Management and Leadership Training for Upazila Health and Family Planning Managers to Strengthen Community Health Systems

Participants' Manual

National Institute of Population Research and Training (NIPORT)
Medical Education and Family Welfare Division
Ministry of Health and Family Welfare

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Published by

Director General
National Institute of Population Research and Training (NIPORT)
Ministry of Health and Family Welfare
13/1 Sheikh Shaheb Bazar, Azimpur, Dhaka – 1205.

Published
April 2018

Funded By
United States Agency for International Development (USAID)

Technical Assistance
MaMoni Health Systems Strengthening Project

Cover Design
Kabirul Abedin

Printing
GraphNet Ltd.

Preface

NIPORT is delighted to introduce the "Management and Leadership Training for Upazila Health and Family Planning Managers to Strengthen Community Health Systems". I think it is a significant addition to the training programs of NIPORT and has the potential to raise/ensure the quality of the basic health services for a large number of population living in rural Bangladesh.

Upazila Program Managers namely Upazila Health and Family Planning Officer (UHFPO), Upazila Family Planning Officer (UFPO), Medical Officer-MCH-FP and Resident Medical Officer (RMO) have vital role in strengthening the community based health interventions particularly the delivery of Essential Service Package (ESP) at community and primary health care facilities. This training program aims at strengthening their capacity to provide leadership and more efficient management support to their teams, developing a positive approach and more proactively engage the community.

The training manuals are comprehensive and were developed taking into account the ground realities and challenges faced by the upazila program managers. It also offers a number of tools which they can use to plan their interventions. I wish the best use of this training curriculum and successful implementation of the training program.

(Rownaq Jahan)
Director General (Additional Secretary)
National Institute of Population Research and Training (NIPORT)

Acknowledgement

I am happy to see the publication of the Facilitators' and Participants' Manuals of the "Management and Leadership Training for Upazila Health and Family Planning Program to Strengthen Community Health Systems". Curriculum of this five-day training program has been developed through following NIPORT's standard curriculum development process as well as a number of consultations and sharing with stakeholders. I think both the manuals (Facilitators' and Participants') are comprehensive and will be of particular help to successfully carry out this important training program.

First and foremost, special thanks to Begum Rownaq Jahan, Director General of NIPORT for her continued support and guidance. She has taken the process to its logical conclusion. Thanks to all respected members of the Technical Committee for their guidance and valuable suggestions.

I would like to thank and congratulate my colleagues and experts of the Core Group from different government and non-government organizations who have invested time and energy to make the manuals happen.

I would like to thank USAID and MaMoni Health Systems Strengthening Project for their technical and financial support for the development of the training manuals.

These training manuals are product of the collaborative effort of many experts inside and outside of NIPORT. All the contributors [only a few has been mentioned here] in curriculum development process deserve thanks for their respective contributions.

The government attaches great importance to improving health care provision and rightly so, because quality health care at the community level is considered to be the most important first step towards achieving universal health coverage. At NIPORT we are also mindful about it and would like to play our roles to strengthen community health systems in Bangladesh.

Finally, I wish the best uses of these manuals and success of the training program on Management and Leadership Training for Upazila Health and Family Planning Program Managers.

Md. Matiar Rahman
Director- Training (Additional Secretary)
National Institute of Population Research and Training (NIPORT)

Message

I would like to begin by thanking NIPORT for undertaking the 'Management and Leadership Training for Upazila Health and Family Planning to Strengthen Community Health Systems'. I believe it is a timely initiative and would contribute to improving the community based health interventions in the long-term. USAID's MaMoni HSS Project is proud to be part of this initiative.

A training program named Strategic Leadership and Management Training Program (SLMTP) was jointly developed and implemented by Johns Hopkins University, Save the Children and BSMMU under the Health Research Challenge Initiative (HRCI) between 2014 and 2015. The managers who were trained, indicated they are better equipped to lead and manage their teams and motivate staff to achieve their goals. Built on the experience of SLMTP, this training program is tailored to develop the skills of Upazila health and family planning managers in addressing the community health needs. I expect this training will help the managers leading their teams more efficiently and to proactively engage the Community Health Workers, local government institutions and various community-based structures.

Finally, on behalf of USAID's MaMoni HSS Project I wish good luck to the training program and hope that this initiative would help to bring about meaningful change in the ways health service is provided to the communities across Bangladesh.

Joby George
Chief of Party
MaMoni Health Systems Strengthening Project

Members of the Technical Committee and the Core Committee

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acronyms

ADP	Annual Development Program
AIDS	Acquired Immune Deficiency Syndrome
AMC	Alternative Medical Care
ANC	Antenatal Care
APIR	Annual Program Implementation Report
ASFR	Age-Specific Fertility Rate
ASMR	Age-Specific Marriage Rate
BBS	Bangladesh Bureau of Statistics
BCC	Behavior Change Communication
BDHS	Bangladesh Demographic and Health Survey
BEmONC	Basic Emergency Obstetric and Newborn Care
BHFS	Bangladesh Health Facility Survey
BMI	Body Mass Index
BNHA	Bangladesh National Health Accounts
BNSMH	Bangladesh National Strategy for Maternal Health
CBHC	Community Based Health Care
CBR	Crude Birth Rate
CC	Community Clinic
CCI	Cross Cutting Issue
CCSDP	Clinical Contraceptive Services Delivery Program
CDC	Communicable Disease Control
CDiR	Crude Divorce Rate
CDR	Crude Death Rate
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CG	Community Group
CH	Child Health
CHW	Community Health Workers
CMR	Crude Marriage Rate
CMSD	Central Medical Stores Depot
COPD	Chronic Obstructive Pulmonary Disease
CPR	Contraceptive Prevalence Rate
CRHCC	Comprehensive Reproductive Health Care Centre
CSBA	Community Skilled Birth Attendant
CSG	Community Support Group
CSR	Crude Separation Rate
DDO	Drawing and Disbursing Officer
DGDA	Directorate General of Drug Administration
DGFP	Directorate General of Family Planning

DGHS	Directorate General of Health Services
DGNM	Directorate General of Nursing and Midwifery Services
DH	District Hospital
DHIS2	District Health Information System - Version 2
e-LMIS	Electronic Logistics Management Information System
ENC	Essential Newborn Care
EPI	Expanded Program of Immunization
EPMM	Ending Preventable Maternal Mortality
ESP	Essential Services Package
FP	Family Planning
FPFSD	Family Planning Field Services Delivery
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
GFR	General Fertility Rate
GMR	General Marriage Rate
GoB	Government of Bangladesh
GRR	Gross Reproduction Rate
GSID	Governance, Stewardship and Institutional Development
HA	Health Assistant
HCFS	Health Care Financing Strategy
HEF	Health Economics and Financing
HEU	Health Economics Unit
HI	Health Inspector
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
HNPSIP	Health, Nutrition and Population Strategic Investment Plan
HPNSP	Health, Population and Nutrition Sector Program
HPNSDP	Health, Population and Nutrition Sector Development Program
HPSP	Health and Population Sector Programs
HRD	Human Resource Development
HRIS	Human Resources Information System
HSM	Hospital Services Management
IBAS	Integrated Budget and Accounting System
ICPD	International Conference on Population and Development
ICT	Information and Communication Technology
IEC	Information, Education and Communication
IFM	Improving Financial Management
IMCI	Integrated Management of Child Illnesses
IMR	Infant Mortality Rate
IYCF	Infant and Young Child Feeding
JHU	Johns Hopkins University
KMC	Kangaroo Mother Care
LARC	Long Acting Reversible Contraceptive
LG	Local Government
LHEP	Lifestyle, and Health Education & Promotion

LMIS	Logistic Management Information System
MAM	Mean Age at Marriage
M&E	Monitoring and evaluation
MCRAH	Maternal, Child, Reproductive and Adolescent Health
MCWC	Maternal and Child Welfare Centers
MDG	Millennium Development Goals
ME& HMD	Medical Education and Health Manpower Development
MIS	Management Information System
MMEIG	Maternal Mortality Estimation Inter-agency Group
MMR	Maternal Mortality Rate
MNCAH	Maternal, Neonatal, Child and Adolescent Health
MNH	Maternal and Neonatal Health
MO	Medical Officer
MOF	Ministry of Finance
MOHFW	Ministry of Health and Family Welfare
MO-MCH-FP	Medical Officer -Maternal & Child Health-Family Planning
MPIR	Mid-term Program Implementation Report
MW	Midwife
NCD	Non-Communicable Disease
NCDC	Non-communicable Diseases Control
NEC	National Eye Care
NGO	Non-Governmental Organization
NHP	National Health Policy
NIPORT	National Institute of Population, Research and Training
NIS	National Integrity Strategy
NMES	Nursing and Midwifery Education and Services
NMR	Neonatal Mortality Rate
NNS	National Nutrition Services
NRR	Net Reproduction Rate
OP	Operational Plan
PFD	Physical Facilities Development
PHC	Primary Health Care
PHCC	Primary Health Care Centers
PIP	Program Implementation Plan
PME	Planning, Monitoring and Evaluation
PMR	Planning, Monitoring and Research
PNC	Postnatal Care
PPt.	PowerPoint Presentations
PPP.	Public-Private Partnership
PRSP	Poverty Reduction Strategy Paper
PSSM	Procurement, Storage and Supply Management
QI	Quality Improvement
RD	Rural Dispensaries
RMNCAH	Reproductive, Maternal, Newborn, Child & Adolescent Health
RMNCH	Reproductive, Maternal, Newborn and Child Health

RMO	Resident Medical Officer
SACMO	Sub-Assistant Community Medical Officer
SAM	Severe Acute Malnutrition
SBCC	Social and Behavior Change Communication
SCMP	Supply Chain Management Portal
SDAM	Strengthening of Drug Administration
SDG	Sustainable Development Goal
SGBV	Sexual and Gender-Based Violence
SLMTP	Strategic Leadership and Management Training Program
SO	Strategic Objective
SOP	Standard Operating Procedures
SVRS	Sample Vital Registration System
SWAp	Sector Wide Approach
SWPMM	Sector-Wide Program Management and Monitoring
TFR	Total Fertility Rate
THE	Total Health Expenditure
TOR	Terms of Reference
TRD	Training, Research and Development
U5MR	Under 5 Mortality Rate
UDCC	Union Development Coordination Committee
UFPO	Upazila Family Planning Officer
UH&FPO	Upazila Health and Family Planning Officer
UH&FWC	Union Health and Family Welfare Centre
UH&FWCMC	Union Health and Family Welfare Centre Management Committee
UHC	Universal Health Coverage
UHMC	Upazila Hospital Management Committee
UNCAC	United Nations Convention Against Corruption
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USC	Union Sub-Centers
VAC	Vitamin A Capsule
VIPP	Visualization in Participatory Planning
WHA	World Health Assembly
WHO	World Health Organization

Participants' Manual

A. Module Overview

The new Health, Population and Nutrition Sector Program (HPNSP) 2017-2022 of the Ministry of Health and Family Welfare (MOHFW) envisages the roll-out of an upgraded Essential Services Package (ESP), which represents the Government of Bangladesh's commitment to ensure that the whole population has access to the most essential services. Different cadre of health care providers are involved in the provision of the ESP, from community-based workers to the Medical Officers and other facility-based providers. Upazila-level managers of Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP)- namely Upazila Health and Family Planning Officer (UHFPO), Upazila Family Planning Officer (UFPO), Medical Officer-MCH-FP (MO-MCHFP) and Resident Medical Officers (RMO)- have a vital role to play in providing leadership and management support for strengthening the community-based health services initiatives, particularly the delivery of ESP at community and primary care health facilities.

The management and leadership training program is a five-day training course designed to enhance management and leadership skills of the upazila level health and family planning managers. The training will help them to provide visionary leadership and more efficient management support to their teams, develop a positive approach to overcoming challenges and more proactively engage with the Community Health Workers (CHWs), local government institutions and various community-based structures in strengthening community health systems.

B. Training Objective

To enhance the management and leadership capacity of upazila level health and family planning managers to strengthen community health systems for effective and efficient ESP delivery.

C. Learning Objectives

By the completion of this training program, participants will be able to

- Describe and apply the core principles of management and leadership in the context of leading the teams to deliver the community-based health interventions
- Understand the health, population and nutrition policies of Bangladesh
- Explain national strategies (maternal health, adolescent health, nutrition) in the context of implementing community-based health intervention programs
- Explain the demographic structure of Bangladesh
- Describe 4th Health, Population and Nutrition Sector Program (4th HPNSP)
- Explain and apply the concept of community involvement, participation, and mobilization in delivering health interventions
- Understand and describe different community-based structures and their roles
- Demonstrate the knowledge and skills for team building, sharing vision, communication, coordination and negotiation
- Utilize available data from information systems (DHIS2, MIS, LMIS, HRIS) for decision making and planning to deliver community-level health intervention programs
- Understand importance of budget, budget monitoring and the role of Drawing and Disbursing Officers (DDOs)
- Understand Decentralized Planning and Management Cycle and describe the steps of program implementation plan development
- Describe the principles of good governance in health systems

D. Participants

Participants for this training course are upazila (sub-district) level managers of Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP). The majority of participants are Upazila Health and Family Planning Officer (UHFPO), Upazila Family Planning Officer (UFPO), and Medical Officer-MCH-FP (MO-MCHFP). In some cases, Resident Medical Officers (RMO) will participate.

E. Schedule

The following schedule outlines the estimated time for each session and provides a suggested schedule for the Training. However, it is important to note that the schedule can be adapted through discussion with participants to meet its particular time constraints and topic interests.

Day-1

Time	Session	Topic
9.00-10.30 (1 hour 30 min.)	Session-1	Introduction Session - Inauguration and Ice breaking - Training objectives and expectations - Training norms - Pretest
10.30-11.00 (30 min.)	Tea Break	
11.00-12.30 (1 hour 30 min.)	Session-2	National Health, Population and Nutrition policies - National Health Policy 2011 - Bangladesh Population Policy 2012 - National Nutrition Policy 2015
12.30-1.30 (1 hour)	Session-3	Demographic Structure of Bangladesh - Population Pyramid - Demographic indicators - Demographic dividend
1.30-2.30 (1 hour)	Lunch and prayer break	
2.30-3.30 (1 hour)	Session-4	National Strategies - Maternal Health Strategy - Adolescent Health Strategy - National Nutrition Policy (strategies)
3.30-3.45 (15 min.)	Tea Break	
3.45-4.15 (30 min.)	Session-4	Continued… National Strategies
4.15-4.30 (15 min.)		Evaluation of the day

Day-2

Time	Session	Topic
9.00-9.15 (15 min.)		**Review of the previous day**
9.15-10.45 (1 hour 30 min.)	**Session-5**	**4th Health, Population and Nutrition Sector Program** - Sustainable Development Goals (SDG) - Health, Population and Nutrition Sector Program (HPNSP) - Operational Plans (OP) - Universal Health Coverage (UHC)
10.45-11.00		**Tea Break**
11.00-11.45 (45 min.)	**Session-6**	**Essential Services Package (ESP)** - Composition of ESP - Minimum standard and extra services by facility levels - Facility and service delivery sites - Role of Upazila Managers
11.45-1.15 (1 hour 30 min)	**Session-7**	**Management concepts** - Management Functions - Management Models - Role of a manager
1.15-2.15 (1 hour)		**Lunch and prayer break**
2.15-3.45 (1 hour 30 min.)	**Session-8**	**Introduction to Leadership** - Overview of leadership - Leadership Self-Assessment - Leader VS Manager
3.45-4.00 (15 minutes)		**Tea Break**
4.00-5.00 (1 hour)	**Session-9**	**Supportive supervision** - Supervision, Supportive supervision - Guiding principles for supervisors - Core competencies of a supervisor
5.00-5.15 (15 min.)		**Evaluation of the day**

Day-3

Time	Session	Topic
9.00-9.15 (15 min.)		**Review of the previous day**
9.15-10.15 (1 hour)	**Session-10**	**Problem solving** - Problem and problem solving technique - 7 Steps of problem solving - Three key skills to use for resolving any problem
10.15-10.30 (15 min.)		**Tea Break**
10.30-12.00 (1 hour 30 min.)	**Session-11**	**Concept of Community and its role in health system** - Community development and participation - Household production of health
12.00-1.30 (1 hour 30 min.)	**Session-12**	**Community based structures and their roles** - Community Group and Community Support Group - UHFWC management committee - Upazila and Union level local govt. Committees - Community Health Workers
1.30-2.30 (1 hour)		**Lunch and prayer break**
2.30-3.30 (1 hour)	**Session-13**	**Role of Manager in engaging community** - Share success stories and best practices
3.30-3.45 (15 min.)		**Evaluation of the day**
3.45-4.00 (15 min.)		**Tea Break and end of the day**

Day-4

Time	Session	Topic
9.00-9.15 (15 min.)		**Review of the previous day**
9.15-10.45 (1 hour 30 min.)	**Session-14**	**Communication, Coordination and Negotiation** - Effective communication - Coordination skill and effective coordination with different stakeholders - Negotiation skill
10.45-11.00 (15 min.)		**Tea break**
11.00-12.00 (1 hour)	**Session-15**	**Team building and Shared vision** - Characteristics of effective team building - Stages of team building - How to build a shared vision
12.00-1.00 (1 hour)	**Session-16**	**Data for decision making** (DHIS2 & MIS) - DHIS2: Overview, data analysis and utilization in decision making
1.00-2.00 (1 hour)		**Lunch and prayer break**
2.00-3.00 (1 hour)	**Session-16**	**Data for decision making** (DHIS2 & MIS) - MIS: Overview, data analysis and utilization in decision making
3.00-4.00 (1 hour)	**Session-17**	**Data for decision making (LMIS & HRIS**) - LMIS: Overview, data analysis and utilization in decision making - HRIS: Overview, data analysis and utilization in decision making
4.00-4.15 (15 min.)		**Evaluation of the day**
4.15-4.30 (15 min.)		**Tea break and end of the day**

DAY-1

Day-1 Schedule

Time	Sessions	Topics
9.00-10.30 (1 hour 30 minutes)	**Session-1**	**Introduction Session** - Inauguration and Ice breaking - Training objectives and expectation - Training norms - Pretest
10.30-11.00 (30 minutes)	**Tea Break**	
11.00-12.30 (1 hour 30 min.)	**Session-2**	**National Health, Population and Nutrition policies** - National Health Policy 2011 - Bangladesh Population Policy 2012 - National Nutrition Policy 2015
12.30-1.30 (1 hour)	**Session-3**	**Demographic Structure of Bangladesh** - Population Pyramid - Demographic indicators - Demographic dividend
1.30-2.30 (1 hour)	**Lunch and prayer break**	
2.30-3.30 (1 hour)	**Session-4**	**National Strategies** - Maternal Health Strategy - Adolescent Health Strategy - National Nutrition Policy 2015
3.30-3.45 (15 min.)	**Tea Break**	
3.45-4.15 (30 minutes)	**Session-4**	**Continue…** **National Strategies**
4.15-4.30 (15 min.)		**Evaluation of the day**

Session -1: Introduction Session

At the end of the session the participants will be able to:

- Know each other through ice breaking
- Describe the training objectives
- Clarify the expectation
- Explain the training norms
- Complete a Pre-test

Time: 1 hour 30 minutes

Participant's note

- **Ice-breaker Activity:** Participants will participate in a game for Ice breaking
- **Expectation:** Participants will write minimum one and maximum 3 expectations in each VIPP card distributed by Facilitator
- **Pretest:** Participants will attend 15 minutes pre-test
- **Day Evaluation:** Use of Mood Meter. A flip paper will be hanged on the wall with three moods. 1: Happy, 2: Fair, 3: Sad. Facilitator would ask any of the participants to say about the whole day and the most important learning for the day. At the end of the day each participant provide their feelings about the day on the mood meter sheet.
- Review of the previous day: At the beginning of each day, some participants will be selected to be "Reflectors." The selected Reflectors should take special notice of the day's activities and the group's reactions. The following morning, the Reflectors will take a few minutes to report their observations to the group.
- The reflections should help us all begin our day with a laugh and a smile. Have fun with it.
- The reflection is not a summary of the previous day's activities or lectures. Rather, the purpose is to share your observations about the training's content and methodology, the trainers and the participants, the food, etc., and to point out activities that you really liked, or didn't like.
- Reflections should last no longer than 15 minutes
- Innovative approaches are encouraged! Reflectors are encouraged to use humor, song, dance, poetry, games, energizers, role-plays, puppet show, etc. to present their observations.

Training Objective

To enhance the management and leadership capacity of upazila level health and family planning managers to strengthen community health systems for effective and efficient ESP delivery.

Learning Objectives:

By the completion of this training program, participants will be able to:

- Describe and apply the core principles of management and leadership in the context of leading the teams to deliver the community-based health interventions
- Understand the health, population and nutrition policies of Bangladesh
- Explain national strategies (maternal health, adolescent health, Nutrition) in the context of implementing community-based health intervention programs
- Explain demographic structure of Bangladesh
- Describe the 4th Health, Population and Nutrition Sector Program (4th HPNSP)
- Explain and apply the concept of community involvement, participation, and mobilization in delivering health interventions
- Understand and describe different community-based structures and their roles
- Demonstrate the knowledge and skills for team building, sharing vision, communication, coordination and negotiation
- Utilize available data from DHIS2, MIS, LMIS, HRIS for decision making and planning to deliver community-level health intervention programs
- Understand importance of budget, budget monitoring and the role of DDOs
- Understand Decentralized Planning and Management Cycle and describe the steps of program implementation plan development
- Describe the principles of good governance in health systems

Training Norms

- ➢ Be Punctual
- ➢ Ensure active participation
- ➢ Talk one by one
- ➢ Raise hand to ask question
- ➢ No side-by-side talking
- ➢ Ask questions when needed
- ➢ Respect each other
- ➢ Silence or turn off mobile phone

Session -2: National Health, Population and Nutrition Policies

Session objectives

At the end of the session the participants will be able to:

- State objectives, principals and major strategies of National Health Policy 2011
- Describe objectives and strategies of Bangladesh Population Policy 2012
- Explain objectives and strategies of National Nutrition Policy 2015

Time: 1 hour 30 minutes

Participant's note

- In this session participants will participate in a discussion.
- Participants will be divided in three groups and would do group work. Select a group leader for moderating group discussion and presentation. Read and discuss the policy (selected for the group) in group for 30 min. Present the objectives, principle and key strategies of the policies in summery within 10 minutes. Use flip paper for group work presentation or any innovative way.

DAY-1

Handout

National Health Policy
Bangladesh Population Policy
National Nutrition Policy

National Health Policy 2011 (NHP)

The National Health Policy 2011 has 19 goals and objectives, 16 policy principles and 39 strategies.

জাতীয় স্বাস্থ্যনীতির মূল লক্ষ্য

প্রথম : সমাজের সর্বস্তরের মানুষের কাছে সংবিধান অনুযায়ী ও আন্তর্জাতিক সনদসমূহ অনুসারে চিকিৎসাকে অধিকার হিসেবে প্রতিষ্ঠার লক্ষ্যে চিকিৎসার মৌলিক উপকরণ পৌছে দেয়া এবং পুষ্টির উন্নয়ন ও জনস্বাস্থ্যের উন্নতি সাধন করা।

দ্বিতীয় : জনসাধারণ, বিশেষ করে গ্রাম ও শহরের দরিদ্র এবং পশ্চাৎপদ জনগোষ্ঠীর জন্য মানসম্পন্ন ও সহজলভ্য স্বাস্থ্য সেবা নিশ্চিত করা।

তৃতীয় : প্রাথমিক স্বাস্থ্য সেবাকে প্রত্যেক নাগরিকের জন্য নিশ্চিত করার লক্ষ্যে প্রতি ছয় হাজার জনগোষ্ঠীর জন্য একটি করে কমিউনিটি ক্লিনিক স্থাপন নিশ্চিত করা।

চতুথ : জরুরি চিকিৎসা সেবাকে অগ্রাধিকার দেয়া।

পঞ্চম : শিশু ও মাতৃমৃত্যুর হার হ্রাস করা, বিশেষ করে স্বাধীনতার পঞ্চাশ বছর পূর্তিতে আগামী ২০২১ সালের মধ্যে এ হারকে যুক্তিসংগত হারে হ্রাস করা।

ষষ্ঠ : আগামী ২০২১ সালের মধ্যে প্রতিস্থাপনযোগ্য জন-উর্বরতা (Replacement level of Fertility) অর্জন করার লক্ষ্যে পরিবার পরিকল্পনা, প্রজনন ও স্বাস্থ্য সেবাকে আরো জোরদার ও গতিশীল করা।

সপ্তম : মা ও শিশু স্বাস্থ্যের উন্নতির জন্য সন্তোষজনক ব্যবস্থা গ্রহণ করা ও যথাসম্ভব প্রতিটি গ্রামে নিরাপদে প্রসূতি সেবা নিশ্চিত করা।

অষ্টম : অতি দরিদ্র ও অল্প আয়ের জনগোষ্ঠীর মধ্যে পরিবার পরিকল্পনা কর্মসূচিকে গ্রহণযোগ্য করা ও পরিবার পরিকল্পনা সামগ্রীর সহজলভ্যতা নিশ্চিত করা।

নবম : স্বাস্থ্যসেবায় লিঙ্গ সমতা নিশ্চিত করা।

দশম : চিকিৎসা সেবাসহ স্বাস্থ্য খাতের সামগ্রিক ব্যবস্থাপনায় তথ্য প্রযুক্তির সর্বোচ্চ ও সর্বোত্তম ব্যবহার নিশ্চিত করা।

একাদশ: সরকারি স্বাস্থ্য সেবাকেন্দ্র ও হাসপাতালসমূহে চিকিৎসার প্রয়োজনীয় উপকরণ ও লোকবল নিশ্চিত করা এবং ব্যবস্থাপনায় উন্নয়ন সাধন পূর্বক সেবার গুণগত মান বৃদ্ধি করা।

দ্বাদশ : বেসরকারি মেডিকেল কলেজ, চিকিৎসা শিক্ষা ও প্রশিক্ষণ প্রতিষ্ঠান, হাসপাতাল, ক্লিনিক, ডায়াগনস্টিক সেন্টারসমূহের সেবার মান নিশ্চিত করা এবং সেবা ও শিক্ষার ব্যয় জনসাধারণের নাগালের মধ্যে রাখা।

ত্রয়োদশ: সকল চিকিৎসা শিক্ষা, নার্সিং শিক্ষা ও মেডিকেল টেকনোলজি ও স্বাস্থ্যসেবা সহায়কদের শিক্ষা ব্যবস্থাকে আধুনিকায়ন ও দেশের প্রয়োজন অনুযায়ী যুগোপযোগী করা।

চর্তুদশ : জনস্বাস্থ্য ও চিকিৎসা সম্পৃক্ত বিভিন্ন মন্ত্রণালয় ও বিভাগ এবং বেসরকারি খাতের সম্মিলিত ও সমন্বিত প্রচেষ্টা নিশ্চিত করা।

পঞ্চদশ : রোগ প্রতিরোধ ব্যবস্থা আরো শক্তিশালী করা এবং এ লক্ষ্যে টিকাদান (Immunization) কার্যক্রমকে অব্যাহত রাখা ও শক্তিশালী করা।

ষষ্ঠদশ : স্বাস্থ্য তথ্য প্রাপ্তিতে জনগণের অধিকার নিশ্চিত করা।

সপ্তদশ : অত্যাবশ্যকীয় ঔষধের সহজলভ্যতা ও মূল্য নিয়ন্ত্রণ নিশ্চিত করা।

অষ্টদশ : জলবায়ু পরিবর্তনজনিত স্বাস্থ্য বিপর্যয় ও রোগ ব্যধির গতি প্রকৃতি লক্ষ্য রাখা এবং তা থেকে পরিত্রাণ পাওয়ার উপায় উদ্ভাবন করা।

উনবিংশ: বিকল্প চিকিৎসা (ইউনানি, আয়ুর্বেদীয় ও হোমিওপ্যাথি) পদ্ধতি ও শিক্ষার মানোন্নয়নের ব্যবস্থা নিশ্চিত করা। জাতীয় স্বাস্থ্যনীতির উল্লেখিত লক্ষ্য ও উদ্দেশ্য অর্জনের জন্য নিম্নবর্ণিত মূলনীতি ও কর্মকৌশলগুলো চিহ্নিত করা হয়েছে।

মূলনীতিঃ

১. জাতি, ধর্ম, গোত্র, আয়, লিঙ্গ, প্রতিবন্ধী ও ভৌগলিক অবস্থান নির্বিশেষে বাংলাদেশের প্রত্যেক নাগরিকের এবং বিশেষ করে শিশু ও নারীর সাংবিধানিক অধিকার নিশ্চিত করে সামাজিক ন্যায় বিচার ও সমতার ভিত্তিতে তাদের স্বাস্থ্য, পুষ্টি ও প্রজনন স্বাস্থ্য সেবা ভোগ করতে প্রচার মাধ্যমের সহায়তায় সচেতন ও সক্ষম করে তোলা ও সুস্বাস্থ্যেও সঙ্গে সঙ্গতিপূর্ণ জীবন-যাত্রা গ্রহণের জন্য আচরণের পরিবর্তন আনার উদ্যোগ নেয়া ।

২ প্রাথমিক স্বাস্থ্য সেবাসমূহ বাংলাদেশের রাষ্ট্রীয় ভূখন্ডের যে কোন ভৌগলিক অবস্থানের প্রত্যেক নাগরিকের কাছে পৌছে দেয়া ।

৩ স্বাস্থ্য সমস্যা সমাধানের ক্ষেত্রে সুবিধা বঞ্চিত, গরিব, প্রান্তিক, বয়স্ক ও শারীরিক ও মানসিক প্রতিবন্ধী জনগণের অধিকার গুরুত্বপূর্ণ স্বাস্থ্য সমস্যাগুলির প্রতি বিশেষ দৃষ্টি দেয়া এবং এ লক্ষ্যে বিরাজমান সম্পদেও প্রাধিকার, পূর্ণ বন্টন ও সদ্ব্যবহার নিশ্চিত করা ।

৪ স্বাস্থ্য ব্যবস্থাপনা বিকেন্দ্রীকরণের লক্ষ্যে এবং স্বাস্থ্য উন্নয়নে জনগণের অধিকার প্রতিষ্ঠা ও দায়িত্ব পালনের সুযোগ সৃষ্টি করার জন্য পরিকল্পনা প্রণয়ন, ব্যবস্থাপনা, স্থানীয় তহবিল গঠন, ব্যয়ন, পরিবীক্ষণ এবং স্বাস্থ্য সেবা প্রদান পদ্ধতি পর্যালোচনাসহ সংশ্লিষ্ট সকল প্রক্রিয়ায় জনগণকে সম্পৃক্ত করা ।

৫ সবার জন্য কার্যকর স্বাস্থ্যসেবা প্রদান নিশ্চিত করার লক্ষ্যে সরকারি প্রতিষ্ঠান ও বেসরকারি সংস্থাসমূহের সমন্বিত প্রয়াসের সুযোগ সৃষ্টি ও সহযোগিতা প্রদান করা এবং অংশীদারিত্বেও সুযোগ সৃষ্টি করা । বিশেষ করে সরকারি স্বাস্থ্য স্থাপনাসমূহে উচ্চমূল্যেও চিকিৎসা যন্ত্রপাতি বেসরকারি অংশীদারিত্বে স্থাপনের বিষয়টি পরীক্ষা করা ।

৬ স্বাস্থ্য সেবার উন্নয়ন ও গুণগত মান বৃদ্ধিও লক্ষ্যে এবং স্বাস্থ্য সেবার সুবিধা প্রতিটি নাগরিকের কাছে পৌছে দেয়ার জন্য সঠিক ও গ্রহণযোগ্য প্রশাসনিক পুনর্বিন্যাস, সেবা দান পদ্ধতি ও সরবরাহ ব্যবস্থা বিকেন্দ্রীকরণ এবং প্রয়োজনের সঙ্গে সঙ্গতিপূর্ণ মানব সম্পদ উন্নয়ন কৌশল কৌশল গ্রহণ করা ।

৭ স্বাস্থ্য, পুষ্টি ও প্রজনন স্বাস্থ্যেও সেবাগুলিকে আরো জোরদার ও সেগুলোর সদ্ব্যবহার নিশ্চিত করার জন্য কার্যকর, ফলপ্রসূ ও সুদক্ষ প্রযুক্তি গ্রহণ ও যথাযথ ব্যবহার, পদ্ধতি উন্নয়ন ও গবেষণা কর্মকে উৎসাহিত করা ।

৮ জন্ম-নিয়ন্ত্রণের প্রত্যাশিত লক্ষ্য অর্জনের জন্যে পরিবার পরিকল্পনা কার্যক্রমকে স্বাস্থ্যের সাথে কার্যকর সমন্বয় করা ।

৯ পুষ্টি কার্যক্রমকে স্বাস্থ্যসেবার সঙ্গে কার্যকর সমন্বয় করা ।

১০ স্বাস্থ্য সেবার সাথে সম্পর্কিত বিষয়ে সকল নাগরিকের অধিকার, সুযোগ, দায়িত্ব, কর্তব্য ও বিধি-নিষেধের ব্যাপাওে সচেতন করা ।

১১ জনগণের আকাঙ্ক্ষা ও চাহিদা পূরণের লক্ষ্যে সার্বিক সুস্থতা ও সুস্থ প্রজনন স্বাস্থ্য নিশ্চিত করার জন্য প্রাথমিক স্বাস্থ্য পরিচর্যা ও অত্যাবশ্যকীয় স্বাস্থ্য সেবা কর্মসূচি বাস্তবায়নের মাধ্যমে স্বাস্থ্য সেবার অন্তর্নিহিত মূলনীতি স্বাস্থ্য ক্ষেত্রে স্বনির্ভরতা প্রতিষ্ঠা করা ।

১২ স্বাস্থ্য সংশ্লিষ্ট জাতীয় লক্ষ্য অর্জনের জন্য সকল স্তরে প্রয়োজনীয় ও মানসম্পন্ন চিকিৎসক ও স্বাস্থ্য সহায়ক প্রশিক্ষিত পেশাজীবী কর্মী-বাহিনী গড়ে তোলা ।

১৩ তথ্য ও যোগাযোগ প্রযুক্তির উদ্ভাবনী প্রয়োগ এবং ই-হেলথ ও টেলি মেডিসেনের মাধ্যমে সকল নাগরিকের জন্য মান সম্পন্ন স্বাস্থ্য নিশ্চিত করা ।

১৪ অত্যাবশ্যকীয় ওষুধ (**Essential Drugs**) এর তালিকা হালনাগাদ করা ও সর্বত্র সেগুলোর যথাযথ প্রাপ্যতা নিশ্চিত করা । দেশীয় ঔষধ শিল্পের উন্নয়ন ও প্রসারের জন্য প্রয়োজনীয় ব্যবস্থা গ্রহণ করা ।

১৫ দুর্যোগ কবলিত এবং জলবায়ু পরিবর্তনজনিত বিপর্যয়ের শিকার জনগণের কাছে জরুরি ত্রাণ হিসাবে স্বাস্থ্যসেবা, ওষুধ, যন্ত্রপাতি প্রভৃতি সরবরাহ নিশ্চিত করার জন্য স্বাস্থ্য সম্পর্কিত নিরাপত্তা বেষ্টনী গড়ে তোলা ।

১৬ প্রচলিত স্বাস্থ্য সেবার পাশাপাশি বিকল্প স্বাস্থ্য সেবা পদ্ধতিসমূহ (যেমন- হোমিওপ্যাথি, ইউনানি, আয়ুর্বেদীয় ইত্যাদি) অন্তর্ভুক্ত করে স্বাস্থ্য সেবার পরিধি সম্প্রসারণ করা ।

কর্মকৌশলঃ

১. সরকার প্রধানের নেতৃত্বে জাতীয় স্বাস্থ্য কাউন্সিল গঠন করা হবে। এ কাউন্সিলে সরকারের সংশ্লিষ্ট মন্ত্রণালয়সহ বেসরকারি খাতের স্টেকহোল্ডার ও এ সংক্রান্ত বিশেষজ্ঞদের অর্ন্তভুক্ত করা হবে। কাউন্সিল স্বাস্থ্যনীতি বাস্তবায়নে দিকনির্দেশনা প্রদান করবে। প্রয়োজনীয় ক্ষেত্রে গুরুত্বপূর্ণ অন্যান্য বিষয়ে কাউন্সিলের কাছে দিক নির্দেশনা চাওয়া হবে।

২. স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়ের দায়িত্বপ্রাপ্ত মন্ত্রীর নেতৃত্বে একটি নির্বাহী কমিটি গঠন করা হবে। এই কমিটি স্বাস্থ্য নীতি, জনসংখ্যা নীতি ও পুষ্টি নীতির আলোকে কর্মকান্ড পর্যালোচনা করবে। তাছাড়া কমিটি প্রয়োজনীয় অবকাঠামো সংস্কার, জনবল নিয়োগ, স্বাস্থ্য সম্পর্কিত মানবসম্পদ উন্নয়ণ পরিকল্পনা ও বাস্তবায়ন, কর্মীদের কর্মজীবন পরিকল্পনা, উন্নয়ন, ব্যবস্থাপনা নীতিসহ স্বাস্থ্যসেবার সঠিক উন্নয়নের পরামর্শ প্রদান করতে পারে। সম্পদের প্রাপ্যতার ভিত্তিতে কমিটির সুপারিশসমূহ পর্যয়ক্রমে বাস্তবায়ন করা হবে।

৩. বিভিন্ন মন্ত্রণালয়ের স্বাস্থ্য সম্পর্কিত কাজগুলো সম্পাদনে স্বাস্থ্য মন্ত্রণালয়কে সম্পৃক্ত করে কর্মপদ্ধতি নির্বাচন করার ব্যবস্থা করতে হবে।

৪. স্বাস্থ্যসেবা প্রদান প্রাথমিক স্বাস্থ্য পরিচর্যার গুরুত্ব সর্বজন স্বীকৃত। প্রাথমিক স্বাস্থ্য সেবার গুণগত মান উন্নয়ন করতে হবে এবং তা সর্বজনীন করা হবে। প্রাথমিক স্বাস্থ্যসেবা সংক্রান্ত কার্যাবলি বাস্তবায়নে কমিউিনিটি ক্লিনিকসমূহই হবে প্রধান ভিত্তি। কমিউিনিটি ক্লিনিকসমূহের কর্মকান্ড জোরালো করা হবে এবং স্থানীয় জনগণ ও স্থানীয় সরকার সংস্থাগুলোর অংশীদারিত্বে পরিচালিত হবে। প্রতি ছয় হাজা রমানুষের জন্য একটি কমিউনিটি ক্লিনিক স্থাপন করা হবে। বিশেষ ভৌগোলিক অবস্থঅন বিবেচনায় অপেক্ষাকৃত কম জনগোষ্ঠীর জন্যও (যেমন- চর, হাওড়, পার্বত্য অঞ্চল) কমিউনিটি ক্লিনিট স্থাপনা করা যেতে পারে। দ্রুত নগরায়নের ফলে শহরাঞ্চলে মোট জনসংখ্যার সাথে সাথে দরিদ্র মানুষের সংখ্যা বাড়ছে। বিদ্যমান স্বাস্থ্যসেবা ব্যবস্থার প্রয়োজনের তুলনায় অপ্রতুল। কার্যকর রেফারেন্স পদ্ধতির মাধ্যমে শহর ও গ্রাম উভয় ক্ষেত্রেই জটিলতর রোগীদের পরবর্তী ধাপে চিকিৎসার ব্যবস্থা করা হবে।

৫. জরুরী স্বাস্থ্য সেবা জীভ বাচাঁতে পারে বিধায় সার্বজনীন জরুরি চিকিৎসার ব্যবস্থা করা হবে।

৬. 'সবার জন্য স্বাস্থ্য' এ মৌলিক উদ্দেশ্যকে সামনে রেখে রোগ প্রতিরোধ ও স্বাস্থ্য সচেতনতা বৃদ্ধির জন্য বিশেষ গুরুত্ব দেওয়া হবে। আরোগ্যমূলক ও পুনর্বাসন সেবাগুলোর সন্তোষজনক প্রয়োগ নিশ্চিত করা হবে।

৭. রোগতাত্ত্বিক পরিবীক্ষণ (Epidemiological Surveillance) পদ্ধতিকে বিস্তৃত করে রোগ নিয়ন্ত্রণ কর্মসূচির সঙ্গে সমন্বিত করতে হবে।

৮. স্বাস্থ্যসেবার চাহিদা পূরণের জন্য স্বাস্থ্যনীতির সঙ্গে সামঞ্জস্য রেখে ঐষধ নীতিকে আরও গ্রহণযোগ্য এবং উন্নত করতে হবে। বর্তমান সময়ের চাহিদা, নিরাপত্তা, উপকারিতা, ক্রয় ক্ষমতার দিকে লক্ষ্য রেখে সর্বস্তরে জরুরি ঔষধ সহজপ্রাপ্যতা নিশ্চিত করা হবে।

৯. জন্মনিয়ন্ত্রণ সমাগ্রী ও পরিবার পরিকল্পনা পদ্ধতির বিভিন্ন সামগ্রীর উৎপাদন, সমহজপ্রাপ্যতা ও সরবরাহ নিশ্চিত করা হবে।

১০. স্বাস্থ্য ও পরিবার পরিকল্পনার কর্মকান্ডের মূল চালিকাশক্তি হিসেবে পুষ্টি, স্বাস্থ্য ও পরিবার পরিকল্পনার শিক্ষার উপর বিশেষ গুরুত্ব দিতে হবে। প্রত্যেক উপজেলায় একটি পুষ্টি এবং একটি স্বাস্থ্য শিক্ষা ইউনিট থাকবে। এগুলোর কর্মকান্ড প্রত্যন্ত অঞ্চল পর্যন্ত বিস্তৃত করা হবে। স্বাস্থ্য সেবার সঙ্গে সমন্বিত ভাবে উপজেলা পর্যন্ত স্বাস্থ্য শিক্ষার ব্যবস্থা করা হবে।

