) of the total population of the project areas. Non-project urban areas are being covered by the health facilities of MOHFW. In total, there are around 4000 satellite centers to reach the urban poor. Moreover, 35 urban dispensaries under the DGHS are providing outdoor patient services including EPI and maternal and child health (MCH) to the urban population. These urban dispensaries will be equipped with necessary facilities to use as the outlet centers of the tertiary hospitals. Various NGOs provide essential services as well some special services (52 HIV/AIDS clinics) through 158 PHC centers, 34 comprehensive centers, 56 DOTS center, 47 VCT centers. In conclusion, the various urban primary health care services are largely inadequate in view of the needs of the fast growing urban population. There is need to establish a permanent coordination structure between the two Ministries to take up the mutual mandated responsibility on a sustained and effective manner. MOHFW will join in tackling this challenge through a consultative process with MOLGRDC, city corporations and concerned stakeholders to jointly assess, map, project and plan HPN services in urban areas. The emphasis on urban health will be a new (and very different) element compared to HPSP and HNPSP. It will involve MOHFW working in new ways with its partners, notably MOLGRDC, NGOs and others. The UPHCP of MOLGRDC and NGOs have a wealth of experience in providing urban primary health care (UPHC) services through contracted NGOs. There have been impressive successes in terms of coverage, monitored quality of services and monitored exemption schemes for the poorest. These will continue, but side by side MOHFW will seek to extend the coverage of PHC services in urban areas not covered by the UPHCP. Services in the urban dispensaries under the DGHS will be improved by introducing an effective referral system in the facilities, so that the population will receive better services. MOHFW also provides health services through secondary and tertiary hospitals that will continue to be strengthened in terms of coverage, quality and equity of service delivery in response to demand.

Objectives/Targets:

1. To provide PHC services to the urban population Strategies:
2. To ensure proper utilization of resources for urban primary health care activities.
3. To provide PHC services to the urban population.
4. To ensure strong coordination between MOLGRDC and MoHFW,

5. To define an adequate referral system between the various urban dispensaries and the second and third level hospitals and explore feasibility of introducing General Physician (GP) system.

Activities:

1. Workshop, seminar to develop an urban health strategy and an urban health development plan in collaboration with MoLGRDC.
2. Advocacy meeting with different partners GoB, NGOs, CSOs for knowledge sharing, awareness raising to strengthen urban health services.
3. Workshop, seminar to develop a guideline for an adequate referral system between the various urban dispensaries and the second and third level hospitals and explore feasibility of introducing General Physician (GP) system.
4. BCC training of the service providers under DGHS and MoLGRDC for self motivation to provide quality services
5. Training/Orientation of the service providers under DGHS and MoLGRDC for effective management of urban health care by using urban HIS.
6. Develop BCC materials (electronic and print) to raise awareness of slum dwellers.

Component 4. Medical Waste Management

Medical wastes are generated as a by-product of health care activities and its generation is unavoidable. The wastes produced in the hospitals carry a high risk of infection than any other waste particularly for the service provider and waste handlers. The medical wastes are capable of transmitting diseases either through direct contact or by contaminating soil, air and water. If not properly handled medical waste is a risk to individuals, community and the environment.

In the Upazila health complexes (UHCs), training of the medical staffs for MWM has been imparted to about 60 per cent of the UHCs of the country and the process is in progress.

Accordingly different colour bins have been supplied to the UHCs for collection of different MW at their generation points. Mainly nurses and ayas carry out segregation and collection of MW and the doctors are responsible for their monitoring. MWM of UHCs has started from 2005-2006. The UHCs have also been provided with trolley for transporting the segregated waste to storage. The general waste, infectious solid waste, infectious liquid waste and sharp waste are collected separately. The general waste and sharp are disposed separately in different pits; the infectious wastes (both solid and liquid) are treated with bleaching powder and the solid portion

is disposed in separate bin, whereas the liquid portion is mixed with water (different dilutions for different wastes) and disposed in sewerage channel. According to Essential Service Delivery (ESD), the filling of the pits would require a period of 6-7 years, by which the waste would be decomposed. Monitoring of the MWM in the UHCs is also done from Dhaka office time to time.

ESD, however, feels the need for enhanced monitoring of MWM of UHCs that requires increase of expert man power for the purpose. They have also stated that there is no proper management for disposal of radio-active waste (although such waste is decreasing with the introduction of ultra-sonogram).

According to ESD establishment of improved facility for waste disposal (with modern technology) at district/divisional locations by DGHS would improve the MWM of the UHCs.