১১. লিঙ্গ সমতা প্রতিষ্ঠা কল্পে জীবনচক্রের সকল পর্যায়ে উত্তম শারীরিক, মানসিক স্বাস্থ্যের উপর নারীর অধিকার নিশ্চিত কর াহবে। মাতৃ মৃত্যু ও এক বছরের কম বয়সী শিশু মৃত্যুর হার কমানোর উপর জোর দিয়ে নারীর জন্য প্রাথমিক স্বাস্থ্যসেবা জোরদার করা হবে। নারীদের বিশেষত গর্ভবতী মাহলাদের পুষ্টি চাহিদা পূরণ করা হবে। সচেতনতা বৃদ্ধির মাধ্যমে নারীদের এইচআইভি/এইডস এবং অণ্যান্য যৌনরোগ হতে রক্ষার পদক্ষেপ গ্রহণ করতে হবে। সকল স্বাস্থ্য প্রতিষ্ঠানে নারী বান্ধব কাঠামো তৈরী করতে হবে।

১২. মাতৃ মৃত্যুর হার ও প্রজনন হার উল্লেখযোগ্য ভাবে কমানোর জন্য প্রজনন স্বাস্থ্য একটি গুরুত্বপূর্ণ উপাদান। গ্রাম ও শহর এলাকায় প্রান্তিক মানুষের কাছে এসব সেবা আরও ব্যাপকভাবে পৌছে দেয়া হবে। সাধারণ স্বাস্থ্য সেবা ও প্রজনন স্বাস্থ্য সেবা সমন্বিতভাবে দিলে তা জন-বান্ধব ও ব্যয় সাশ্রয়ী হবে। স্বাস্থ্য ও পরিবার কল্যাণ কর্মসূচি কার্যকর ভাবে সমন্বয় করা হবে।

১৩. একটি সমন্বিত তথ্য ব্যভস্থঅপনা পদ্ধতি (Integrated Management Information System) এবং কম্পিউটার নির্ভর যোগাযোগ ব্যবস্থা সারাদেশে প্রতিষ্ঠা করা হবে যা কর্মসূচি বাস্তবায়ন, কর্ম পরিকল্পনা প্রণয়ন এবং মনিটরিং এর জন্য সহায়ক হিসেবে কাজ করবে ।

১৪. স্বাস্থ্য সেবার সাথে সম্পৃকত্ সকলের জবাবদিহিতা নিশ্চিত করার জন্য নীতিমালা বা আইন প্রণয়ন করা হবে ।

১৫. স্বাস্থ্য খাতে ব্যভস্থঅপনার দক্ষতা বৃদ্ধির জন্য ব্যবস্থাপনা ও প্রশাসনিক বিষয়েল উপর চিকিৎসকসহ স্বাস্থ্য খাতে নিয়োজিত অন্যান্যদের প্রশিক্ষণের জন্য বিদ্যমান প্রতিষ্ঠানসমূহকে আরো আধুনিক ও যুগোপযোগী করা হবে ।

১৬. বেসরকারি ও এনজিও সংস্থাগুলোকে স্বাস্থ্য সেবায় সম্পূরক ভূমিকা পালনে উৎসাহিত করা হবে । বেসরকারি খাতে স্বাস্থ্য সেবা ও চিকিৎসা ব্যবস্থা রোগীদের সঠিক ও মান সম্পন্ন চিকিৎসা সেবা প্রাপ্তি নিশ্চিত করার জন্য প্রয়োজনীয় বিধি-বিধান তৈরী করা ও প্রয়োজন করার ব্যবস্থা করা হবে । পরীক্ষা-নিরীক্ষাসহ অন্যান্য চিকিৎসা ব্যয় সহনীয় পর্যায়ে রাখার ব্যবস্থা নেয়া হবে ।

১৭. স্বাস্থ্য গবেষণার মান ও পরিধি বাড়ানো হবে । এ খাতে অর্থ বরাদ্দ বাড়ানো হবে । জনস্বাস্থ্য, স্বাস্থ্য ব্যবস্থাপনা ও নীতি, সামাজিক ও আচরণগত এবং প্রয়োগিক গবেষণার উপর জোর দেয়া হবে । বাংলাদেশ যে সমস্ত রোগের প্রাদুর্ভাব বেশী, সেগুলোর গবেষণা অগ্রাধিকার পাবে । বিভিন্ন গবেষণা প্রতিষ্ঠান ও সংশ্লিষ্ট ব্যক্তিবর্গের সামর্থ্য ও দক্ষতা বাড়ানো হবে ।

১৮. প্রচলিত স্বাস্থ্য সেবার পাশাপাশি আয়ুর্বেদীয়, ইউনানি ও হোমিওপ্যাথী চিকিৎসা ব্যবস্থাকে বিকল্প চিকিৎসা পদ্ধতি হিসেবে সম্পৃক্ত করা হবে । সে লক্ষ্যে আয়ুর্বেদীয়, ইউনানি ও হোমিওপ্যাথি চিকিৎসাকে বিজ্ঞানভিত্তিক ও যুগোপযোগী করে গড়ে তোলা হবে । এ লক্ষ্যে সরকার যথাযথ সহায়তা প্রদান, অনুদান বৃদ্ধি, প্রশিক্ষণের ব্যবস্থার মান নিয়ন্ত্রণের জন্য প্রয়োজনীয় ব্যবস্থা গ্রহণ করবে ।

১৯. স্বাস্থ্য সেবার পূর্ণতা অর্জনের জন্য সরকারি ও বেসরকারি স্বাস্থ্য অর্থ ব্যবস্থা পর্যাপ্ত নয় । স্বাস্থ্যখাতে বরাদ্দকৃত বাজেটের পরিমাণ প্রয়োজনের তুলনায় অপ্রতুল । গড়ে বাংলাদেশের জিডিপির মাত্র এক শতাংশ সরকার স্বাস্থ্য, জনসংখ্যা ও পষ্টি খাতে বরাদ্দ করে । স্বাস্থ্য খাতে বরাদ্দ মোট বাজেটের মাত্র সাত শতাংশ । স্বাস্থ্য, জনসংখ্যা ও পুষ্টি খাতে প্রতি বছর বাজেট বরাদ্দ বাড়ানো হবে ।

২০. স্বাস্থ্য খাতে অর্থায়ন একটি সমস্যা । যদিও এ খাতে ব্যয়ের দুই-তৃতীয়ংশই জনগণ বহন করে, তারপরেও সম্পদের ঘাটতি থেকেই যায় । এটি সমাধানের লক্ষ্যে আনুষ্ঠানিক (ঋড়ৎসধষ) প্রতিষ্ঠানসমূহের চাকুরিজীবীদের জন্য স্বাস্থ্য বীমার ব্যবস্থা করা প্রয়োজন । প্রয়োজনে পর্যায়ক্রমে অন্যান্য গোষ্ঠীর জন্য স্বাস্থ্য বীমার ব্যবস্থা নেওয়া হবে । আর্থিকভাবে দুস্থ লোকদের জন্য দেশে সার্বজনীন স্বাস্থ্য সুরক্ষার পদ্ধতির অভাব রয়েছে । অতি দরিদ্র ও বঞ্চিত জনগোষ্ঠীর জন্য বিনামূল্যে চিকিৎসা নিশ্চিত করা প্রয়োজন । সরকার কর্তৃক স্বীকৃত উপায়ে এসব জনগোষ্ঠীকে পর্যায়ক্রমে কার্ড দেয়ার ব্যবস্থা করা হবে ।

২১. সর্বস্তরে স্বাস্থ্যসেবা প্রদানের ক্ষেত্রে জনগণ, স্থানীয় সরকার এবং বেসরকারি খাতকে সম্পৃক্ত করা হবে ।

২২. স্বাস্থ্য সেবা পরিকল্পনা প্রণয়ন ও বাস্তবায়নে বাংলাদেশ মেডিকেল এসোসিয়েশন (ইগঅ), বাংলাদেশ প্রাইভেট মেডিকেল প্র্যাকটিশনার্স এসোসিয়েশন (ইচগচঅ), আয়ুর্বেদিক মেডিকেল এসোসিয়েশন, ইউনানি মেডিকেল এসোসিয়েশন ও হোমিও প্যাথি মেডিকেল এসোসিয়েশন, নার্সিং এসোসিয়েশন ইত্যাদি পেশাজীবী সংগঠনসমূহকে সম্পৃক্ত করা হবে ।

২৩. সকলে স্তরের হাসপাতাল বর্জ্যের নিরাপদ, পরিবেশ বান্ধব ও ব্যয় সাশ্রয়ী ব্যবস্থাপনা নিশ্চিত করা হবে । দেশব্যাপী তার বিস্তার করা হবে ।

২৪. স্বাস্থ্য বিষয়ক মানব সম্পদ থেকে জ্ঞান ও দক্ষতার সর্বোচ্চ সুল অর্জনের লক্ষ্যে সর্বস্তরের জন্য ্কটি সঠিক ও চাহিদাভিত্তিক স্বাস্থ্য বিষয়ক মানব সম্পদ উন্নয়ন পদ্ধতি গড়ে তোলা হবে । চিকিৎসক, নার্স, ফার্মাসিস্ট , ফিজিওথে রাপি, প্যারামেডিক, টেকনোলজিস্টসহ বিভিন্ন স্বাস্থ্য কর্মীর স্বল্পতা ও অসম বন্টন ব্যবস্থা, দক্ষতা সংমিশ্রণের ক্ষেত্রে বিদ্যমান ভারসাম্যহীনতা, ন্যায়বিচার ও প্রণোদনার অভাব দূর করার ব্যবস্থা মানব সম্পদ উন্নয়ন কৌশলে থাকবে ।

চাহিদা যাচাই করে অতিরিক্ত জনশক্তি (ডাক্তার, নার্স, ফার্মাসিস্ট , ফিজিওথেরাপি, প্যারামেডিক, টেকনোলজিস্টসহ প্রভৃতি) তৈরীর পদক্ষেপ নেয়া হভে। স্বাস্থ্য জনশিক্তর সকল স্তরে নিয়োগ, পদোন্নতি, পদায়ন ও বদলির স্বচ্ছ নীতিমালা বাস্তবায়ন করা হবে।

২৫. চিকিৎসা শিক্ষঅ, নার্সি শিক্ষা, প্যারামেডিক ও টেকনোলোজিস্টদের শিক্ষা, ফিজিও থেরাপিস্ট এবং অন্যান্য স্বাস্থ্য কর্মীদের শিক্ষঅ এবং প্রশিক্ষণ ব্যবস্থাকে আধুনিকীকরণ করা হবে এবং গণমুখী ও দেশের প্রয়োজন ভিত্তিক করা হবে। চিকিৎসা জনশক্তির শিক্ষাদানে সেবার মান, রোগীর প্রতি সংবেদনশীল আচরণ, মমত্ববোধ ও নৈতিকতা বিষয়ে সচেতনতা সৃষ্টির উপর গুরুত্ব দেয়া হবে।

(ক) নার্সিং, ডিপ্লোমা পর্যায়ে দেশের চাহিদা পূরণ করার জন্য যথাযথ মানসম্পন্ন শিক্ষা প্রতিষ্ঠান বাড়ানো হবে। হাতে কলমে প্রশিক্ষণ ও আধুনিক প্রযুক্তির শিক্ষায় জোর দেয়া হবে। দেশে গ্রাজুয়েট নার্সদের স্বল্পতা রয়েছে এবং শিক্ষা প্রতিষ্ঠান বৃদ্ধির মাধ্যমে তাদের সংখ্যা বাড়ানো হবে। বিশেষায়িত নার্সি শিক্ষা (Specialized Nursing) যেমন- কার্ডিয়াকে সার্জারি, নিউরো সার্জারি, করোনারি কেয়ার এবং অন্যান্য বিশেষায়িত ডিসিপ্লিনে নার্সি শিক্ষা শুরু করা হবে। নার্সিং শিক্ষকদের স্বল্পতাও প্রকট। পোস্ট গ্রাজুয়েট নার্সিং শিক্ষা বঙ্গবন্ধু শেখ মুজিব মেডিক্যাল বিশ্ববিদ্যালয়সহ অন্যান্য প্রতিষ্ঠানে শুরু হবে।

(খ) প্যারামেডিক, টেকনোলোজিস্ট সংখ্যা প্রয়োজনের তুলনায় অনেক কম। এ পর্যায়ের শিক্ষা প্রতিষ্ঠানের সংখ্যা বাড়ানো হবে। আধুনিক প্রযুক্তির জ্ঞানসহ দক্ষতা অর্জনের উপর জোর দেওয়া হবে।

(গ) ধাত্রীঃ সরকারী স্বাস্থ্য সেবায় মাঠ পর্যায় পর্যন্ত ধাত্রীবিদ্যায় দক্ষ জনশক্তি দেয়া হবে। এজন্য প্রয়োজনীয় মানব সম্পদ প্রশিক্ষণের ব্যবস্থা করা হবে।

(ঘ) গ্রাজুয়েট পর্যায়ে চিকিৎসা শিক্ষার মান উন্নয়ণ করার লক্ষ্যে আরও মেডিক্যাল বিশ্ববিদ্যালয় প্রতিষ্ঠা করা প্রয়োজন। দেশের প্রয়োজন ভিত্তিক শিক্ষাদান ও হাতে-কলমে প্রশিক্ষণের উপর জোর দেয়া হবে। দেশের প্রচলিত পোস্ট গ্রাজুয়েট শিক্ষা ও বিভিন্ন কোর্স সমূহকে সমমানের করা হবে এবং সমন্বয় করা হবে। এখানেও আধুনিক প্রযুক্তি ও হাতে কলম প্রশিক্ষণের উপর জোর দেয়া হবে। চিকিৎসকদের পেশাগত মান বজায় রাখার জন্য দেশে ও বিদেশে Continuting Medical Education ও প্রশিক্ষণ ও এবং মূল্যায়নের ব্যবস্থা করা হবে।

(ঙ) গ্রামীণ জনগণের স্বাস্থ্য সেবা নিশ্চিত করার জন্য ইন্টার্নিশীপ বিদ্যমান এক বৎসরের পরিবর্তে ভবিষ্যতে প্রয়োজনীয় অর্থের প্রাপ্তি নিশ্চিত হওয়া সাপেক্ষে পর্যায়ক্রমে দুই বৎসরে উন্নীত করে তার মধ্যে অন্তঃত এক বৎসর গ্রাম পর্যায়ের স্বাস্থ্য কেন্দ্রসমূহে তাদের কার্যসম্পাদন নিশ্চিত করা হবে।

২৬. মেডিক্যাল প্রাকটিশনারদের রেজিষ্ট্রেশন, পেশাগত মান এবং এথিক্যাল প্রাকটিস সংক্রান্ত সঠিকভাবে তদারক করার জন্য বাংলাদেশ মেডিকেল ও ডেন্টার কাউন্সিল আরো শক্তিশালী করা হবে। অনুরূপভাবে বাংলাদেশ নার্সিং কাউন্সিলকেও পুনর্বিন্যস্ত ও শক্তিশালী করা হবে। ফার্মাসিস্ট, মেডিকেল টেকনোলজিস্ট এবং অন্যান্য প্যারামেডিকেল সেবা, শিক্ষা ও প্রশিক্ষণের গুণগত মান নিশ্চিত করার জন্য যথাক্রমে ফার্মেসি কাউন্সিল এবং স্টেট মেডিকেল ফ্যাকাল্টিকে পুনর্বিন্যাস করা হবে।

২৭. সুষ্ঠু স্বাস্থ্য সেবা নিশ্চিত করার জন্য মেডিক্যাল কলেজ এবং সংশ্লিষ্ট হাসপাতালা বা প্রতিষ্ঠানগুলোর ব্যবস্থাপনার উন্নতি সাধন করা হবে এবং সেগুলো যাবতীয় কর্মকান্ড পরিচালনার জন্য অধিকতর আর্থিক ও প্রশাসনিক ক্ষমতা প্রদান করা হবে।

২৮. সরকারি চিকিৎসকদের মধ্যে যে সমস্ত চিকিৎসক বা শিক্ষার্থী সার্বক্ষণিক ও আবাসিক পদে এবং জরুরি বিভাগে কর্মরত আছেন এবং যারা এর শিক্ষক তদের প্রাইভেট প্রাকটিস থেকে বিরত রেখে নন-প্রাকটিসিং ভাতা প্রদানের ব্যবস্থা করা প্রয়োজন।

২৯. প্রত্যেক সরকারি ও বেসরকারি স্বাস্থ্য সেবা দানকারী প্রতিষ্ঠানে রোগী পরিচর্যার ক্ষেত্রে মান সম্মত সেবা নিশ্চিত করতে হবে। এ লক্ষ্যে প্রত্যেক স্বাস্থ্য কেন্দ্রে সেবার গুণগত মান নিশ্চিতকরণ, মনিটরিং ও মূল্যায়ন পদ্ধতির উপর একটি সহায়িকা তৈরী করা হবে।

৩০. সর্বস্তরের কর্মকর্তা ও স্বাস্থ্য-কর্মীদের তাদের কর্মস্থলে উপস্থিতি ও সর্বোত্তম সেবা প্রদান নিশ্চিত করা হবে।

৩১. মানসিক ও শারীরিক প্রতিবন্ধী, বয়স্ক জনগোষ্ঠী, পশ্চাৎপদ জনগোষ্ঠী সমূহের স্বাস্থ্য সেবার প্রতি বিশেষ দৃষ্ দেয়া হবে। এজন্য বিশেষ স্বাস্থ্য সেবা কর্মসূচী তৈরী করা হবে।

৩২. সংক্রামক রোগসমূহ যেমন- শ্বাসতন্ত্রে প্রদাহ, ডায়রিয়া, ডেঙ্গু প্রভৃতি রোগ প্রতিরোধ ও নিয়ন্ত্রণের কর্মসূচী জোরদার করা হবে। যক্ষ্মা, কুষ্ঠ, ম্যালেরিয়া, কালাজ্বর, ফাইলেরিয়া নিয়ন্ত্রণের কর্মসূচি জোরদার করা হবে। সংক্রামক রোগসমূহের নিরাময়মূলক সেবা জোরদার করা হবে।

৩৩. অসংক্রামক রোগের প্রাদুর্ভাব বাড়ছে। সমন্বিত উপায়ে সকল পর্যায়ে প্রতিরোধ, চিকিৎসা ও পুনর্বাসনের ব্যবস্থা করা হবে। প্রধান অসংক্রামক রোগগুলো যেমন- ডায়াবেটিস, উচ্চ রক্তচাপ, হৃদরোগ, আর্সেনিকোসিস সম্বন্ধে সচেতনতা সৃষ্টি করা হবে এবং জীবনধারা পরিবর্তনের উদ্যোগ নেয়া হবে।

৩৪. জলবায়ু পরিবর্তনের ক্ষতিকর প্রভাব থেকে রক্ষার জন্য সমন্বিত উদ্যোগ গ্রহণ করা হবে। স্বাস্থ্যের উপর জলবায়ু পরিবর্তের স্বল্প, মধ্য ও দীর্ঘ মেয়াদি প্রভাব চিহ্নিত করার লক্ষ্যে মাঠ জরিপ ও সমীক্ষা পরিচালনা করা হবে। জলবায়ু পরিবর্তনের ফলে সৃষ্ট রোগগুলোর বোঝা কমাতে একটি জাতীয় কর্মসূচি গ্রহণ করা হবে।

৩৫. টিকাদানের মাধ্যমে রোগ প্রতিরোধ ব্যবস্থা আরো শক্তিশালী করে যত সংখ্যক রোগ প্রতিরোধ করা যায়, তা পর্যাক্রমে নিশ্চিত করতে হবে।

৩৬. ভবিষ্যৎ প্রজন্মের সুস্বাস্থ্যের লক্ষ্যে পূর্নাঙ্গ স্কুল হেলথ কার্যক্রম চালু করা এবং প্রজনন স্বাস্থ্য শিক্ষাসহ জীবন-যাপনের শিক্ষা সম্বন্ধে সম্যক ধারণা দেয়ার ব্যবস্থা করা হবে।

৩৭. শিল্প ও কৃষি খাতে শ্রমিকদের স্বাস্থ্যের উন্নয়ন নিশ্চিত করা হবে।

৩৮. চিকিৎসা সেবার ক্ষেত্রে নিউক্লিয়ার মেডিসেনের প্রয়োগ সম্প্রসারিত করা হবে। এজন্য দক্ষ জনবল তৈরী ও গবেষনার বিষয়ে গুরুত্ব আরোপ করা হবে।

৩৯. বিদেশ হতে প্রত্যাগতদের মাধ্যমে, বিশেষ করে মারাত্মক সংক্রামক রোগের প্রাদুর্ভাব রয়েছে এমন দেশ থেকে প্রত্যাগতদের মাধ্যমে দেশে সংক্রামক ব্যাধির বিস্তার যাতে ঘটতে না পারে সে লক্ষ্যে স্থল, জল ও বিমান বন্দরসমূহে প্রত্যাগতদের স্বাস্থ্য পরীক্ষার ব্যবস্থা রাখা হবে।

Bangladesh Population Policy (2012)

1. Introduction

Socioeconomic development for every citizen is one of the major commitments laid down in the Constitution of the People's Republic of Bangladesh. According to clauses 15, 16, 17 and 18 of the Bangladesh Constitution formulated in 1972, it is the responsibility of the State to ensure health, education, food and security for all citizens. The Government has been undertaking various policies with a view to ensuring these constitutional rights for the people of the country. The population growth was identified as the foremost national problem in the first Five Year Plan (1973-1978) of Bangladesh. In this regard the speech delivered by the Father of the Nation Bangabandhu Sheikh Mujibur Rahman in a public meeting held at the historical SuhrawardyUdyan on the 26th March, 1975 deserves close attention. He said, "My dear brothers, we should not ignore the fact that our population increases by three million every year. On the other hand, the area of our country is only 55,000 square miles. If our population continues to increase at this rate, there would be no cultivable land left in Bangladesh in 25-30 years, and the people of Bangladesh would be reduced to cannibalizing each other. That is why it is imperative that we control our population growth through family planning." An outline of the population policy was subsequently formulated in 1976.[1] Against this backdrop, a population policy was developed and approved formally in 2004.

In the population policy outline, population control and family planning activities were considered integral elements of social reform and national development with a view to reducing family size for ensuring sound maternal and child health, family welfare and higher standard of living. The outline provided for the decentralization of financial power and strengthening of the monitoring system along with strengthening of the organizational structure of population control and family planning activities. Notable among the activities undertaken were creating opportunities for gaining access to different methods of family planning according to one's choice, strengthening maternal and child health care, undertaking educational activities on family planning, involving community people in population control and family planning programs, and augmenting research and training activities. It also stressed the importance of increasing the legal ages for marriage as well as strengthening the basic information registration system. As a result, the percentage of use of family planning methods increased from 8% in the mid-1970s to 61.2% in 2011. At the same time the Total Fertility Rate (TFR) came down to 2.3 in 2011 from 6.3 in 1975.[2] It had also been possible to lower the population growth rate from 3% in the mid-1970s to 1.34% in 2011. However, this success is not adequate for improving the living standards of the people. Apart from excessive population density (with 964 people per square kilometer,[3] Bangladesh is one of the most densely populated countries in the world). The depletion of forests and arable land, air and water pollution, shortage of pure drinking water, insufficient housing facilities, unemployment, malnutrition, and slow rate of progress in health and nutrition sectors are the most notable among the problems that are hindering Bangladesh's development efforts.

The main objective of Bangladesh Population Policy 2004 was to achieve Net Reproductive Rate (NRR) = 1 by 2010 in order to have a stable population by 2060. But as it has not been possible to achieve NRR = 1 by 2010 as targeted originally, it is now imperative to update the current population policy to accelerate the related activities.

Moreover, it is essential to implement family planning activities that are in keeping with the Millennium Development Goals (MDGs), International Conference on Population and Development (ICPD) held in 1994, Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and other related policies along with the Sixth Five Year Plan. All these were taken into account while steps were taken to formulate the Bangladesh Population Policy 2012.

2. Rationale behind Updating the Bangladesh Population Policy

According to the preliminary results of the latest census published in 2011, the current population of Bangladesh is 14 crores and 23 lakhs (142.3 million). It is increasing by approximately 18-20 lakhs (1.8-2 million) every year. By the year 2015, the population density will increase to 1,050 people per square kilometer from the current 964 people per square kilometer. This will put enormous pressure on all utilities and infrastructures including food, clothing, education, health care, accommodation, water, the sewerage system, electric supply, etc. Besides,

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[1] Bangladesh Population Policy – An outline, June 1976, Dhaka, Department of Population Control and Family Planning, Government of the People's Republic of Bangladesh

[2] Bangladesh Demography and Health Survey (BDHS), Preliminary Report - 2011

[3] Population & Housing Census, Preliminary Results - July 2011.

population growth varies greatly across different regions of the country, and certain areas and communities in the country are still being deprived of essential social services. Therefore, it is indispensable to update the population policies and strategies in order to keep the population of the country within tolerable limits.

The Population Policy 2004 aimed to achieve Replacement Level Fertility and Net Reproduction Rate (NRR) = 1 by the year 2010. But considering the present Replacement Level Fertility rate and the number of users of family planning methods, it was observed that NRR = 1 was not achieved within the said period of time. Besides, success as expected could not be achieved with regard to planning and implementation of various strategies and activities including client-oriented services, youth-friendly services, empowerment and equality of women, services for the poor and the elderly, human resources development, and environment-friendly planning, etc. The program failed to achieve expected results due to the prevalence of early marriages and pregnancies, and a persistent lack of interest in using long-term and permanent family planning methods. Moreover, it was not possible to achieve the desired results because of the fact that an adequate number of special localized programs were not undertaken in inaccessible areas including backward regions.

It is important to achieve NRR = 1 within a definite time span, and if it can be achieved by 2015 then the population of Bangladesh would be 22 crores (220 million) in 2050 and it would stand still at 23-25 crores in the year 2070. If achieving NRR = 1 is delayed, it would take more time to achieve a stable population due to the momentum originated from a young population age structure. If the present rate of population growth continues, it would be difficult to meet the basic needs including food, clothing, education, accommodation, health care, climate, and environment and communication structures for the huge population within the geo-physical limits of Bangladesh. It will be almost impossible to achieve the expected higher standard of living of the people by dealing with the pressure on proper distribution and utilization of national resources. Against this backdrop, it is necessary to develop a pragmatic and widely acceptable policy through involving government, non-government and private sector institutions and undertake programs and strategies in the light of the policy.

3. Vision

Develop a healthier, happier and wealthier Bangladesh through planned development and control of the nation's population.

4. Objectives

4.1 Lower the Total Fertility Rate (TFR) to 2.1 by increasing the rate of prevalence of contraceptive users to 72%, and achieve NRR = 1 by the year 2015;

4.2 Ensure the availability of family planning methods to eligible couples by providing easy access to reproductive health services including family planning methods; build awareness among the poor and the adolescents of family planning, reproductive health, reproductive tract infections and HIV/AIDS; and prioritize counseling services;

4.3 Reduce maternal and infant mortality, and take steps to improve health care for mothers and children by ensuring safe motherhood;

4.4 Ensure gender equity and women's empowerment, and strengthen activities to eliminate gender discrimination in family planning and maternal and child health care programs;

4.5 Undertake short-, medium- and long-term plans for developing the population into human resources with the participation of the concerned Ministries;

4.6 Ensure easy access to information on reproductive health including family planning at all levels.

5. Major Strategies for Implementation of the Population Policy

5.1 Client-Centred Service

Improve service centre practices and door-to-door services to ensure client-centred services, such as:

a) Ensure services through existing Health and Family Welfare Centers in districts, upazilas, and unions, including Satellite and Community Clinics in the community

b) Ensure client-centred services through the participation of non-government and private sectors;

5.2 Urban Health Care

Undertake action plans through effective coordination between the Ministry of Local Government and the Ministry

of Health and Family Welfare with the aim of ensuring urban health care services, especially family planning and maternal and child health care services for the slum-dwellers and the floating and destitute people in the City Corporation and the Municipal areas.

5.3 Area-Based Plans and Strategies

Upon assessing the present health and family planning activities in Bangladesh, it is observed that acceptance of service varies across different geographical, economic, social and educational backgrounds. In this context, undertake special plans of action and strategies aimed at particular regions and relatively backward areas along with greater national plans and strategies.

5.4 Behavior Change Communication (BCC) Program

Undertake various informative, educational and motivational activities under the Population, Nutrition and Health program for behavioral change. Such as:

(a) Make all-out efforts to popularize and establish the slogan 'No more than two children, but one is better.'

5.5 Adolescent Welfare Program

More than one-fifth of the population of Bangladesh is adolescent, and one third of the female adolescents are either mothers or pregnant. Although there is no provision of marriage before 18 years of age, two-thirds of the adolescents are married off before they are 18. Integrated initiatives efforts must be made through government and non-government organizations and religious and social institutions in order to change this practice.

a) Ensure providing information and advice in favour of late marriage and having children with adequate birth intervals;

b) Create employment opportunities for the unmarried women in the rural areas; assist in developing their skills through loan facilities and technical training.

5.6 Participation of Non-Government and Private Sectors

Active participation of government, non-government and private sectors in different phases of population program is imperative. Adopt the following strategies with this end in view:

a) Encourage the affiliated non-government organizations to expand their programs on health, nutrition and population in areas where these services are absent.

5.7 Empowerment of Women and Equal Partnership of Men and Women

The women of Bangladesh are still far behind with regard to equal ownership for men and women and gender equality. In some families, the female children have less access to nutrition, health service and education in comparison to the male children. A number of deep-rooted social and cultural barriers in the society have led to discriminatory behavior between men and women. The women in most cases are engaged in services with lower rates of remuneration and are earning less compared to men.

a) Formulate gender sensitive strategies for both men and women in all government and non-government activities;

b) Women's skills development through imparting appropriate education and vocational training, and ensure their participation in economic activities.

5.8 Human Resources Development

Adopt the following strategies considering that skilled manpower is indispensable for the proper implementation of activities under the population policy framework with a view to providing quality services on family planning, maternal and child health, and reproductive health care in the service centres at all levels, such:

a) In order to ensure quality services in government facilities as per existing population, assess manpower requirement at all levels, appoint them, and impart basic training.

5.9 Legal Measures

With the assistance from other concerned ministries, the following strategies to be adopted by the Ministry of Health and Family Welfare in order to achieve the objectives of Population Policy:

a) As per birth registration information, ensure the citizens' rights for all children, get them enrolled in schools at an appropriate age and prevent early marriage of girl children. Use birth certificate during admission into school and marriage registration in order to ensure birth registration;

b) Make marriage registration mandatory according to the prevailing law and ensure compliance by all citizens; confirm age as per birth certificate before marriage registration.

5.10 Social Measures

Welfare Services for the Elderly, Poor and Disabled People:

A considerable portion of the population of Bangladesh is elderly, poor and disabled. Undertake special priority programs for them with regard to health, education and social security/safety net.

5.11 Population and Environment

Rapid growth of urban population leading to scarcity of housing, inadequate supply of water and sewerage facilities, and air pollution is constantly affecting the environment. Take the following measures to resolve these problems:

a) Strengthen social aforestation program in the rural areas and undertake appropriate measures to create pollution-free environment in urban and rural areas;

b) Ensure availability of pure, arsenic-free water for all citizens, and identify alternative sources for arsenic-free water.

5.12 Discourage Urban Migration and Introduce Planned Urbanization

Minimize disparities between citizens' facilities/services in rural and urban areas in order to discourage migration from villages to towns, and create new employment opportunities in rural areas. Ensure effective coordination among all respective departments to promote planned urbanization.

5.13 Integrated Information Collection and its Use

Census, demographic survey and the findings of different research are the primary sources of population information.

a) Conduct regular survey and research on population, health and nutrition;

5.14 Decentralization of Administrative and Financial Power

To ensure delivery of quality family planning and maternal and child health care services it is essential to decentralize administrative and financial decision-making authority and ensure community participation in all activities.

a) Decentralize administrative and financial decision-making power, and ensure community participation in population, nutrition and health programs; decentralize services by delegating more power to those at district to union levels;

5.15 Production and Supply of Family Planning Commodities

Every year the Government imports family planning commodities at the expense of a huge amount of foreign currency. Provide encouragement and incentives to local entrepreneurs for taking initiatives to produce family planning commodities in the country; take necessary steps to ensure contraceptive security at all levels. Especially, ensure supply of necessary materials for providing family planning and reproductive health services to organizations engaged in such services in labour intensive areas.

5.16 Coordination with Different Policies and Plans

Formulate strategies for implementation of this policy in coordination with the related policies, plans and programs of the government.

6. Role of Different Ministries, Non-Government Organizations and Private Sector in Population Program

Expected achievements in various economic sectors are being hindered due to rapid growth of population. As such, it is essential to include the ministries and institutions as partners in population planning and development programs whose target groups are heavily affected by growth of population. In this regard, the concerned ministries and institutions can play fruitful roles within the scope of their own activities:

6.1 Role of Different Ministries in Population Program

A. Ministry of Health and Family Welfare

This ministry will act as the leading ministry with regard to population and family welfare programs.

B. Ministry of Public Administration

This ministry can take necessary initiatives to implement family planning and maternal and child health activities at the field level through division, district and upazila administrations.

C. Ministry of Finance

With increased focus on planned population and its development, this ministry will be responsible for allocating necessary funds for the Health and Family Welfare Ministry as well as the Directorate General of Family Planning for implementing family planning, maternal and child health, and reproductive health programs.

D. Ministry of Education

Upholding the high standards in accordance with the National Education Policy, this ministry will ensure development and implementation of curricula for secondary and higher secondary levels that include family planning, maternal and child health, and reproductive health issues.

E. Ministry of Primary and Mass Education

Upholding the high standards in accordance with the National Education Policy, this ministry will ensure development and implementation of curricula for primary level that include topics on planned families, maternal and child health, and reproductive health.

F. Ministry of Agriculture

This ministry will include topics related to population and health education in the curricula of the vocational training institutes under it. Moreover, this ministry can play an important role in discouraging urban migration through stakeholder counseling.

G. Ministry of Information

This ministry will allocate time and resources for broadcasting information on health education, family planning, maternal and child health, reproductive health.

H. Ministry of Local Government, Rural Development and Cooperatives

This Ministry can undertake activities to involve members of the Union Councils, Upazila Councils and District Councils, and local opinion leaders in population and development programs.

I. Ministry of Planning / Planning Commission

This ministry will assist the government in its policy making and planning with serious deliberations on demography, population projection and development, and connect these issues to all development plans.

J. Ministry of Social Welfare

This ministry will play a role in encouraging the communities to receive family planning services from these centers. Moreover, the ministry can instruct the institutions who receive grants from it and the registered NGOs to conduct population programs.

K. Ministry of Women and Children Affairs

The Ministry of Women and Children Affairs will take necessary steps to implement women's programs related to family planning, maternal and child health, and reproductive health while giving special importance to women's skill development training, arrangement of loans for trained women, institutional training, and the rights and responsibilities of women.

L. Ministry of Youth and Sports

The Ministry of Youth and Sports can organize various sports programs at school and college levels for wider dissemination of messages related to family planning, and maternal and child health.

M. Ministry of Cultural Affairs

This ministry can undertake different cultural activities for wider dissemination of messages related to family planning, and maternal and child health.

N. Ministry of Environment and Forests

In compliance with the National Environment Policy, the Ministry of Environment and Forests will encourage people to plant trees, discourage them from encroaching on forest land for habitation, implement the ban on using vehicles that pollute the environment, give importance to population issues in the programs of the ministry to promote better natural environment, and take initiative to implement its programs according to the National Climate Change Strategy and Action Plan.

O. Ministry of Food and Disaster Management

This ministry can take special initiatives to incorporate population issues in all field level activities implemented by it. Besides, this ministry can take initiatives to motivate the beneficiaries of the Vulnerable Group Development (VGD), Vulnerable Group Feeding (VGF) and other social security programs to accept family planning methods in order to have planned families.

P. Ministry of Home Affairs

This ministry can provide family planning, maternal and child health, and reproductive health care services through hospitals and other service centers under it.

Q. Ministry of Labour and Employment

This ministry will introduce family planning and reproductive health care services in labour welfare centers, tea garden clinics and other service centers under it.

R. Ministry of Expatriates 'Welfare and Overseas Employment

In order to collect specific information regarding sexually transmitted diseases and HIV/AIDS, Ministry of Expatriates' Welfare and Overseas Employment can strengthen surveillance on the workers back from abroad. Besides, it can take necessary steps to create awareness among the workers going abroad regarding the deadly impacts of these diseases.

S. Ministry of Religious Affairs

This ministry can strengthen its training programs for religious leaders and Imams on family planning, maternal and child health care services, and prevention of sexually transmitted diseases and HIV/AIDS in the light of the religious teachings.

T. Ministry of Land

This ministry will introduce activities related to family planning and reproductive health care information and services in different development programs conducted by it including Ideal Village, Rootless and Slum Rehabilitation programs.

U. Ministry of Industries

This ministry will take necessary steps to provide family planning and reproductive health information and services in order to ensure the reproductive health rights of the female and male workers who are engaged in government and non-government industries.

V. Ministry of Housing and Public Works

This ministry will take initiatives for planned housing and urbanization in rural and urban areas through the departments under it in order to provide accommodation and other necessary civic facilities for the increasing population.

W. Ministry of Science and Technology

This ministry can allocate funds for conducting research on population, family planning and reproductive health issues through its scientific research programs.

X. Ministry of Information and Communication Technology

This ministry can take initiative to disseminate information on population issues through the website maintained under its e-Governance program.

Y. Ministry of Defense

This ministry can undertake activities for encouraging the members of Bangladesh Army, Bangladesh Navy and Bangladesh Air Force to receive health and family planning services and to participate in health education programs, and for creating awareness of control and prevention of different contagious diseases including HIV/AIDS among them.

6.2 Role of Non-Government and Private Organizations in Population Program

a) Production and distribution of family planning commodities by non-government and private sectors would be encouraged. Incentives would be given to all types of private sector service providers, professional bodies, employment-generating industries and other institutions for playing complementary roles in implementing population program of the government.

b) Import, distribution and marketing of family planning commodities by non-government and private sectors would be facilitated.

National Nutrition Policy 2015

Nutrition is the Foundation for Development

1. Introduction

Nutrition is an important determinant of physical growth, mental development and good health for every human. When foetal growth is compromised in the mother's womb because of undernourishment; a child is born with low birth weight. In young children, stunting, wasting, underweight and micronutrient deficiency are signs of malnutrition. In addition, malnutrition represents a major cause of child mortality. Undernutrition is an important indicator of malnutrition, although overweight and nutrition-related non-communicable diseases also are on the rise in the country. Overall, a malnourished child grows up with multiple physical and mental limitations; as a result, it becomes difficult for her /him to contribute to society and national development as an adult.

Nutrition also is a basic human right, with both equity and equality related to eliminating malnutrition and ensuring human development. In all, the Government of the People's Republic of Bangladesh is committed to improving the nutritional status of the people. The Constitution of Bangladesh cites nutrition in Article 18 (1), describing the principles of State governance: "...the State shall regard raising the level of nutrition and improvement of public health as among its primary duties... "Nutritional status in Bangladesh already has improved following formulation of the national Food and Nutrition Policy in 1997. Even so, nutritional status of the population has not reached expected levels.

In both urban and rural areas across the country, overweight, obesity, high blood pressure, diabetes, heart attack, stroke, cancer and osteoporosis are considered key nutrition-related issues. Lack of physical activity or physical labour, inappropriate food habits, and a sedentary lifestyle are all major emerging factors, making formulation of a new nutrition policy necessary. To improve overall nutritional status, new evidence in development programming, as well as strategy development and implementation, has been useful in preparing the Bangladesh National Nutrition Policy 2015. The policy takes into consideration both global policies such as ICN2 and relevant national policies in areas such as health, food, agriculture, environment and education, reflecting the multisectoral nature of ensuring nutrition.

2. Background

Childhood malnutrition in Bangladesh has been decreasing only slowly. The most common form of under nutrition is stunting, the result of chronic undernourishment; a stunted child, who is more than two standard deviations below median height for age, is prone to recurrent infections that hinder her/his brain development. In Bangladesh, 2 out of 5 children younger than age 5 years are stunted, with levels twice as high among the poor as among the wealthy. Annual rates of reduction of stunting between 2004 and 2014 were only 1.5 percent.[4]

About 14[1] percent of under-5 children in Bangladesh are wasted, or more than two standard deviations below median weight for height, which is the result of acute malnutrition. About 450,000 young children in the country, or 3.1 percent suffer from the most serious form of wasting, known as severe acute malnutrition. Those who survive frequently suffer compromised mental development. Lastly, having less weight for age and sex is known as underweight, a condition that also affects children in Bangladesh.

The absence of appropriate child feeding and nutrition practices is the primary reason for childhood malnutrition in Bangladesh. Internationally recognized infant and young child feeding and nutrition guidelines recommend breastfeeding be started within one hour after birth; the baby be exclusively breastfed up to age 6 months (180 days); and the baby be given home cooked, nutritious complementary food between 6 months and 2 years of age along with breastfeeding. However, the percentage of exclusive breastfeeding up to age 6 months in Bangladesh, while improving, stands at only 55 percent. Moreover, only 23 percent of children aged 6-23 months receive a minimum acceptable diet.[1]

At the same time, 1 in 4 adolescent girls in Bangladesh are undernourished, while 1 in 8 women of reproductive age is stunted. During delivery, stunted women are at higher risk of complications; in addition, the risk of intra-uterine growth retardation is high and, as a result, newborns of these women are more likely to be underweight and very frequently are low birth weight. Early marriage and early pregnancy contribute significantly to these conditions, thus stunting passes from generation-to-generation, and a vicious cycle of undernutrition is perpetuated. There are differences in under nutrition between rural and urban areas, women and children living in urban slums are especially worse off.

[4] Bangladesh Demographic and Health Survey, 2011

Among women, rates of overweight and obesity are increasing. The incidence of chronic diseases, including type 2 diabetes, high blood pressure and heart diseases, likewise are on the rise in the country because of overweight and obesity. Overweight also is found among people living below the poverty level and is particularly rising among people living in urban slums.

Although micronutrients play an important role in physical and mental development, micronutrient deficiency in Bangladesh also is very high, especially with regard to vitamin A, iron, iodine, zinc, vitamin B12, and folic acid. For example, high proportions of under-5 children and women suffer from anaemia because of deficiencies of iron, folic acid and vitamin B-12 in their food. In all, anaemia causes health risks among women, reduces iron reserves in children, and ultimately burdens the national economy.

The Government of the People's Republic of Bangladesh has taken the initiative to mainstream nutrition into public health and family planning services, with the aim of improving the nutrition situation of the country. Strategies for ensuring nutrition are also being adopted in other sectoral policies outside the health sector. This National Nutrition Policy thus reflects the commitment of the State as a whole to improve the nutritional status of the population.

3. Vision

The people of Bangladesh will attain healthy and productive lives through gaining expected nutrition.

4. Goal

The goal of the National Nutrition Policy is to improve the nutritional status of the people, especially disadvantaged groups, including mothers, adolescent girls and children; to prevent and control malnutrition; and to accelerate national development through raising the standard of living.

5. Objectives

5.1 Improve the nutritional status of all citizens, including children, adolescent girls, pregnant women and lactating mothers

5.2 Ensure availability of adequate, diversified and quality safe food and promote healthy feeding practices

5.3 Strengthen nutrition-specific, or direct nutrition, interventions

5.4 Strengthen nutrition-sensitive, or indirect nutrition, interventions

5.5 Strengthen multisectoral programs and increase coordination among sectors to ensure improved nutrition

6. Strategies

6.1 Improve the nutritional status of all citizens, including children, adolescent girls, pregnant women and lactating mothers

Strategies to achieve this objective are:

6.1.1 Ensure nutrition security for all citizens:

Availability, access and utilization of nutritious food play important roles in overall improvement of nutrition for individuals and families alike. The National Nutrition Policy aims to ensure appropriate nutrition through securing a safe and balanced diet during all phases of the life cycle.

6.1.2 Ensure required nutrition at all stages of the life cycle:

Ensuring required nutrition at all stages of the life cycle is a continuous process. The vicious cycle of malnutrition starts with childbearing, through malnourished mothers giving birth to malnourished babies, which subsequently affects all phases of the life cycle and even future generations. The National Nutrition Policy has stressed the following life-cycle strategies to mitigate this intergenerational effect of malnutrition:

6.1.2.1 Ensure appropriate and adequate nutrition for all pregnant women and lactating mothers throughout pregnancy, so that healthy children are born with expected birth weight.

6.1.2.2 Ensure that mothers are able to exclusively breastfeed their children up to 6 months of age and continue breastfeeding through age 2 years, by ensuring a supportive family environment, services and regulatory safety net.

6.1.2.3 Following exclusive breastfeeding until age 6 months to ensure an appropriate nutritional foundation for all newborns and very young children, ensure the start of complementary food after age 6 months together with breastfeeding, and ensure continuation of breastfeeding up to age 2 years.

6.1.2.4 Ensure the availability of adequate and safe nutritious food for growth and development of adolescent girls and boys, including through prevention of early marriage, to develop a healthy and productive future generation.

6.1.2.5 Ensure appropriate nutrition for adults and elderly persons suffering from malnutrition-related non-communicable diseases.

6.1.2.6 Take steps to ensure regulation of unabated making of processed and commercial food items, given that the food habits of people, especially children, are at stake and influenced by advertisement of such foods. As a result, obesity, diabetes and other chronic non-communicable diseases have become an epidemic in the country. Encourage appropriate food habits and a healthy lifestyle.

6.1.2.7 Ensure easy availability and the best utilization of family planning methods to prevent early marriage, delay pregnancy and space births.

6.1.3 Ensure adequate nutrition for disadvantaged groups: The nutrition status of disadvantaged groups is particularly affected during illnesses and natural and manmade disasters. Programs based on the National Nutrition Policy will:

6.1.3.1 Ensure the adoption of nutrition programs targeting people living in poor rural and urban areas and in remote locations identified through nutrition surveillance. Give special targeting to those who have very limited access to food and are unable to earn.

6.1.3.2 Ensure adequate nutrition for the people in emergencies (natural disaster, epidemic or conflict), as well as ensure the inclusion of basic nutritional needs of affected people in disaster preparedness plans. Further, ensure application of the related Act [Breastmilk substitute, infant food, commercially prepared complementary food and the accessories thereof (Regulation of Marketing) Act 2013].

6.1.3.3 Ensure adequate nutrition during and after illness of people suffering from chronic diseases, including those who are living with tuberculosis and HIV/AIDS.

6.2 Ensure availability of adequate, diversified and quality safe food and promote healthy feeding practices

On average, the energy gap between need and intake for a typical adult Bangladeshi is 82 kilocalories (2,400 kilocalories[5] vs. 2,318 kilocalories[6]). These figures are calculated based on level of physical activity, basal metabolic rate and expected body weight. However, energy intake also may differ based on socioeconomic status, urban/rural location, and food security status.

Diets of Bangladeshi people are comprised mostly of cereals, which provide 70 per cent of energy requirements. In all, the dietary menu does not contain adequate meat, milk, vegetables and fruits, so that nutritional needs are not met. The absence of quality protein and micronutrients is evident.

Strategies to increase food diversity:

The main strategy to increase food diversity is to raise the awareness of people in both rural and urban areas with regard to the importance of such diversity and taking of a well-balanced combination of macro- and micronutrients. In addition to nutrition education, behaviour change communication is to be ensured.

The Government will encourage food-based strategies to achieve food variety, emphasizing the agricultural sector, including fisheries and livestock. In addition, it will create awareness among rural and urban people through the provision of information on the importance of food diversity, along with increasing the availability of food.

Strategies to take up for achieving food diversity and emphasizing the important role of the agricultural sector are:

6.2.1 Encourage coordinated homestead gardening and small-scale livestock and poultry rearing, at family level or collectively, to increase the availability of diverse, safe and nutritious food.

6.2.2 Initiate a special behaviour change communication program to create awareness of the need to avoid processed food, excess salt, saturated fat and trans fat.

[5] FAO/WHO recommended daily energy requirement

[6] Household Income and Expenditure Survey Report 2010

6.2.3 Encourage local production and indigenous varieties of crops, fruits and vegetables to promote biodiversity and uninterrupted food diversity.

6.2.4 Encourage enhanced nutritional value through the combination of different types of food, given that an appropriate such combination is important for achieving food diversity.

6.2.5 Improve, encourage and accelerate clean and hygienic food preparation practices so that safe and quality food consumption is increased and nutrition quality in food is restored. Encourage food preparation and preservation using local and appropriate technologies to ensure availability of food throughout the year.

6.2.6 Ensure the supply of the required amount of animal protein through the promotion of the cultivation of small fish such as mola, dhela and puti in homestead water bodies to meet the nutritional needs of rural families.

6.2.7 Supply supplementary food to affected populations during disasters and times of severe food insecurity.

6.2.8 Initiate a food fortification program and expand its use and perimeter (including, e.g., iodine in edible salt, vitamin A in edible oil, and enriched main food for children, cooked at home with mixed micronutrients).

6.2.9 Popularize the effective consumption of fats, carbohydrates and micronutrients to control malnutrition, overweight and micronutrient deficiencies.

6.2.10 Reduce stunting, wasting and micronutrient deficiencies through diversifying food production and ensuring a variety of food intake by children and their families.

6.3 Strengthen nutrition-specific, or direct nutrition, interventions

Two inter-dependent nutrition-related programs are being implemented in Bangladesh: nutrition-specific (direct) interventions and nutrition-sensitive (indirect) interventions. Nutrition-specific or direct interventions for children include the promotion of: (a) exclusive breastfeeding during the first 6 months after birth; (b) providing complementary food after age 6 months, appropriately prepared at home, alongside breastfeeding; (c) washing hands with soap before feeding a child;, (d) vitamin A supplementation for children every diarrhoea treatment, and (e) treatment of moderate or severe acute malnutrition. For adolescent girls and women, their nutritional status is being improved through: (a) behaviour change communication to provide nutritional knowledge through counselling at family level; (b) provision of iron, folic acid or multiple micronutrients as supplements, as appropriate; (c) promotion of the use of iodized salt; (d) promotion of the use of calcium during pregnancy as a supplement; and (e) preventative activities in educational institutions and communities to avert incidences of overweight and obesity.

Strategies adopted to expand nutrition-specific (direct) programs include:

6.3.1 Motivate mothers to: (a) take appropriate nutritious food during pregnancy; (b) to gain adequate weight during pregnancy; (c) ensure taking of micronutrient supplements, especially iron-folic acid, during pregnancy and lactation period, as applicable; (d) prevent infection and ensure appropriate treatment; (e) reduce physical labour during pregnancy and ensure appropriate rest; and (f) bring about behavioral changes, including avoiding tobacco products and smoking, during pregnancy.

6.3.2 Promote the consumption of adequate quantities of nutritious food to prevent malnutrition in lactating mothers and ensure appropriate care to children.

6.3.3 Start breastfeeding within one hour of birth to ensure appropriate care to the newborn, with exclusive breastfeeding up to age 6 months; and encourage the provision of complementary food from age 6 months 3-4 times a day, prepared at home (combining at least four food groups), with continuation of breastfeeding up to age 2 years.

6.3.4 Immediately treat any infection that may have adverse effects on nutrition.

6.3.5 Treat moderate and severe acute malnutrition both at health centres and in the community.

6.3.6 Ensure care through families and communities for physical growth and mental development of children, and motivate the ensuring of a supportive environment for child development.

6.3.7 Ensure intake of adequate varieties of food for adolescent girls and boys for their appropriate growth, so that they can develop as adults with expected height and weight.

6.3.8 Extend and strengthen nutrition education in educational institutions.

6.3.9 Ensure availability of food enriched with energy, protein and micronutrients for elderly persons.

6.3.10 Scale up nutrition-specific programs in rural areas, through coordination between non-Government organizations and the Ministry of Health and Family Welfare, as well as through primary health care services in urban areas under the Ministry of Local Government, Rural Development and Cooperatives.

6.3.11 Scale up nutrition-specific or direct programs for marginalized persons in urban slums and people in hard-to-reach locations.

6.3.12 Change behaviours through strengthened nutrition counseling, information and education. Undertake intensive communication through all media, involving all stakeholders, to raise public awareness on maintaining a balanced diet, the nutritional value of food, and physical activity and exercise. In light of experiences with successful national programs such as family planning, immunization and distribution of oral saline solution, develop a plan for a nutrition and food security campaign through the mass media, and allocate resources for this purpose.

6.3.13 Build knowledge about appropriate micronutrient-enriched family foods and promote increased consumption.

6.3.14 Make the existing health system universal, utilize the system effectively, and estimate effective manpower needs for the purpose–particularly including the number of health workers to be employed at community clinics and union health centres, as well as assessment of their skills and identification of their training needs—so that the ratio between health workers and beneficiaries is maintained and nutrition services can be scaled up.

6.3.15 Provide the required number of health workers through filling of all vacant posts and ensuring of required supplies. Develop local-level health facilities, such as community clinics, union sub-centres, family welfare centres and upazila health complexes, to be suitable for providing nutrition services.

6.3.16 Mainstream nutrition services appropriately with health services, through effective coordination between health and family welfare workers at grassroots level.

6.3.17 Ensure improved services, through increasing the accountability of Government and non-Government nutrition service providers at all levels to meet people's expectations.

6.3.18 Develop and establish a strong national monitoring and evaluation system to ensure accountability with regard to nutrition services.

6.3.19 Conduct a needs assessment for a comprehensive work-plan and appropriate allocation of resources.

6.3.20 Appoint nutritionists in hospitals and in public health nutrition programs.

6.4 Strengthen nutrition-sensitive, or indirect, interventions

Issues of malnutrition, particularly low birth weight and stunting, cannot be controlled through nutrition-specific programs only. In turn, this necessitates the addition of nutrition-sensitive interventions, especially with regard to food security, female education and empowerment, increased employment opportunities, hygiene and sanitation, agriculture, and expansion of social safety nets.

Strategies to be adopted to expand nutrition-sensitive (indirect) interventions include:

6.4.1 Enhance food security at household level. Publicize and promote food-based dietary guidelines. Ensure informed food selection and consumer rights.

6.4.2 Encourage investment in nutrition-sensitive agriculture to produce fruits, vegetables, chicken, fish, fish products, milk and meat.

6.4.3 Increase the rate of female education and women's empowerment. Create employment opportunities for women, and encourage the delay of pregnancy until at least age 20 years.

6.4.4 To combat different types of infection (diarrhoea, pneumonia, environmental enteropathy) that adversely affect child nutrition, motivate people to follow hygiene practices, especially washing hands with soap. Also ensure safe drinking water and strengthen the sanitation system to reduce the risks of these infections.

6.4.5 Engage all relevant Ministries, Divisions, institutions, civil society and non-Government organizations in nutrition interventions.

6.4.6 Accelerate research activities to increase production of non-cereal agricultural products, such as pulses, fruits and vegetables.

6.4.7 Initiate new programs and strategies to implement nutrition programs involving all concerned Ministries and agencies (e.g., food, agriculture, education, fishery and livestock, local government, women and children affairs, disaster and relief).

6.4.8 Coordinate nutrition-sensitive programs to be implemented under Ministries such as Agriculture, Food, Fishery and Livestock, Women and Children Affairs, Education, Industry and Local Government, Rural Development and Cooperatives, among others.

6.5 Strengthen multisectoral programs to ensure countrywide efforts toward ensuring nutrition, including necessary financing for such programs. Increase joint efforts and coordination among sectors/Ministries/non-Government organizations and development partners with regard to social safety nets, women's empowerment, education, and water, sanitation and hygiene, among others. Prepare a National Plan of Action (with costing, indicators and targets) for the next decade. Strategies to achieve this objective include:

- Strengthen nutrition-specific (direct) and nutrition-sensitive (indirect) programs.
- Involve human resources in renewed nutrition efforts, including effective supervision and monitoring of nutrition services.
- Support increased coordination among relevant programs, including with regard to social safety nets, education and women's empowerment.
- Monitor and evaluate implementation of nutrition programs. Enhance knowledge and skills of human resources involved in nutrition programs through appropriate trainings.
- Mainstream nutrition education in all types of training programs and in general educational curricula.
- Conduct nutrition-related research and collect and analyze disaggregated data, providing feedback.

6.5.1 Ensure joint work by the Ministries of Local Government, Rural Development and Cooperatives and Health and Family Welfare in malnutrition-stressed urban areas, especially urban slums.

6.5.2 Implement interventions in all educational institutions and communities, in both rural and urban areas, to reduce overweight and obesity. Encourage physical labour and exercise.

6.5.3 Strengthen cooperation and coordination among the Ministry of Health and Family Welfare, international organizations, development partners, educational and research institutions, non-Government organizations and concerned Ministries toward development and implementation of multisectoral nutrition programs in the areas of nutrition security, safety nets for marginalized communities, hygiene and sanitation, and employment generation.

6.5.4 Jointly implement nutrition programs through strengthened partnerships and coordination between Government institutions and non-Government organizations and institutions.

6.5.5 Include issues of nutrition in the National Social Security Strategy paper, particularly with regard to food diversity in food-related programs. Initiate nutrition programs targeting ultra-poor and deprived communities, and link up nutrition programs with other social safety net programs.

6.5.6 Strengthen research activities on nutrition in the Bangladesh context so that policymakers are informed about nutrition programs and strategies and able to make decisions accordingly. In addition, undertake action-oriented research.

6.5.7 Strengthen research activities to boost production of non-cereal crops. Increase food security for the ultra-poor through appropriate food preservation methods.

6.5.8 Strengthen the enforcement of laws against the adulteration of food and raise public awareness on the issue.

6.5.9 Adapt food security, employment and disease management strategies in line with the situation related to climate change in Bangladesh.

6.5.10 Strengthen the National Nutrition Council, with the Honorable Prime Minister as the Chair, to review the nutritional situation of the country and implement/coordinate multisectoral programs.

7. Conclusion

The National Nutrition Policy 2015 has given importance to ensuring appropriate nutrition through identification of its different causes. This Policy will provide the necessary direction to implement and strengthen existing strategies, as well as to develop new strategies to improve the people's nutritional status in Bangladesh.

Indicators for achieving optimal nutrition:

- Increase the initiation of breastfeeding in the first hour of life
- Increase the rate of exclusive breastfeeding in infants younger than age 6 months
- Increase the rate of continued breastfeeding in children aged 20 to 23 months
- Increase the proportion of children aged 6-23 months receiving a minimum acceptable diet
- Reduce the rate of low birth weight
- Reduce stunting among under-5 children
- Reduce wasting among under-5 children
- Reduce the proportion of underweight among under-5 children
- Reduce the rate of severe malnutrition among children
- Reduce malnutrition among adolescent girls
- Increase vitamin A coverage
- Reduce malnutrition among pregnant women and lactating mothers
- Increase the rate of iodized salt intake
- Reduce maternal overweight (BMI>23)
- Reduce the rate of anaemia among women

References

- *National Health policy 2011, MOHFW*
- *Bangladesh Population Policy 2012, MOHFW*
- *National Nutrition Policy 2015¸MOHFW*

DAY-1

Session -3: Demographic Structure of Bangladesh

Session objectives:

At the end of the session, the participants will be able to:

- ➢ Define demography and its and components
- ➢ State the population structure of Bangladesh
- ➢ Explain selected demographic measures
- ➢ Understand the concept of demographic dividend

Time: 1.00 hour

Participant's note

- In this session participants will participate in discussion
- Will observe a video clip on demographic dividend

DAY-1

Handout

Demography and Demographic Structure of Bangladesh

Demographic Structure of Bangladesh

What is Demography?

Greek demos - People + Graphic - Study

The scientific study of human population, including their size, composition, distribution, density, growth, demographic and socioeconomic characteristics, and the cause and consequences of changes in these factors.

There are four basic components of demography

- Birth - Fertility
- Death - Mortality
- Marriage
- Migration

Sources of demographic data:

- **Civil registration** of births and deaths is the primary source of fertility and mortality data.
- Bangladesh Bureau of Statistics (BBS) routinely collects demographic information/vital statistics under **Sample Vital Registration System (SVRS)**. A SVRS report is published each year and a softcopy of the report is available online in BBS website (www.bbs.gov.bd).
- The primary source of data on the size, structure and distribution of national populations is the **population census**. The census aims to enumerate the whole population of a defined geographical area. They collect individual-level data on the population's characteristics that refer to a single point in time. The census is conducted every 10 years, with the last census in Bangladesh completed in 2011.
- In recent decades, demographers have relied increasingly on survey data to supplement those from traditional sources. In particular, in countries where registration of vital events is incomplete, **national sample surveys** (Demographic and Health Surveys) are the main sources of demographic data.
- The United Nations Population Division regularly publishes vital statistics of member countries based on population projection. **World Population Prospects and World Urbanization Prospects** are two widely used data sources for population projections (https://esa.un.org/unpd/wpp/).
- Bangladesh Bureau of Statistics (BBS) also published the Bangladesh **Population Projection** 2011-2016 in 2015:

Link: (http://203.112.218.65:8008/WebTestApplication/userfiles/Image/PopMonographs/PopulationProjection.pdf).

DAY-1

Bangladesh Population 1901-2016		
Year	**Population (in million)**	**Inter-censul**
1901	29	0.69
1951	44	0.50
1961	55	2.26
1974	76	2.48
1981	90	2.32
1991	111	2.17
2001	131	1.54
2011	150	1.37
2016	161	-

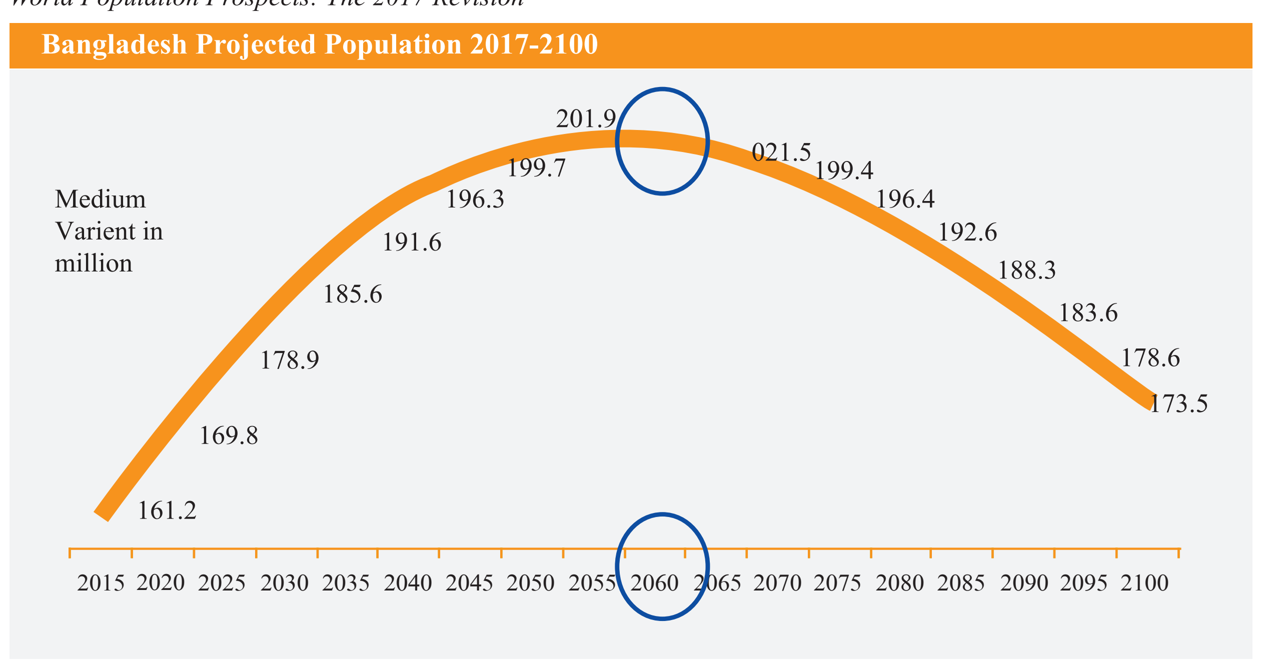
Source: Nurun Nabi 2011, BBS 1994 and BBS 2017

World Population 2017

Bangladesh the eighth populous country of the world		
World	**Country**	**Inter-censul**
7,550 million	China	1410
	India	1339
	USA	324
	Indonesia	264
	Brazil	209
	Pakistan	197
	Nigeria	191
	Bangladesh	165
	Russia	144
	Japan	127

Source: UN Population Division:
World Population Prospects: The 2017 Revision

Bangladesh Projected Population 2017-2100

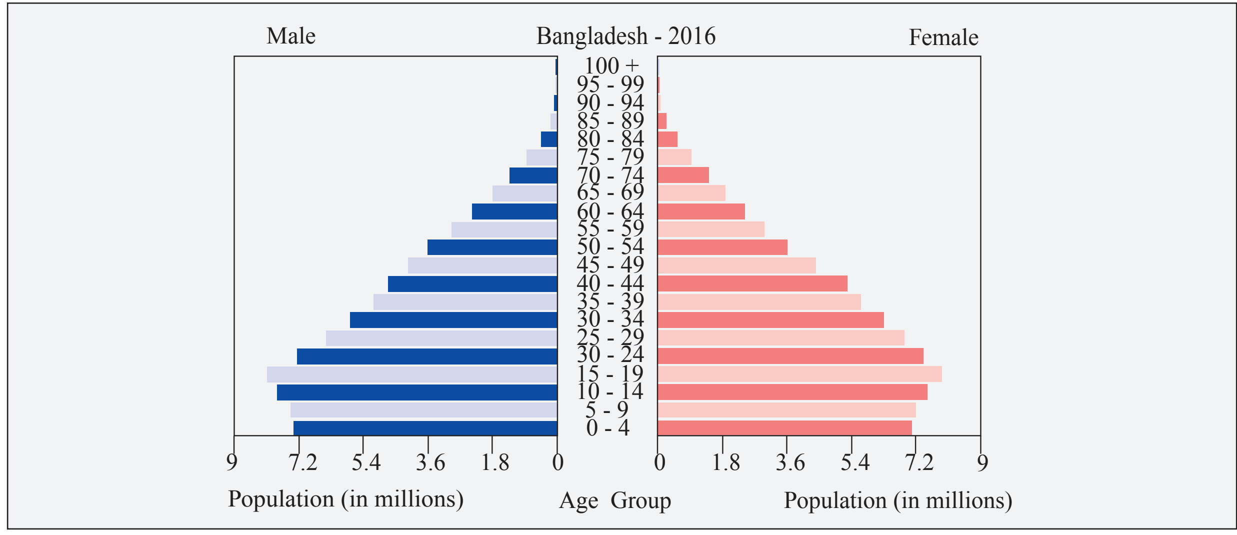


Source: UN Population Division:
World Population Prospects: The 2017 Revision

DAY-1

Population Pyramid of Bangladesh

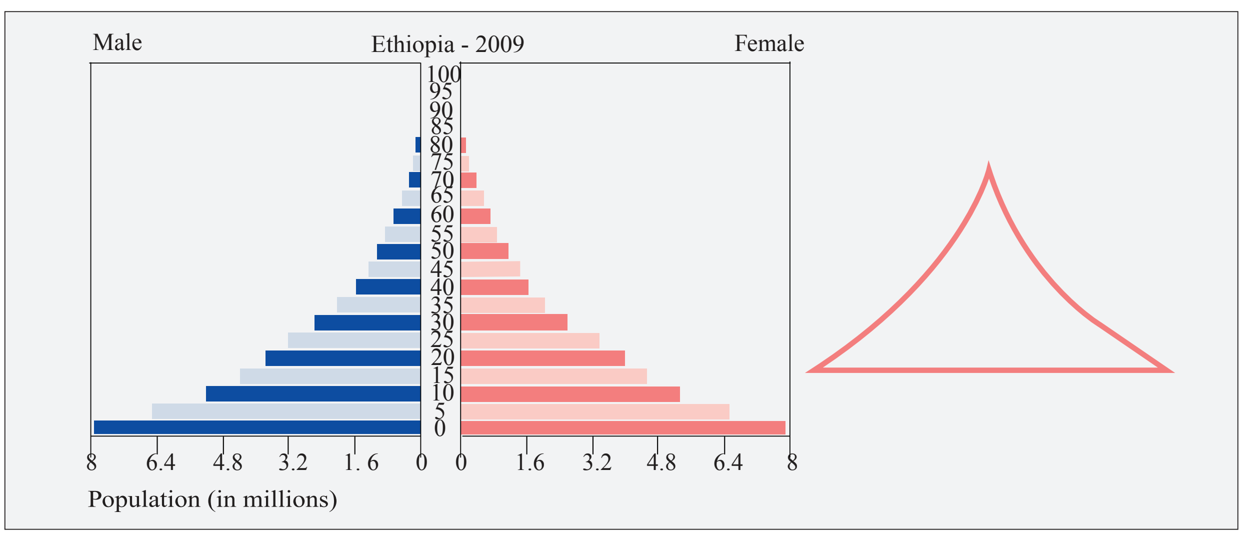
A population pyramid illustrates the age and sex structure of a country's population and may provide insights about political and social stability, as well as economic development. The population is distributed along the horizontal axis, with males shown on the left and females on the right. The male and female populations are broken down into 5-year age groups represented as horizontal bars along the vertical axis, with the youngest age groups at the bottom and the oldest at the top. The shape of the population pyramid gradually evolves over time based on fertility, mortality, and international migration trends.



There are five general shapes of population pyramid -

- Unstable
- Expanding
- Stable
- Stationary
- Declining

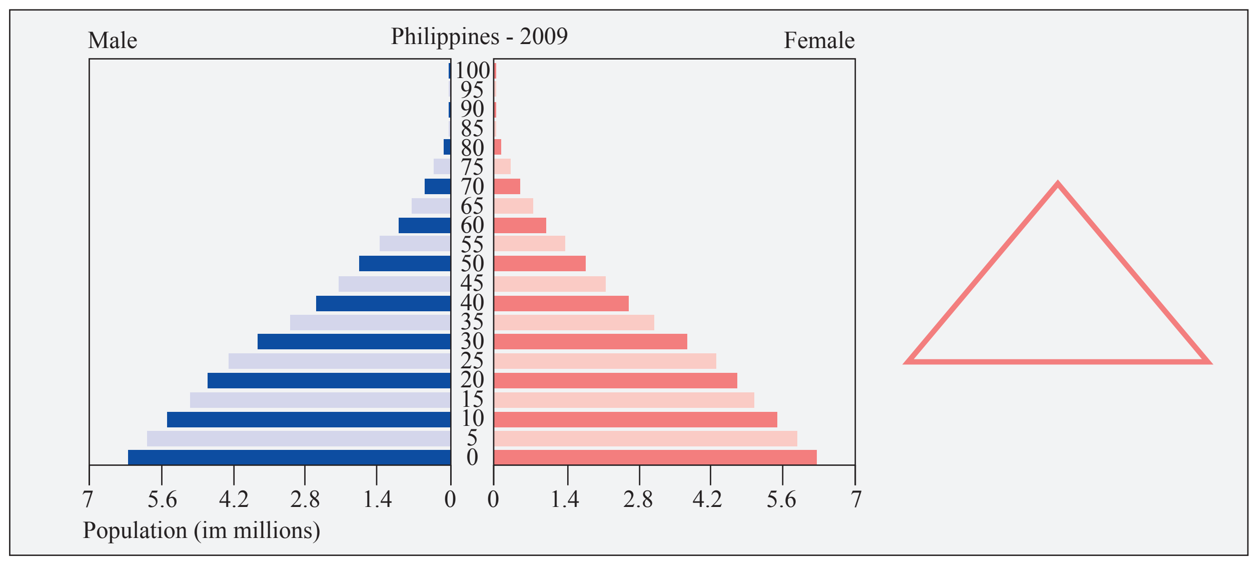
Unstable Population



Characteristics

- High birth rates
- High death rates
- Brings a country medical system or political system into question
    - Lack of contraceptives
    - Lack of medical treatment
    - War

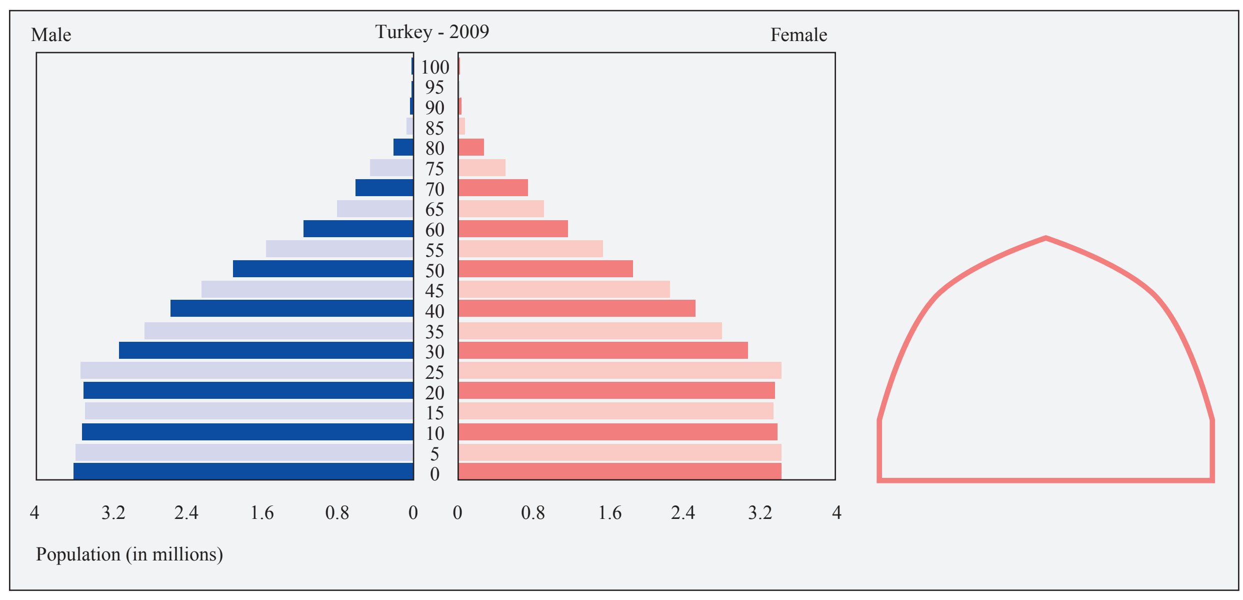
Expanding Population



Characteristics

- High birth rates
- Death rates a bit lower
- Suggests a decent medical system
- Expect the country's population to increase rapidly
- Lots of young people, not many elderly people

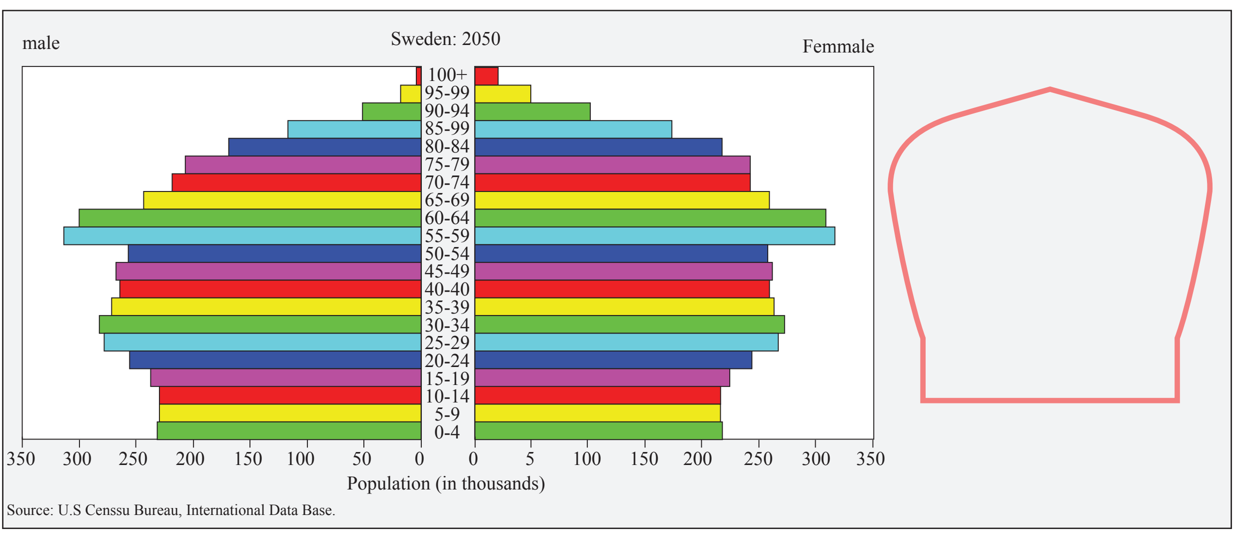
Stable Population



Characteristics

- Slow growth
- Low birth rate
- Low death rate
- Birth rate > Death rate
- Suggests a good medical system: availability of contraceptives/medical treatment
- Incomes increasing, standard of living increasing, children are becoming more of an expense

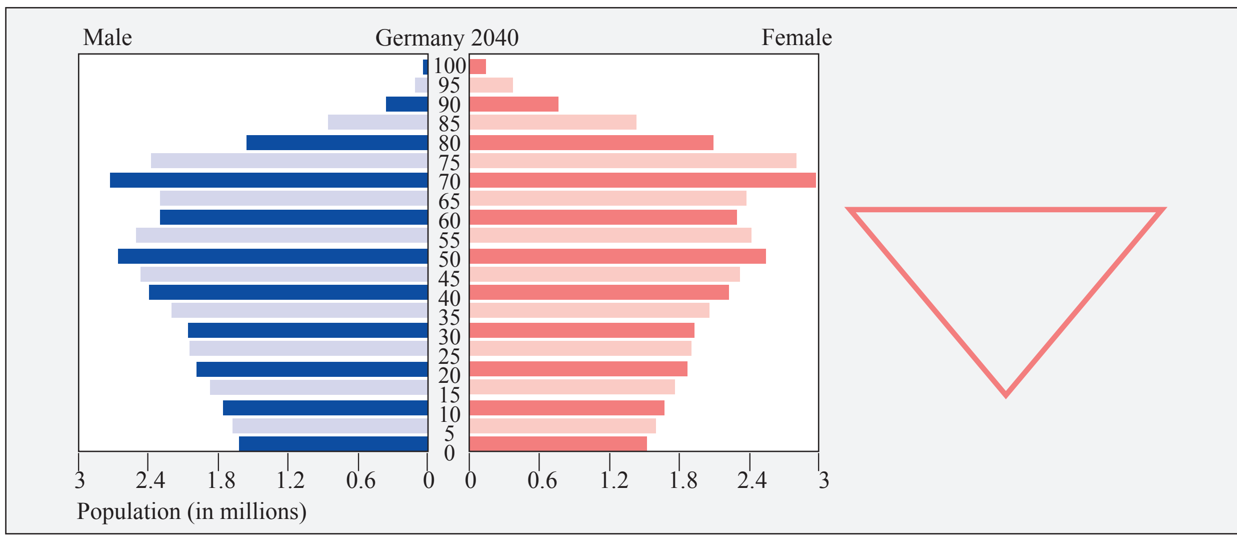
Stationary Population



Characteristics

- All age groups similar
- Birth rates low
- Death rates low
- Less and less babies
- No growth
- Birth rate = death rate

Declining Population



Characteristics

- No country has reached this stage yet, therefore this pyramid represents a prediction of future trends
- Low birth rate
- Low death rate
- Death rate > Birth rate

Source: cgw4u.files.wordpress.com/2010/10/population-pyramids-23.ppt

Demographic Measures:

Basic tools of measures of demography: Ratio, proportion and rate

Ratio:

A ratio is simply a relationship between two numbers. A ratio can be written as one number divided by another (a fraction) of the form **a/b**. Both a and b refer to the frequency of some event or occurrence

For example:

Sex ratio-the number of males per 100 females.

Proportion:

A proportion is a special type of ratio in which the numerator is included in the denominator.

A proportion is a special type of ratio in which the numerator is a subset (or part) of the denominator and can be written as **a/(a+b)**

For Example:

The proportion of the female population is the number of female divided by the total number of male and female together.

A proportion can only range from 0.0 to 1.0. The proportion can be expressed as percentage simply multiplying by 100.

Rate:

The numerator of a rate is a number of events such as births, deaths occurring during a period of time, and the denominator is the population at risk of experiencing these events.

Some measures which are commonly called "rates" in demography are strictly ratio and proportion.

A rate is a ratio of the form **a*/ (a+b)**

a* = the frequency of events during a certain time period

a+b = the number at risk of the event during that time period

For example:

Literacy rate is just the proportions of the population i.e. Literate.

Relationship between Ratio, Proportion and rate

- A proportion is always a ratio
- A rate is always a ratio
- A rate may or may not be a proportion

FERTILITY INDICATORS

Crude Birth Rate (CBR)

The ratio of live births in a specific period (usually one calendar year) to the average population in that period (normally taken to be the mid-year population). The value is conventionally expressed per 1,000 population.

General Fertility Rate (GFR)

The ratio of number of live births in a specific period to the average number of women of child bearing age (15-49) in the population during the same period. The value is conventionally expressed per 1,000 women age 15-49. The general fertility rate (GFR) is expressed as the annual number of live births per 1,000 women age 15-49, and the crude birth rate (CBR) provides a measure of the annual number of live births per 1,000 population.

Age-Specific Fertility Rate (ASFR)

Age-specific fertility rates (ASFRs) usually calculated for seven five-year age groups from 15-19 to 45-49. For each of the age-group ASFR is calculated as a ratio of the number of live births during a specific period to women of that

age group divided by the number of woman (all) lived in that age group during the same period. ASFR expresses as the number of births per 1,000 women in a certain age group.

Total Fertility Rate (TFR)

The total fertility rate (TFR) is calculated as the sum of the age-specific fertility rates multiplied by five (each age group covers five years of age). TFR represents the average number of children a woman would have by the end of her reproductive period if her experience followed the currently prevalent age specific fertility rates.

Gross Reproduction Rate (GRR)

The gross reproduction rate (GRR) is calculated as the sum of the age-specific fertility rates for female births multiplied by five (each age group covers five years of age). GRR represents the average number of daughters a woman would have by the end of her reproductive period if her experience followed the currently prevalent age specific fertility rates for female births and no mortality till they reach to their reproductive period.

Net Reproduction Rate (NRR)

The average number of daughters that would be born to a woman if she passed through her lifetime from births confirms to the age specific fertility rates of a given year. This rate is similar to the gross reproduction rate and takes into account the mortality risk (some women will die before completing their childbearing years).

MORTALITY INDICATORS

Crude Death Rate (CDR)

The crude death rate (CDR) is the ratio of deaths in a specific period (usually one calendar year) to the average population in that period (normally taken to be the mid-year population). CDR presents the number of deaths per 1,000 mid-year population in a given year.

Under-Five Mortality Rate (U5MR)

The under-five mortality rate is the ratio of under-five deaths (for specific time period) to the number of live births in that period. U5MR presents the number of deaths to children under-five year of age per 1,000 live births in a given period.

Infant Mortality Rate (IMR)

The infant mortality rate is the ratio of infant (under-one year of age) deaths (for specific time period) to the number of live births in that period. IMR presents the number of deaths occurring during a given period among the live-born infants who have not reached their first birthday, divided by the number of live births in the given period and usually expressed per 1,000 live births.

Neo-natal Mortality Rate (NMR)

The neo-natal mortality rate is the ratio of deaths of newborn (within 28 days of birth/under one month of age) to the number of live births in that period. NMR presents the number of deaths of newborn during a year per 1,000 live births in that year.

Maternal Mortality Ratio (MMR)

The maternal mortality ratio is the ratio of the number of deaths of women (for specific time period) while pregnant or within 42 days of termination of pregnancy from any cause related to or aggravated by the pregnancy, but not from accidental or incidental causes to the number of live births in that period. MMR presents the number of maternal deaths per 1,000/100,000 live births during a year.

NUPTIALITY (MARRIAGE) INDICATORS

Crude Marriage Rate (CMR)

Crude Marriage Rate is the ratio of the number of marriages in a specific period (usually one calendar year) to the average population irrespective of their marital status in that period (normally taken to be the mid-year population). The value is conventionally expressed per 1,000 population.

General Marriage Rate (GMR)

GMR is the relative number of marriage of population aged 15+ years per 1,000 population of the same group.

Age-Specific Marriage Rate (ASMR)

ASMR is defined as the relative number of marriage per 1,000 population of specific age group.

Mean Age at Marriage (MAM)

Mean age at marriage is defined as an estimate of the mean number of years lived by cohort of women before their first marriage.