The transportation, treatment and disposal of the MW can be done by expert NGO for the purpose that should be paid by MOLGRD.

Various steps and efforts need to be carried out for improvement of medical waste management in the country. HNPSP stressed on taking steps to improve the capacity of DGHS for strengthening, inspection and monitoring of MWM by the office of the LDs (ESD and HSM). As in-house management of MW is the responsibility of MOHFW and out-house (off-site) management of MW to be done by MOLGRD, inter-communication should be established and maintained between them. Cleanliness of public and private HCFs will be checked by using a formal tool. It may be estimated that about 35 per cent of HCFs are conducting MWM on the whole country basis, although according to the HNP sector program (2003-2011) the target was 100 per cent achievement. The progress in MWM is expected to attain 40-45 per cent (safely 40%) by 2010-2011. Based on the recommendations of the MWM review a MWS an action plan has been developed. The key elements of the strategy for improving MWM are the following:

- Building awareness and capacity at all levels.
- Developing appropriate guidelines and manuals.
- Create accountability through appropriate legal\regulatory framework.
- Create appropriate institutional framework to facilitate implementation of MWM on a sustainable basis.
- Making targeted and phased investment.
- Creating the enabling framework for private sector participation in centralized facilities.

All activities related to MWM cannot be initiated and implemented simultaneously because of various limitations (like fund, time, agency, expert-manpower etc.). So, there is need of prioritization of activities and to be targeted and implemented phase wise, although other MWM activities will continue as usual. Thus a specific target along a time based realistic plan will be formulated on the basis of the present scenario and capacity of MWM

At the upazila and below level facilities, the current practice of MWM will be continued. Different colour bins will be supplied to the UHCs for collection of waste at their generation points. Mainly nurses and cleaners will segregate and collect the waste while the doctors will be responsible for their monitoring. The UHCs will also be provided with trolley for transporting the segregated waste to storage.

General waste, infectious solid waste, infectious liquid waste and sharp waste will be collected separately. The general waste and sharps will be disposed separately in different pits. Infectious wastes (both solid and liquid) will be treated with bleaching powder; the solid portion will be disposed in separate bin while the liquid waste will be mixed with water (different dilutions for different wastes) and disposed in sewerage channel.

Objectives/Targets:

To develop a feasible and sustainable system for safe medical waste management.

MWM activities at the Upazila level will be rolled out in phases with the following targets:

Unit of Measurement	Baseline	Projected Target	
		Mid 2014	Mid 2016
No. of UHC implementing	206		421
No. of UHC with personnel trained on MWM	250	400	421
No. of UHC having disposal pits	206	306	421
% of waste handlers using safety gears	49%	73%	100%

Strategies:

1. To establish a feasible and sustainable system for safe medical waste management
2. To improve community awareness regarding hazards of sharps and infectious medical wastes and the safe ways for their disposal.
3. To ensure safety of the health care providers, recipients and waste handlers.

Activities:

1. Construction of pits in UHCs.
2. Procurements of logistics (drum, plastic bucket etc)
3. Training/Orientation of personnel on medical waste management
4. Develop BCC materials (electronic and print) for community awareness.
5. Develop form, checklist for supervision and monitoring.
6. Provision for Regular Supervision and Monitoring.

Component 5 Mental Health and Autism

The Govt. has decided to address mental health as it is becoming a problem due to rapid change of life style. For the emerging size of the mental health problems amid changing life styles and in pursuance of government's strong commitment for adequately addressing the counseling and treatment of mental health, partnerships with the media and NGOs will be developed to raise public awareness about appropriate attitude and behavior towards mental and autistic cases. In addition to public sector workers, NGO/CBO workers and school and religious teachers, will be trained to identify and counsel substance abuse and mental and emotional cases, provide and follow up simple treatment as per feasibility, provide life skill training and refer serious cases to an appropriate facility. This OP will give focus on community awareness, providing health services to mental patients at upazila level and establishing referral system for mental health cases. Establishing coordination in regard to behavioral interventions with other ministries / agencies including NGOs will be important effort under this OP.

Objectives/Targets:
To address and take necessary measures and thereby reduce the risks of mental health and autism.

Strategies:

1. To adequately address the counseling and treatment of mental health including autism and other neurodevelopment disorders.
2. To develop partnership with the media and NGOs to raise public awareness about appropriate attitude and behavior towards mental and autistic cases.