Crude Divorce Rate (CDiR)

Crude Divorce Rate is a relative number of divorces per 1,000 population.

Crude Separation Rate (CSR)

Crude separation rate is a relative number of separations per 1,000 population.

MIGRATION INDICATORS

In-Migration Rate

In-migration rate is the ratio of the number of people IN in a geographic location in a specific period (usually one calendar year) to the average number of population lives in that location in that period (normally taken to be the mid-year population). The value is conventionally expressed per 1,000 population.

Out-Migration Rate

Out-migration rate is the ratio of the number of people OUT in a geographic location in a specific period (usually one calendar year) to the average number of population lives in that location in that period (normally taken to be the mid-year population). The value is conventionally expressed per 1,000 population.

Gross Migration Rate

Gross migration rate is the summation of in-migration rate and out-migration rate. The rate is expressed per 1,000 population.

Net Migration Rate

Net migration rate is calculated subtracting out-migration rate from in-migration rate. The rate is expressed per 1,000 population.

Demographic Dividend

Demographic dividend occurs when the proportion of working people in the total population is high because this indicates that more people have the potential to be productive and contribute to growth of the economy. According to the United National population research, during the last four decades the countries of Asia and Latin America have been the main beneficiaries of the demographic dividend. Advanced countries of Europe, Japan and USA have an aging population because of low birth rates and low mortality rates. Neither the least developed countries nor the countries of Africa have as yet experienced favorable demographic conditions according to the research by UN population division. China's one-child policy has reversed the demographic dividend it enjoyed since the mid 1960s, according to a World Bank global development report.

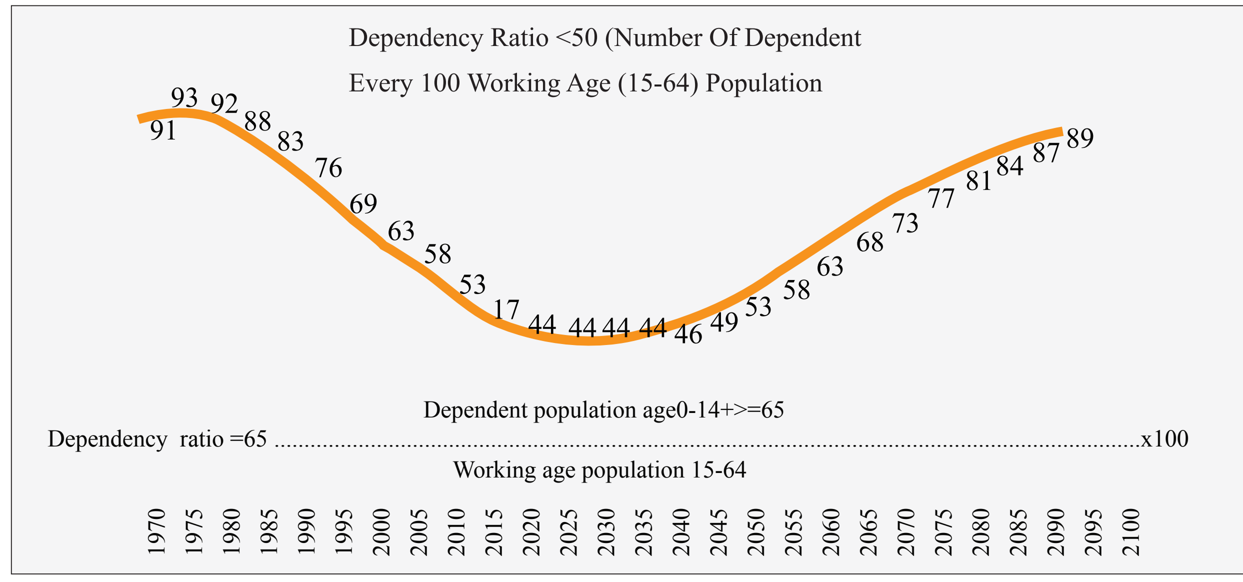
Demographic dividend, as defined by the United Nations Population Fund (UNFPA) means, "the economic growth potential that can result from shifts in a population's age structure, mainly when the share of the working-age population (15 to 64) is larger than the non-working-age share of the population (14 and younger, and 65 and older)." In other words, it is "a boost in economic productivity that occurs when there are growing numbers of people in the workforce relative to the number of dependents." UNFPA stated that, "A country with both increasing numbers of young people and declining fertility has the potential to reap a demographic dividend.

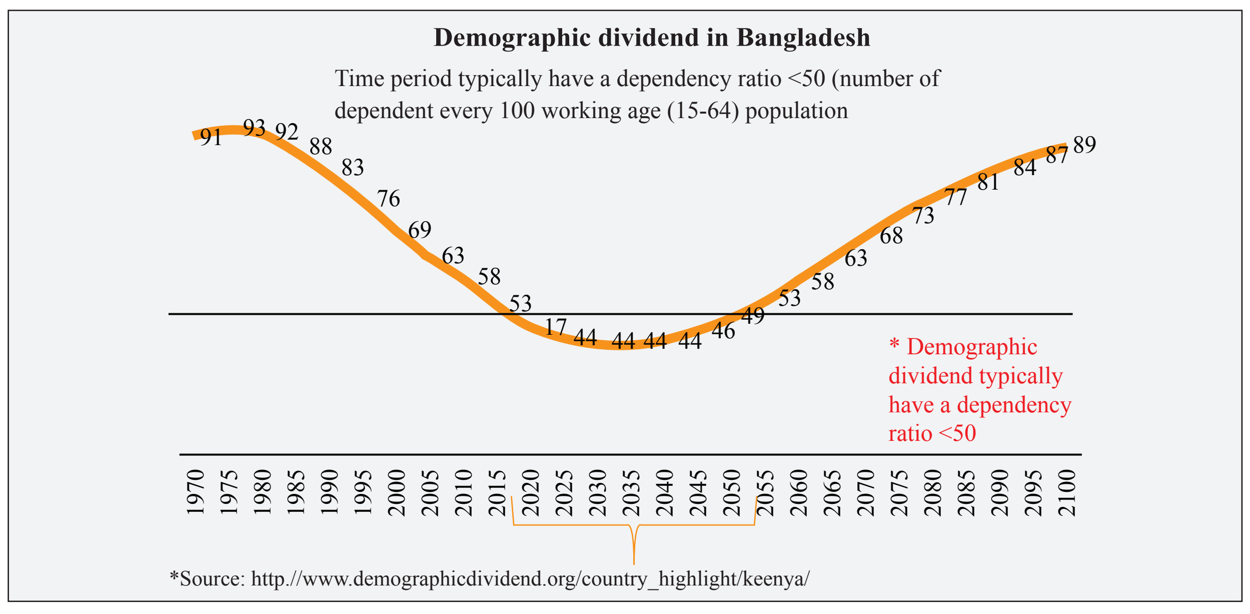
Due to the dividend between young and old, many argue that there is a great potential for economic gains, which has been termed the "demographic gift". In order for economic growth to occur the younger population must have access to quality education, adequate nutrition and health including access to sexual and reproductive health.

Therefore, in order to reap the benefits of a demographic dividend, countries must recognize and cultivate the potential of young people and close the gap between the demands placed on young people and the opportunities provided to them.

According to the Population Reference Bureau

- The demographic dividend is accelerate economic growth that can happen as the population age structure changes
- Population age structure changes
- Fertility decline due to family planning, child survival, education, and socio-economic development
- The number of births each year declines the population age structure begins to change
- More working population and less dependent population creates economic window of opportunity called demographic dividend
- It works together with strategic investment
- Health and education for productive workforce
- Economic policy and governance for investment and faster economic growth





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- *Module on Programme management training, NIPORT*
- *https://knoema.com/atlas/Bangladesh/topics/Demographics/Mortality/Crude-death-rate*
- *https://en.wikipedia.org/wiki/Demographic_dividend*

Session -4: National Strategies (Maternal, Adolescent and Nutrition)

Session objectives

At the end of the session the participants will be able to:

- Describe the guiding principles and key strategic direction of the Maternal Health strategy.
- Explain Adolescent Health Strategic objectives and key strategies and cross cutting issues.
- Explain strategies of National Nutrition policy.

Time: 1 hour 30 minutes

Participant's note

- In this session participant will participate in a discussion
- They divide into 3 groups. Select a group leader for moderating group discussion and presentation. Read and discuss the strategy (selected for the group) in group for 20 min. Present the objectives, principle and key strategies in summery within 10 minutes. Use flip paper for group work presentation or any innovative way.
- Participants will observe a video clip on Adolescent health

Handout

Bangladesh National Strategy for Maternal Health

Bangladesh National Strategy for Adolescent Health

Bangladesh National Strategy for Maternal Health 2015-2030 (Summery)

Introduction

Over the past decades, Bangladesh has made significant progress in reducing maternal and child mortality and achieved the MDG4 well ahead of target. The momentum generated by this globally recognized progress presents an opportunity to further accelerate these achievements.

The broad objective of the Bangladesh National Strategy for Maternal Health (BNSMH) 2015-2030 is to guide the Ministry of Health and Family Welfare (MOHFW) and the Government of Bangladesh (GoB) in addressing the existing gaps and inequities in the delivery of quality maternal health services, as well as the social and development factors that impact on maternal health.

The Strategy upholds principles of rights and equity, acknowledges that efforts are needed for strengthening the health system and enhancing managerial capacity at national and local levels, and call to cooperate other government sectors as well as the private sector, both profit and non-profit, and development partners.

The Bangladesh National Strategy for Maternal Health2001 was developed based on the *then* health needs, commitments and knowledge. Over the last three decades, Bangladesh has undertaken newer strategies and policies in alignment with the MDGs, further national and international commitments have been made and new knowledge has emerged about effective interventions and policies for maternal and neonatal health. Most of these advancements have been incorporated into Health Nutrition and Population (HNP) sector programs and maternal health related plans. Through successive sector programs (HPSP, HNPSP, HPNSDP & HPNSP (2017-2022) and mid-term review, the government affirmed a strong commitment to maternal health and the focus moved towards newer directions. The Poverty Reduction Strategy Paper (PRSP), the National Adolescent Reproductive Health Strategy 2006 and the National Neonatal Health Strategy and Guidelines 2009 envisage the achievement of universal health coverage with quality care for mothers and newborn babies.

Changing reproductive needs and behaviors, emerging evidence about effective interventions and service delivery modes, and better understanding of the determinants of maternal health call for a new vision;. How to achieve better maternal and neonatal outcomes and generate an increased awareness of the benefits of improved maternal health for the whole country.

The MOHFW initiated a process for updating the Bangladesh National Strategy for Maternal Health 2001, by ensuring wide participation in the process within the Ministry and outside, including professional bodies, development partners, UN organizations, international and national NGOs and institutions. The consultative process included review of program evaluation reports and global evidence on effective policies and interventions.

The Strategy is aligned to global commitments and initiatives such as the United Nations Secretary General's *Global Strategy for Women's and Children's Health* and its accompanying '*Every Woman Every Child'* initiative, the 'Every Newborn Action Plan', the 'Ending Preventable Maternal Mortality' initiative, and its complementary to 'A Promise Renewed', a global effort to accelerate action on maternal, newborn and child survival.

The strategy also calls for the involvement of other sectors of the government in adopting and implementing policies to address the underlying factors that impact maternal and neonatal health outcomes. Investments in the earliest years, starting from pre-conception through early childhood, yield the highest returns for the social and economic development of a society. Investments in maternal health should therefore be seen as a key development issue and consequently a whole-of-government concern.

Changes occurring in key social and economic dimensions such as urbanization, women's education, employment and status, income growth and distribution, are rapidly modifying reproductive and care-seeking behaviors with important implications for the planning of health services and particularly of the required workforce. The strategy therefore needs to be conceived as a dynamic process requiring periodic review and updating.

The Global Context: emphasis on a broader policy approach

Every year, complications from pregnancy and childbirth claim nearly 300,000 women's lives globally, with an additional 3 million neonatal deaths and 2.6 million stillbirths[1]. Moreover, millions of women and children suffer

from long term consequences of poor maternal health and poor access to healthcare. The high maternal and neonatal mortality and morbidity in many parts of the world reflect gaps in coverage, equity and quality of health services as well as underlying adverse social conditions from poverty to low education, poor nutrition and gender discrimination[2]. Both maternal and neonatal outcome indicators show huge gaps among and within countries.

In response to the persisting challenges, the UN Secretary General launched The Global Strategy for Women's, Children's and Adolescents' Health in 2015[3]. The strategy calls for better synergy and accountability among all involved partners and calls the governments to focus on country-led health plans, comprehensive, integrated packages of essential interventions and services, health systems strengthening, health workforce capacity building and integrated action between different sectors. WHO and the Partnership for Maternal, Newborn and Child Health developed a Global Review of Key Interventions related to RMNCH[4] and a policy guide for implementing, essential interventions for RMNCH strategies and plans[5]. The guide emphasizes the role of sectors outside health that have impact on RMNCAH outcomes by affecting demand for and delivery of health services, such as finance, education, social welfare, agriculture, justice, home and others.

The 67th World Health Assembly (WHA) held in Geneva in May 2014 endorsed the Every Newborn Action Plan, the Ending Preventable Maternal Mortality (EPMM) initiative, and the Every Mother Every Newborn initiative focusing on access and quality of health services around child birth. A review of success factors, which contributed to reduce maternal and child mortality globally, showed that maternal and child health outcomes are the result of enabling policies and interventions across all sectors[6].

Vision

All Bangladeshi women will live with their heads held high, smiling in the fulfillment of their right to safe motherhood.

Mission

To promote an enabling policy environment and nurture a socio-cultural movement that views the reduction of maternal mortality and morbidity as a fundamental women's right and a key developmental issue for the nation.

The experience in Bangladesh shows that reducing maternal and neonatal mortality and morbidity is both a product of and an entry point for key strategic women's rights issues, such as equity, disparity and violence. Strategies and interventions will therefore require a focus on enhancing women's status, dignity and self-esteem.

Efforts will foster a policy environment whereby all women enjoy the highest attainable level of health through adolescence, pregnancy, childbirth and beyond, free from long-term suffering due to a sequel of obstetric complications.

Goal and Targets

The overarching goal of the Bangladesh National Strategy for Maternal Health (2015-30) is to accelerate the reduction of maternal and neonatal mortality and to reduce the burden of maternal and neonatal morbidity.

To achieve this goal, the strategy aims at creating the conditions to make skilled attendance at birth available to all women, and equitable access to quality delivery care in appropriately equipped and staffed health facilities available to the highest proportion of women. To reduce risks and achieve the best outcomes for both mothers and babies, the provision of delivery care must be accompanied by the provision to all women of reproductive health services and of pre-conception, antenatal and post-partum care.

The strategy sets a series of key coverage and impact targets, which are summarized in the below table

Key coverage and impact targets 2015 to 2030

Indicators	2010	2015	2020	2025	2030
Skilled birth attendance at home	3%	5%	10%	10%	8%
Facility delivery	29%	37%	50%	70%	85%
Total deliveries attended by skilled professional	32%	40%*	55 %	75%	80%
Four antenatal care contacts	25%	37%	40%	60%	75%
Postnatal care contacts	30%	36%	50%	65%	80%
Contraceptive Prevalence Rate (modern method)	52%	62.4%	75%*	80%*	80%*
Total Fertility Rate	2.5	2.3	2.0	1.7	1.7
MMR (per 100,000 live births)	194	176***	103	78	70 **
NMR (per 1,000 live births)	32	28	19	15	12

*Projected target based on The HPNSDP (2011-2016) and HPNSP (2016-2022) result framework
** Reduce MMR to 70 by the year 2030 according to Sustainable Development Goals (SDG)
*** UN estimate 2015

Guiding Principles and main strategic directions

BNHMS (2015-30) has formulated the following set of guiding principles mentioned below:

1. **Ensure a continuum of care approach in delivering maternal health services**

   The health system should ensure access to evidence-based maternal and neonatal health care for all women along the different stages of the life cycle (adolescence, pre-pregnancy, pregnancy, post-natal) and full integration and adequate communication across all levels of health service delivery structure, from outreach and community to facility.

2. **Strengthen key components of the health system**

   Policies and plans will ensure adequate financing, improve managerial capacity at all levels, provide adequate training, deployment and retention of skilled health professionals, adequate supplies and infrastructural facilities, and set an effective monitoring system complemented by good governance, accountability, and operational research.

3. **Enforce women's rights and improve equity**

   Maternal and neonatal heath service delivery will be fully responsive to the national commitment to women's and children's right to health. Discrimination against women and girls will be fought by eliminating child marriage and domestic violence, promoting gender equality for all program interventions. Hard-to-reach areas and urban slums will be prioritized. Participation of the disadvantaged and marginalized groups will be ensured.

4. **Adopt mechanisms and build capacity to ensure quality of care**

   All public and private facilities should establish a system for continued improvement in quality of care using quality management frameworks and systems. The Standard Operating Procedures (SOP) will be the basis of all quality management and related regulatory mechanisms. Attention will be paid to ensure quality of care while increasing the coverage of essential interventions.

5. **Promote innovation and operational research**

   Emphasis will be put on innovation in service delivery and communication strategies. Operational research will be promoted to build evidence on cost-effective interventions to improve supply and access to and demand for health services.

6. **Engage and empower communities**

   Community empowerment and engagement will be promoted as key to improve access and utilization of MNH services and ownership and sustainability of programs, to mobilize resources and improve the accountability of health services. Communication activities will be instrumental to mobilizing individuals, families and communities and promoting community participation.

7. **Foster partnership with the private sector**

   Partnerships with both the non-profit and profit private sector will be encouraged for complementing, supplementing and integrating programs and interventions, filling service gaps and avoid duplications. The contribution of the private sector to maternal health service delivery will be fully recognized and a regulatory framework will be set and enforced to ensure equitable access and quality throughout the public and private service providers.

8. **Institutionalize inter-sectoral collaboration and multi sector engagement**

   The strategy will be a multi-sector initiative. The MOHFW will promote inter-sectoral collaboration and multi-sector government involvement to address the underlying determinants of maternal and neonatal health. An ad-hoc inter-ministerial mechanism will be established to coordinate and monitor action across sectors and ensure alignment with government provisions and inform future sector plans and financial allocation.

9. **Set effective accountability mechanisms at all levels**

   Mechanisms will be established to ensure accountability at all levels, the government to community, and will include input and output indicators, timelines and responsibilities. The impact of the strategy on coverage, equity and quality of services and achievements with respect to targets will be assessed periodically, and aligned with sector-wide reviews.

Bangladesh National Strategy for Adolescent Health 2017-2030 (Summery)

Defining Adolescence

Adolescence, a near universal life stage of the socialization process, is defined as a period of human growth and development that occurs after childhood and before adulthood and, according to the UN, includes those persons between 10 and 19 years of age (WHO 2014). Adolescence is a time of transition involving multi-dimensional changes: biological, psychological, mental and social (UNICEF, 2006). Biologically, adolescents experience pubertal changes and changes in brain structure. Psychologically and mentally, adolescents' cognitive capacities mature and they develop critical thinking skills. Adolescents also experience social change as a result of the multiple roles they are expected to play in the family, community and at school. These changes occur simultaneously but at a different pace for each adolescent depending on her/his gender, socioeconomic background, education and exposure to various other structural and environmental factors (UNICEF, 2006). As a developmental phase in human life, adolescence is further divided into early adolescence (10-14 years) and late adolescence (15-19 years). An understanding of these sub stages of development during adolescence is important from the perspective of policy planning as well as designing and implementing adolescent-related programs.

Adolescents in Bangladesh

Bangladesh has a significant adolescent population. In 2011, more than one-fifth (20.5 percent) of the total population, that is 30.68 million, were adolescents (BBS, 2011) and according to population projections, both the percentage and absolute number of adolescents will continue to increase until 2021 (UNFPA 2015). It is only by 2031 there will be a decline in the adolescent population of Bangladesh – highlighting the importance of ensuring this national adolescent health strategy is comprehensive and meets the needs of all adolescents, especially the most vulnerable and disadvantaged adolescents. The sheer number of persons in this population cohort, whose health needs have to be addressed, also makes it imperative for this strategy to be effectively implemented. This significant adolescent population presents a demographic window of opportunity, which, if well harnessed and invested in, will contribute to the development of the country. Investment in adolescent health will have an immediate and direct impact on Bangladesh's health goals and on the achievement of the Sustainable Development Goals (SDGs), especially goals 3 (ensure healthy lives and promote well-being for all at all ages), 4 (ensure inclusive and equitable quality education and promote lifelong learning opportunities for all), 5 (achieve gender equality and empower all women and girls), and 8 (promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all). Investments in adolescent health will also require supporting programs and services, which recognize the special needs of adolescents and ensure their needs are addressed both comprehensively and sensitively.

The Social Context of Adolescent Health

Many adolescents, especially adolescent girls in Bangladesh, are not provided with optimal conditions to develop their full potential and ensure their overall health in their transition into adulthood. The challenges adolescents face, during this transitory phase, are due to a variety of factors including structural poverty, lack of access to information and services, negative social norms, inadequate education, social discrimination, child marriage and early child-bearing for adolescent girls. Adolescents who are marginalized and especially vulnerable because of their living conditions have a set of other, more varied, challenges which further exacerbate this transitional process. Adolescents who live on the streets, in slum dwellings, in char and haor areas, adolescents with disability, married and/or pregnant adolescent girls, adolescents who engage in sex work, adolescent children of sex workers, adolescents in child labour, adolescents who are in detention and adolescents who are refugees/live in refugee camps will need special interventions to meet their overall health needs. Adolescents continue to experience major constraints in making informed life choices: a significant number of adolescents experience risky or unwanted sexual activity, do not receive prompt or appropriate care and, as a result, experience adverse health outcomes. Adolescent girls also face gender-based discrimination, evident in the practice of child marriage, the high rates of adolescent fertility, the high prevalence of domestic violence, the increasing incidence of sexual abuse and higher drop-out rates from secondary education due to the patriarchal social norms of Bangladesh. Adolescent boys also face pressure to comply with prevailing norms of masculinity, which drives them to risky behaviors such as unsafe sex, violence and substance use. All these factors have a direct as well as indirect influence on the health and well-being of adolescents, and form an essential component of the context within which health issues of adolescents should be understood.

The Vision

By 2030, all adolescent boys and girls of Bangladesh, especially who are most vulnerable, will be able to enjoy a healthy life.

The Goal

By 2010, all adolescents will lead a healthy and productive life in a socially secure and supportive environment where they have easy access to quality and comprehensive, information, education and services.

The Time Frame

The strategy will span over a period of 14 years (2017-2032) in line with the Sustainable Development Goals. The strategy will be revisited periodically to review and assess its relevance in a rapidly changing context.

Guiding Principles

The National Adolescent Health Strategy 2017-2032 is based on human rights principles, and highlights the right of all adolescents, those between the ages of 10 and 19 years, to attain the highest standard of health.

Strategic Directions

SD1 Adolescent Sexual and Reproductive Health

Strategic Objectives

1. To create an enabling environment at all levels—national and local—by strengthening legislation, policy development and implementation;
2. To integrate and strengthen age-appropriate comprehensive sexuality education

   programs at all academic and training institutions;
3. To improve the sexual and reproductive health status of adolescents by engaging a range of evidence based and effective interventions.

Key Strategies

1. Enable evidence-based advocacy for comprehensive policy and program development, investments and implementation;
2. Promote age-appropriate, comprehensive sexuality education, which is on par with international standards, through all academic and training institutions;
3. Build capacity for the delivery of age and gender-sensitive sexual and reproductive health services, which includes HIV/STI prevention, treatment and care;
4. Create a robust system for data collection/analysis on the sexual and reproductive health of adolescents, including unmarried adolescents, to inform policy and programming.

SD2 Violence against Adolescents

Strategic Objectives

1. To promote positive social norms that address age and gender-based discrimination and violence, including child marriage, by engaging and influencing policy makers and key stakeholders;
2. To empower adolescents, especially adolescent girls, by providing them with life skills to stand up for their rights, including their rights to fully and freely consent to marriage;
3. To strengthen health and social protection systems to provide services to meet the needs of the most vulnerable adolescents.

Key Strategies

1. Enable evidence-based advocacy and communication at national and local level to raise awareness on the issue of age- and gender-based discrimination, child marriage and its consequences;

2. Build the capacity of the health and social protection sector to respond to age- and gender-based violence and child marriage prevention by providing effective and efficient services;
3. Develop and implement evidence-based programs to prevent and mitigate the consequences of age- and gender-based violence, including child marriage;
4. Create a robust system for data collection/analysis on the prevalence of age- and gender-based violence to be used to inform policy and programming.

SD3 Adolescent Nutrition

Strategic Objectives

1. To reduce under-nutrition and anaemia among adolescent girls (pregnant and non-pregnant) and boys;
2. To reduce the risk of low birth weight babies, pregnancy related complications and nutritional risks among adolescent girls;
3. To reduce micronutrient deficiencies such as calcium, vitamin D and iodine deficiency among pregnant adolescent girls;
4. To improve lifestyles and reduce the risks of overweight and obesity among all adolescents.

Key Strategies

1. Mainstream nutrition education and promotion and hygiene education including hand washing into the health care system, education system as well as other systems which reach out-of-school adolescents;
2. Establish programs that promote dietary diversification, dietary adequacy, fortified foods and nutrition security through community and school-based interventions;
3. Strengthen the capacity of service providers to deliver effective nutrition counseling and services to all adolescents, with a special focus on raising awareness on the consequences of child marriage and meeting the nutritional needs of pregnant adolescent girls;
4. Provide and promote micronutrient supplementation (i.e., IFA and MMS), consumption of fortified foods and de-worming at health facilities, schools, and workplace;
5. Conduct community based awareness campaigns on the importance of good nutrition, healthy foods and the consequences of malnutrition, anaemia and obesity on the overall development and growth of adolescents;
6. Promote and improve access to sports and physical activity in the community, schools and at the workplace.

SD4 Mental Health of Adolescents

Strategic Objectives

1. To integrate the mental health agenda within primary health care services and other relevant health and education services;
2. To promote mental health and prevent mental ill health by implementing a range of evidence based interventions and screening for common mental illnesses and suicidal behaviour as per the provisions of primary mental health care;
3. To create an enabling environment for mental health services including counselling and to develop the capacity to provide effective services at all levels of facilities.

Key Strategies

1. Enable evidence-based advocacy for comprehensive program development to promote mental health among adolescents and reduce stigma against mental ill health;
2. Develop skills among adolescents to deal with stress, manage conflict and develop healthy relationships;
3. Develop the capacity of the health sector to address mental health issues as per the provisions of primary mental healthcare and to screen for anxiety, stress, depression and suicidal tendencies;

4. Promote school and facility level interventions, which include counselling and management of mental health disorders, through linkage with the national mental health program;
5. Create a robust system for data collection/analysis on mental health issues including substance use, to inform policy and programming.

Cross Cutting Issue

CCI 1 Social and Behavior Change Communication (SBCC)

Strategic Objectives

1. To ensure political commitment and adequate resources to support SBCC interventions;
2. To promote social mobilization and ensure wider participation, coalition and ownership of issues that affect adolescents among community members;
3. To use SBCC interventions to bring about changes in knowledge, attitudes and practices among specific audiences.

Key Strategies

1. Development of messages and materials for communication and advocacy through sound research;
2. Utilize Information and Communication Technology (ICT) (including call centres) and media to reach adolescents, key community members, parents and guardians;
3. Develop the capacity of respective institutions and systems to design, plan, implement and monitor SBCC interventions.

CCI 2 Health Systems Strengthening

The WHO Health Systems Framework (WHO 2007) refers to six building blocks of a health system that need to be strengthened if we are to ensure the availability of effective services that meet the health needs of adolescents and thereby improve their health status. These building blocks include leadership/governance, healthcare financing, health workforce, health information systems, access to essential medicines and service delivery. The effective implementation of this National Adolescent Health Strategy will require each of these building blocks to be strengthened and for the MOHFW to play a lead role in this process.

Vulnerable Adolescents and Adolescents in Challenging Circumstances

As special adolescent population groups, vulnerable adolescents and adolescents in challenging circumstances, have a range of needs that will specifically need to be addressed through the above-mentioned Strategic Directions (SDs) and Cross Cutting Issues (CCI). This special group of adolescents include, but are not limited to, adolescents who live on the streets, in slum dwellings, in char and haor areas; adolescents with disability; married and pregnant adolescent girls; adolescents who engage in sex work; adolescent children of sex workers; working adolescents; adolescents who are in detention; adolescents living in areas prone to natural disasters; and adolescents who are refugees/live in camps.

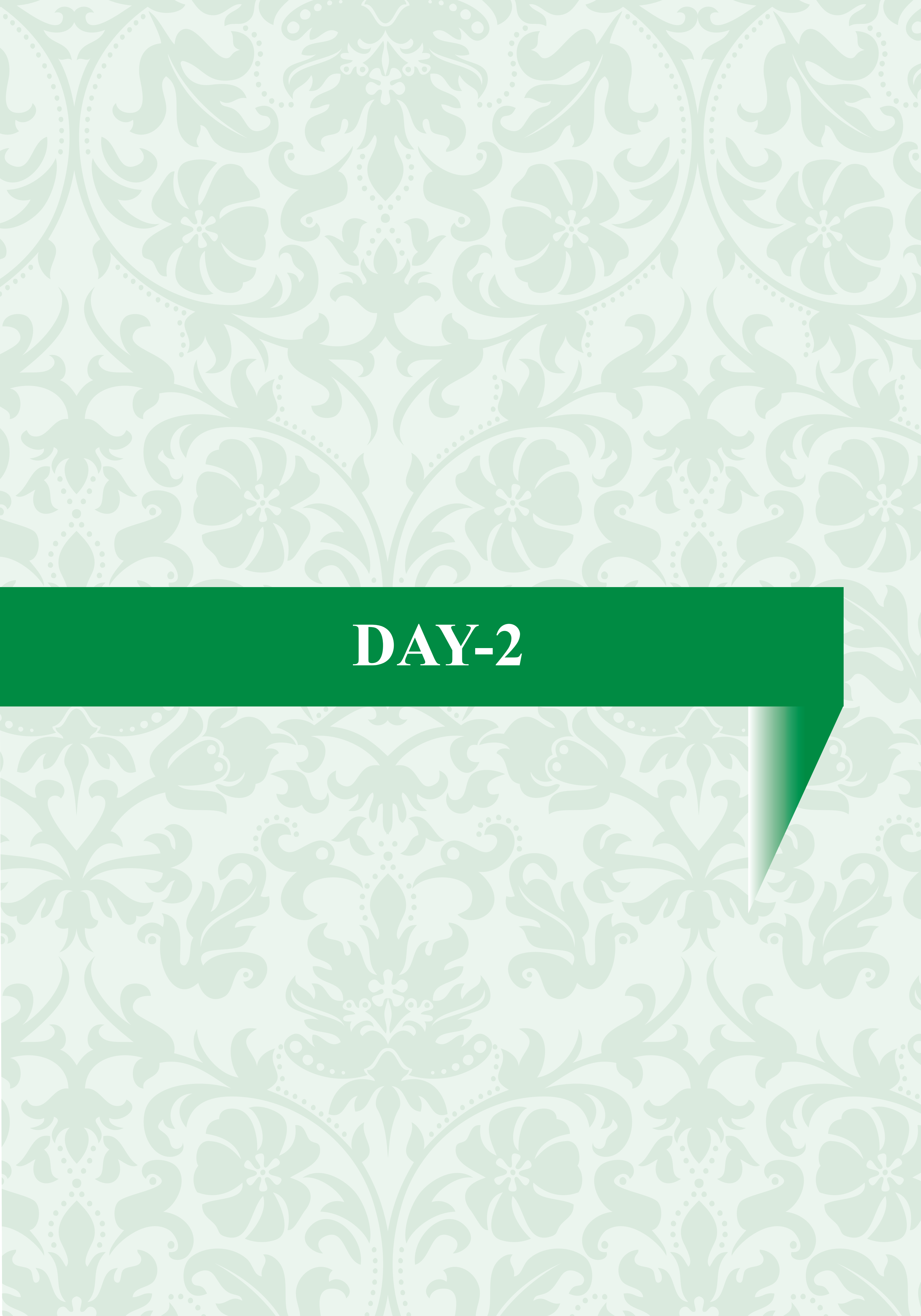
Despite the limited data on these vulnerable adolescents and adolescents living in challenging circumstances, it has been established globally that when it comes to the health of these groups, it is imperative to allocate resources and conduct tailored programs. These programs should not only address their health needs but also take into consideration issues of affordability and accessibility of the health services that are made available. Many of these adolescents come from the socio-economically most disadvantaged segments of society and therefore their health needs will need to be understood through a more holistic and broader perspective.

National Nutrition Policy 2015 (Strategies)

Please see Handout session -2

References

- *Bangladesh National Strategy for Maternal Health 2015-2030 (draft), GoB, MOHFW*
- *National Strategy for Adolescent Health 2017-2030, MCH Services Unit, DGFP, MOHFW*



DAY-2

Day-2 Schedule

Time	Sessions	Topics
9.00-9.15 (15 min.)		**Review of the previous day**
9.15-10.45 (1 hour 30 min.)	**Session-5**	**4th Health, Population and Nutrition Sector Program** - Sustainable Development Goals (SDG) - Health, Population and Nutrition Sector Program (HPNSP) - Operational Plans (OP) - Universal Health Coverage (UHC)
10.45-11.00		**Tea Break**
11.00-11.45 (45 min)	**Session-6**	**Essential Services Package (ESP)** - Composition of ESP - Minimum standard and extra services by facility levels - Facility and service delivery sites - Role of Upazila managers
11.45-1.15 (1 hour 30 min)	**Session-7**	**Management Concepts** - Management Functions - Management Models - Role of a manager
1.15-2.15 (1 hour)		**Lunch and Prayer Break**
2.15-3.45 (1 hour 30 min.)	**Session-8**	**Introduction to Leadership** - Overview of leadership - Leadership self-assessment - Leader VS manager
3.45-4.00 (15 min)		**Tea Break**
4.00-5.00 (1 hour)	**Session-9**	**Supportive Supervision** - Supervision, Supportive supervision - Guiding principles for supervisors - Core competencies of a supervisor
5.00-5.15 (15 min.)		**Evaluation of the day**

Session -5: 4th Health, Population and Nutrition Sector Program

Session objectives

At the end of the session the participants will be able to:

- State Sustainable Development Goals (SDG) and identify health-related SDG
- Describe the strategic objectives and identify program priorities of 4th HPNSP
- Identify the major activities of operational plans (OPs)
- Understand the Universal Health Coverage concept

Time: 1 hour 30 minutes

Participant's note

- In this session participants will participate in a discussion
- They will observe video clips on SDG and UHC

DAY-1

Handout

Sustainable Development Goal

Health Population and Nutrition Sector Program

Operational Plans

Universal Health Coverage

Sustainable Development Goal (SDG)

Background of the Goals

The Sustainable Development Goals (SDGs) were born at the United Nations Conference on Sustainable Development in Rio de Jeneiro in 2012. The objective was to produce a set of universals goals that meet the urgent environmental, political and economic challenges facing our world.

The SDGs replace the Millennium Development Goals (MDGs), which started a global effort in 2000 to tackle the indignity of poverty. The MDGs established measurable, universally agreed objectives for tackling extreme poverty and hunger, preventing deadly disease and expanding primary education to all children, among other development priorities.

For 15 years, the MDGs drove progress in several important areas reducing income poverty, providing much-needed access to water and sanitation, driving down child mortality and drastically improving maternal health. They also kick-started a global movement for free primary education, inspiring countries to invest in their future generations. Most significantly, the MDGs made huge strides in combating HIV/AIDS and other treatable diseases such as malaria and tuberculosis.

What are the Sustainable Development Goals?

Goal 1: No Poverty

Extreme poverty rates have been cut by more than half since 1990. While this is a remarkable achievement, one in five people in developing regions still live on less than $1.25 a day, and there are millions more who make little more than this daily amount, plus many people risk slipping back into poverty.

Poverty is more than the lack of income and resources to ensure sustainable livelihood. Its manifestation includes hunger and lack of resources to ensure a sustainable education and other basic services, social discrimination and exclusion as well as the lack of participation in decision-making. Economic growth must be inclusive to provide sustainable jobs and promote equality.

Goal 2: Zero Hunger

It is time to rethink how we grow, share and consume our food. If done right, agriculture, forestry and fisheries can provide nutrition and food for all and generate decent incomes, while supporting people-centred rural development and protecting the environment.

Right now our soils, freshwater, oceans, forest and biodiversity are being rapidly degraded. Climate change is putting even more pressure on the resources we depend on, increasing risks associated with disasters such as droughts and floods. Many rural women and men can no longer make ends meet on their land, forcing them to migrate to cities in search of opportunities.

A profound change of the global food and agriculture system is needed if we are to nourish today's 795 million hungry people and the additional 2 billion people expected by 2050. The food and agriculture sector offers key solutions for development, and is central for hunger and poverty eradication.

Goal 3: Good Health and Well-Being

Ensuring health and promoting the well-being for all at all ages is essential to sustainable development. Significant strides have been made in increasing life expectancy and reducing some of the common killers associated with child and maternal mortality. Major progress has been made on increasing access to clean water and sanitation, reducing malaria, tuberculosis, polio and the spread of HIV/AIDS. However, many more efforts are needed to fully eradicate a wide range of diseases and address many different persistent and emerging health issues.

GOAL 3 TARGETs

The global and national targets for the SDG indicators are shown in Table below (Source: Health Bulletin 2017, MIS, DGHS)

Global and national targets of SDG indicators				
SDG target	**Name of the indicator**	**Target to be achieved by 2030**	**Baseline value for Bangladesh**	**National target (HNPSIP 2016-2021 and other strategic documents)**
3.1: Maternal health	3.1.1: Maternal mortality ratio (MMR)	Less than 70 per 100,000 live births	176 (WHO estimate 2016)	105 per 100,000 live births by 2021 (HNPSIP 2016-2021)
	3.1.2: Births attended by skilled health personnel		42.1 (BDHS 2014)	65% by 2021 (HNPSIP 2016-2021)
3.2: Newborn and child health	3.2.1: Under-five mortality rate	Less than 25 per 1,000 livebirths	46 (BDHS 2014)	37 per 1000 live births by 2021 (HNPSIP 2016-2021)
	3.2.2: Neonatal mortality	Less than 12 per 1,000 live births	28 (BDHS 2014)	21 per 1000 live births by 2021 (HNPSIP 2016-2021)
3.3: Communicable diseases	3.3.1: Estimated HIV incidence rate	By 2030 end the endemic of AIDS	<1 (WHO 2014)	Keep the AIDS epidemic from expanding beyond the current level (<1%) Avoid a gradual spread of HIV infection from high risk groups to the general population
	3.3.2: TB case detection rate/ TB incidence rate per 100,000 population	End epidemics of TB by 2030	53% (GTBR 2014 estimates)	75% (HNPSIP 2016-2021)
	3.3.3: Malaria incidence rate per 1000 population	End epidemics by 2030	High endemic (three districts): 1.0-10/1000 population Low endemic (ten districts): .1-1.0/1000 population World Malaria Report 2015	Reduce malaria morbidity and mortality until the disease is no longer a public health problem in the country
	3.3.4: Hepatitis incidence per 100,000 population	Combat hepatitis		
	3.3.5: Neglected Tropical Diseases (NTDs): people requiring intervention (preventive + new cases) against NTDs	End epidemic by 2030		Kala-azar: Annual incidence rate to <1/10,000 population in all endemic upazilas (sub districts) by 2015. Elimination of filariasis. Prevention and control of dengue.

Global and national targets of SDG indicators

SDG target	Name of the indicator	Target to be achieved by 2030	Baseline value for Bangladesh	National target (HNPSIP 2016-2021 and other strategic documents)
3.4: Non communi-cable diseases	3.4.1: Mortality rate attributed to cardiovascular disease, cancer, diabetes, or chronic respiratory disease	Reduce by one-third the premature mortality by 2030	18% (World Health Organization Non com-municable Diseases (NCD) Country Profiles, 2014)	Reduce by one-third the premature mortality due to NCDs from current rate
	3.4.2: Suicide mortality rate (per 100,000)	Reduce one-third of premature mortality by 2030	8 per 100,000 according to WHO 2014 report	Reduce by one-third the prema-ture suicidal death from current level
3.5: Substance abuse	3.5.1: Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance abuse disorders	Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol		
	3.5.2: Alcohol per-capita consumption (aged 15 years and older) within a calendar year in liters of pure alcohol	Strengthen the prevention and treatment of substance-abuse, including narcotic drug-abuse and harmful use of alcohol	Almost zero alcohol consumption (0.2 in 2010) WHO report 2014	Committed to global target
3.6: Road traffic injuries	3.6.1: Deaths due to road traffic accidents/ Mortality rate from road traffic injuries (per 100,000 population)	By 2020, halve the number of global deaths and injuries from road-traffic injuries	According to World Bank statistics, annual fatality rate from road accidents is found to be 85.6 fatalities per 10,000 vehicles (WB, World Development Indicators 2002) According to the Accident Research Institute (ARI), Bangladesh University of Engineering and Technology (BUET), road accidents claim, on average, 12,000 lives annually and lead to about 35,000 injuries (Road Safety Facts 2012 through 2014)	Committed to global targets

Global and national targets of SDG indicators

SDG target	Name of the indicator	Target to be achieved by 2030	Baseline value for Bangladesh	National target (HNPSIP 2016-2021 and other strategic documents)
3.7: Sexual and reproductive health	3.7.1: Proportion of women married or in a union of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods (met need) Unmet need for family planning	By 2030, ensure universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs	12%, for limiting and 5% for birth spacing	Reduce unmet need to 7% by 2021 (FP 2020 commitment, Govt. of Bangladesh)
	3.7.2: Adolescents' childbirth rate per 1,000 adolescent women aged 15-19 years	Universal access to sexual and reproductive healthcare by 2030	30.8% in 2014 (BDHS)	25% by 2021 (HNPSIP 2016-2021)
3.8: Universal health coverage	3.8.1: Coverage of essential health services Total fertility rate	Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all	2.3 in 2014 (BDHS)	1.7 by 2021 (HNPSIP 2016-2021)
	Contraceptive prevalence rate (CPR)	Achieve universal health coverage	62.4 in 2014 (BDHS)	75% by 2021, CPR in lagging region: 60% by 2021 (HNPSIP 2016-2021)

Global and national targets of SDG indicators

SDG target	Name of the indicator	Target to be achieved by 2030	Baseline value for Bangladesh	National target (HNPSIP 2016-2021 and other strategic documents)
3.8: Universal health coverage	ANC 4 coverage	Achieve universal health coverage	31.2 (BDHS 2014)	ANC 4 coverage 50% by 2021 (HNPSIP 2016-2021)
	Measles immunization coverage	Achieve universal health coverage	86.6% (CES Report 2014)	95% (HNPSIP 2016-2021)
	% of children aged less than 6 months receiving exclusive breastfeeding	Achieve universal health coverage	55.3% (BDHS 2014)	65% (HNPSIP 2016-2021)
	% of infants aged 6-23 months are fed with minimum acceptable diet	Achieve universal health coverage	22.8% (BDHS 2014)	45% (HNPSIP 2016-2021)
	Estimated prevalence of diabetes and hypertension among adult men and women aged 35 years and older	Achieve universal health coverage	Diabetes: 11.2%; Hypertension: 31.9% (BDHS 2011)	Diabetes: 10% Hypertension: 30% (HNPSIP 2016-2021)
	3.8.2: Number of people covered by health insurance or a public health system (per 1,000 population)	Achieve universal health coverage, including financial risk protection		
3.9: Mortality For environmental pollution	3.9.1: Mortality rate attributed to household and ambient air pollution	By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination		
	3.9.2: Mortality rate attributed to unsafe water, unsafe sanitation, and lack of hygiene	By 2030, substantially reduce the number of deaths and illnesses due to unsafe water, sanitation and lack of hygiene		
	3.9.3: Mortality rate attributed to unintentional poisonings	By 2030, substantially reduce the number of deaths and illnesses due to poisoning		

Global and national targets of SDG indicators				
SDG target	**Name of the indicator**	**Target to be achieved by 2030**	**Baseline value for Bangladesh**	**National target (HNPSIP 2016-2021 and other strategic documents)**
3.a: Tobacco control	3.a.1: Tobacco use rate (Age standardized prevalence of current tobacco use among persons aged 15 years and older/ Tobacco-use among persons aged 18+ years (WHO)	Strengthen the implementation of World Health Organization Framework Convention on Tobacco Control in all countries as appropriate	Tobacco-use by male: 48%, female: 2%, total: 25% in 2011 (2014 WHO Report)	Reduce tobacco-use from current prevalence
3.b: Provide access to all essential medicines and vaccines	3.b.1: Percentage of health facilities with essential medicines and lifesaving commodities	Ensure availability in all facilities	Facilities with essential drugs: 66%; FP methods: 84.4% (HFS2014)	Facilities with essential drugs: 75%; FP methods: 90% by 2021 (HNPSIP2016-2021)
3.c: Health workforce	3.c.1: Health workers' density and distribution per 1,000 population: Reduction in functional vacant positions in public facilities by category (physician, nurse/midwife, paramedics)	Substantially increase health financing and the recruitment, development, training, and retention of the health workforce in developing countries, especially in the least-developed countries and small island developing states	Physician: 30.5% in 2014 Nurse: 7.8% in 2014 (BHFS) Paramedic: 7.1% in 2014	Physician: 15% by 2021 Nurse: 4% by 2021 Paramedic: 4% by 2021 (HNPSIP 2016-2021)
3.d: National and global health risk	3.d.1: International Health Regulations (IHR) capacity and health emergency preparedness: International Health Regulations (IHR) core capacity index/number of attributes attained out of 13 core attributes	Strengthen the capacity of all countries, in particular, developing countries, for early warning, risk reduction and management of national and global health risks		

Global and national targets of SDG indicators				
SDG target	**Name of the indicator**	**Target to be achieved by 2030**	**Baseline value for Bangladesh**	**National target (HNPSIP 2016-2021 and other strategic documents)**
2.2: Child Malnutrition	Prevalence of stunting in under-5 children/ Proportion of stunted U5 children Proportion of wasted and overweight U5 children	By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children below 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons	36.1 in 2014 (BDHS 2014)	25% by 2021 (HNPSIP 2016-2021)
6.1: Drinking water	Proportion of population using improved drinking-water sources	By 2030, achieve universal and equitable access to safe and affordable drinking-water for all	98% (DHS2014)	100%
6.2: Sanitation and hygiene	Proportion of population using improved sanitation facilities	By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations	45% (BDHS 2014)	
7.1: Clean household energy	Percentage of population with primary reliance on non-solid fuels (%)	By 2030, ensure universal access	18% (DHS 2014)	
11.6: Clean cities	Ambient air pollution Percentage of urban solid waste regularly collected and well-managed (disaggregated by type of wastes)	By 2030, reduce the adverse per-capita environmental impact of cities, including by paying special attention to air quality and municipal and other waste management		

Global and national targets of SDG indicators				
SDG target	**Name of the indicator**	**Target to be achieved by 2030**	**Baseline value for Bangladesh**	**National target (HNPSIP 2016-2021 and other strategic documents)**
13.1: Natural disasters	Number of deaths, missing people, injured, relocated or evacuated due to disasters per 100,000 people	Strengthen resilience and adaptive capacity to climate-related hazards and natural disasters in all countries		
16.1: Violence	Homicide conflicts Women and girls subjected to physical, sexual or physiological violence		Prevalence of intimate partner violence: 15-71% (WHO multicounty study on women's health and domestic violence, Lancet 2006)	

Goal 4: Quality Education

Obtaining a quality education is the foundation to improving people's lives and sustainable development. Major progress has been made towards increasing access to education at all levels and increasing enrolment rates in school particularly or women and girls. Basic literacy skills have improved tremendously, yet bolder efforts are needed to make even greater strides for achieving universal education goals. For example, the world has achieved equality in primary education between girls and boys, but few countries have achieved that target at all levels of education.

Goal 5: Gender Equality

While the world has achieved progress toward gender equality and women's empowerment under the Millennium Development Goals (including equal access to primary education between girls and boys), women and girls continue to suffer discrimination and violence in every part of the world.

Gender equality is not only a fundamental human right, but a necessary foundation for a peaceful, prosperous and sustainable world.

Providing women and girls with equal access to education, health care, decent work, and representation in political and economic decision-making processes will fuel sustainable economics and benefit societies and humanity at large.

Goal 6: Clean Water and Sanitation

Clean, accessible water for all is an essential part of the world we want to live in. There is sufficient fresh water on the planet to achieve this. But due to bad economics or poor infrastructure, every year millions of people, most of them children, die from diseases associated with inadequate water supply, sanitation and hygiene.

Water scarcity, poor water quality and inadequate sanitation negatively impact food security, livelihood choices and educational opportunities for poor families across the world. Drought afflicts some of the world's poorest countries, worsening hunger and malnutrition. By 2050, at least one-in-four people is likely to live in a country affected by chronic or recurring shortage of fresh water.

Goal 7: Affordable and Clean Energy

Energy is central to nearly every major challenge and opportunity the world faces today. Be it for jobs, security, climate change, food production or increasing incomes, access to energy for all is essential.

Sustainable energy is opportunity—it transforms lives, economies and the planet. UN Secretary–General is leading a sustainable energy for all initiative to ensure universal access to modern energy survives, improve efficiency and increase use of renewable sources.

Goal 8: Decent Work and Economic Growth

Roughly half the world's population still lives on the equivalent of about US$2 a day. And in too many places, having a job doesn't guarantee the ability to escape from poverty. This slow and uneven progress requires us to rethink and retool our economic and social policies aimed at eradicating poverty.

A continued lack of decent work opportunities, insufficient investments and under-consumption leads to an erosion of the basic social contract underlying democratic societies; that all must share in progress. The creation of quality jobs will remain a major challenge for almost all economies well beyond 2015. Sustainable economic growth will require societies to create the conditions that allow people to have quality jobs that stimulate the economy while not harming the environment. Job opportunities and decent working conditions are also required for all working age people.

Goal 9: Industry, Innovation and Infrastructure

Investment in infrastructure—transport, irrigation, energy and information and communication technology—are crucial to achieving sustainable development and empowering communities in many countries. It has long been recognized that growth in productivity and incomes, and improvement in health and education outcomes require investment in infrastructure.

Inclusive and sustainable industrial development is the primary source of income generation, allows for rapid and sustained increases in living standards for all people, and provides the technological solutions to environmentally sound industrialization.

Technological progress in the foundation of efforts to achieve environmental objectives, such as increase resource and energy-efficiency. Without technology and innovation, industrialization will not happen, and without industrialization, development will not happen.

Goal 10: Reduced Inequalities

The international community has made sufficient strides towards letting people out of poverty. The most vulnerable nations—the least developed countries, the landlocked developing countries, the small island developing states—continue to make inroads into poverty reduction. However, inequality still persists and large disparities remain in access to health and education services and other assets.

Additionally while income inequalities between countries may have been reduced, inequalities within countries have risen. There is growing consensus that economic growth is not sufficient to reduce poverty. It is not inclusive and if it does not involve the three dimensions of sustainable development—economic, social and environmental. To reduce inequality, policies should be universal on principle, paying attention to the needs of disadvantaged and marginalized populations.

Goal 11: Sustainable Cities and Communities

Cities are hubs for ideas, commerce, culture, science, productivity, social development and much more. At their best, cities have enabled people to advance socially and economically.

However, many challenges exit to maintain cities in a way that continues to create jobs and prosperity while not straining land and resources. Common urban challenges include congestion, lack of funds to provide basic services, a shortage of adequate housing, and declining infrastructure. The challenges cities face can be overcome in ways that allow them to continue to thrive and grow, while improving resource use and reducing pollution and poverty. The future we want includes cities of opportunities for all, with access to basic services, energy, housing, transportation and more.

Goal 12: Responsible Consumption and Production

Sustainable consumption and production is about promoting resource and energy efficiency, sustainable infrastructure, and providing access to basic services, green and decent jobs and a better quality of life for all. Its implementation helps to achieve overall development plans, reduce economic competitiveness and poverty.

Sustainable consumption and production aims at "doing more and better with less" increasing net welfare gains from economic activities by reducing resource use, degradation and pollution along the whole lifecycle, while increasing quality of life. It involves different stakeholders, including business, consumers, policy makers, researchers, scientists, retailers, media and development cooperation agencies, among others. It also requires a systemic approach and cooperation among actors operating in the supply chain, from producer to final consumer. It involves engaging consumers

through awareness-raising and education on sustainable consumption and lifestyles, providing consumers with adequate information through standards and labels, and engaging in sustainable public procurement, among others.

Goal 13: Climate Action

Climate change is now affecting every country on every continent. It is disrupting national economics and affecting lives, costing people, communities and countries dearly today and even more tomorrow.

People are experiencing the significant impacts of climate change, which include changing weather patterns, rising sea levels, and more extreme weather events. The greenhouse gas emissions from human activities are driving climate change and continue to rise. They are now at their highest levels in history. Without action, the world's average surface temperature is projected to rise over the 21st century and is likely to surpass 3 degrees Celsius this century–with more areas of the world expected to warm even more. The poorest and most vulnerable people are being affected the most.

Affordable, scalable solutions are now available to enable countries to leapfrog to cleaner, more resilient economies. The pace of change is quickening as more people are turning to renewable energy and a range of other measures that will reduce emissions and increase adaptation efforts. But climate change is a global challenge that does not follow national borders. Emissions anywhere affect people everywhere. It is an issue that requires solutions that need to be coordinated at the international level and it requires international cooperation to help developing counties move towards a low-carbon economy.

Goal 14: Life below Water

The world's ocean-their temperature, chemistry, currents and life drive global systems that make the Earth habitable for human kind. Our rain water, drinking water, weather, climate, coastlines, much of our food and even the oxygen in the air we breathe, are all ultimately provided and regulated by the sea. Throughout history, oceans and seas have been vital conduits for trade and transportation. Careful management of the essential global resource is a key feature of a sustainable future.

Goal 15: Life on Land

Preserving diverse forms of life on land requires targeted efforts to protect, restore and promote the conservation and sustainable use of terrestrial and other ecosystems. Goal 15 focuses specifically on managing forests sustainably, restoring degraded lands and successfully combating desertification, reducing degraded natural habitats and ending biodiversity loss.

Goal 16: Peace, Justice and Strong Institutions

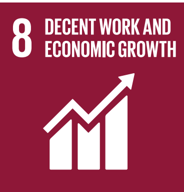
This goal is dedicated to the promotion of peaceful and inclusive societies for sustainable development, the provision of access to justice for all, and building effective, accountable institutions at all levels.

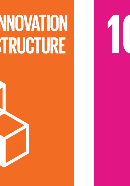
Goal 17: Partnership for the Goals

A sustainable development agenda requires partnerships between governments, the private sector and civil society. These inclusive partnerships built upon principles and values, a shared vision and shared goals that place people and the planet at the centre, are needed at the global, regional, national and local level.

Urgent action is needed to mobilize, redirect and unlock the transformative power of trillions of dollars of private resources to deliver on sustainable development objectives. Long-term investments, including foreign direct investments, are needed in critical sectors, especially in developing countries. These include sustainable energy, infrastructure and transport, as well as information and communications technologies. The public sector will need to set a clear direction. Review and monitoring frameworks, regulations and investments and reinforce sustainable development. National oversight mechanism such as supreme audit institutions and oversight functions by legislatures should be strengthened.

SUSTAINABLE DEVELOPMENT GOALS





17 Sustainable Goals

4th Health Population and Nutrition Sector Program (HPNSP)

Main Objectives and Brief Description of the Program:

Main Objectives

The 4th HPNSP is built on existing achievement to improve equity, quality and efficiency with a view to gradually moving towards UHC and achieving health related Sustainable Development Goals (SDGs) through pursuing the following *strategic objectives (SOs)* during the next five and half years starting from January 2017:

SO 1	:	*To strengthen governance and stewardship of the public and private health sectors*
SO 2	:	*To undertake institutional development for improved performance at all levels of the system*
SO 3	:	*To provide sustainable financing for equitable access to health care for the population and accelerated progress towards universal health coverage*
SO 4	:	*To strengthen the capacity of the MOHFW's core health systems (Financial Management, Procurement, Infrastructure development)*
SO 5	:	*To establish a high quality health workforce available to all through public and private health service providers*
SO 6	:	*To improve health measurement and accountability mechanisms and build a robust evidence-base for decision making*
SO 7	:	*To improve equitable access to and utilization of quality health, nutrition and family planning services*
SO 8	:	*To promote healthy lifestyle choices and a healthy environment*

The 4th HPNSP coincides with the adoption of the United Nations' SDGs by world leaders in New York on the 25 September 2015. The 2030 Agenda for Sustainable Development articulates an ambitious set of targets aimed at transforming the world by ending poverty, hunger and inequality, taking action on climate change and the environment and improving health and education. The new Global Goals replace and expand the previously agreed MDGs.

Out of the 17 SDGs, SDG 3 specifically relates to good health and well-being, while several SDGs have bearing on the determinants of health like improvements in hunger, food security and nutrition (SDG 2), inclusive and equitable quality education (SDG 4), water and sanitation (SDG 6), environments (SDG 11 & 16), reducing inequality (SDG 10), gender equity and empowerment of women and girls (SDG 5), etc. SDG 3 aims - among others - to achieve UHC, and provide access to safe and effective medicines and vaccines for all.

The SDG 3 targets are numerous and wide-ranging and cover issues of communicable and non-communicable diseases, lifestyle and healthy environments and provide a holistic framework for development of national responses. The SDGs provide new background to looking at health, nutrition and population in a more holistic and multi-sectoral way and this is reflected in this 4th HPNSP document for Bangladesh.

The 4th HPNSP has been designed with appropriate strategies and efforts for focused improvements in increasing access to, and quality of health care and improving equity along with financial protection in order to meaningfully realize the objectives of UHC.

I. Vision, Mission and Goal of the Program:

The Program Implementation Plan (PIP) of 4th HPNSP is based on the vision, mission, goal, development objectives, strategic objectives and resource envelope as mentioned in the Strategic Investment Plan (SIP) of MOHFW developed in mid-2016.

Vision	:	*"To see the people healthier, happier and economically productive to make Bangladesh a middle income country by 2021"* (Vision 2021)
Mission	:	*"To* create *conditions whereby the people of Bangladesh have the opportunity to reach and maintain the highest attainable level of health"*
Goal	:	*"To ensure that all citizens of Bangladesh enjoy health and well-being by expanding access to quality and equitable health care in a healthy environment"*

II. Development Objective of the Program:

The development objective of the 4th HPNSP is to have focused improvements in increasing access to quality health care and improving equity along with efficiency by gradually achieving UHC.

III. Program Priorities and Strategies :

On the basis of the experience in the previous health SWAp periods a set of three underlying principles has been identified in preparing the 4th HPNSP. One of these is to ensure that all citizens have access to high *quality* services whether these are obtained from the public or private, modern or alternate medical providers. The other is on *equity*, i.e. all citizens are treated equally and no one is left behind. Finally the Program aims to gain efficiency by reducing wastage and maximizing the impact of all available resources.

Program Priorities

During the 4th HPNSP, various innovative approaches will be explored for improving service delivery, which comprise review of existing field-based service delivery; diversification of service provision (inclusive of public-private partnership as referred by the PPT. Act) particularly for hard-to-reach areas; development of a functional referral system involving all levels of facilities; ensuring access to and utilization of quality health services by the poor and the marginalized, etc. Moreover, emphasis will be given on: ensuring SBAs at birth; newborn care; CDC and NCD control; adolescent care; health for the tribal population; mental and disability healthcare; climate change and health protection; health regulation: geriatric healthcare; urban healthcare; health research; etc.

Focus will be given to accelerate initiatives in low-performing and hard-to-reach areas as well as to address child marriage, adolescent pregnancies, obstetric fistula, unsafe abortions and a rise in reproductive health cancers/cervical and breast cancers among women and adolescent girls, etc. The existing family planning program will be strengthened through delivering regional packages in less well performing divisions/pockets. Shifting of existing method-mix of contraceptive use to emphasize long acting and permanent methods (LAPM) will continue to be promoted through informed voluntary choice and counseling. Other FP approaches will be targeting newly-wed couples, particularly adolescents to delay the first birth; addressing the existing unmet need and reducing the discontinuation through improving collaboration with DGHS.

The nutrition program will continue to be mainstreamed within the DGHS and DGFP service provision. Regular nutritional services will be provided for strengthening the IYCF program, distribution of iron-folic acid supplementation among pregnant and lactating women and adolescent girls, continuation of existing half-yearly Vitamin A capsules distribution program, scaling up postpartum Vitamin A distribution to improve vitamin A status of neonates through breast milk, monitoring of universal iodization of edible salt, promotion of zinc for treatment of diarrhea, etc. The 4th HPNSP will also strengthen inter- and intra- ministerial coordination; collaboration with the Ministry of Local Government, Rural Development and Cooperatives, and the Ministry of Food to address nutrition and food safety issues within urban contexts.

The 4th HPNSP will continue to strengthen the HNP system that may require reorganizing various systems and institutions based on needs of the day. Moreover, the regulatory functions and stewardship role of the MOHFW including the agencies under it will be strengthened.

Strategies

The 4th HPNSP will continue to (a) expand HNP services and (b) improve health systems for program implementation and oversight. However it is unique in terms of its focus on (a) strengthening MOHFW's stewardship and regulatory roles in the HNP sector; (b) emphasizing service quality both in public and private sectors for achieving equitable healthcare increasingly; and (c) strengthening systems/ institutions for efficient program delivery.

The challenge for the sector is to prevent ill health and provide better services for all within a constrained resource environment. The Government allocations to health remain low in terms of regional comparisons while performance is high. The MOHFW will concentrate on demonstrating improved performance across the sector and building the investment case for health funding as a foundation for future growth and national prosperity.

Achieving sustainable levels of financing for the sector will depend on a combination of managing demand for health care through prevention and effective treatment, seeking efficiency gains based on reducing wastage and introducing better systems for providing care, and through advocacy with the Government and the development partners for increased financial and technical support. Thus, the 4th HPNSP will be translated into actions through implementation of the following strategies:

(i) Building capacities in leadership, management and regulation with stronger governance and stewardship role of the MOHFW for better quality services;

(ii) Restructuring the MOHFW, to increase performance, efficiency and accountability while removing duplication and waste;

(iii) Rolling out an upgraded Essential Services Package (ESP) with greater functional coordination of services at the field level and a functional referral system;

(iv) Developing new approaches and partnerships with the private sector and the community to ensure that basic services reach the poor, the hard-to-reach, the disabled, elderly and those left behind;

(vi) Focusing improvement in quality of care, including ensuring the implementation of a comprehensive health workforce strategy and action plan;

(vii) Promoting the importance of public health and increased investment in prevention, primary care and strengthening community engagement;

(viii) Tackling the rising burden of NCDs through cross-sectoral interventions on public health awareness and to establish healthy lifestyles and healthy environment;

(ix) Tackling the burden of established and new communicable diseases;

(x) Adopting new technologies to strengthen surveillance, data quality and information systems for evidence based decision making; and

(xi) Increasing investment in health, ensuring a focus on managing demand, increasing efficiency and creating strong case for health funding.

IV. New Elements or Issues That Would Add More Value to the Program

The 4th HPNSP is characterized by restructured OPs, implementation mechanisms and program contents, activities or focus in OPs. The Program has elements that are different and/or add value to the third Sector Program-HPNSDP, particularly in reproductive, maternal, newborn, child & adolescent health; nutrition & food safety; and non-communicable diseases. The objectives of the new elements/focus are to address the unfinished agenda of HPNSDP; challenges posed by demographic and/or epidemiological changes taking place; changing national economy, society and citizen's aspirations; and the Sustainable Development Goals (SDGs) related to health and well-being. Some notable new focuses are stated below:

(i) ***Governance, Stewardship and Institutional Development (GSID):*** *This is an increasingly* critical area for urgent intervention, especially in view of fast expanding and unregulated private sector investment in different branches of the HNP sector in Bangladesh e.g. in laboratory/clinical service provision, medical education including for doctors, nurses, midwives, paramedics and different categories of technicians etc. and the production/supply of pharmaceuticals including those of alternative medicine.

(ii) ***Essential Service Package (ESP):*** The new focus will be to restore centrality to ESP in PHC service delivery with a view to emphasize on equity, gender sensitivity and efficiency in resource use. This is planned to be achieved through greater coordination among service providers in health & family planning, co-operation and alignment with the NGOs and other private sector HNP service providers at the District level and below.

(iii) ***Mainstreamed Nutrition:*** Nutrition services and awareness building activities will be expanded, using MOHFW service facilities and through co-operation with NGO stakeholders. This will require recognizing nutrition related services provided by a host of sources like multilateral interventions in water and sanitation, food safety and security, education, welfare and social safety net programs, salt iodization and food fortification, etc.

(iv) ***NCDs*****:** Links need to be established with existing service providers in the private sector (esp. the not-for-profit organizations). Some non-government actors are playing a recognized and important role for a number of NCDs like the Bangladesh Diabetic Association, Heart Foundation for hypertension, Cancer Institute/Ahsanulla Cancer Hospital for cancer, Blind Welfare Society, etc. All these organizations receive substantial funds from both MOHFW and MOSW.

(v) ***Urban Health***: The 4th HPNSP focuses on reducing the burden of cost of service available to urban dwellers and to expand their access to essential services through additional interventions by MOHFW.

(vi) ***Autism, Mental and geriatric healthcare**: Given the size of mental health problems and autism spectrum disorders, it will be necessary during the 4th HPNSP to strengthen the public health services for counseling and treatment. Partnership with the media and NGOs will be augmented to raise public awareness about appropriate attitudes toward mental and autistic patients.*

Evolving socio-economic changes and demographic transition are resulting in rapidly rising number of older population in the country; people over sixty years are expected to grow to 14.4% in 2021. This requires expensive and long-term specialist management for which the country's health system is ill-prepared. During the 4th HPNSP the existing institutional arrangements for health service delivery will be reoriented and incremental investment will be made in developing an appropriate geriatric – friendly healthcare service system.

(vii) ***Community Clinic***: Further consolidation of community-supported PHC service delivery as per updated ESP with special emphasis on under-served clientele including those in hard-to-reach areas will be provided by the community clinics.

(viii) ***Field-level supervision***: Strengthening of field-level supervision of service delivery at district level and below and reporting has been given importance. This will be made effective through (a) development of supervision guideline (Inspection Manual), training of the supervisors and supervised – with special focus on financial integrity; (b) improvement of reporting practice – issuance of guidelines, establishment of reporting chain and providing training; and (c) sensitizing managers and service providers about the legal requirements of Right to Information Act, etc.

(ix) ***Facility management***: Importance is given to improved facility management using best practices-e.g. Jhenidah/Chaugacha practices and the Narshingdi model for involving community and local government. Special focus is put on asset management; waste management; revisiting complaint handling system; and establishing complaint management to improve two-way communication between service receivers and providers.

Results Framework for the 4th HPNSP (2017-2022)

RESULT	INDICATOR[7]	MEANS OF VERIFICATION & TIMING	BASELINE & SOURCE	TARGET 2022
Goal: *All citizens of Bangladesh enjoy health and well-being.*	GI 1. Under 5 Mortality Rate (U5MR)	BDHS, every 3 years	46, BDHS 2014	34
	GI 2. Neonatal Mortality Rate (NMR)	BDHS, every 3 years	28, BDHS 2014	18
	GI 3. Maternal Mortality Ratio (MMR)	BMMS/MPDR/ MMEIG[8], every year	176, WHO 2015[9]	121
	GI 4. Total Fertility Rate (TFR)	BDHS, every 3 years	2.3, BDHS 2014	2.0
	GI 5. Prevalence of stunting among under-five children	BDHS, every 3 years/UESD, every non-DHS years	36.1%, BDHS 2014	25%
	GI 6. Prevalence[10] of hypertension among adult population	BDHS, every 3 years/NCD-RF, every 2 years	Female 32%, Male 19%, BDHS 2011	Female 32%, Male 19%
	GI 7. % of public facilities with key service readiness[11] as per approved Essential Service Package (ESP)	BHFS, every 2 years	FP: 38.2; ANC 7.8%; CH 6.7%, BHFS 2014	FP: 70%; ANC 50%; CH 50%
	GI 8. % of total health expenditure (THE) financed from public sector[12]	BNHA, every 3 years	23.1%, BNHA 2012	26.2%

Program Objective:
To have focused improvements in increasing access to quality health care and improving equity along with efficiency by gradually achieving UHC

[7] Indicators in general would be stratified (where applicable) by age, gender, geographic area and wealth quintiles
[8] MMEIG: Maternal Mortality Estimation Inter-agency Group, created by WHO, UNICEF, UNFPA, UN Population Division and The World Bank
[9] http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/
[10] Estimated as elevated blood pressure among women and men aged 35 years or older
[11] Defined as facilities (excl. CCs) having a) for FP: guidelines, trained staff, BP machine, OCP and condom; b) for ANC: guidelines, trained staff, BP machine, hemoglobin and urine protein testing capacity, Fe/folic acid tablets; c) for CH: IMCI guideline and trained staff, child scale, thermometer, growth chart, ORS, zinc, Amoxicillin, Paracetamol, Anthelmintics
[12] Government schemes and compulsory health care financing schemes

Results Framework for the 4th HPNSP (2017-2022)				
RESULT	INDICATOR[7]	MEANS OF VERIFICATION & TIMING	BASELINE & SOURCE	TARGET 2022
Component 1: MOHFW's governance and stewardship roles strengthened				
Result 1.1 Legal and operational framework on governance and stewardship in place	1.1.1 Governance and Stewardship Action Plan implemented in line with milestones	Admin records/APIR, every year	GSAP developed and approved, Planning Wing 2016	GSAP implemented
Result 1.2 Overall sector governance improved	1.2.1 Number of public and non-public facilities accredited	Admin records/ APIR, every year	Process initiated, Planning Wing 2016	a) Accreditation mechanism established; b) 22 MCH, 59 DH and 50 non-public hospitals accredited
	1.2.2 % of DPs submitting annual performance reports on off-budget activities	Admin records/ APIR, every year	54%, MPIR 2014	100%
	1.2.3 Incremental budget for MOHFW ensured	APIR/MOF's Budget Book, every year	14.0% increase of MOHFW Budget in FY '15-16, MOF	Annual increment of MOHFW budget >15%
Component 2: Health systems strengthened to increase performance and efficiency				
Result 2.1 Quality workforce made available in health sector	2.1.1 % of service provider positions functionally vacant in district and upazila-level public facilities, by category (physician, nurse/midwife)	BHFS, every 2 years	Physician: 37.8%, Nurse/MW: 19.3%, BHFS 2014	Physician: 19%, Nurse/midwife: 10%
Result 2.2 Core systems (FM, infrastructure, procurement) strengthened	2.2.1 Increase in the number of Operational Plans (OPs) with annual budget execution over 80%	ADP/APIR, every year	13, APIR 2015	19
	2.2.3 Procurement lead time reduced for the packages tracked through SCMP	Admin records/ SCMP, every year	57.3 weeks, SCMP 2014-15	40 weeks

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Results Framework for the 4th HPNSP (2017-2022)				
RESULT	**INDICATOR**[7]	**MEANS OF VERIFICA-TION & TIMING**	**BASELINE & SOURCE**	**TARGET 2022**
Result 2.3 Strengthened Performance monitoring to promote evi-dence-based decision making	2.3.1 Number of performance monitoring reports prepared and disseminated annually	Reports/APIR, every year	3 (HB, APIR, SmPR), APIR 2015	08 (APIR, SmPR, MISs, NIPORT, DGDA, DGNM, HEU[13])
	2.3.2 Number of UHFWCs under e-MIS scale up	Admin records, every year	30 2016 (E-MIS/ DGFP)	1,500
	2.3.3 Number of districts implementing comprehensive maternal perinatal and newborn death review	Admin records/ APIR, every year	10, CIPRB/ DGHS 2014[14]	64
Component 3: Quality basic services reach the disadvantaged population to progress towards UHC				
Result 3.1 Public health services strengthened to promote healthy behavior	3.1.1 % of newborn received essential newborn care (ENC)	BDHS, every 3 years/UESD, every non-DHS years	6.1% BDHS 2014	25%
	3.1.2 % of infants age 6-23 month are fed with minimum acceptable diet	BDHS, every 3 years/UESD, every non-DHS years	22.8%, BDHS 2014	45%
	3.1.3 % of women age 15-19 who have begun childbearing	BDHS, every 3 years/UESD, every non-DHS years	30.8%, BDHS 2014	25%
	3.1.4 % of population of age 25 years or above use tobacco	BDHS, every 3 years; NCD-RF, every 2 years/ GATS, every 3 years	51%, NCD-RF 2011[15]	45%

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[13] For HEU, the report will be Public Expenditure Review (PER)
[14] http://www.ciprb.org/wp-content/uploads/2015/01/MPDR-Fact-Sheet.pdf
[15] Repeat Global Adult Tobacco Survey (GATS) is scheduled to take place in 2016

Results Framework for the 4th HPNSP (2017-2022)				
RESULT	**INDICATOR**[7]	**MEANS OF VERIFICATION & TIMING**	**BASELINE & SOURCE**	**TARGET 2022**
Result 3.2 Equitable coverage of ESP ensured	3.2.1 Contraceptive Prevalence Rate (CPR)	BDHS, every 3 years/UESD, every non-DHS years	62.4%, BDHS 2014	75%
	3.2.2 CPR (modern methods) in lagging regions	BDHS, every 3 years/UESD, every non-DHS years	Syl: 40.9%, Ctg: 47.2%, BDHS 2014	60%
	3.2.3 Antenatal care coverage (at least 4 visits)	BDHS, every 3 years/UESD, every non-DHS years	31.2%, BDHS 2014	50%
	3.2.4 % of delivery by skilled birth attendant (SBA)	BDHS, every 3 years/UESD, every non-DHS years	42.1%, BDHS 2014	65%
	3.2.5 % mothers with non-institutional deliveries receiving postnatal care from a medically trained provider within 2 days of delivery	BDHS, every 3 years/UESD, every non-DHS years	5.4%, BDHS 2014	10%
	3.2.6 Ratio of births in health facilities of the richest wealth quintile to the poorest quintile (Q1:Q5)	BDHS, every 3 years/UESD, every non-DHS years	14.9% : 70.2% = 1 :4.7, BDHS 2014	1 : 3.5
	3.2.7 % of public health facilities/public service delivery points without stock-outs of essential medicines/FP supplies	Essential medicines, BHFS, every 2 years; FP supplies, E-LMIS/DGFP, every year	Drugs[16]: 66%, BHFS 2014; FP methods[17]: >98%, E-LMIS/ DGFP	Drugs: 75%, FP methods: >98%
	3.2.8 Tuberculosis case detection rate	NTP MIS, every year	53%, GTBR[18] 2014	75%
	3.2.9 Measles-Rubella (MR) immunization coverage among children under 12 months	CES, every year	86.6%, CES 2014	90%
Result 3.3 Quality of care improved	3.3.1 % of public health facilities with at least one staff trained in IMPAC (integrated management of child birth and pregnancy)in the last 24 months	BHFS, every 2 years	9.9%[19], BHFS 2014	50%
	3.3.2 % of public facilities implement and monitor quality improvement activities[20]	Admin records/ APIR, every year	2 (1 MCH, 1 DH), APIR 2015	100% MCHs & DHs, 70% UHCs

[16]Defined as availability of at least six of eight essential medicines of a DDS kit: amoxicillin tablet/capsule, amoxicillin syrup, cotrimoxazole, paracetamol tablet, paracetamol syrup, tetracycline eye ointment, iron tablet, and vitamin A capsule.
[17]Service delivery points include family planning field workers
[18]Global Tuberculosis Report 2014 by the World Health Organization (WHO)
[19] Staff in facilities up to union-level trained in integrated management of pregnancy and child birth (IMPAC) during the last 24 months
[20] QA activity to be specified by HEU/HSM; check baseline with HEU

Operational Plans and Implementing Agencies

Sl. #	Operational Plans (OPs)	Implementing Agency
Component 1 – Strengthening Governance and Stewardship		
1	Sector-Wide Program Management and Monitoring (SWPMM)	MOHFW
2	Planning, Monitoring and Research (PMR)	DGHS
3	Planning, Monitoring and Evaluation (PME)	DGFP
4	Health Economics and Financing (HEF)	HEU, HSD
5	Strengthening of Drug Administration (SDAM)	DGDA, HSD
Component 2 – Health Systems Strengthening		
6	Health Information Systems & e-Health (HIS & e-Health)	DGHS
7	Management Information System (MIS)	DGFP
8	Medical Education and Health Manpower Development (ME& HMD)	DGHS
9	Procurement, Storage and Supply Management – HS (PSSM-HS)	CMSD, DGHS
10	Procurement, Storage and Supply Management – FP (PSSM-FP)	DGFP
11	Physical Facilities Development (PFD)	MOHFW
12	Human Resource Development (HRD)	MOHFW (HRD, HSD)
13	Improving Financial Management (IFM)	HSD, MOHFW
14	Training, Research and Development-NIPORT (TRD)	NIPORT
15	Nursing and Midwifery Education and Services (NMES)	DGNM
Component 3 – Provision of Quality Health Services		
16	Maternal, Neonatal, Child and Adolescent Health (MNCAH)	DGHS
17	Maternal, Child, Reproductive and Adolescent Health (MCRAH)	DGFP
18	National Nutrition Services (NNS)	DGHS
19	Communicable Diseases Control (CDC)	DGHS
20	TB-Leprosy and AIDS/ STD Program (TB-L & ASP)	DGHS
21	Non-communicable Diseases Control (NCDC)	DGHS
22	National Eye Care (NEC)	DGHS
23	Community Based Health Care (CBHC)	DGHS
24	Hospital Services Management (HSM)	DGHS
25	Clinical Contraceptive Services Delivery Program (CCSDP)	DGFP
26	Family Planning Field Services Delivery (FPFSD)	DGFP
27	Lifestyle, and Health Education & Promotion (LHEP)	DGHS
28	Information, Education and Communication (IEC)	DGFP
29	Alternative Medical Care (AMC)	DGHS

14 Operational Plans of DGHS

SL No	Name of the OPs	Main Functions/ Objective
1	Alternative Medical Care (AMC)	To Scale up Unani, Ayurvedic & Homoeopathic Medical service throughout the country along with the Allopathic treatment to ensure quality & equitable health services for all citizen of Bangladesh and develop of Unani, Ayurvedic & Homoeopathic education system.
2	Community Based Health Care (CBHC)	To ensure healthy lives and promote well-being for all at all ages by increasing accessibility, affordability and utilization of quality Primary Health Care Services within the stipulated time.
3	Communicable Disease Control (CDC)	To bring malaria death to 5 within 2019 and to zero within 2022 and achieve elimination in phases within 2025 To prevent and control aides transmitted viral diseases including dengue, chikungunya and zika To achieve filaria free status by 2022 To reduce the prevalence of sth among <15 Children to 5% within 2022 To eliminate kata-azar by 2017 and achieve kata-azar frees Bangladesh by 2022 To eliminate rabies within 2022 To strengthen capacity for decoction, management, prevention and control of various communicable diseases. To strengthen to strengthen disease surveillance
4	Health Information System & e-Health (HIS & e-H)	To improve health information system, eHealth and medical biotechnology
5	Hospital Services Management (HSM)	To provide equitable and accessible healthcare services at district hospitals, medical college hospitals and specialized hospitals of Bangladesh.
6	Lifestyle and Health Education & Promotion (L&HEP)	To influence the healthy behavior of individuals and community, and living conditions that influence health by improving their knowledge, attitude, practices and skills by creating a ‘health literate society’.
7	Medical Education & Health Manpower Development (ME & HMD)	To strengthen medical education and health manpower development system for developing medical professionals and health workforce to deliver standard and high quality services in achieving universal health coverage.

SL No	Name of the OPs	Main Functions/ Objective
8	Maternal Neonatal Child & Adolescent Health (MNC&AH)	i. To strengthen efforts of making home deliveries safe ii. To strengthen *2417* EmONC services at the upazila level in phases iii. To establish a functional referral system from community to facility level iv. At least 95 percent fully vaccination coverage among under one year children at national level and 90 percent fully vaccination coverage at each district level; and *TTS* coverage among women of childbearing age reached at least 80 percent at national level and 75 percent at each district level v. Maintain Polio Free Certification status, achieve Measles and Rubella Elimination status and control of Congenital Rubella Syndrome (CRS) vi. Strengthen the Immunization supply chain and management system and reduce disease prevalence by introduction of new and underused vaccines vii. Increase access and utilization of Newborn and IMCI services at facilities and communities including national scale-up of evidence based priority newborn health interventions viii. Improved knowledge of Adolescents on Sexual and Reproductive Health issues ix. Improved knowledge of primary school level student on personal hygiene issues
9	Non Communicable Diseases Control (NCDC)	To reduce mortality and morbidity of NCDs in Bangladesh through control of risk factors and improving health service delivery,
10	National Eye Care (NEC)	To improve eye care service delivery at all levels of health facilities in Bangladesh
11	National Nutrition Services (NNS)	To reduce malnutrition and improve nutritional status of the people of Bangladesh with special emphasis on the children, adolescents, pregnant & lactating women, elderly, poor and underserved population of both rural and urban area in line with National Nutrition Policy 2015.
12	Planning, Monitoring and Research (PMR_DGHS)	To strengthen planning, monitoring and research activities at different levels of health services.
13	Procurement, Storage and Supplies Management of Health Services (PSSM-HS)	Enhancement of Procurement Capacity and Supplies Management for Health Services
14	Tuberculosis-Leprosy and AIDS/ STD Program (TB-L & ASP)	Reduce the incidence of TB (all forms) by 50% by 2025 and 90% by 2035 (from 2015 baseline figure) and achieving registered prevalence of leprosy to less than lease per 10,000 populations and minimize the spread of HIV and the impact of AIDS on the individual, family, community, and society, working towards Ending AIDS in Bangladesh by 2030.

7 Operational Plans of DGFP

SL No	Name of the OPs	Main Functions/ Objective
1	Planning Monitoring and Evaluation	• Strengthen domiciliary visits and center based services • Intensify Satellite clinic service • Recruitment of volunteers to increase service coverage at HtR • FP package programs in selected urban slum • Ensure quality clinical contraception services including Post-Partum Family Planning (PPFP) PAC & Post MR FP Services. • Strengthen comprehensive and basic EmONC services • Improve quality ANC, PNC services • Provide 24/7 delivery services at facility level • Ensure adolescent health care services • Implementation of comprehensive New born care packages • Regional service package • Re-vitalization of Model FP clinic at Medical College Hospital. • LARC & PM client fair activities in hard to reach and low performing areas. • Create demand for FP-MNCH information and services through massive SBCC activities using different innovative channels • Observance World Population Day and different special service week • Introduce e-FWA register, e-facility register • Implement e-procurement and on line procurement tracking system • Scale up e-FWA register & e-monitoring to Strengthening field level activities. • monitoring and performance review • Partnership with GO-NGO and private sector collaboration • Co-ordination between DGHS & DGFP. • Co-ordination with different partners for Public Private Partnership (PPT.). • All services implemented according to ESP.
2	Management Information System	
3	Procurement, Storage and Supply Management-FP	
4	Maternal, Child, Reproductive and Adolescent Health	
5	Clinical Contraception Services Delivery Program	
6	Family planning Field Services Delivery	
7	Information, Education and Communication	

Universal Health Coverage (UHC)

What is Universal Health Coverage?

Universal coverage ensures that all people can use quality health services without financial hardship (WHO, Fact file: 10 facts on universal health coverage, 2012). Universal Health Coverage (UHC) aims to ensure everyone receives the quality services they need, and is protected from health threats, without suffering financial hardship. It's a way of reducing poverty and increasing health security, so that no-one is left behind.

Why does Bangladesh need Universal health Coverage?

Paying for health is one of the main reasons why people fall into poverty in Bangladesh. In addition, many people, especially the poor, are afraid of the high costs which health care incurs and do not seek medical attention at all. In Bangladesh, less than 1% of the population has a health coverage scheme which protects them against catastrophic health expenditures.

In Bangladesh, approximately 3.8% of the total population, or 6 million people, are pushed into poverty because of out-of-pocket payments for health services every year (BD Health Watch 2011).