Activities:

1. Updating National protocol for mental health care including autism.
2. Advocacy meeting with professionals, health care providers (GO, NGOs) to raise awareness about appropriate attitude and behavior towards mental patients.
3. Workshops/meeting to develop training module, treatment guideline for different level health workers (doctors, nurses, paramedics and field staffs.) for identification, counseling and treatment of mental illness at primary level
4. Developing training module, treatment guideline for NGO/CBO workers, school and religious teachers to identify and counsel substance abuse and mental and emotional cases.
5. Advocacy meeting with Medias and NGOs to develop partnership to raise awareness about appropriate attitude and behavior towards mental patients.
6. Training of the service providers for early diagnosis, counseling and intervention on mental health and autism.
7. Observance of Autism day/ week or month.
8. Development of autism strategy.
9. Training/orientation of NGO/CBO workers, school and religious teachers on mental health and autism.
10. Develop appropriate BCC materials.

Component 6. Tribal Health

In Bangladesh there are about 45 different tribal groups spread across the country. The proportion of the tribal population in the 64 districts varies from less than 1% in majority of the districts to 56% in Rangamati, 48.9% in Kagrachari and 48% in Bandarban in the Chittagong Hill Tracts (CHT). It is believed that the tribal/ethnic population ranges between 1.5-2.5 million. The tribal groups belong to different ethno-lingual communities, profess diverse faith, have unique cultures which is different to mainstream culture and are at varied/different levels of development (economically and educationally). Most of them inhabit in hard to reach areas such as hilly terrains or the forest areas where access is generally difficult. Moreover, many of these tribal groups are also characterized by slow/low growth rate compared to the mainstream population.

Due to the variations (in terms of culture, socio-economic situation) across the different tribal/ethnic groups, GOB recognizes the need to approach these communities differently in order to ensure that the health care delivery system is accessible and acceptable to them. The Government is committed to have a more targeted approach for the tribal/ethnic communities in order to achieve better outcomes. As a result of its firm commitment to improve the status of

tribal/ethnic communities and honor the various international (Millennium Development Goals) and national goals (Vision 2021), MOHFW under its new sector program Health, Population and Nutrition Sector Development Program (HPNSDP) 2011-2016 is making provision to implement HNP services to the tribal/ethnic communities through the THNPP 2011.

Diseases Burden among Tribal/Ethnic Community

Malaria, diarrhea, and acute respiratory infection are the most common diseases in CHT. In CHT 52% of the girls get married before their eighteenth birthday, which increases the risk of dying due to complications related to early pregnancy. Although TFR is low, maternal mortality is still high about roughly 4.71 per 1000 births (UNFPA). The Multiple Indicator Cluster Survey reported that only 17% of deliveries in CHT were assisted by medically trained personnel in 2006. Infant mortality rate in CHT is close to the national level (51/1000 compared to 45/1000). Antenatal care (ANC) and post-natal care (PNC) visits to trained personnel by women in CHT are lower than the national average of ANC which is 32.7% and PNC which is 9.8% respectively (Bangladesh Maternal Mortality Survey 2001). Full immunization coverage by age is 12 months is 51% in CHT compared to 71% overall in Bangladesh according to the Coverage Evaluation Survey under taken in 2006. In general food poverty is wide spread in CHT with majority of the Tribal/Ethnic people not secured with respect to food.

Objectives/Targets:

To bring tribal population of Chittagong Hill Tracts and others in the northern hilly regions and some costal districts mainstreamed under the existing health services network of the Government

Strategies:

1. To develop special measures and adjustments in delivery mechanism of tribal health for ethnic people.
2. To strengthen collaboration with the Ministry of Chittagong Hill Tracts Affairs (MoCHTA), CHT-Regional Council and CHT-Hill district Council in the greater Chittagong Hill Tracts and respective district and upazila administration and local government representatives with a view to increase support of the health sector.
3. Involve NGOs, local leaders, Religious leaders and school teachers.
4. Provision of rewards for the doctors who serve in these areas.

Activities:

1. Advocacy and multi-sectoral meeting to develop special measures and adjustments in delivery mechanism of tribal health for ethnic people.
2. Coordination meeting with the Ministry of Chittagong Hill Tracts Affairs (MoCHTA), CHT-Regional Council and CHT-Hill district Council in the greater Chittagong Hill Tracts and respective district and upazila administration and local government representatives with a view to increase support of the health sector.
3. Meeting with NGOs to procure voluntary services. with a view to increase support of the health sector.
4. Develop and procure user friendly local dialects BCC materials (Flipchart, booklets, poster etc)
5. IPC with the communities to raise awareness.
6. Satellite Clinics to render integrated health services both preventive and curative.
7. River Ambulance for Rangamati hill district and coastal areas.
8. Exchange visits for experience sharing in home and abroad