Bangladesh needs Universal Health Coverage because it has a direct impact on a population's health. Besides this, Universal Health Coverage contributes to people being more productive and active contributors to their families and communities. It also ensures that children can go to school and learn.

Universal Health Coverage could transform the lives of millions people by bridging life savings health care to those who need it most.

What is the Health Care Financing Strategy (HCFS) 2012-2032?

The Health Care Financing strategy of the Ministry of Health and Family Welfare is the foundation on which Universal Health Coverage will be established in Bangladesh.

The ultimate aim of the Health Care Financing Strategy is to achieve Universal Health Coverage by 2032 and ensure access to affordable, equitable and quality health services for the people of Bangladesh.

The Health Care Financing Strategy provides a framework for developing and advancing health financing in Bangladesh. The framework and its direction are aimed at:

- Increasing the level of funding for health
- Ensuring an equitable distribution of the health financing burden
- Improving access to essential health services
- Reducing the incidence of impoverishment due to catastrophic health care expenditure and Improving quality and efficiency of service delivery

What is needed to achieve Universal Health Coverage?

The six elements which are needed to achieve Universal Health Coverage are:

- Strong political leadership and long term commitment \
- Involvement from multiple stakeholders to support Health Care Financing Strategy and Universal Health Coverage implementation
- Broader technical discussion on design issues with key stakeholders and joint development of a roadmap on Universal Health Coverage implementation

- Development and strengtheningof institutions which perform the functions of stewardship, oversight and governance with respect to Universal Health Coverage.
- Initial coverage and future up scaling criterion
- Finalization of regulatory, legal and institutional framework
- Development and implementation of Monitoring and Evaluation framework

References

- *Program Implementation Plan (PIP), 4th Health, Population and Nutrition Sector Program, MOHFW*
- *Health Bulletin 2017, MIS, DGHS*
- *http://www.undp.org/content/undp/en/home/sustainable-development-goals.html*
- *Operational Plans of MOHFW*
- www.icddrb.org/research/research.../universal-health-coverage

Session -6: Essential Service Package

Session objectives

At the end of the session the participants will be able to

- Describe the overview of ESP

Time: 45 minutes

Participant's note

- In this session participants will participate in discussion on ESP

DAY-2

Handout

Bangladesh Essential Service Package

Bangladesh Essential Service Package (ESP)

According to the WHO, an Essential Health Package (ESP) consists of a limited list of public health and clinical services which will be provided at the primary and/or secondary care level. ESP is a tool to define, in practical terms, access to Universal Health Coverage (UHC) by selecting the services that should be made available to the whole population as a guaranteed minimum, thus enhancing equity. The ESP represents the Government of Bangladesh's commitment to Universal Health Coverage by ensuring people's right to health in accessing the most essential health services.

The Ministry of Health and Family Welfare (MOHFW) intends to use the ESP for three complementary purposes:

- Associated with Universal Health Coverage initiatives, the ESP represents the Government of Bangladesh (GoB) commitment to ensure the right to health and that the whole population has access to the most essential health services.
- The ESP will become the basis to define the set of standards by type of health facility. A minimum set of services is defined as a requirement for a public facility to be considered within a level. While all required services are part of the ESP, some may be qualified as "extra" for that level.
- The package, common to the whole territory, is to be used for resource allocation, in a way that promotes equity and increases efficiency.

Composition of ESP

ESP has been structured in five core services complemented by one another andincluding some common conditions and three support services. The ESP is to be provided at nine main delivery sites, from Community to District Hospitals, including urban facilities. Social and Behavioral Change Communication (SBCC) activities are integrated in each of the services.

Five Core Services	
1.	**Maternal, neonatal, child and adolescent health care**
	▪ Maternal and Newborn Care o Maternal care: pre-conception, antenatal, delivery, postnatal o Newborn care: during delivery, after delivery o Obstetric and neonatal care
	▪ Child Health and Immunization o Integrated Management of Child Illnesses (IMCI) o Expanded Program of Immunization (EPI)
	▪ Adolescent Health o Adolescent Sexual and Reproductive Health o Adolescent Nutrition o Adolescent Mental Health o Risk taking behavior
2.	**Family Planning**
	▪ Pre-Conception ▪ Post-partum ▪ Post-abortion ▪ Post-MR
3.	**Nutrition**
	▪ Child Nutrition: assessment of nutrition status, prevention of malnutrition, management of malnutrition ▪ Maternal Nutrition ▪ Adolescent Nutrition
4.	**Communicable Diseases**

	▪ Tuberculosis ▪ Malaria ▪ HIV/AIDS ▪ Neglected Tropical Diseases: Kala-Azar, Lymphatic Filariasis, Leprosy, Dengue, Rabies, Intestinal Parasites ▪ Other Communicable Diseases
5.	**Non-Communicable Diseases (NCD)**
	▪ Hypertension ▪ Diabetes Mellitus ▪ NCD screening and management based on total risk assessment ▪ Cancer: breast, cervical ▪ Other NCDs: Arsenicosis, Chronic Obstructive Pulmonary Disease (COPD) ▪ Mental Health ▪ Sexual and Gender- Based Violence (SGBV)
One Complementary service	
Management of other common conditions	
	▪ Eye care ▪ Ear care ▪ Dental care ▪ Skin care ▪ Emergency care ▪ Geriatric care
Three support (non-clinical) services	
	1. Laboratory
	2. Radiology and other image tools
	3. Pharmacy

Minimum Standards and Extra Services by facility level

CC	UHFWC	UHC	MCWC	DH
		General Surgery Obstetric Fistula		Trauma Care Ophthalm. Surgery General Surgery Obstetric Fistula
		CEmONC		CEmONC
	BEmONC	Severe cases BEmONC		Severe cases BEmONC
	Pre-term NB Newborn Sepsis	Pre-term NB Newborn Sepsis	CEmONC	Pre-term NB Newborn Sepsis
Normal Newborn N.V. Deliveries	NCD management Normal Newborn N.V. Deliveries	NCD management Normal Newborn N.V. Deliveries	BEmONC Pre-term NB Newborn Sepsis	NCD management Normal Newborn N.V. Deliveries
NCD Screening SBCC EPI/IMCI FP Short Acting Growth Monitoring ANC/PNC Lim. curative care	NCD Screening SBCC EPI/IMCI FP Short Acting GM, SAM mngmt ANC/PNC Lim. curative care	NCD Screening SBCC EPI/IMCI FP Short Acting GM, SAM mngmt ANC/PNC Lim. curative care	Normal Newborn N.V. Deliveries SBCC EPI/IMCI GM, SAM mngmt FP all methods ANC/ PNC	NCD Screening SBCC EPI/IMCI FP Short Acting GM, SAM mngmt ANC/PNC Limited curative care

(shaded)	Minimum standard by facility levels
(blank)	Extra services

Facilities and Service Delivery Sites

There **are six sites** *where the ESP is provided by MOHFW teams:*

1. **Domicile:** HA/FWA and other community-based health workers conduct home visits, mainly with the purpose of identifying people in need of health care (e.g. children who should be immunized) and conducting BCC sessions including the Birth and Newborn Care Preparedness Plan. Home visits may also be used to deliver some of

the ESP services, such as Post-Natal Care or Family Planning. Community-based workers do not usually carry medicines, so home visits are not a site for curative activities. CSBA can attend normal deliveries at home, if no risk sign has been identified and the woman does not want to or cannot go to a facility with delivery services.

2. **Satellite Clinics or Outreach Sites** are non-health facilities, rather well-identified sites (e.g. school premises) where mobile teams deliver specific services at regular intervals. The most common services are Immunization and Family Planning, but other possibilities include Ante and Post Natal care, and even curative care for common conditions.

3. **Community Clinics (CC).** This is the most-basic facility of the public health system. It should provide curative care on a daily basis (by CHCP) within the limits set by the contents of the Essential Drugs Kit, but including IMCI, and mother-and-child services (ANC, PNC, ENC, FP, Growth Monitoring) according to the schedule of its assisting community workers (HA/FWA). CCs usually act as EPI outreach sites for routine immunizations. The CC should also ensure screening and risk assessment for NCD conditions, whose diagnoses and management plans are established at higher levels. Where at least one of the workers has been capacitated as a Community Skilled Birth Attendant (CSBA), the CC can attend deliveries on the premises; however, it is not expected to provide this service round-the-clock and the number of cases attended should be limited. Social and Behavioral Change Communication (SBCC) activities are also part of the CC profile.

4. **Union-level facilities.** There are two main types of facilities – Union Sub-Centres or Rural Dispensaries (USC/RD) and Union Health and Family Welfare Centres (UHFWC) — which should converge functionally into one – the UHFWC — providing a wide array of preventive and curative services and characterized by the presence of a Medical Officer or at least Family Welfare Visitors (FWV) and a Sub-Assistant Community Medical Officer (SACMO), both with clinical skills well above those of the staff working at CCs. The UHFWC should provide the complete set of curative and preventive services on ambulatory regime for cases that do not require investigations and do not show signs of emergency or severity. Some facilities may attend normal deliveries, although not on a permanent basis. Although CCs may refer patients to these facilities because of the presence of more skilled clinicians and a wider range of medicines, this is not a referral facility at present.

5. **Upazila Health Complex (UHC).** This is the first-level referral facility, and together with lower level facilities, is equivalent to an operational health district. It is characterized by the availability of physicians (occasionally specialists), diagnostic tools (basic lab and simple radiology), inpatient care and emergency surgery, including obstetric interventions. The UHC also may act as storage for medicines to be supplied to lower level facilities, as well as hosts a cold chain for vaccine storage. It is the only facility providing round-the-clock maternity and emergency care services, and also the only setting delivering daily immunization sessions.

6. **District Hospital (DH).** These facilities provide specialized secondary care, acting as referral facilities at the UHC level. In some areas, DHs have the double function of UHCs for the nearest population and referral hospital for other UHCs within the district. Only those services common with UHC – most notably CEmONC — are included in the ESP for this level of care.

7. **Maternal and Child Welfare Centres (MCWC)** may be integrated in the overall UHC or alongside DH, or provide services as a self-standing facility. The range of services includes complete Maternal, Neonatal, Child and Adolescent health to the level of CEmONC, and complete Family Planning services. Where these facilities are not present, UHC and DH assume the provision of the mentioned services.

8. **Comprehensive Reproductive Health Care Centre (CRHCC).** Usually managed by NGOs and providing services in urban areas, the CRHCC is the referral facility for the local system, offering a wide range of preventive and curative services, including maternity care. Since access to referral hospitals is better in urban areas, CRHCC are not required to deal with emergencies and serious cases.

9. **Primary Health Care Centres (PHCC).** These urban facilities provide basic maternal, neonatal, child, adolescent and family planning care – excluding maternity services — as well as outdoors curative care.

10 **Other facilities:** Higher-level and specialized public hospitals, as well as NGO facilities providing some of the ESP components, are to be similarly integrated. To that end, the ESP-related services they provide should adopt the same standards as that of the facilities described in more detail.

References

- *Bangladesh essential health service package (ESP), MOHFW*

Session -7: Management Concepts

Session objectives

At the end of the session the participants will be able to

- Explain the concept of Management
- Describe management function
- Identify managerial roles

Time: 1 hour 30 minutes

Participant's note

- In this session Participants will participate in a discussion
- They will analyze a case study and identify management functions
- Participants will divide into three groups and participate in a role play as per the given scenario

Case Study of Management Functions

In an upazila, recent MNCH data shows that performance is going downwards in comparison to the previous years. The Upazila Health & Family Planning Officer (UH&FPO), as Upazila manager and responsible for the health service activities in the respective area, had become worried about the declining performance. He couldn't find out at first what went wrongs in recent months. He then analyzed the previous and current performance of the upazila and decided to act.

To boost the performance and morale of the department, he came up with a vigorous program. In the monthly staff meeting, he shared the program idea with his fellow medical officers. They also supported the idea and within the next week, UH&FPO called a managerial level meeting including all MOs and HIs. He also invited UFPO to the meeting. In the meeting, a presentation was shown based on latest MNCH data to illustrate the performance of the upazila. Based on the evidence, the forum decided to set a goal for the current year to increase MNCH performance. To achieve the goal, besides regular health and family planning activities, a number of additional related activities were taken by the forum. Also, they set a timeline for achieving targets and making strategic decisions on how to achieve the target.

In the next week, both the managers shared the new program goal and activities in the respective staff meeting with the health and family planning department. In the staff meeting, field level activities were reviewed and the staff were given specific tasks to carry out the activities. The additional activities to boost up the performance were also delegated to the responsible staff. Coordination among the team and also with other departments were identified and responsibility for coordination was assigned to respective persons.

In a few months, the situation was starting to turn over. However, in few areas, performance was still not up to the mark even after feedback given during the monthly meeting. The UH&FPO and UFPO decided to go for a joint visit to low-performance areas on a weekly basis. During the field visit, they provided supervision support to the field staff. They also conducted a coordination meeting with local government representatives and other community support groups. They interacted with service receivers (pregnant women and lactating mothers) by visiting both facilities and home. These visits lifted the moral of the staff. In a few weeks, low-performance areas started to show improvement. The health and family planning departments established both internal and external coordination mechanisms at the field level to carry out the activities. They also coordinated with the local government institutes, community support systems and development organizations to achieve the target. The UH&FPO and UFPO both called for data unification at the filed level and ensured both departments had an accord presentation MNCH data. The managers also set performance standards for the staff and reviewed the progress in the monthly meetings. If deviation in performance became evident, the respective persons was asked to provide a statement on the low performance and the measures taken to boost the performance. Based on the statement, the managers decided the actions to be taken and sometimes became strict by sending notice to show-cause on low performance even after providing continuous support.

At the end of that year, the results were positive. All the indicators of MNCH had experienced astonishing improvement. The Upazila received the best upazila award at both district and national level from Ministry and respective departments. Once again, it became evident that team effort and proactive leadership can provide ample support to reach targets.

Now please share your opinion on the following statements-

1. By reading the story, what you think about the core problem was?
2. Can you identify the management functions here? If so, what functions did happen here?
3. As a manager, in the same situation what would be your course of actions? Please describe in key bullet points.

Role Play Scenario 1: Interpersonal Role

Scenario -1: A new Upazila Manager is appointed in an Upazila who is very sincere, punctual and honest. He works hard and wants his team should work accordingly. But his colleagues are becoming annoying on him. He doesn't give space to his colleagues. He needs only output. (Please play the role)

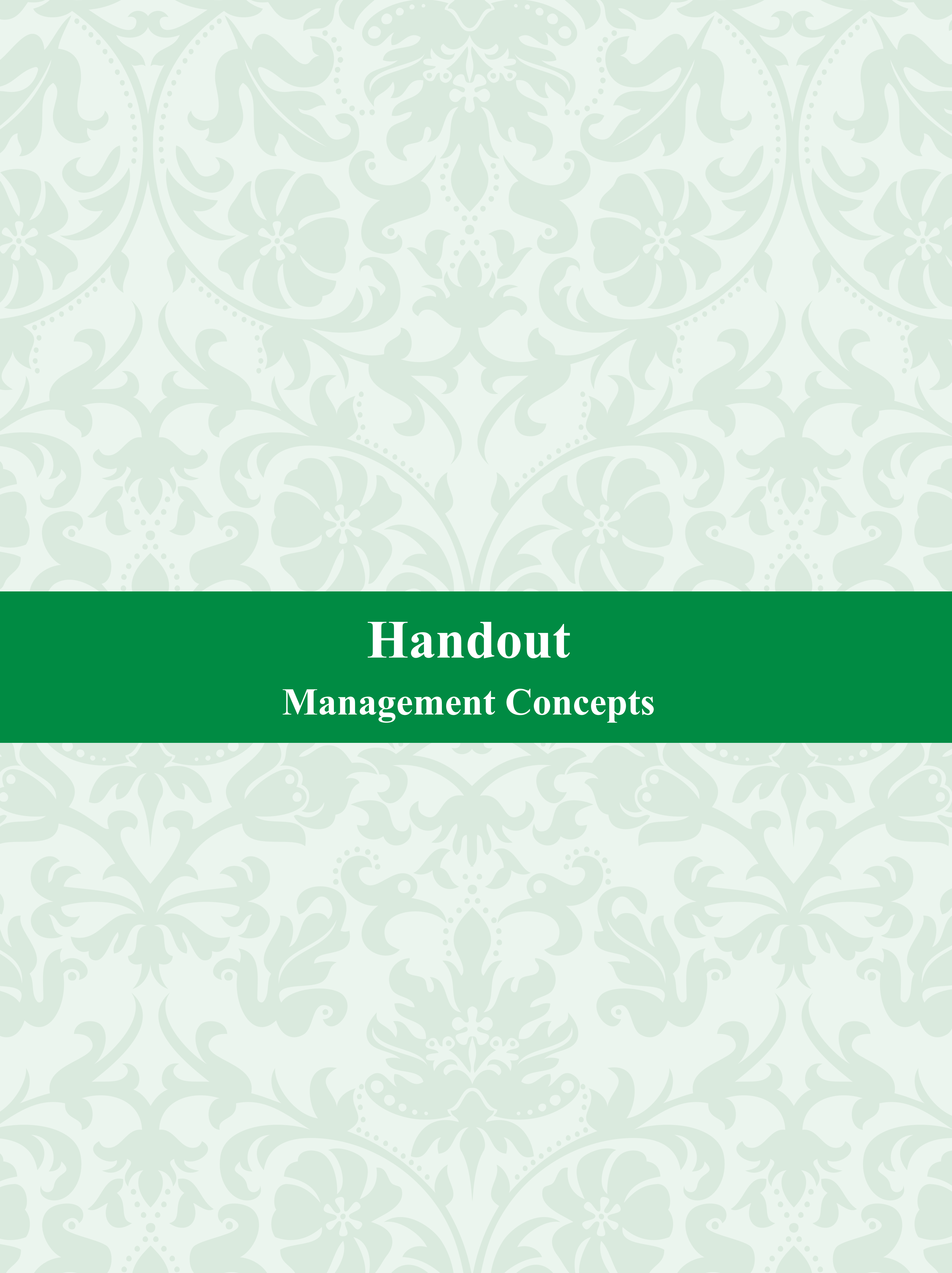
Scenario -2: A new Upazila Manager is appointed in an Upazila who is very sincere, punctual, honest and likable personality. He works hard and wants his team should work accordingly. He takes family news of his colleagues, drink tea with them. Do light humor. His colleagues are pleased with his personality and works with sincerity. His output is moving forward without any hassle. (Please play the role)

Role Play Scenario 2: Informational Role

Dr. Asad is the UHFPO of an Upazila. There is a new program Kagaroo Mother Care (KMC) needs to be launched in his Upazila. Please show the Informational Role as an Upazila Health and Family Planning Manager.

Role Play Scenario 3: Decisional Role

Mr. Baten is the UFPO of an Upazila. There is a new program (Long Acting Reversible Contraceptive (LARC)) that needs to be emphasized in his Upazila. Please show the decisional role as an Upazila Family Planning Manager.



Handout

Management Concepts

Management Concepts

Concept of Management:

Management is as old as human civilization. In ancient times, Roman and Babylonian rulers introduced group efforts management to accomplish their large projects (construction of pyramids and excavations of cannel). Gradually, the influence of science and technology forced managers to introduce team work to promote a work friendly environment. Good work relations among top managers, middle managers and other professionals helped produce effective outputs and outcomes. To facilitate program performance, program managers plan and organize human and other relevant resources and control machines and activities to give necessary direction to supervisors and their subordinates. There are many definitions of management. As defined by professor Weihrich and Koontz (2006, p. 27-29) management is "a process of designing and maintaining an environment in which individuals, working together in group, efficiently accomplish selected aims."

The managers of this century work in a complex environment. They need to acquire knowledge on globalization, information technology, economic, social, ethical, ecological, political, and legal issues. For speedy implementation of programs in developing countries, managers adapt a list of suitable principles. These principles include staffing, division of labor, convergence of work, substitution of resources, and so on. Results have shown that these common principles enhance program performances.

Management

The term "management" refers to the process of completing activities efficiently and effectively with and through other people. The process represents the function or primary activities of planning, organizing, leading, and controlling.

Management Functions:

Management means getting people to work harmoniously and to make efficient use of resources to achieve objectives (McMahon et al., 1992). Successful management depends mainly on the management practices applying appropriate approaches and principles and taking care of management functions including the style of supervision and staff motivation.

Planning involves setting a vision, mission goals and specific objectives for future action and output and outcome of a program. In this stage, alternative future course options are necessary to frame so that the best alternative may be chosen. A real program plan can exist with strong political decision-making, commitment of human resources and proper allocation of essential materials. Before launching a program, the planners need to analyze the existing situation and previous related plan documents. In short, planning involves setting goals and objectives and then scheduling the tasks and allocating the resources, both human and material program(McMahon et al, 1992).

Organizing function includes all managerial activities that translate required planned activities into a structure of tasks and authority (Gibson et al., 1994). In a program, people work together to achieve the goals of the program. To perform work, people have certain roles and responsibilities. For smooth implementation, the top executives should create a favorable environment for human resources management. Program management experts pointed out two functions, which are: a) designing the responsibility and authority of each individual job; and b) determining which of these jobs will be grouped in specific departments (Gibson et al., 1994).

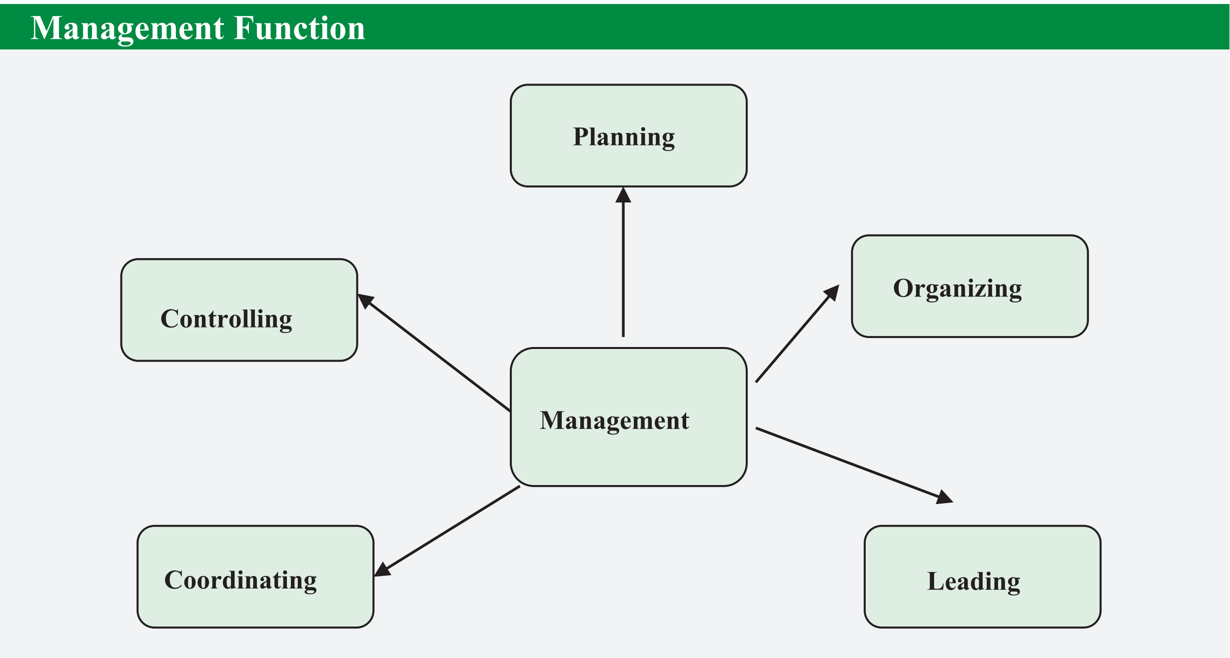
Leading involves assigning responsibilities, as well as motivating and supervising subordinates through resource mobilization, conflict resolution, the encouragement of innovation, and the establishment of networks outside the organization to expedite actions towards desired ends (Middleton and Quash, 1979).

Coordinating is one of the most important functions of management. It is essential to coordinate the activities of various individuals in the organization to achieve common goals. Coordination includes:

- Creating a team spirit
- Achieving goals through collective efforts
- Providing unity of action in the pursuit of common objectives.

Controlling involves monitoring and evaluation to evaluate whether performances are satisfactory when measured against an agreed plan and whether the desired goal is achieved as stipulated in the plan. Controlling also involves setting up criteria for work standards, and allocating organizational means so that desired behaviors are rewarded and undesired ones are sanctioned (Simmons, 1987). The senior executives should be prepared to make necessary

corrections if deviation occurs during the implementation process. Two important elements of successful management are supervision and staff motivation.



Effectiveness is concerned with completion of activities, which is referred to as goal attainment.

Efficiency is concerned with minimizing resources in the completion of those activities.

Management in Health Services

Management in health services is distinctly different from other fields of management. In managing health services, health managers should keep in mind the following points:

- The nature and process of health service delivery is different from other fields of management
- The demand in health services is different and is called "derived demand"
- Many health services are "tailor made"
- Health services are strictly legalized
- Many health services are based on referral system

Min.zberg's Managerial Roles

Category	Role	Nature of Role
Interpersonal Roles	1. Figurehead	As a symbol of legal authority. Performing certain ceremonial duties (e.g. signing documents and receiving visitors)
	2. Leader	Motivating subordinates to get the job done properly
	3. Liaison	Serving as a link in a horizontal (as well as vertical) chain of communication
Informational Roles	4. Nerve center	Serving as a focal point for non routine information; receiving all types of information
	5. Disseminator	Transmitting selected information to subordinates
	6. Spokesperson	Transmitting selected information to outsiders
Decisional Roles	7. Entrepreneur	Designing and initiating changes within the organization
	8. Disturbance	Taking corrective action in handler non routine situations
	9. Resource allocator	Deciding exactly who should get what resources
	10. Negotiator	Participating in negotiating sessions with other partiers (e.g. vendors and unions) to make sure the organization's interests are adequately represented

Source: Adapted from Henry Minzberg. Managerial Work: Analysis from Observation management Science, 18 (October 1971): B97 – B 110

Interpersonal roles:

These roles derive from formal authority and status which helps managers maintain their organizations by providing them with a unique position in the organization from which they can become the possessors of information. The three interpersonal roles are:

The Figurehead – constitutes the manager's symbolic role. As the formal head of a division or department managers, from time to time, the manager is required to perform certain ceremonial duties such as attending meetings, signing documents and greeting visitors. This fulfils the social necessity for a person in charge to be present and visible.

The Leader – Leadership permeates almost all of the managers' activities since it involves directing subordinates towards goal accomplishment. This involves selecting, training, motivating, and encouraging subordinates.

The Liaison – A manager's interaction with peers and other people external to the managers' work unit or organization involves the use of formal and informal communication networks. Liaison is a horizontal activity which provides managers with opportunities to gain the contacts, favors and information necessary for maintaining a link between the organization and the environment.

Informational roles

The manager's involvement with a number of interactions gives rise to the information flow in the organization, which inevitably makes the manager a focal point for information change. Thus, it is not surprising to see that receiving and communicating information, whether for communication or decision making purposes, becomes the most important aspect of a manager's job. The informational roles which managers play to fulfill their duties are:

- Monitor
- Disseminator
- Spokesperson

Decisional Role:

Decisional roles entail making decision or choices. The four decisional roles are:

- Entrepreneur
- Disturbance Handler
- Resource Allocator
- Negotiator

The Resource Allocator – An important role for a manager is allocating resources in the organization. By using their authority, managers have to meet the responsibility of allocating money, materials, manpower, and their own time to oversee competing demands. This process is central to the decision making system and comprises three essential elements: scheduling time, programming work and authorizing decisions to be made by others. The manager maintains control by authorizing decisions before they are put into effect.

The Negotiator – A manager's position of authority, their credibility and their access to information make them ideal candidates for the role of negotiator. These negotiations may take place internally, externally or both. In the role of negotiator, managers use their authority to formally make organizational commitments and ratify their final agreements.

Management Skills

There are three types of management skills:

- Technical skills
- Human skills
- Conceptual skills

1. Technical skills: Technical skills are the job specific knowledge and techniques needed to proficiently perform work tasks. These skills tend to be more important for first line managers because these employees typically manage lower-level employees who use tools and techniques to produce the organizational products or to serve the organizational customers.

2. Human skills: Human skills involve the ability to work well with other people. Because all managers deal with people, these skills are equally important for all levels of management. Managers who possess human skills get the best out of their people.

3. Conceptual skills: Conceptual skills are the skills managers use to think and conceptualize about abstract and complex situations. Using these skills, managers see the organization as a whole, understand the relationship among various subunits, and visualize how the organization fits into its broader environment. These skills are more important for top managers.

References

- *MANAGEMENT by Stephen P Robbins and Mary Coulter*
- *Module on Program Management Training, NIPORT*

Session -8: Introduction to Leadership

Session objectives

At the end of the session the participants will be able to:

- Describe the concept of Leadership and its importance in the health sector
- Identify the qualities of a leader through case study analyses
- Identify the qualities of a leader through a video
- Complete the leadership self-assessment

Time: 1 hour 30 minutes

Participant's note

- In this session participate will participate in a discussion
- Will analyze two case studies and identify leadership roles
- They will observe a video clip
- Participants will identify their Leadership skills by a Self-Assessment checklist

Case Sutdy-1:

Dr. Subimol Chanda inspiring change in Baniachong Upazila's healthcare provision

When he joined as the Medical Officer- MCH-FP at Baniachong Upazila in Habiganj district, Subimol Chanda realized he had a lot of work to do. He started by visiting the field, specifically the UH&FWCs, to figure out the reasons behind low demand for healthcare services. He consulted the front line service providers, field workers and community members to understand the barriers and how he could address the challenges.

An action plan was developed for Baniachong Upazila as part of the district planning exercise. Chanda closely followed up on the plan. He saw to it that the Family Welfare Visitors of different union facilities who were largely inactive became serious about their job. Thanks to his intervention, Subidpur and Northeast Baniachong UH&FWC started to draw more patients looking for ANC, PNC, family planning and delivery services.

He also managed to secure help from Union Parishad to renovate the Southeast Baniachong UH&FWC so it could offer 24/7 delivery service. He also received monetary assistance to bear the cost of operating a water ambulance and those of salary night guards and aya employed at three facilities. He then shuffled the location of five satellite clinics to maximize the client's accessibility and ensured pregnant women's lists were regularly updated.

Dr. Subimol participated in a joint Supervisory Visit and had Muradpur UH&FWC open its doors to clients again. In less than a year, he has displayed his commitment to the cause of public health and capacity to deliver on his promise to improve Baniachong Upazila's healthcare scenario.

Collected From: Mamoni Health Systems Strengthening Project, Newsletter, issue 10, July-September, 2017

Case Sutdy-2:

Dr. Salah Uddin Ahmed, Upazila Health & Family Planning Officer, Potya Upazila, Chittagong

Dr. Salah Uddin Ahmed was the Upazila Health & Family Planning Officer of Potya Upazila in Chittagong District during the 1990s. Burly and relatively young, always with a smile on his face, Dr. Salah Uddin had an unassuming appearance but possessed a natural leadership ability. The resources available to him were what the other UHFPOs received throughout the country. The human and material resources at his disposal were not any different from other UHFPOs and yet his Upazila Health Complex (UHC) was the cleanest among all the UHCs. The corridors of the hospital outside, the upholsteries on the inside, the linens, the mattresses, and the toilets were all clean and fresh. I never found any patient uncared for or neglected. Its cleanliness was comparable to any western hospital that we see in movies.

During one of the visits, I asked puzzled, “Salahuddin how do you keep your health complex so clean, without any complaints from your administration and without any absenteeism? How come running water never ceases in the indoor toilets and how do you keep the outdoor toilets in usable condition, while most of the outdoor toilets are kept under lock and key in other health complexes since these are very difficult to keep clean and odorless? I even find that you have a sufficient supply of Lysol. All rooms have curtains and nobody is soiling or spitting in the corridor or on the walls. He smiled and said, “Sir, these are your blessings.”

I told him, “No Salahuddin, I really want to learn, so that I can tell other colleagues of yours to follow your management approach.”

His reply was simple: “I rely on the public, to be more specific, on their informal and formal elected leaders”.

“That is very fine, but what in operational terms do you get from them?”

Salahuddin said, “My shortfalls in resources are covered by the Upazila Porishod. Since I belong to a place close to this upazila, it is not difficult to motivate them in their dialect. It is also easy to motivate the users of the Health Complex. My message is simple and direct. I tell them that this is your home, albeit temporary, your home nevertheless, so it is your responsibility to keep it comfortable, soothing and appealing.”

Dr. Salahuddin also never failed in ensuring electricity in his health complex, thanks to the support of the Upazila Porishod, which in those days used to allocate 4500 Tk on a monthly basis for running the hospital generator alone.

Callected from: SCMTP Facilitators Manual, Shared by Dr. Zakir Hossain

Handout

Leadership

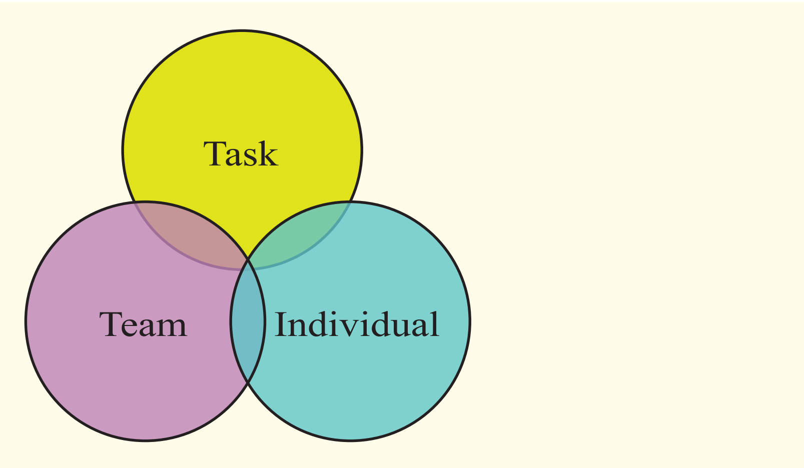
Leadership

Definition:

A simple definition of leadership is that leadership is the art of motivating a group of people to act towards achieving a common goal.

Professor **John Eric Adair** (born 18 May 1934) is a British academic who is a leadership theorist and author of more than forty books (translated into eighteen languages) on business, military and other leadership strategies.

Functional Leadership Model



Functional Leadership Theory (Hackman & Walton, 1986; McGrath, 1962) is a particularly useful theory for addressing specific behaviors of leaders expected to contribute to organizational or unit effectiveness. This theory argues that the leader's main job is to see that whatever is necessary to group needs is taken care of; thus, a leader can be said to have done their job well when they have contributed to group effectiveness and cohesion.

Functional theories of leadership are developed by studying successful leaders and identifying the actions and behaviors they show. Large studies with sufficient data make it possible to correlate what leaders actually do, i.e. their actions or functions and their successful results.

In the Functional Leadership Model, leadership does not rest with one person but rests on a set of behaviors by the group that accomplishes tasks. Any member of the group can perform these behaviors, so any member can participate in leadership. The Functional Theory of Leadership places greater emphasis on how an organization or task is being led rather than who has been formally assigned a leadership role.

One of the best known and most influential of Functional Theories of Leadership, used in many leadership development programs, is John Adair's "Action-Centered Leadership."

John Adair developed a model of Action-Centered Leadership that has connecting circles that overlap because:

- the task can only be performed by the team and not by one person;
- the team can only achieve excellent task performance if all the individuals are fully developed; and
- the individuals need the task to be challenged and motivated.

Adair's model challenged Trait Theory by focusing on what leaders do. He showed that leadership could be taught and did not depend on the traits a person had.

Importance of Leadership

Leadership is an important function of management because it helps to maximize efficiency and achieve organizational goals. The following points justify the importance of leadership:

1. **Initiates action-** A leader is a person who starts the work by communicating the policies and plans to the subordinates from where the work actually starts.
2. **Motivation-** A leader proves to be playing an incentive role. A leader motivates the employees with

economic and non-economic rewards and thereby receives the work from the subordinates.

3. **Providing guidance-** A leader has to not only supervise but also play a guiding role for the subordinates. Guidance here means instructing the subordinates in the way they are expected to perform their work effectively and efficiently.

4. **Creating confidence-** Confidence is an important factor that can be achieved through expressing the work efforts to the subordinates. It is important to explain work efforts clearly, to define subordinate's roles and to provide them with guidelines to achieve the goals effectively. It is also important to hear the employees with regards to their complaints and problems.

5. **Building morale-** Morale denotes willing cooperation of the employees towards their work by inspiring confidence and gaining trust. A leader can be a morale booster by achieving full cooperation so that employees perform to the best of their abilities as they work to achieve goals.

6. **Building a work environment-** An efficient work environment helps to achieve sound and stable growth. Therefore, human relations should be kept in mind by a leader. A leader should have personal contacts with employees and should listen to their problems and solve them. A leader should also treat employees on humanitarian terms.

7. **Coordination-** Coordination can be achieved through reconciling personal interests with organizational goals. This synchronization can be achieved through proper and effective coordination.

Types of Leaders

Leaders can be categorized into the following four types:

1. Thought Leaders
2. Courageous Leaders
3. Inspirational Leaders
4. Servant Leaders

There are few leaders who have strongly demonstrated each type of leadership category. However, many leaders are a combination of two or more leadership types. For example, Martin Luther King, Jr., is an example of an inspirational leader and a courageous leader.

1. Thought Leaders

Thought leaders harness the power of ideas to actualize change. They stretch their followers by helping them see new possibilities. Oliver Wendell Holmes said, "The human mind once stretched to a new idea never goes back to its original dimension."

Sometimes a new idea can bring about a paradigm shift, which may provide a new lens for viewing or a radically different context for understanding. At other times, the new idea leads to only incremental change. But all change, whether large or small, starts with a new idea.

For centuries, thought leaders have competed in the marketplace of ideas using books, papers, and oral presentations. They still do, but today they also use the Internet, social media, and other technological advances to disseminate their ideas more rapidly and broadly. E-books, blogs, e-zines, teleseminars, and Webinars have made thought leadership instantaneously available to ordinary citizens.

Examples of thought leaders:

- **Steve Jobs** was the co-founder, chairman, and CEO of Apple Inc., where he oversaw the development of the iMac, iTunes, iPod, iPhone, iPad, and numerous other innovations. He has been referred to as the "Father of the Digital Revolution," a "master of innovation," and a "master evangelist of the digital age."

2. Courageous Leaders

Courageous leaders bravely pursue a vision in the face of considerable opposition and risks. They have strong convictions about their mission (purpose), vision (long-term goals), and values (right and wrong). They speak up for their core beliefs and fight for their values, even when their stance is unpopular.

Rudy Giuliani, the former mayor of New York City, said, “There are many qualities that make a great leader. But having strong beliefs, being able to stick with them through popular and unpopular times, is the most important characteristics of a great leader.”

In addition, they seek the truth and speak the truth.

Examples of courageous leaders:

- **Abraham Lincoln**, the 16th president of the United States, served during one of the most difficult and dangerous period of the America’s history. Even though his life was constantly in danger and his policies were unpopular with many, he steadfastly held to his convictions and governed with strength, fairness, and dignity. On January 1, 1863, he courageously issued his memorable Emancipation Proclamation, which declared the freedom of slaves within the Confederacy.

3. Inspirational Leaders

Inspirational leaders promote change by the power of their passionate commitment to ideas and ideals. They lift our eyes from present practicalities to future possibilities. Their words stir up our spirits, strengthen our convictions, and move us to action. We are eager to follow them because they call forth the best that is in us.

Inspirational leaders have positive attitudes that create strong emotional connections with people. Their speech is enlivened with words such as justice, freedom, honor, respect, pride, and love. Their affirming and encouraging demeanor builds the confidence of their followers and elicits their wholehearted devotion. Their can-do attitude keeps hope alive during difficult times.

Inspirational leaders create a sense of urgency by explaining why it’s important to take action sooner rather than later. In addition, they describe actionable steps people should take.

Examples of inspirational leaders:

- **Martin Luther King, Jr.,** was an American clergyman, activist, and leader in the African-American Civil Rights Movement. He is best known for his belief in nonviolent civil disobedience. His words and actions have inspired many people to speak up and stand up for what’s right.

4. Servant Leaders

Servant leaders care deeply about people. They seek to remove the barriers and obstacles that hold others back from achieving their full potential. They strive to create an environment where their followers can do their best work. Servant leaders frequently ask, “How can I help?”

Former AT&T executive Robert K. Greenleaf popularized the concept of the servant leader in “The Servant as Leader,” an essay first published in 1970. Kent Keith, CEO of the Greenleaf Center for Servant Leadership, states, “I think the simplest way to explain it would be to say that servant leaders focus on identifying and meeting the needs of others rather than trying to acquire power, wealth, and fame for themselves.”

Examples of servant leaders include:

- Mother Teresa founded the Missionaries of Charity, a Roman Catholic religious congregation, in Calcutta, India. Today, the ministry has more than 4,500 sisters ministering in 133 countries. Members vow to give “wholehearted and free service to the poorest of the poor.”
- **Oprah Winfrey** is the chairman of Harpo Inc. Her focus is helping others succeed. Many of her TV programs and outreach initiatives are aimed at removing obstacles, so people can achieve their potential. Her goal is to empower people to achieve their dreams.

Different Leadership Styles

The is document covers 12 different types of ways people tend to lead organizations or other people. Not all of these styles would deem fit for all kind of situations. Read them through to see which one fits right to your or situation.

1. Autocratic Leadership

The autocratic leadership style is centered on the boss. In this type of leadership, the leader holds all authority and responsibility and leaders make decisions on their own without consulting subordinates. They reach decisions,

communicate them to subordinates and expect prompt implementation. An autocratic work environment normally has little or no flexibility.

In this kind of leadership, guidelines, procedures and policies are all natural additions of an autocratic leader. Statistically, there are very few situations that can actually support autocratic leadership.

Some of the leaders that support this kind of leadership include: Albert J Dunlap (Sunbeam Corporation) and Donald Trump (Trump Organization) among others.

2. Democratic Leadership

In this leadership style, subordinates are involved in making decisions. Unlike the autocratic style, this type of leadership is centered on subordinates' contributions. The democratic leader holds final responsibility, but he or she is known to delegate authority to other people, who determine work projects.