Component 7. Strengthening Upazila Health System and Referral System

The Upazila Health Complex is the first inpatient facility in the network, and provides both primary and secondary level services. The UHS comprises linking a community with the district through the functional UHS. UHS is not just a structure or form of organization, but is also the manifestation of a set of activities such as community involvement, integrated and holistic health care services, intersectoral collaboration and a strong 'bottom-up' approach to planning, policy development and management. The organization and management of the entire health system proposed to be Upazilla based, meaning that policy areas such as health sector financing, utilization of the UHCs, the relationship with the private sector and governance should be UHS- based or UHS-centered. The community based and the facility based HPN activities would be implemented under a single HPN plan for a given population and area. It will also comprise the relationship of the UHS and the respective roles of each spheres of the government particularly local government, NGOs, Private sector and district health services and lower level UHFWCs as well as CCs. The district level health administration will play a crucial role to oversee the work of the UHS and provide the support needed as part of the national decentralization process.

In the first 2-3 years of the next sector program, MOHFW would start piloting the UHS with a limited number of selected Upazilas, where the required staff (doctors, nurses, paramedics, etc) and equipment is

available for caesarians and other surgical interventions. After successful piloting, the UHS will gradually be scaled up countrywide.

Referral System: Primary health care centers need to maintain a close relationship between all the levels of a health system. This linkage between primary health care services and first referral units upwards is crucial in providing health care for the people of any country. Continuous collaboration between health care personnel at primary health care level and those of referral facilities is very essential. In order to bring down mortalities and disabilities following any disease condition or accidental injuries, availability of an operational referral system is one of the prerequisites where it will help the patient to receive optimal Health care from the next level of referral care.

Although a limited number of patients will develop life threatening complications, very few of these can be predicted. Therefore the system of referring any of the patients to the next referral centre needs to be improved. However, the first care referral centers need to be provided with essential equipments and facilities to handle any such complications of those referred patients. It also recognizes the importance of support and linkages with the household and community for safe care.

Referral system network will start from the Community Clinics (CCs), Union Health and Family Welfare Centre (UHFWC), Upazilla Health Complex (UHC) & upwards. Equal importance should be given to the downward referrals as well. Effective referral requires clear communications to assure that the patient receives optimal care at each level of the system.

While establishing well functioning and effective & structured referral system some key factors will be considered:

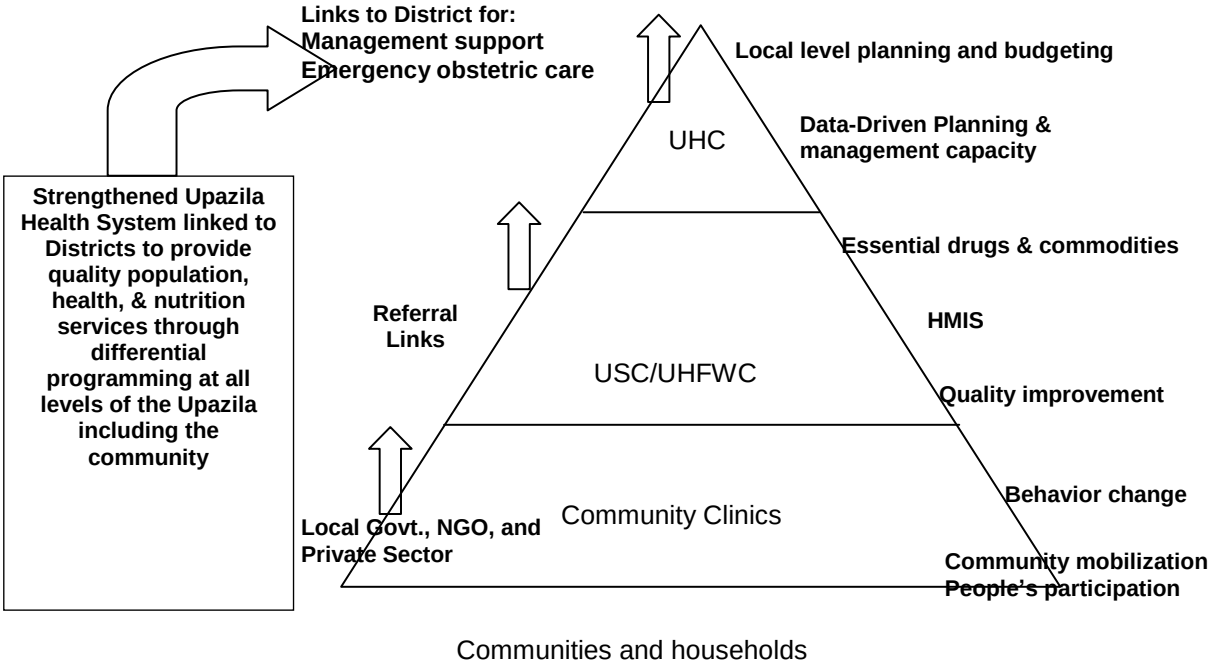
- Identification of types of services to be provided through each level of institutions
- Development of referral protocols and referral form.
- Streamline the referral procedures.
- Creating awareness among the health staff and the communities on the referral mechanism
- Provision of adequate resources based on the norms for each level of institutions
- Establishment of proper communication mechanism between UHC and other higher Level referral centers.
- Identification of suitable transport mechanisms to transfer the patients in need for referral care. Developing transport systems to transfer the patient to the higher level is also very essential.
- A diseases code (ICD-10) to be used for better patient management

Objectives/Targets: To provide equitable, efficient and effective health services and establish a well functioning, effective and structured referral system in different tiers of existing health system.

Strategies:

1. Formation of National UHS Task team to provide policy guideline and preparation of action plan with support of TA.
2. Formation of Upazila health Financing Committee for making expenditure reviews and development of practical budget for upazila health services.
3. Development of a core package of ESD services with a comprehensive integrated MNCAH programs, nutrition,TB, BCC, QA and UHCs services
4. Development of an appropriate and equitable resource allocation guideline
5. Establishment of upazila integrated HIS with a number of indicators would be developed for the proposed pilot upazilas.
6. Appropriate delegation of financial power and administrative authority should be taken..
7. Development of referral protocols
8. Creating awareness among the health staff and the communities on the referral mechanism..
9. Identification of suitable transport mechanism to transfer the patients in need for referral care.

Figure 1



Activities:

1. Notification of the National UHS Task team and Upazila Health Financing Committee with their TORs;
2. Development of an appropriate and equitable resource allocation guideline and appropriate delegation of financial power and administrative authority
3. Develop a core package of ESD services with a comprehensive integrated MNCAH programs, nutrition,TB, BCC, QA and UHCs services
4. Developing a number of indicators for the establishment of upazila integrated HIS for the proposed pilot upazilas.
5. Meetings to develop referral protocols, patients Charter, define Norms and standards of clinics, identification of types of services and others;
6. Meeting for development of Upazila mangers handbook, guide to upazila Health planning, supervision and monitoring tool etc.
7. Develop comprehensive BCC materials (electronic and print) for raising awareness.

8. Establish referral linkages among the public-public and public-private facilities.
9. Training of all health care service providers for raising awareness and effective implementation of referral system.
10. Technical Assistance / support.

9.b Related PIP Strategy

The HPNSDP continues Bangladesh's long-term commitment to the principles of primary health care as articulated in Alma Ata in 1978, renewed with the Community Clinics strategy of the government articulated in the Sixth Five Year Plan. The provision of primary health care is described around three tiers: upazila, union and the community with linkages to the district as part of the public sector health service.

Primary Health Care (PHC): Lead OPs are MNCAH, ESD, CBHC, MCRAH, FPFSD

Priority Interventions

(a) The Upazila Health System (UHS)+(b) Health Care at Union Levels+ (c) Community Health Care Service (CHCS)

- Providing adequate human resources, drugs and equipment etc. through the Upazila Health System to the CC and the UHFWC.
- Defining the referral and supervision linkages between the various levels of care (District, Upazila, Union and Community) and spell out the responsibilities among all actors and stakeholders in order to ensure the necessary 'unity of command'.
- Defining the composition and tasks/responsibilities of the Upazila Health Management Committee (UHMC) with tasks in planning, budgeting, priority setting, implementation, supervision and reporting.
- Developing a Capacity Building Program that prepares the committee members in managing the various (support) services in the UHC, the Union-level facilities and the Community Clinics.
- Involving local government institutions and NGOs to support the CC Management Groups (CCMG) for stimulating informed demand, quality services and appropriate utilization along with accountability, particularly to the poor, women and elderly.

The implementation of primary health care is not delegated to any single OP as virtually all OPs have an important front-line function. It draws more heavily on the Essential Services Delivery OP; and the Community-based Health Care 0P with strong links to the local level planning (LLP) functions found in the Planning, Monitoring and Research OP and the Planning, Monitoring and Evaluation OP of the DGHS and DGFP respectively.

The priority interventions identified for primary health care relate entirely to "how" services can be provided more effectively touching on challenges of ensuring adequate and efficient supplies and use of human resources; defining referral and supervision linkages, and strengthening management capacity.