The most unique feature of this leadership is that communication is active both upward and downward. With respect to statistics, democratic leadership is one of the most preferred leadership styles, and it entails the following: fairness, competence, creativity, courage, intelligence, and honesty.

3. Strategic Leadership Style

Strategic leadership is one that involves a leader who is the head of an organization. The strategic leader is not limited to those at the top of the organization. It is geared to a wider audience at all levels who want to create a high performance life, team or organization.

The strategic leader fills the gap between the need for new possibilities and the need for practicality by providing a prescriptive set of habits. An effective strategic leadership delivers the goods in terms of what an organization naturally expects from its leadership in times of change. 55% of this leadership normally involves strategic thinking.

4. Transformational Leadership

Unlike other leadership styles, transformational leadership is all about initiating change in organizations, groups, oneself, and others.

Transformational leaders motivate others to do more than they originally intended and often even more than they thought possible. They set challenging expectations and typically achieve higher performance.

Statistically, transformational leadership tends to have more committed and satisfied followers. This is mainly the case because transformational leaders empower followers.

5. Team Leadership

Team leadership involves the creation of a vivid picture of the organization's future, where it is heading and what it will stand for. The vision inspires and provides a strong sense of purpose and direction.

Team leadership is about working with the hearts and minds of all those involved. It also recognizes that teamwork may not always involve trusting and cooperative relationships. The most challenging aspect of this leadership style is whether or not it will succeed. According to Harvard Business Review, team leadership may fail because of poor leadership qualities.

6. Cross-Cultural Leadership

This form of leadership normally exists where there are various cultures in one society. This leadership has also industrialized as a way to recognize front runners who work in the contemporary globalized market.

Organizations, particularly international ones, require leaders who can effectively adjust their leadership style in different environments. Most of the leadership in the United States is cross-cultural because of the different cultures that live and work there.

7. Facilitative Leadership

Facilitative leadership is too dependent on measurements and outcomes- it is not a skill, although it takes much skill to master. The effectiveness of a group is directly related to the efficiency of its process. If the group is high or very high functioning, the leader uses a light hand on the process.

On the other hand, if the group is low functioning, the facilitative leader will be more directive in helping the group run

its process. An effective facilitative leadership involves monitoring of group dynamics, offering process suggestions and interventions to help the group stay on track.

8. Laissez-faire Leadership

Laissez-faire Leadership gives authority to employees. Departments or subordinates are allowed to work as they choose with minimal or no interference. According to research, this kind of leadership has been consistently found to be the least satisfying and least effective management style.

9. Transactional Leadership

This is the leadership style that maintains or continues the status quo. It is also the type of leadership that involves an exchange process, whereby followers get immediate, tangible rewards for carrying out the leader's orders. Transactional leadership can sound rather basic, with its focus on exchange.

10. Coaching leadership

Coaching leadership involves teaching and supervising followers. A coaching leader is highly operational in settings where results or performance requires improvement. In this kind of leadership, followers are helped to improve their skills. Coaching leadership includes the following: motivates, inspires and encourages followers.

11. Charismatic Leadership

In this type of leadership, the charismatic leader manifests his or her revolutionary power. Charisma does not mean sheer behavioral change, but it actually involves transforming followers' values and beliefs.

Therefore, this distinguishes a charismatic leader from a simply populist leader who may affect attitude toward specific objects, but who is not prepared as the charismatic leader is to transform the underlying normative orientation to structure specific attitudes.

12. Visionary Leadership

This form of leadership involves leaders who recognize that the methods, steps and processes of leadership are all obtained with and through people. Most great and successful leaders possess the aspects of this leadership style.

However, those leaders that are highly visionary are the ones considered to be exhibiting visionary leadership. Outstanding leaders will always transform their visions into realities.

The Top 7 Leadership Qualities & Attributes of Great Leaders

Vision

Great leaders have a vision… They can see into the future.

They have a clear, exciting idea of where they are going and what they are trying to accomplish and are excellent at strategic planning.

This quality separates them from managers. Having a clear vision turns the individual into a special type of person. This quality of vision changes a *"transactional manager"* into a *"transformational leader."*

While a manager gets the job done, great leaders tap into the emotions of their employees.

Courage

One of the more important qualities of a good leader is courage. Having the quality of courage means that you are willing to take risks in the achievement of your goals with no assurance of success. Because there is no certainty in life or business, every commitment you make and every action you take entails a risk of some kind.

Among the seven leadership qualities, courage is the most identifiable outward trait.

Integrity

In every strategic planning session that I have conducted for large and small corporations, the first value that all the gathered executives agree upon for their company is integrity. They all agree on the importance of complete honesty in everything they do, both internally and externally.

The core of integrity is truthfulness.

Integrity requires that you always tell the truth, to all people, in every situation. Truthfulness is the foundation quality of the trust that is necessary for the success of any business.

Humility

Great leaders are those who are strong and decisive but also humble.

Humility doesn't mean that you're weak or unsure of yourself. It means that you have the self-confidence and self-awareness to recognize the value of others without feeling threatened.

This is one of the rarer attributes – or traits – of good leaders because it requires containment of one's ego.

It means that you are willing to admit you could be wrong, that you recognize you may not have all the answers. And it means that you give credit where credit is due – which many people struggle to do.

Strategic Planning

Great leaders are outstanding at strategic planning. It's another one of the more important leadership strengths. They have the ability to look ahead, to anticipate with some accuracy where the industry and the markets are going.

Leaders have the ability to anticipate trends, well in advance of their competitors. They continually ask, *"Based on what is happening today, where is the market going? Where is it likely to be in three months, six months, one year, and two years?"* They do this through thoughtful strategic planning.

Because of increasing competitiveness, only the leaders and organizations that can accurately anticipate future markets can possibly survive. Only leaders with foresight can gain the *"first mover advantage."*

Focus

Leaders always focus on the needs of the company and the situation. Leaders focus on results, on what must be achieved by themselves, by others, and by the company. Great leaders focus on strengths, in them and in others.

They focus on the strengths of the organization, on the things that the company does best in satisfying demanding customers in a competitive marketplace.

Your ability as a leader to call the shots and make sure that everyone is focused and concentrated on the most valuable use of their time is essential to the excellent performance of the enterprise.

Cooperation

Your ability to get everyone working and pulling together is essential to your success. Leadership is the ability to get people to work for you because they want to.

The 80/20 rule applies here:

Twenty percent of your people contribute 80 percent of your results.

Your ability to select these people and then to work well with them on a daily basis is essential to the smooth functioning of the organization.

Gain the cooperation of others by making a commitment to get along well with each key person every single day. You always have a choice when it comes to a task: You can do it yourself, or you can get someone else to do it for you. Which is it going to be?

Management Vs Leadership

Leadership is a broader concept than management. Management is thought of as a special kind of leadership in which the accomplishment of organizational goals is paramount. Any time you are engaging in leadership; therefore, it is obvious that all your leadership behavior is not directed towards accomplishing organizational goals. When you are trying to get some friends to go somewhere with you, you are not engaging in management, but you certainly are attempting leadership. If they agree to go, you are an effective leader but not an effective manager.

Manager Vs Leader

Manager	Leader
The manager maintains	The leader develops
The manager focuses on systems and structure	The leader focuses on people
The manager relies on control	The leader inspires trust
The manager has a short-range view	The leader has a long-range perspective
The manager asks how and when	The leader asks what and why
The manager has his or her eye always on the bottom line	The leader's eye is on the horizon
The manager imitates	The leader originates
The manager is the classic good soldier	The leader is his or her own person
The manager does things right	The leader does the right thing

Leadership Self-Assessment

This self-assessment tool aims to help the participants managing their own learning and development by allowing them to reflect on which areas of the leadership framework they would like to develop further.

Instructions:

1. On the scale next to each statement, choose a rating that reflects how frequently it applies to you
2. Total your score for each domain, reflect upon your answers, then submit paper to the facilitator

	Often	Sometimes	Rarely
1. DEMONSTRATING PERSONAL QUALITIES			
Developing Self Awareness			
I reflect on how my own values and principles influence my behavior and impact on others	O	O	O
I seek feedback from others on my strengths and limitations and modify my behavior accordingly	O	O	O
Managing Yourself			
I remain calm and focused under pressure	O	O	O
I plan my workload and deliver on my commitments to consistently high standards demonstrating flexibility to service requirements	O	O	O
Continuing Personal Development			
I actively seek opportunities to learn and develop	O	O	O
I apply my learning to practical work	O	O	O
Acting with Integrity			
I act in an open, honest, and inclusive manner – respecting other people's culture, beliefs, and abilities	O	O	O
I speak out when I see that ethics or values are being compromised	O	O	O
TOTAL			

2. WORKING WITH OTHERS			
Developing Networks			
I identify opportunities where working collaboratively with others will bring added value to patient care	O	O	O
I share information and resources across networks	O	O	O
Building and Maintaining Relationships			
I communicate clearly and effectively with others	O	O	O
I listen to and take into account the needs and feelings of others	O	O	O
Encouraging Contribution			
I actively seek contributions and views from others	O	O	O

I am comfortable managing conflicts of interests or differences of opinion	O	O	O
Working within Teams			
I put myself forward to lead teams, whilst always ensuring I involve the right people at the right time	O	O	O
I acknowledge and appreciate the efforts of others within the team and respect the team's decision	O	O	O
TOTAL			

3. MANAGING SERVICES			
Planning			
I use feedback from patients, service users, and colleagues when developing plans	O	O	O
I assess the available options in terms of benefits and risks	O	O	O
Managing Resources			
I deliver safe and effective services within the allocated resource	O	O	O
I take action when resources are not being used efficiently & effectively	O	O	O
Managing People			
I support team members in developing their roles and responsibilities	O	O	O
I provide others with clear purpose and direction	O	O	O
Managing Performance			
I analyze information from a range of sources about performance	O	O	O
I take action to improve performance	O	O	O
TOTAL			

	Often	Sometimes	Rarely
4. IMPROVING SERVICES			
Ensuring Patient Safety			
I take action when I notice shortfalls in patient safety	O	O	O
I review practice to improve patient safety and minimize risk	O	O	O
Critically Evaluating			
I use feedback from patients, carers and service users to contribute to improvements in service delivery	O	O	O
I work with others to constructively evaluate our services	O	O	O
Encouraging improvement and innovation			
I put forward ideas to improve the quality of services	O	O	O
I encourage debate about new ideas with a wide range of people	O	O	O
Facilitating Transformation			
I articulate the need for change and its impact on people and services	O	O	O
I focus myself and motivate others to ensure change happens	O	O	O
TOTAL			

5. SETTING DIRECTION			
Identifying the Contexts for Change			
I identify the drivers of change (e.g. political, social, technical, economic, organizational, profession environment)	O	O	O
I anticipate future challenges that will create the need for change and communicate these to others	O	O	O

Applying Knowledge and Evidence			
I use data and information to suggest improvements to services	O	O	O
I influence others to use knowledge and evidence to achieve best practice	O	O	O
Making Decisions			
I consult with key people and groups when making decisions taking into account the values and priorities of the service	O	O	O
I actively engage in formal and informal decision-making processes about the future of services	O	O	O
Evaluating Impact			
I take responsibility for embedding new approaches into working practices	O	O	O
I evaluate the impact of changes on patients and service delivery	O	O	O
TOTAL			

	Often	Sometimes	Rarely
6. CREATING THE VISION			
Developing the Vision for the Organization			
I actively engage with others (including patients and public) to determine the direction of the organization	O	O	O
I take into account the full range of factors that will impact upon the future of health and care services	O	O	O
Influencing the Vision of the Wider Healthcare System			
I look for opportunities to engage in debate about the future of healthcare	O	O	O
I influence key decision makers who determine future government policy that impacts health system and its services	O	O	O
Communicating the Vision			
I communicate the vision with enthusiasm and clarity	O	O	O
I take time to build critical support for the vision	O	O	O
Embodying the Vision			
I show confidence, commitment and passion for the vision in my day to day actions	O	O	O
I challenge behaviors, symbols & rituals which are not consistent with the vision	O	O	O
TOTAL			

Total your scores and reflect on what you have given yourself. If you have mainly "Sometimes" and 'Rarely" circles in any particular domain, these domains may be areas you wish to develop further. If you have " Often" circles then check that these are not overplayed strengths. An overplayed strength could be a behaviour you over rely on and one which might impact negatively on your performance.

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Session -9: Supportive Supervision

Session objectives

At the end of the session the participants will be able to

- Explain supervision and supportive supervision
- Identify guiding principles for supervisors
- Describe core Competencies of a Supervisor

Time: 1 hour

Participant's note

- In this session participants will participate in discussion on supportive supervision

Handout

Supportive Supervision

Concepts of Supervision

Supervision is the process of directing and supporting staff so they may effectively perform their duties. (Ref.: *Stinson, W., et al. 1998, Quality supervision. QA Brief 7(1):4–6. Bethesda, MD: Quality Assurance Project.)*

Supportive supervision is a facilitative approach to **supervision** that promotes mentorship, joint problem-solving and communication between supervisors and supervisees. In recent years, **supportive supervision** has been implemented to improve routine program monitoring and evaluation (M&E).

By definition, supportive supervision is a process that promotes quality at all levels of the health system by strengthening relationships within the system, focusing on the identification and resolution of problems, optimizing the allocation of resources, promoting high standards, teamwork and better two-way communication (Marquez and Kean 2002). The MOHSW of Tanzania supportive supervision guidelines similarly describe supportive supervision as a "process which promotes quality outcomes by strengthening communication, identifying and solving problem, facilitating team work, and providing leadership and support to empower health providers to monitor and improve their own performance." Supportive supervision involves directing and supporting health care workers in order to enhance their skills, knowledge and abilities with the goal of improving health outcomes for the patients they manage. It is an ongoing relationship between health care workers and their supervisors.

Some of the benefits of supportive supervision as described include: helping service providers to achieve work objectives by improving their performance, ensuring uniformity to set standards, identifying problems and solving them in a timely manner, making a follow-up on decisions reached during previous supervision visit, identifying staff needs and providing opportunities for personal development and reinforcing administrative and technical link between higher and lower level.

Traditional Supervision vs. Supportive Supervision

Although the traditional approach to doing supervisory visits is effective to some extent, it also has several shortcomings. For example, the supervisors leaned more towards facility inspection rather than guidance for problem-solving to improve performance. Supportive supervision promotes sustainable and efficient program management through interactive communication, as well as performance planning and monitoring.

Traditional Supervisor	Supportive Supervisor
Administrative related	**Provider's skill related**
• Usually no checklist is used • Problems identified, but no plan for immediate solution • No planned follow up visit to resolve problems identified earlier. • Usually service providers are informed of expected task standard • Little/no emphasis on service provider's motivation • No/little emphasis on improvement of work environment.	• Checklist is a must and used • Problems identified and planned for solution. • Planned follow up visit to resolve problems detected earlier • Regularly informed of task standard • Strong emphasis on service providers' motivation. • Strong emphasis on improvement of work environment

DAY-2

Guiding principles for supervisors

- Work as a team member to model facilitative supervision
- Talk with and listen to all levels of staff
- Recognize jobs well done
- Solve problems on the spot, when possible
- Provide feedback in a constructive way
- Involve staff in the decision-making process
- Never criticize staff in front of a client or other staff

Attributes of a Supervisor

A supervisor should have the following attributes:

- Familiar with health care system;
- Familiar with the program related health services to be provided at each level of health system,
- Ability to address both administrative and programmatic issues and needs
- Committed, responsible and have strong interpersonal skills;
- Ability to train, motivate and support supervisees; and
- Flexible, respectful and hardworking attitude.

Core Competencies of a Supervisor

- Analytic skills: ability to listen, probe and analyze situations, problems and formulate solutions;
- Comprehensive knowledge about health system;
- Ability to coach, train and convey information to others and learn from them;
- Sufficient knowledge about concept of quality improvement (QI) including supportive supervision and mentoring and the use of national guidelines and SOPs:
- Deep understanding of the roles and responsibilities of both supervisors and mentors and align oneself with mentors; and
- Ability to provide and receive feedbacks after each visit and write reports.

As a pneumonic, the following might be helpful:

S	Supportive attitude
U	Unique thinking
P	Patience to listening
P	Polite to others
O	Obligation to support
R	Respect to others
T	Time frame
I	Impartial attitude
V	Virtual (Effective or practical)
E	Empathy (Good relation & rapport building)
S	Strong leadership
U	Undertaking responsibilities
P	Pro-active
E	Evaluation of relationship
R	Responsive
V	Values
I	Inspiration to others
S	Sincerity
I	Innovative
O	Observation skill
N	Negotiation skills

Listening Skill

Listening is a highly valued and important skill for communication.

To be a good active listener, there are two components for success: attention and reflection.

- **Attentive listening** includes eye contact, posture, facial expressions, gestures and genuine interest in what the person is saying.
- **Reflection** includes repeating and paraphrasing what you have heard; showing the person that you truly understand what has been said.

What Makes a Good Listener?

Good listeners actively endeavor to understand what others are really trying to say, regardless of how unclear the messages might be. Listening involves not only the effort to decode verbal messages, but also to interpret nonverbal cues such as tone of voice, facial expressions, and physical posture.

Effective listeners make sure to let others know that they have been heard, and encourage them to share their thoughts and feelings fully.

One way to show your listening skills is to carefully listen to the interviewer's questions in their entirety before responding. Don't interrupt and do be sure your responses reflect what you were asked. It's fine to take a few moments to frame a response to the question. That shows that you've listened and are considering the best way to answer the question.

Feedback

Feedback is when the effect or output of an action is 'returned' (fed-back) to modify the next action. Feedback is essential to working and survival of all regulatory mechanisms found throughout living and non-living nature and in man-made system such as education systems and economy. As a two way flow, feedback is inherent to all interactions, whether human-to-human, human-to-machine or machine–to-machine. In an organizational context, feedback is the information sent to an entity (individual or a group) about its prior behavior so that the entity may adjust its current and future behavior to achieve the desired result.

3 types of Feedback

1. Positive feedback: applies to situations where a person did a good job; may consist of a simple praise, but even more powerfully reinforcing if you specifically highlight why or how that person did a good job.

2. Constructive feedback: highlights how a person can perform better next time; needs to be delivered sensitively. Focus on observable facts, not assumed traits.

3. Negative feedback: describes a perceived negative behavior, without proposing a resolution – is essentially destructive and is only used, usually by accident, to terminate relationships.

Importance of Supervision:

A. Qualitative improvement of service provider's performance by:

- Improving service providers' knowledge and skills;
- Regularly monitoring the performance of service providers; and
- Regularly supporting service providers by supervisors.

b. Service provider's work environment will be improved through:

- Ensuring required register, forms, supplies and medicines;
- Increasing regular communication and coordination between service providers and supervisors; and
- Accelerating community participation and cooperation.

c. Clients will get quality services by:

- Standard service facilities;
- Standard health care; and
- Poor women and children will have access to health care facilities.

Difference between Supervision and monitoring

Supervise implies more interaction than ***monitor***. Supervisors have the responsibility of informing and directing, while monitors observe without instructing.

A person who supervises children is expected to step in if they behave contrary to expectations; a person or machine engaged in monitoring an activity is not generally expected to deal directly with a problem, but to alert a person in charge.

The noun form for *supervise* is *supervisor*; monitor serves as noun as well as verb. A supervisor is always human; a monitor may be a human being or a machine.

Monitor comes from Latin *monere*, "to warn." It's the monitor's job to warn someone that some activity is not proceeding according to plan.

Responsibilities of a supervisor:

- To clearly inform service providers what the supervisor expects from him/her;
- To decide the target/goal of work discussing personally or collaborate with the worker;
- To make certain that the responsibilities, guidelines, standard or policy is within their knowledge.

DAY-2

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– *Strategic Leadership and Management Training Program for District and Upazila Level Health and Family Planning Managers Serving Hard to Reach Areas to Improve Maternal and Newborn Health in Bangladesh. Johns Hopkins University, Baltimore, USA*

– *Stinson, W., et al. 1998, Quality supervision. QA Brief 7(1):4–6. Bethesda, MD: Quality Assurance Project.*

– *https://www.thebalance.com/types-of-listening-skills-with-examples-2063759*

Read more: http://www.businessdictionary.com/definition/feedback.html

DAY-3

Day-3 Schedule

Time	Sessions	Topics
9.00-9.15 (15 minutes)	**Review of the previous day**	
9.15-10.15 (1 hour)	**Session-10**	**Problem solving** - Problem and Problem Solving Technique - 7 Steps of problem solving - Three key skills to use for resolving any problem
10.15-10.30 (15 min.)	**Tea Break**	
10.30-12.00 (1 hour 30 min-utes).	**Session-11**	**Concept of Community and its role in health system** - Community development and participation - Household production of health
12.00-1.30 (1hour 30 min.)	**Session-12**	**Community based structures and their roles** - Community Group and Community Support Group - UHFWC management committee - Local Govt Committees (Upazila and Union level committees) - Community Health Workers
1.30-2.30 (1 hour).	**Lunch and prayer break**	
2.30-3.30 (1 hour)	**Session-13**	**Role of Manager in engaging community** - Share success stories and best practices
3.30-3.45 (15 min.)		**Evaluation of the day**
3.45-4.00 (15 min.)	**Tea Break and end of the day**	

Session -10: Problem Solving

Session objectives

At the end of the session the participants will be able to

- Explain Problem and Problem Solving Techniques
- Describe the 7 Steps of problem solving
- Identify key skills to use for resolving any problem
- Characteristics of good problem solvers

Time: 1 hour

Participant's note

- In this session participants will participate in a discussion
- Participants will solve a programmatic problem scenario

DAY-3

Problem Scenario

A two year old child previously sick, died after taking a vitamin A capsule in a VAC supplementation program in your upazila. Naturally people became angry and they march at upazila health complex with slogans against the vitamin A supplementation program and the health administration.

- What type of problem it is?
- What steps should to be undertaken to resolve the problem?
- Which stakeholders should be involved in mitigating the problem?
- What preventive measures were required to adopt beforehand?
- What will be the future plan to prevent such problems?

Handout

Problem Solving

Problem Solving

Definition of Problem

A discrepancy between an existing and desired state of affairs.

Characteristics of Problems

- A problem becomes a problem when a manager becomes aware of it.
- There is pressure to solve the problem.
- The manager must have the authority, information, or resources needed to solve the problem.

Types of Problems

Structured Problems

- Involve goals that are clear
- Are familiar (have occurred before)
- Are easily and completely defined—information about the problem is available and complete

Unstructured Problems

- Are problems that are new or unusual and for which information is ambiguous or incomplete.
- Are problems that will require custom-made solutions

Seven Steps for Resolving Problems

STEP 1: State what *appears* to be the problem

- The real problem may not surface until facts have been gathered and analyzed.
- Therefore, start with what you assume to be the problem, that can later be confirmed or corrected (do the root cause analysis to identify the real problem)

STEP 2: Gather facts, feelings and opinions

- What happened?
- Where, when and how did it occur?
- What is it's size, scope, and severity?
- Who and what is affected?
- Likely to happen again?
- Need to be corrected?
- May need to assign priorities to critical elements.

STEP 3: Restate the problem

The real facts help make this possible, and provide supporting data. The actual problem may, or may not be the same as stated in Step 1.

STEP 4: Identify alternative solutions

- Generate ideas.
- Do not eliminate any possible solutions until several have been discussed.

STEP 5: Evaluate alternatives

- Which will provide the optimum solution?

- What are the risks?
- Are costs in keeping with the benefits?
- Will the solution create new problems?

STEP 6: Implement the decision

- Who must be involved?
- To what extent?
- How, when and where?
- Who will the decision impact?
- What might go wrong?
- How will the results be reported and verified?

STEP 7: Evaluate the results

- Test the solution against the desired results.
- Make revisions if necessary.

3 Key Skill to use for resolving any problem

KEY SKILL A: Being Open to Other Perspectives

- Remember: the same problem may not be experienced in the same way for another person
- Remaining open to the perspectives of other people involved in the same problem is a critical skill for resolving problems

KEY SKILL B: Defining the problem as a personal need and not as a solution

- People involved in the problem often think their problem in terms of their solution, which are often stated as "you should do this" or you should do that."
- Solutions direct others on what you want them to be doing and can potentially make the situtation worse
- Expressing your needs tells others what you are concerned about or what you want to accomplish for yourself

Example of Solution statement:

- Salma says to her housemates:
- "I MUST have peace and quiet! You have to turn off your music"
- Her housemates say:
- "Well, we like our music, you can go somewhere else"

Example of Need statement:

- Salma says instead:
- "I MUST need a quiet place to work because I have homework to do"
- Her housemates say:
- "We will be leaving shortly and you will be able to have peace and soon"

KEY SKILL C: Identify the helping forces & hindering forces for problem solution

This entails:

- Listening to the 'forces' helping the client move towards the desired goal

- Listening to the 'forces' hindering the client from motivating towards the goal
- In 'force-field analysis,' the problem is viewed as a balance between forces pushing in opposite directions.

Characteristics of good problem solvers

Good problem solvers are good thinkers. They use a combination of intuition and logic to come up with their solutions. Some of the general characteristics of good problem solvers are:

1. They don't need to be right all the time

2. They go beyond their own conditioning

3. They look for opportunity within the problem

4. They know the difference between complex and simple thinking

5. They have clear definition of what the problem is

6. They use the power of words to connect with people

They don't create problems for others

8. They do prevention more than intervention

9. They explore their options

10. They have reasonable expectations

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- *Module of Strategic Leadership and Management Training Program for District and Upazila Level Health and Family Planning Managers Serving Hard to Reach Area to Improve Maternal and Newborn Health in bangladesh, Johns Hopkins University, Baltimore, USA*
- *MANAGEMENT by Stephen P. Robbins and Mary Coutler*
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Read more: http://www.businessdictionary.com/definition/feedback.html

DAY-3

Session 11: Concept of Community and its Role in Health System

Session objectives

At the end of the session the participants will be able to

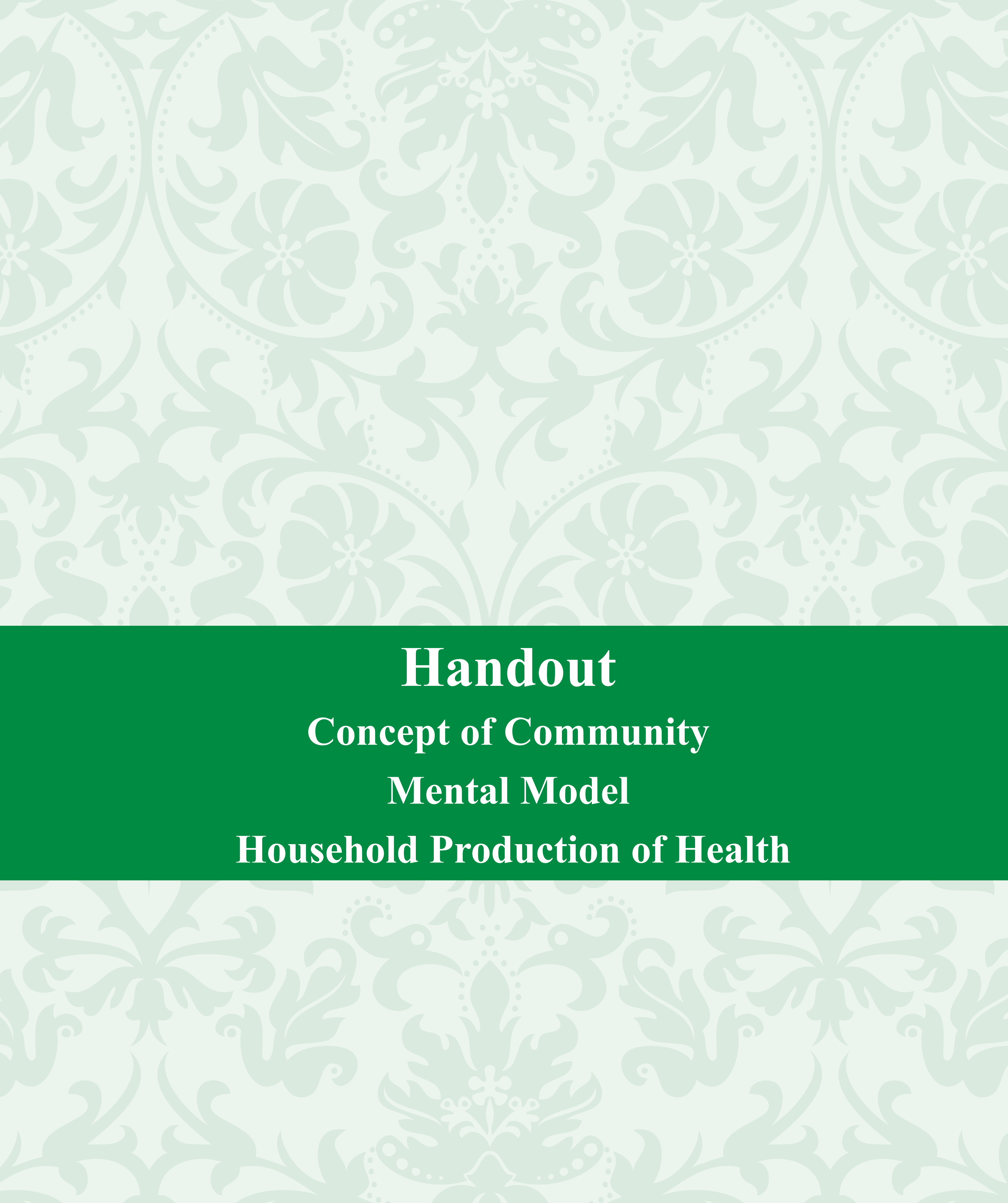
- Describe the Community, Community mobilization, Community participation, Community development
- Explain concept of household production of health

Time: 1 hour 15 minutes

Participant's note

- In this session Participants will participate in a discussion
- They will divide into four groups. Select a group leader to moderate group discussion and presentation.

DAY-3



Handout

Concept of Community

Mental Model

Household Production of Health

Community Mobilization, Community Participation, Community Development

A **community** is a small or large social unit (a group of living things) who have something in common, such as norms, religion, values, or identity. Communities often share a sense of place that is situated in a given geographical area (e.g. a country, village, town, or neighborhood) or in virtual space through communication platforms. Durable relations that extend beyond immediate genealogical ties also define a sense of community. People tend to define those social ties as important to their identity, practice, and roles in social institutions like family, home, work, government, society, or humanity, at large. Although communities are usually small relative to personal social ties (micro-level), "community" may also refer to large group affiliations (or macro-level), such as national communities, international communities, and virtual communities.

The word "community" derives from the Old French comuneté, which comes from the Latin communit as "community", "public spirit" (from Latin communis, "shared in common").

Types of Community

A number of ways to categorize types of community have been proposed. One such breakdown is as follows:

1. **Location-based Communities:** Range from the local neighborhood, suburb, village, town or city, region, nation or even the planet as a whole. These are also called communities of place.
2. **Identity-based Communities:** Range from the local clique, sub-culture, ethnic group, religious, multicultural or pluralistic civilization, or the global community cultures of today. They may be included as communities of need or identity, such as disabled persons, or frail aged people.
3. **Organizationally based Communities:** Range from communities organized informally around family or network-based guild and associations to more formal incorporated associations, political decision making structures, economic enterprises, or professional associations at a small, national or international scale.

Community mobilization

Community mobilization is an attempt to bring both human and non-human resources together to undertake developmental activities in order to achieve sustainable development.

"Community mobilization" is a frequently used term in developmental sector. Recently, community mobilization has been proved to be a valuable and effective concept which has various implications in dealing with basic problems like health and hygiene, population, pollution, and gender bias.

Process of Community Mobilization

Community mobilization is a process through which action is stimulated by a community itself, or by others, that is planned, carried out, and evaluated by a community's individuals, groups, and organizations on a participatory and sustained basis to improve the health, hygiene and education levels so as to enhance the overall standard of living in the community. A group of people have transcended their differences to meet on equal terms in order to facilitate a participatory decision-making process. In other words, it can be viewed as a process which begins a dialogue among members of the community to determine who, what, and how issues are decided, and also to provide an avenue for everyone to participate in decisions that affect their lives.

Requirements for Community mobilization

Community mobilization needs many analytical and supportive resources which are internal (inside the community) and external (outside the community) as well. Resources include:

- Leadership
- Organizational capacity
- Communications channels

- Assessments
- Problem solving
- Resource mobilization
- Administrative and operational management

Community Participation

Community participation can be loosely defined as the involvement of the people in a community in projects to solve their own problem. People cannot be forced to 'participate 'in projects which affect their lives but should be given the opportunity where possible. This is held to be a basic human right and a fundamental principle of democracy. Community participation is especially important.

Community participation can take place during any of the following activities:

- **Need Assessment:** expressing opinions about desirable improvements, prioritizing goals and negotiation with agencies
- **Planning:** formulating objectives, setting goals, criticizing plans
- **Mobilizing:** raising awareness in a community about needs, establishing and supporting organizational structures within the community
- **Training:** participation in formal or informal training activities to enhance communication, construction, maintenance and financial management skill
- **Implementing**: engaging in management activities; contributing directly to construct-cost, paying of services or membership fees of community organizations.
- **Monitoring and Evaluation**: participating in the appraisal of work done, recognizing improvements that can be made and redefining needs

Community participation can contribute greatly to the effectiveness and efficiency of a program.

Community Development

Community development is often linked with community work or community planning, and may involve stakeholders, foundations, governments, or contracted entities including non-government organizations (NGOs), universities or government agencies to progress the social well-being of local, regional and, sometimes, national communities. More grassroots efforts, called community building or community organizing, seek to empower individuals and groups of people by providing them with the skills they need to effect change in their own communities. These skills often assist in building political power through the formation of large social groups working for a common agenda. Community development practitioners must understand both how to work with individuals and how to affect communities' positions within the context of larger social institutions. Public administrators, in contrast, need to understand community development in the context of rural and urban development, housing and economic development, and community, organizational and business development.

Stakeholder: A person, group or organization that has interest or concern in an organization. Stakeholder ca affect or be affected by the organization's action, objectives and policies. Some examples of key stakeholders are creditors, directors, employees, government (and its agencies), owners, suppliers, unions, employees, the community which the organization draws its resources.

Types of stakeholders include:

- Primary stakeholders: are those ultimately affected, either positively or negatively by an organization's actions.
- Secondary stakeholders: are the 'intermediaries', that is, persons or organizations who are indirectly affected by an organization's actions.
- Key stakeholders: who can also belong to the first two groups have significant influence upon or importance within an organization.

Therefore, stakeholder analysis has the goal of developing cooperation between the stakeholder and the project team and, ultimately, assuring successful outcomes for the project.

Mental Models and Household Production of Health

Mental Models

Knowledge grows when we challenge our mental models. How can we continuously open our minds to new ideas? However, all ideas are not equally valuable, so we must reflect deeply on what we know our experiences are.

"Mental models" are deeply ingrained assumptions, generalizations, or even pictures or images that influence how we understand the world and how we take action. (Peter Senge, The Fifth Discipline)

"Mental Model" is also known by the following other names:

- Perceptions
- World View
- Assumptions
- Paradigm, Conceptual Framework
- Beliefs
- Prejudice

How we think determines what we see and how we act.

It is not "seeing is believing" – but "believing is seeing."

- How many believe that?
- Which comes first?
- How many have ever seen the sun rise in the morning and set in the evening? Have you really? What is reality? The earth rotates on its axis so the sun appears to move across the sky…but it doesn't. Suppose there were two groups of people: one who believes the sun rises, the other who believes the earth turns on its axis. Is this worth dying for? Fighting for? The example of Galileo—he said that the earth is not the center of the universe. He challenged the religious order of the day. He was tried and convicted, then exonerated 400 years later.
- What difference does it make to the universe what we believe? None, it exists regardless of our beliefs. However, in human behavior, mental models are our reality.

Reflect, Discuss, and Synthesize—Reality or Mental Model? "Women are intrinsically inferior to men".

1. What are the "right" and "wrong" choices and actions that are predetermined in societies that accept this as reality?
2. How does one go about improving the status of women in these societies?

- Does it require donors to change mental models? Time?
- How do leaders grow and start?

Laws of Mental Model

1. Mental models provide the basis for the choices we make and the actions we take
2. In human relations and social institutions, our mental models are our reality
3. Misconceptions about reality are self-fulfilling prophecies

Examples of how one person changed the mental models of society (other examples can include Ghandi, Martin Luther King Jr., Mandela):

- Are there any international agreements on global mental models? Example: ICPD, Beijing, Human Rights, etc. There is a global consensus that certain mental models are more right than others (e.g., human rights watch groups around the world).
- What do we do if culture is part of the problem?

Reflect, Discuss, Synthesize. What are the Health Production Capabilities for every 1000 births?

Household Production of Health

70 – 90% of all sickness care takes place in the home (WHO, World Health Report 2002. Reducing Risks, Promoting Healthy Life)

Viewing health through a systems thinking lens led to a new paradigm for Dr. Henry Moseley: households are central to health systems, and therefore health interventions that incorporate building the capacity of households can lead to system-wide health improvement.

Our current mental model in health is that physicians and other health practitioners are the predominant producers of health. However, households – dwellings and all those living therein – actually provide roughly 70-90% of all health treatment, making households the primary providers of health. As such, these units are central components to our current health systems and thus, in this paradigm, households must be the major focus of policies and programs aimed at improving health, especially in low-income countries.

As the primary producers of health, it is important that the family has the capacity to deliver healthcare treatments within the home. Mothers are the primary managers and implementers of health within households; therefore, programs and policies that include the education and instruction of women as an emphasis can make a greater impact. Many social studies have shown that the biggest impact in health can be made through building capacity of mothers and women, as women manage the most fundamental unit in a health system: the family.

(https://st4chealth.com/2013/08/12/systems-thinking-applied-the-household-production-of-health/)

Household members, especially mothers, make the primary diagnoses of illnesses, assess the severity and likely outcomes, select among available providers and treatment options, and procure and administer treatments

Barriers to access and use are not just physical distance and technical deficiencies, but also relate to household beliefs and values such as:

- Trust and confidence in the provider
- Awareness of morbidities and treatment options ("culture of silence")
- Gender roles
- Fear - of the unknown, of revealing private matters, etc.
- Information/misinformation about health services and products

Premises of Household Production of Health

1. Households are the primary units for the production of health.
    - Mothers are the primary managers and implementers of the household health production tasks, and women and children are the major "beneficiaries/victims"
    - Therefore, gender relations and status of women are key determinants of health in the developing world
2. Households, like every social institution, have three basic capabilities for the production of the desired outputs:
    - Values
    - Practices
    - Resources

Regarding resource fullness: "A developed person with limited (material) resources is likely to be able to improve his quality of life and that of others more than a less developed person with unlimited (material) resources." (Jamshid Gharajedaghi)

3. Households produce health in the context of the local community and the wider society, which is a nation's health production system.

1. Households are the primary units for the production of health.	Mothers are the primary *managers and implementers* of the household health production tasks, and women and children are the major "beneficiaries/victims
2. Households, like every social institution, have three basic capabilities for the production of the desired outputs- Value, Practice, Resource	Culture is self-replicating from generation to generation Like DNA, a cultural system is resistant to change . Stable even if government changes (good). But hard to make necessary changes
3 . Households produce health in the context of the local community and the wider society – which is a nation's health production system	Local Community has social capital Government influences the whole process

Exercise:

Minister of Health/Minister of Agriculture Example for Household production of health:

- Who produces food in your country?
- Who produces health?
- What are the components of a health system? (Communities, families and government)

Values, Resources and Practices: Questions

- Which is better, a centralized or decentralized system? Regardless, if the values remain, people are still not happy.
- What is better, preventative or curative health?
- What are the resources?

Essentially, values, resources and practices must all be aligned because all three exist within households, community and government.

Tip of the Iceberg: there is much more underneath.

Practices Burden of Disease Graph :The top four diseases account for over 40% of burden of disease. How is underweight produced? The underpinnings are household production tasks, not those of health workers, hospitals, clinics….That's why the problem of under nutrition is varied greatly among families. Unsafe sex – similar in that the factors are also due to activities/practices of families.

Values – what are some values that make us what we are?

Practices – which are most commonly followed – the formal or the informal?

Resources – What is more important, non-material or material resources?

Households, communities and governments each have values, practices and resources. This complex system has inherent stability, it is hard to change. This stability is good. Even when governments change, everything is not disrupted. But it is also bad, when you want to change, it is hard to change.

Local and Global Driving Forces Are Major Sources of Change

- Political
- Economic
- Social
- Technological
- Environmental

Driving force for change – share example.

- Technology revolutions (e.g., cell phones). Traditional birth attendants with cell phones client's call to say they are coming, in case of emergency, TBA calls hospital or physician.
- Growth of garments sector prevents early marriage and early pregnancy.

- Political commitment for family planning in 80s

How can we enhance and expand the resourcefulness of the primary producers of health, and of other actors in the health production system, so that they can more effectively and efficiently produce favorable health outcomes?

"… these units (household) are central components to our current health systems and thus, in this paradigm, households must be the major focus of policies and programs aimed at improving health, especially in low-income countries."

" … Programs and policies that include the education and instruction of women as an emphasis can make a greater impact.

" … the biggest impact in health can be made through building capacity of mothers and women, as women manage the most fundamental unit in a health system: the family."

- Henry Mosley

Additional reading

(Excerpt from Family as Centre of Health Development Report of the Regional Meeting, Bangkok, Thailand, 18–20 March 2013, organized by WHO.)

Family is the fundamental institution of organization in society. Families provide the millieu where individuals are born, nurtured, learn to socialize and where an individual's behaviour and views take shape. Socio-cultural traditions and economic influences including those that affect health are extended through families to individuals and impact health behaviour. Interventions designed to modulate education and empowerment of individuals through families are an opportunities for contributing to health development of societies.

The tradition of "family" in South-East Asia is particularly strong. However, factors like globalization, economic boom, inequities vis-a-vis social determinants of health, urbanization, gender issues and so on are influencing the traditional joint family norm. Traditional roles ascribed to men, women and the aged are undergoing a metamorphosis. The increasing participation of women in the workforce is challenging the stereotype of the woman as a home-maker and man as the breadwinner.

Whatever the nature of family – joint or nuclear – it will continue to play a pivotal role in nurturing and socializing children and influencing the development of adolescents, serving as a support structure for family members, influencing health impacting behaviours – both positive and negative and providing opportunities and role models for healthy living.

Early childhood development— including social/emotional and language/cognitive domains — are determined by family conditions, and subsequently influence health. Adopting a life-course perspective directs attention to how social determinants of health operate at every stage of development — early childhood, childhood, adolescence, adulthood and on age — to both immediately influence health as well as provide the basis for health or illness during later stages of the life-course.

Traditionally, women play an important role in the family's health. How well they perform this role is affected by their social status, education, employment and cultural practices that permit or inhibit them from family decision-making. Evidently, educational level and social status of women in countries of the South-East Asia Region is relatively low. There is an urgent need to improve the educational status of women. A systematic action that requires participation/ cooperation from other sectors such as education, social welfare, local administrative bodies, and local health staff to educate and empower women to take informed health decisions will go a long way in improving the health status of the people.

There is a need for interventions that proactively work towards educating, empowering and supporting families to practice healthy behaviors. Community-based health workers and community health volunteers (CBHWs/CHVs) must be educated and skilled in facilitating people for empowerment. Women, in their role as mothers, play a crucial role in health decisions. With support from men, women can play an effective role in laying the foundation of healthy living.

Policies aimed at human development, including health policies, must aim to facilitate actions that support individuals and families to inculcate and practice healthy lifestyles and appropriate health behaviors. Health systems strengthening based on PHC principles needs to take this into account.

It may not be out of place to mention that the UN places a lot of emphasis on the role of families for social development.

Every year, 15 May is celebrated as the International Day of Families. In the past few years, health-related themes have been adopted for the International Day of Families (HIV/AIDS and Family Well-being in 2005; Families and Persons with Disability in 2007; Mothers and Families: Challenges in a Changing World in 2009).

Several sectors contribute towards improving family health. These include employers, educational institutions, social welfare schemes, and health policies. Health development efforts need to focus on multisectoral policies that facilitate adoption of healthy lifestyles by individuals and families. These include the following:

- Gender-sensitive initiatives that assist women to play an effective role in the family for health decision-making;
- Building capacity of CBHWs/CHVs to educate and empower individuals and families for healthy living/ lifestyles;
- Making use of the opportunities in primary care for health education, especially utilizing family physicians for health promotion; and
- Strengthening school health programs to serve as a two-way channel to influence better health practices.

References

– *SIX. Sci. Med. Vol. 38, No. 2, pp. 201-204, 1994 0277-9536/94 $6.00 + 0.00 Printed in Great Britain. All rights reserved Copyright Q 1994 Pergamon Press Ltd*

– *(https://st4chealth.com/2013/08/12/systems-thinking-applied-the-household-production-of-health/)*

DAY-3

Session -12: Community Based Structures and their Roles

Session objectives

At the end of the session the participants will be able to

- Identify the different stakeholders at community
- Explain the role of the different stakeholders (eg: CG, CSG, UH&FWCMC, CHW, Standing committee of local government)

Time: 1 hour 30 minutes

Participant's note

- In this session Participants will participate in discussion
- They will divide into five groups. Select a group leader to moderate group discussion and presentation.
- Terms of Reference (ToR) of various committees: **Annex: I**

Session -13: Role of Manager in Engaging Community

Session objectives

At the end of the session the participants will be able to

- ➢ Share the success story on Best practices from their own experiences
- ➢ Identify the role of manager in engaging the community (case studies)
- ➢ Observe the video on best practices available in the country

Time: 1 hour

Participant's note

- In this session Participants will participate in discussion
- They will analyze a case study and will observe a video clip

Case Study Exercise:

Mobilizing marginalized community members for MNCH promotions

An international NGO, World Renew, has been working with a local NGO in your sub-district on a 5-year USAID-funded project to establish People's Institutions (community groups that mobilize marginalized populations). Through this project, the local NGO has facilitated regular communication between the new community groups and your government personnel concerning the health needs of their community, and have developed strong relationships. They have trained their own cadre of community health volunteers who enumerate pregnant women, births, deaths, etc. in their community and share these data with your own office's HMIS which strengthens reporting. Furthermore, they have been referring a large number of patients to your facility and thus significantly increasing service utilization, which helps you meet your targets. Now the overall project's funding has ended and the local NGO does not have the scope to continue facilitating the activities directly. However, the community groups have built their own capacity and should be able to sustain themselves.

DAY-4

Day-4 Schedule

Time	Sessions	Topics
9.00-9.15 (15 minutes)		**Review of the previous day**
9.15-10.45 (1 hour 30 minutes)	**Session-14**	**Communication, Coordination and Negotiation** - Effective communication - Coordination skill and effective coordination with different stakeholders - Negotiation skill
10.45-11.00 (15 minutes)		**Tea break**
11.00-12.00 (1 hour)	**Session-15**	**Team building and Shared vision** - Characteristics of effective team building - Stages of team building - How to build a shared vision
12.00-1.00 (1 hour)	**Session-16**	**Data for decision making** (DHIS2&MIS) - DHIS2: Overview, data analysis and utilization in decision making
1.00-2.00		**Lunch and prayer break**
2.00-3.00 (1 hour)	**Session-16**	**Data for decision making** (DHIS2&MIS) - MIS: Overview, data analysis and utilization in decision making
3.00-4.00 (1 hour)	**Session-17**	**Data for decision making (LMIS & HRIS)**) - LMIS: Overview, data analysis and utilization in decision making - HRIS: Overview, data analysis and utilization in decision making
4.00-4.15 (15 min.)		**Evaluation of the day**
4.15-4.30 (15 min.)		**Tea break and end of the day**

DAY-4

Session -14: Communication, Coordination and Negotiation

Session objectives

At the end of the session the participants will be able to

- Describe effective communication
- Explain coordination skill and effective coordination
- Understand Negotiation skill

Time:1 hour 30 minutes

Participant's note

- In this session Participants will participate in discussion
- Will observe a video clip
- Participate in a game as per facilitator's instruction
- Participate in a role play according to a given case scenario

Scenario for negotiation role play

Teherpur Upazila Healh Complex (UHC) of Sunamgong district. You are the UH&FPO of that UHC since 1 year. During the rainy season there is need for boats as it is a haor area. The condition of the existing boat is not up to the mark. Another boat will be helpful for the clients. Government has no specific budget. You sought few local level elites have the financial potentiality to donate a boat. Please do a role play as a negotiator and win with a situation that they are agreed to bear the cost of the boat and will donate it for the UHC.

Handout

Communication, Coordination and Negotiation

Effective Communication

Communication

Concept

Communication is a process of change. It is the transfer of information and understanding from one person to another person. It is a way of reaching other ideas, facts, thoughts, & values. Thus, it forms the basis of understanding between the members of the organization. In other words, communication is a bridge of meaning and understanding. It is an art of expressing the Right things at the Right Occasions.

Definition

It is a process of passing an understanding from one person to another. It is derived from the Latin word "Communist" which means common. Communication provides common grounds of understanding.

Importance of communication for managers:

Managers of health and family planning sector have to get work done through their employees. So regularly they have to communicate verbally or in writing with their subordinates. Colleagues, NGO people, local leaders and so on their smooth running of the program without effective communication the managers can't perform their managerial activities properly. So, they should have this skill for achieving the objectives of the program as a whole.

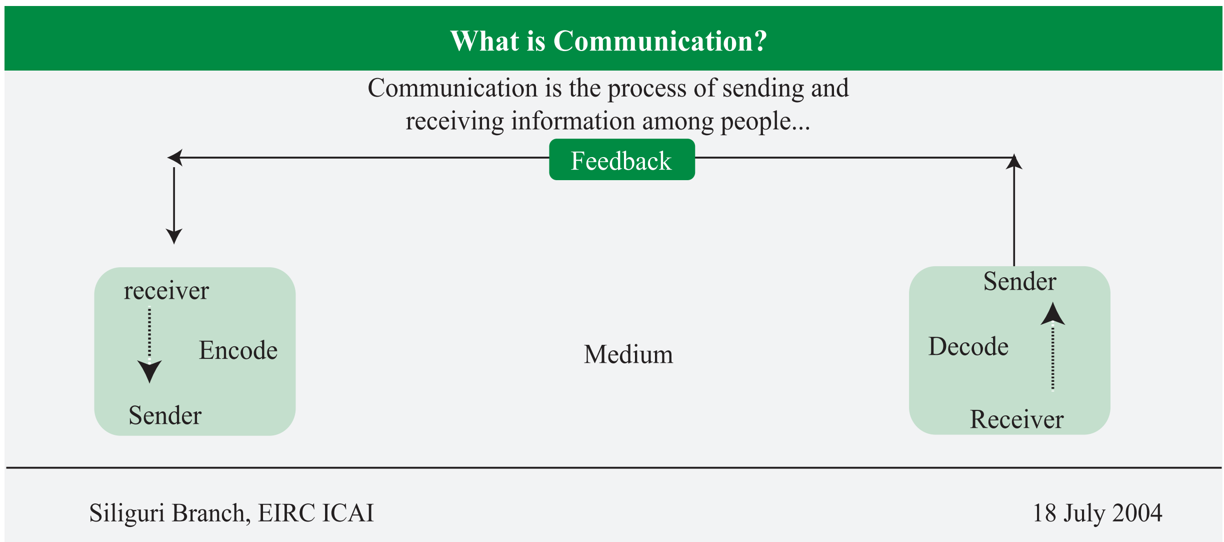
Types of Communication

The three most common types of communication used by managers include:

1. **Verbal communication**: Verbal communication consists of oral communication which includes inter-personal communication. Listen to a person to understand their meaning.
2. **Nonverbal communication**: Nonverbal communication (body language) consists of actions, gestures, and other aspects of physical appearance that, combined with facial expressions (such as smiling or frowning), can be powerful means of transmitting messages.
3. **Written communication:** in which you read their meaning.

Process of Communication

The **communication process** is the steps we take in order to successfully **communicate**. Components of the **communication process** include a sender, encoding of a message, selecting of a channel of **communication**, receipt of the message by the receiver, and decoding of the message.



DAY-4

Methods of Communication

We communicate through various methods, such as:

- √ Speaking
- √ Writing
- √ Listening
- √ Observing/seeing
- √ Body gesture
- √ Silently
- √ Smelling

The 7 characteristics of effective communication

Today we're exploring the 7 characteristics of effective communication, as outlined by University of Wisconsin professor Scott M. Cutlip in his book **Effective Public Relations** (1953). Over time, his listing of features of effective communication has become one of the key concepts in advertising and PR theories, and is now known as the ***7 C's of communication.***

1. Completeness

To be effective, communication should be complete, i.e. it should include all the information the recipient needs to evaluate its content, solve a problem or make a decision. Complete communication reduces the need for follow-up questions and answers, and improves the quality of the overall communication process.

2. Conciseness

Conciseness is not about keeping the message short, but rather about keeping it to a point. Conciseness in communication happens when the message does not include any redundant or irrelevant information. Concise communication prompts a better understanding of the message, because the recipient can focus on the key points and does not get distracted by a wealth of minor details.

3. Consideration

When engaging in communication, a sender should always consider and value the recipient's needs, moods and points of view. Tailoring the contents and style of your messages based on their target audience strengthens the key points delivered within, as the sender can use argumentations and examples relevant to the recipient's experience, thus catering for a more thorough understanding of the message.

4. Concreteness

Effective communication happens when the message is supported by facts and figures. Concreteness in communication is also about answering to questions timely and consistently, and developing your argumentations based on real-life examples and situations rather than on general scenarios or theories. Concreteness fosters effectiveness in communication, as the recipient gets a more comprehensive overview of the message and its implications.

5. Courtesy

Courtesy in communication implies being respectful of the recipient's culture, values and beliefs. Also, it involves the need to adopt a register your audience can easily relate to and understand. Courteous communication has a positive impact on the overall communication, as it prompts a more positive and constructive approach to the conversation.

6. Clearness

To be effective, communication has also to be clear and specific. To achieve clearness, the message should focus on a single objective, thus emphasizing its importance and catering for a prompt understanding of its contents. Clear communication also requires the adoption of the relevant terminology, thus reducing ambiguities and confusion in the communication process.

7. Correctness

Using grammar and syntax correctly vouches for increased effectiveness and credibility of the message. In **fact, grammar and syntax mistakes make it harder for the recipient to decode the message and understand its** contents. Also, they have a negative impact on the overall communication, as they show that the sender hasn't taken his time to craft his messages more carefully.

Coordination

Introduction:

Coordination is one of the important management functions that help to develop a harmonious relationship among different types of activities of different organizations. Through proper coordination program targets can be achieved smoothly and easily.

Definition:

Coordination is synthesizing different activities towards the achievement of the same goal.

Coordination is the means of:

- Distributing authority;
- Providing channels of communication and
- Arranging the work so that:
  - The right things are done (What)
  - In the right place (Where)
  - At the right time (When)
  - In the right way (How)
  - By the right people (by Whom)

When an activity is coordinated, everything works well.

A coordinated activity is orderly, harmonious, efficient, and successful. When an activity is not coordinated, it is liable to fail in its objectives; and uncoordinated activity is disorderly, discordant, ineffective, inefficient and unsuccessful.

Principles:

For successful coordination one is to follow some principles which are stated below.

1. Directness:

The coordination that makes direct interaction between responsible people is the best coordination. It helps to exchange ideas, methods more independently and removes misunderstanding.

2. Early start:

To make the work of the organization more effective, coordination should start from the beginning of the planning process.

3. Dynamism:

Coordination should be flexible like other work of management. It should be dynamic as well

4. Continuity:

Coordination is an ongoing process. It starts with planning and continuous up to monitoring and calculation.

Effective coordination:

In any organization coordination should be established through the voluntary cooperation among the employees. To make coordination effective the manager is to follow the following steps:

- **To instill (to infuse slowly into the mind) dominant objectives:**
- For voluntary coordination the role of main objective is very important. The workers should be motivated to follow that objective laboriously.
- **To develop generally accepted customs and terms:**

  The best coordination is achieved if the workers work closely. It can happen by improving the accepted work pattern. If the employees do not know the manner, language, etiquette etc. of the organization, then

they cannot be good colleagues.

- **To encourage informal contacts:**
- Informal discussion is very much important in a voluntary coordination. Discussion of an execution during tea can help much in coordination.
- **To use committees:**

  Committees give chances for direct contact and informal exchange of opinion.
- **Management attitude:**

  The attitude of an executive is very important in coordination. The manager should be cooperative in his dealing with the subordinates. There are such problems in coordination, which needs direct and personal attention of the manager.

A coordinating checklist:

A health worker responsible for any action will find it useful to apply the following checklist:

• What is to be done? • Where will the action take place? • When will the action take place? • What equipment is needed? • How will the action be arranged?	**Coordinating the activities**
• Which members of the health team will take part? • Who outside the health team will take part? • Who will do what? • Who will lead?	**Coordinating the people**
•Is all necessary information available? •Has the information been communicated?	**Communication**

Negotiation

Negotiation is a dialogue between two or more people or parties intended to reach a beneficial outcome over one or more issues where a conflict exists with respect to at least one of these issues. This beneficial outcome can be for all of the parties involved, or just for one or some of them.

The word "negotiation" originated in the early 15th century from the Old French and Latin expressions "negotiation" and "negotiationem". These terms mean "business, trade and traffic". By the late 1590s negotiation had the definition, "to communicate in search of mutual agreement." With this new introduction and this meaning, it showed a shift in "doing business" to "bargaining about business".

Why It Matters? (Importance of Negotiation)

The list is endless. The important thing to remember is that negotiation is not necessarily adversarial; it often is a strategic process. The objective is to come up with an agreement that benefits all parties. Sometimes parties must give up some things, but this is indeed part of the negotiation, and giving something up frequently allows for gains in other areas of the negotiation.

The best negotiators prepare themselves by studying the situation extensively before entering the negotiating room. They also consider deadlines, timing, cultural expectations, personalities, and the distribution of information in their negotiating strategies

Types of Negotiation

Distributive negotiation

Zero sum game

Distributive negotiation is also sometimes called positional or hard-bargaining negotiation and attempts to distribute a "fixed pie" of benefits. Distributive negotiation operates under zero sum conditions and implies that any gain one party makes is at the expense of the other and vice versa. For this reason, distributive negotiation is also sometimes called *win-lose* because of the assumption that one person's gain results in another person's loss. Distributive negotiation examples include haggling prices on an open market, including the negotiation of the price of a car or a home.

Integrative negotiation

Non-zero-sum game and Win-win game

Integrative negotiation is also called interest-based, merit-based, or principled negotiation. It is a set of techniques that attempts to improve the quality and likelihood of negotiated agreement by taking advantage of the fact that different parties value various outcomes differently. While distributive negotiation assumes there is a fixed amount of value (a "fixed pie") to be divided between the parties, integrative negotiation often attempts to create value in the course of the negotiation ("expand the pie").

Integrative negotiation often involves a higher degree of trust and the forming of a relationship. It can also involve creative problem-solving that aims to achieve mutual gains. It is also sometimes called *win-win* negotiation.

Integrated negotiation

Integrated negotiation is a strategic approach to influence that maximizes value in any single negotiation through the astute linking and sequencing of other negotiations and decisions related to one's operating activities.

This approach in complex settings is best executed by mapping out all potentially relevant negotiations, conflicts and operating decisions in order to integrate helpful connections among them, while minimizing any potentially harmful connections.

An alternative approach to integrated negotiation is to assume each negotiation or operating activity is standalone.

Integrated negotiation is not to be confused with *integrative negotiation*, a different concept related to a non-zero sum approach to creating value in negotiations.

Bad faith

When a party pretends to negotiate, but secretly has no intention of compromising, the party is considered negotiating in bad faith. Bad faith is a concept in negotiation theory whereby parties pretend to reason to reach settlement, but have no intention to do so, for example, one political party may pretend to negotiate, with no intention to compromise, for political effect.

Bad faith negotiations are often used in political science and political psychology to refer to negotiating strategies in which there is no real intention to reach compromise,

Types of negotiators

Three basic kinds of negotiators have been identified by researchers involved in The Harvard Negotiation Project. These types of negotiators are: soft bargainers, hard bargainers, and principled bargainers.

Soft

These people see negotiation as too close to competition, so they choose a gentle style of bargaining. The offers they make are not in their best interests, they yield to others' demands, avoid confrontation, and they maintain good relations with fellow negotiators. Their perception of others is one of friendship, and their goal is agreement. They do not separate the people from the problem, but are soft on both. They avoid contests of wills and insist on agreement, offering solutions and easily trusting others and changing their opinions.

Hard

These people use contentious strategies to influence, utilizing phrases such as "this is my final offer" and "take it or leave it." They make threats, are distrustful of others, insist on their position, and apply pressure to negotiate. They see others as adversaries and their ultimate goal is victory. Additionally, they search for one single answer, and insist you agree on it. They do not separate the people from the problem (as with soft bargainers), but they are hard on both the people involved and the problem.

Principled

Individuals who bargain this way seek integrative solutions, and do so by sidestepping commitment to specific positions. They focus on the problem rather than the intentions, motives, and needs of the people involved. They separate the people from the problem, explore interests, avoid bottom lines, and reach results based on standards independent of personal will. They base their choices on objective criteria rather than power, pressure, self-interest, or an arbitrary decisional procedure. These criteria may be drawn from moral standards, principles of fairness, professional standards, and tradition.

The six steps of negotiating

STEP-1

Getting to know each another

Negotiating is like any other social situation that has a business purpose. It moves more smoothly when the parties take a little time to get to know one another. It is helpful to assess those involved before negotiations begin. Individual backgrounds will provide an excellent guide to the level of importance placed on the issues, and the degree of expertise brought to bear on the subject. As the process starts, you should observe, listen, and learn. A good rule of thumb is to keep the beginning friendly and relaxed, yet businesslike.

STEP-2

Statement of goal and objectives

Negotiating normally flows after the opening, into a general statement of goals and objectives by the involved parties. Specific issues may not be raised at this time because the parties are just beginning to explore the needs of the other. The person who speaks first on the issues may say, for example, `I would like to insure this agreement works in a way that is beneficial to everyone concerned.' No terms have been suggested yet, but a positive statement has been made on behalf of an agreement being reached, which is favorable to all concerned.

The person making the opening statement should then wait for feedback from the other party to learn if they have similar goals and objectives. If there are differences, now is the time to learn them.

It is normally a good idea to make the initial statements positive and agreeable. This is no time for hostility or defensiveness. You need to build an atmosphere of cooperation and mutual trust.

STEP-3

Starting the process

Some negotiations are complex and have main issues to resolve. Others may only have a few. Also, individual issues may vary greatly in complexity. No one can predict the direction negotiations kill take until both parties have presented the issues. There may be hidden needs neither party has risen, but these will surface as things proceed.

Often issues are bundled, so the solution to one is contingent on the solution to another. For example, "I will not agree to buy the new furnace at that pace unless a tree one year maintenance warranty is included."

Conversely there may he an attempt to separate issues to make them mutually exclusive. For example, in the sale of a furnished house, the seller may prefer to discuss the house and furnishings as separate negotiations. The buyer may feel they should be combined. In some negotiations, all issues are connected. No one issue is considered resolved until all have been resolved.

A skilled negotiator skill studies the issues closely *before* negotiations begin in order to determine where advantages lie insofar as splitting or combining issues.

STEP-4

Expressions of disagreement and conflict

Once the issues have been defined, disagreement and conflict often will occur. This is natural and should be expected. Good negotiators never try to avoid this phase because they realize that this process of give and take is where successful deals are made.

Disagreement and conflict handled properly kill eventually bring the negotiators together. If handled poorly, it will widen the differences. Conflict has a way of bringing out different points of view, and crystallizing the real wants and needs of the negotiators.

When presenting the issues, most negotiators will explain what they "want". It is the task of the other negotiator to find out what they "need", or will settle for. Few negotiators will get all they want, even in a successful negotiation. But good negotiators will work to get as much as possible, yet understand compromise may be necessary, and a modification of goals may be required.

This confrontation can involve stress. It is important to remember, therefore, that conflict resolution under these circumstances is *not a test of power but an opportunity to reveal what people need.* Properly understood this should lead to possible areas of agreement or compromise.

STEP-5

Reassessment and compromise

At some point, normally one party will move toward compromise. Statements reflecting this often begin with words like, "Suppose that......?", What if...? , "How would you feel about...?" When these statements begin, the other negotiator should listen carefully to see if an attempt to compromise is being uttered. The response should be carefully stated. Too quick an attempt to pin something down may cause the other party to withdraw because the climate may not seem conducive to giving and getting.

STEP-6

Agreement in Principle or settlement

When agreement is reached, it will be necessary to affirm it. A decision about how the final settlement will be obtained is needed, especially if additional approval is required. This normally means placing the agreed terms in writing. If possible, this should be done while the parties are together so they can agree on the language. This can reduce the danger of a misunderstanding later.

Since agreement is the ultimate objective of a negotiation, it is important to determine the level of authority of the party you are negotiating with at the outset. Some sellers, for example, will negotiate in order to determine your position, and then inform you they do not have the authority to accept your terms. They then go to some unseen person who will reject the tentative "agreement" in order to attempt to leverage a better deal for the seller.

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Session -15: Team Building and Shared Vision

Session objectives

At the end of the session the participants will be able to

- Describe team and group
- Explain stages of team building
- Discuss the concept of shared vision

Time: 1 hour

Participant's note

- In this session Participants will participate in a discussion
- They will observe a video clip
- Participants will be divided into four groups and analyze four case studies

Team Development Case Study #1

Unique NGO was founded 10 years ago as a community-based organization. It enjoys a good reputation with both the community it serves as well as with its donors. Most of the staff have been with Unique for at least 5 years and feel a strong commitment to the organization.

This year, Unique's founder announced that he would retire. A new executive director was named and has just joined the organization. The hand off was done carefully with a lot of planning. There was a reception to introduce the new executive director to the community and the donors. It has been thought of as a time of renewal for the organization and there is a lot of excitement about the future.

Case Study #1 Discussion Questions

1. In what stage of development is this team?
2. If you were the new executive director, what would you do? What task/support functions would be appropriate?
3. If you were a staff member, what actions could you take to best support the organization?

Team Development Case Study #2

Ms. Nafisa is very proud of her administrative/finance team. It provides a solid foundation for the organization through clockwork support and strict adherence to policies and procedures. The team's reports are always accurate and on time.

As a result of a new grant, the team expanded its department with two new positions. To recognize the good work of her staff, Ms. Nafisa promoted one staff member to unit manager and recruited two new junior staff members to fill the gaps. As expected, everyone was very happy with this development at first. But now Ms. Nafisa's day is filled with petty bickering among her staff. Some complain that the new unit manager has become arrogant in his new role and thinks he is superior to his former peers. Others complain that the new members are the cause of reporting delays. To top that off, her trusted book keeper has started calling in sick frequently. Exasperated, she wonders what is happing to her team.

Case Study #2 Discussion Questions

1. In what stage of development is this team?
2. If you were Ms. Nafisa, what would you do? What task/support functions would be appropriate?
3. If you were a staff member, what actions could you take to best support your department?

Team Development Case Study #3

It has been a year since the new project was signed, and the start-up for the nutritional support program was a greater challenge than Mr. Baqui anticipated. Quite a difference from the project development phase where everyone was enthusiastic! There were logistical delays in getting internal access to organizational vehicles, processing vouchers, and establishing work plans. The international donor was interested only in demonstrable results according to the proposed time line, which clashed with cultural practices of building trust and project buy-in .As a result, the community was not forth coming with its cost share. This was not helped by the poor choices made in some of the original staff hires that had to be replaced. Thankfully, the new staff seems to be enthusiastic and is working out quite well.

Now it is time to submit the one-year report. Mr. Baqui has scheduled a full-day retreat with the project staff to review their year and prepare the content of their report. He senses that everyone is tired of the delays and struggles and is ready to get on with it. With the one-year report coming up, people have started to pull out their work plans and have begun asking questions about the monitoring plan. Mr. Baqui senses that this is a critical moment and wonders how to organize the retreat to make it productive.

Case Study #3 Discussion Questions

1. In what stage of development is this team?
2. If you were Mr. Baqui how would you organize the retreat? What task/support functions would be appropriate?
3. If you were a staff member, what actions could you take to best support the organization?

Team Development Case Study #4

After two years as executive director of his NGO, Mr. Hannan has established equilibrium within the organization. He has straightened out all the donor reporting problems his predecessor left and was able to get good people to head each department. Staff have *finally* gotten used to the new monitoring system and stopped their complaining and resistance. The monthly staff meeting has been established with a regular agenda. Everything is going so well it is starting to get a little boring.

As Mr. Hannan contemplates what to do next, he thinks about several things. Communities are being hard hit by the financial crisis, and it seems more and more are not able to pay the program fees, even as low as they are. He hears that several fathers have had to take jobs in the city nearby to support their families. Relations with his long-standing donors are good, but this funding cycle will come to an end in about 18 months.And then, of course, there is that invitation to chair the regional NGO council, which might take him away from the organization more frequently. So many directions to consider!

Discussion Questions

1. In what stage of development is this team?
2. If you were Mr. Hannan what would you do? What task/support functions would be appropriate?
3. If you were a staff member, what actions could you take to best support the organization?

Facilitators' Debrief Notes for Team Development Case studies

Points to watch for in each scenario–

Case Study #1 (Unique NGO): Although there has been long-term stability within the organization, the arrival of the new ED has put the organization back to the FORMATION stage. Indications of this stage are that people are polite and excited about the future–a clear "honeymoon".

The new ED could support this stage by holding meetings within the organization to learn of the success and accomplishments of the past and clarify values, purpose and operational structures. She could then introduce her own vision and work with staff to harmonize the two.

Focusing strongly on task while respecting team expertise will lay the ground for minimizing the STORM to come.

Case Study #2 (Ms. Nafisa): Staff turnover has moved the department back to the STORM stage, as seen through arguments, blame, delayed work, and even avoidance of some staff through sickness. The initial happiness of the FORM where one colleague was promoted has given way to the reality of the new hierarchy. To help the team traverse this stage, Ms. Nafisa could hold department meetings to clearly outline the new role and expectations by demonstrating her confidence in the promotion as well as her pride in the department and concern for good relations among staff. She could then meet privately with any parties still experiencing conflict to mediate a resolution objectively, emphasizing the new structures and mutual responsibilities of each party. This will help everyone accept the new structure and turn energies to finding new ways to work together (NORM).

Case Study #3 (Mr.Baqui): Over the year, the project staff have FORMED and STORMED. Now there is evidence that people may be ready to tip toward NORM. Staff are reportedly tired of the bickering and ready to return to getting the work done. There is renewed interest in reviewing work and monitoring plans, although Mr. Baqui should be watchful of new staff still in the FORMING stage. The retreat could be very well timed to move them in this direction. It should focus on accomplishment of goals and the results of the monitoring system. Any gaps or short comings should not be the focus of blame to further fuel conflicts but instead used to generate plans for what needs to be done better in the coming year to be successful. Mr. Baqui can show his confidence in the team and allow staff to begin formulating the systems and work plan, rather than providing top-down solutions himself. If staff assumes responsibility for these plans and systems, they will create the basis for their new PERFORM.

Case Study #4 (Mr. Hannan): While he should be congratulated for his good leadership, this is no time for Mr. Hannan be to relaxing and take his eye off his organization. Too often this happens and the organization begins to decline. This could be the perfect time to offer new challenges to the staff by capturing lessons learned to share with the NGO council or finding ways to better meet the needs of the NGO's beneficiaries. The economic

situation has changed so perhaps this is the time for a new strategic planning process or operational review to lower costs. If he takes the chairmanship of the council, Mr. Hannan should find key staff ready to take on additional responsibility that can fill in for some of the gap he leaves in his increased absence. This would allow these staff to develop under his mentorship and still ensure that other staff have the strong leadership they deserve.

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- *Team Building Module Facilitator's Guide. New Partners Initiative Technical Assistance Project (NuPITA), John Snow, Inc. September 2012*

DAY-4

Handout

Team Building and Shared Vision

Team Building

Definition of TEAMS

"A team is a small number of people with complementary skills who are committed to a common purpose, performance goals, and approach for which they are mutually accountable."

(Katzenbach and Smith, 1993)

TEAM

T-Together

E-Everyone

A-Achieve

M-More

Group

A **group** is a set of people who have the same interests or aims, and who organize themselves to work or act together.

Difference between Team and Group

Team	Group
Number of people with same goal and they are interdependent	Number of people with same goal but they are not interdependent
Example: Football play	**Example:** Snake game, Stage drama

Why team building is so important?

Team building in the workplace significantly contributes towards employee motivation and **building** trust among the employees, thereby ensuring better productivity.

Characteristics of Effective Teams

1. Clear vision or purpose
2. Shared commitment
3. Clear roles and responsibilities
4. Trust
5. Mutual accountability
6. Celebrate individual *and* team success
7. Concern for group tasks *and* process
8. Address challenges with creativity
9. Inclusive in decision making
10. Regular communication and feedback

Characteristics of Effective Teams

1. **Clear vision or purpose** – A vision is a clear, concise statement of purpose that engenders involvement and commitment. A vision provides a pulling force that can impel a team toward a new realization of its possibilities. A vision appeals to people's motivations and captures their imaginations.
2. **Shared commitment** – If each member is motivated to work for the vision, each works to his/her full potential to see that the group achieves success. In so doing, the work becomes its own reward.
3. **Clear roles and responsibilities** – Each team member knows what s/he is to do and knows the roles of other members and how they all interact to form the whole.

4. **Trust**– With clear commitment and roles, each person knows that s/he can rely on the others. With high trust, members are more willing to face challenges and support one another through ups and downs

5. **Mutual accountability** – The collective responsibility of the team toward generating results and achieving success, in addition to the individual obligations in specific roles. This creates a supportive environment within the team, and the performance of the team improves in the presence of this type of mutual support and cohesion.

6. **Celebrate individual *and* team success** - Keep the whole in view, and work to support each other. Team success is valued in theory and in practice.

7. **Concern for group tasks *and* process** – Team members are skilled at raising both specific task issues and issues that explore how the team itself is functioning. These distinct perspectives are usually raised at different times by different team members-not everybody pays attention to both functions at all times, but both functions are always present.

8. **Address challenges with creativity**– The team strives to maintain a sense of open-ness and to solve problems creatively.

9. **Inclusive decision making**– Effective teams allow an appropriate level of group participation in decision making - not too much so decisions are agonizingly slow, and not too little to result in insufficient team input and commitment to agreements.

10. **Regular communication and feedback** - Team members give and receive feedback effectively.

The Common Aim

The first questions a person potential leader or member should ask himself are: Is a team needed? Does this task require the complementary efforts of a group of people? These raise the further questions; why do teams arise in the first place? What are the kinds of tasks that are needed in teamwork?

Often the source of a team lies on one person doing a job that he discovers is too large for him in the time available. You can now think of a large cricket field with a motor mower. If you have an assistant to remove and empty the grass box, then you can do the job in less time.

The example can be developed into others where two, three or four people and so on are needed. That involves the leader of the group, getting to know the members, their abilities and characteristics.

Stages of Team Development

1. Form
2. Storm
3. Norm
4. Perform

Team Formation: Form, Storm, Norm, Perform

When teams and other groups of people come together, they typically go through a number of developmental stages. This process can take a few days or easily stretch over six months or longer. Note that the stages can play out simultaneously or in different order so it is important to be aware of the signs and signals of each stage. The leader or team manager supporting team formation cannot jump straight to "perform" but must instead facilitate the group through this process and bring the group through the four stages. The role of the leader is to help resolve issues and move the team toward performance if it gets stuck at any point.

1. Forming Stage

When people first come together, they are initially polite. They find out about one another and the work to be done. There is typically a "honeymoon" period when people are excited about the newness and potential of being on the team. Some may also be fearful or timid in response to the change.

Forming is best done with high task and low support to provide structure while the new group develops. Introduce people to one another with an orientation of how everyone will work together. Allow opportunities for people to socialize. Clearly communicate the vision and goals of the work to be done to help the team understand what is to be

achieved. Do not overwhelm people with too much detail or expect "perform" behavior at this stage. Engage all team members and draw out quiet ones.

2. Storming Stage

As the initial politeness fades and people start to work, tension forms around things that were vague or left unsaid in the last stage. Conflicts may arise regarding roles or procedures. Members may appear confused and dissatisfied. Output is generally low. Storming can be very strong if roles or objectives are unclear; the team faces external challenges, or if there is competition for formal or informal leadership.

Managing the storming stage productively requires both a high-task and high-process focus. The manager asserts his/her role as leader to surface and resolve differences. Work goals and individual roles and responsibilities may need review and clarification. The key is not to let disputes continue to block team cohesion. Use the stage to develop new methods for collaboration and addressing conflicts.

3. Norming Stage

As roles and personal conflicts are sorted out, the focus returns to the task and what needs to be done. Objectives are clarified and the detail of work is laid out. Group rules develop and people start to collaborate as a team. Team identity emerges. Internal clashes may be replaced with external conflicts.

Managing the process requires a higher focus on process than task to provide opportunities for group members to take responsibility for people and for work. Work planning is directed toward goal accomplishment. This is more productive as people feel comfortable with the objectives and in their roles. Team members take more responsibility for forging group norms and behaviors. Emergence of regular venues for socializing and creating a "family" environment may begin.

4. Performing Stage

Finally, the optimal level of performance is achieved. The team works interdependently and feels like a family. There is a strong sense of team achievement and pride. Mutual accountability is maintained, and personal differences are largely kept under control.

Leaders can take a lower task and support role by increasing delegation of responsibilities as the need for direction decreases. Social activities and celebrations of success are important support functions. However, this is not the time to relax but rather to focus on sustaining high performance.

Shared Vision

How to build a shared vision for your team or organization?

"A shared vision is not an idea. (...) It is a force in the heart people, a force of awesome power. You can be inspired by an idea, but if it is so convincing to gain the support of more than one person, ceases to be an abstraction. It is palpable. People begin to see it as if there. Few human forces are as powerful as a shared vision" (Peter Senge).

Peter Senge, in his book "The Fifth Discipline" describes a shared vision as "... a force in people's hearts, a force of impressive power....At its simplest level, a shared vision is the answer to the question, "What do we want to create?" "A shared vision is a picture that everyone in the company carries in their heads and hearts.

Peter Michael Senge (born 1947) is an American systems scientist who is a senior lecturer at the MIT Sloan School of Management, co-faculty at the New England Complex Systems Institute, and the founder of the Society for Organizational Learning. He is known as the author of the book The Fifth Discipline: The Art and Practice of the Learning Organization.

The project, the company or the organization is no longer "theirs" but "ours".

Some proposals for building a shared vision

Building a shared vision is the product of several interactions of individual visions, requiring regular conversations where people feel free to express themselves. It also includes the process of sharing experiences and seeking ways in which each individual is accountable for doing what is necessary to realize the vision. Methods of guiding this process are:

- Ensure the empowerment of team members, give them confidence and show them that they are an important part of the company.
- Encourage members of the organization/centre to have a personal vision.
- Convene meetings to describe a futuristic image of the organization/centre you want to create.
- Ask them aloud why the organization/centre exists? Listen and clarify whether the concepts expressed do not match yours, clarifies doubts and seeks synergies.
- Talk about your values and how they guide your actions inside and outside the organization/centre.
- Tell them how you want to interact with stakeholders (clients, different groups, elites, leaders, other departments etc) and society in general.
- Do some brainstorming about what is the ideal organization/centre they have in mind?
- Formulate various visions and share with team regarding future changes
- Listen carefully
- Then describe a vision that encompasses the feelings of the people and convincingly expresses your dream

DAY-4

References

– *Team Building Module, Facilitator's Guide, John Snow Inc,*

– *Strategic Leadership and Management Training Program for District Managers in Health & Family Planning (SLMTP), Johns Hopkins University, Baltimore, USA*

Session 16: Data for Decision Making (DHIS2 & MIS)

Session objectives

At the end of the session the participants will be able to

- ➢ Explore the indicators in DHIS-2
- ➢ Identify the indicators in the DGFP web-based MIS
- ➢ Describe how to extract data for use in planning and decision making

Time: 2 hours

Participant's note

- In this session participants will participate in a discussion
- They will observe the live demonstration on use of DHIS2 and DGFP web based MIS

Handout

Management Information System (MIS) and DHIS2

MIS and DHIS2

Management Information Systems (MIS) provides information that organizations require to manage themselves efficiently and effectively. This term is commonly used to refer how individuals, groups, and organizations evaluate, design, implement, manage and utilize systems to generate information to improve efficiency. The development of the MIS was given due importance since inception by the sector-wide program approach undertaken by the MOHFW in 1998. The Health Information System (HIS) is a component of MIS. The major components of the HIS include:

1. Service based HIS
2. Human resource based HIS
3. Institution based HIS covering logistics and financial HIS
4. Program based HIS.

After completing this chapter you will learn about the history of MIS and DHIS2 in Bangladesh, what the management information system (MIS) is, and its utility in management. You will also learn about issues in the MIS of the MOHFW, the software used in MIS (DHIS2), and the analysis and presentation of routine MIS data.

History of MIS in Bangladesh

There are five health related routine Management Information Systems (MIS) at different levels of development. Four of these belong to the Ministry of Health & Family Welfare:

- MIS Health (DGHS) and its subsystems;
- MIS Family Planning (DGFP) and its subsystems;
- Directorate General of Drug Administration;
- MIS National Nutrition Program (NNP); and
- MIS of the 2nd Urban Primary Health-care Project of the Ministry of Local Government Rural Development & Cooperatives (UPHCSDP).

Before 2009 the collection of routine health information in the public sector in Bangladesh was done manually, using paper forms which would be completed by health workers at a decentralized level and submitted upwards, through the administrative hierarchy and would take, on average, two months from the lowest level health facilities to reach the MIS department at DGHS and DGFP, Dhaka. The main features of the MIS system in the health sector include:

- Parallel systems: The MOHFW has two main MIS units – one in the DGHS and one in the DGFP – each responsible for collecting routine data about the health and family planning services, as well as information about logistics and personnel.
- Overlapping reporting requirements: Facilities and field workers collect certain types of routine data using different reporting formats, which were not harmonized to prevent duplicated information.
- Insufficient human resources for MIS: The MIS units both in the Health Services Directorate and Family Planning Directorate are understaffed (160 out of 660 sanctioned posts were vacant in 2009)

Starting in 2009 a virtual explosion of e-Health projects within the MOHFW were initiated: from telemedicine centers, electronic attendance systems to monitor staff punctuality at health facilities, and mobile phone-based medical consultations for patients at district and sub-district health facilities, to a nationwide patient complaint system using text messaging. Beyond this, efforts also began in earnest to build a digital infrastructure within the Ministry, extending from the national to the peripheral levels. The offices of the MIS unit at the Health Services directorate were renovated; a MIS Data Center – a modern, air-conditioned space with a backup generator – was established to host a new web-based server. An IT lab was also set up to facilitate staff training. The MIS unit of DGHS had provided internet connectivity through the entire health public sector in Bangladesh and across all health points down to the community clinic level (about 14,000 locations) by April 2014. The community clinics were given laptops, and community health workers were given handheld tablet devices.

What is DHIS2

In 2010, the MIS unit of DGHS installed DHIS2 on its servers and Bangladesh joined the ranks of countries utilizing the product.

DHIS 2 is a tool for collection, validation, analysis, and presentation of aggregate statistical data, tailored (but not limited) to integrated health information management activities. It is a generic tool rather than a pre-configured database application, with an open meta-data model and a flexible user interface that allows the user to design the contents of a specific information system without the need for programming. DHIS2 is a modular web-based software package built with free and open source Java frameworks with interoperability between users and programs.

DHIS 2 Benefits:

- DHIS 2 is a flexible, easy, system to adapt for local data collection tools
- DHIS 2 has been adapted in numerous countries around the world and there are several online communities and resources for additional information exchange and interoperability
- Can run as a web-based or as an offline application.
- Relatively easy to learn and adapt (does not require high level of programming knowledge)
- Allows multiple levels of organization units to enter into the system and data can be aggregated accordingly (dept. →Site → District → Division → National level)
- Incorporates data checks during data entry and after data collection
- Maintains Security through defining user levels
- Allows user to tailor indicators
- Streamlines data and site census management because all program areas data are kept in one place
- Facilitates data use because all staff can access data at any time from office

Session -17: Data for Decision Making (LMIS & HRIS)

Session Objectives

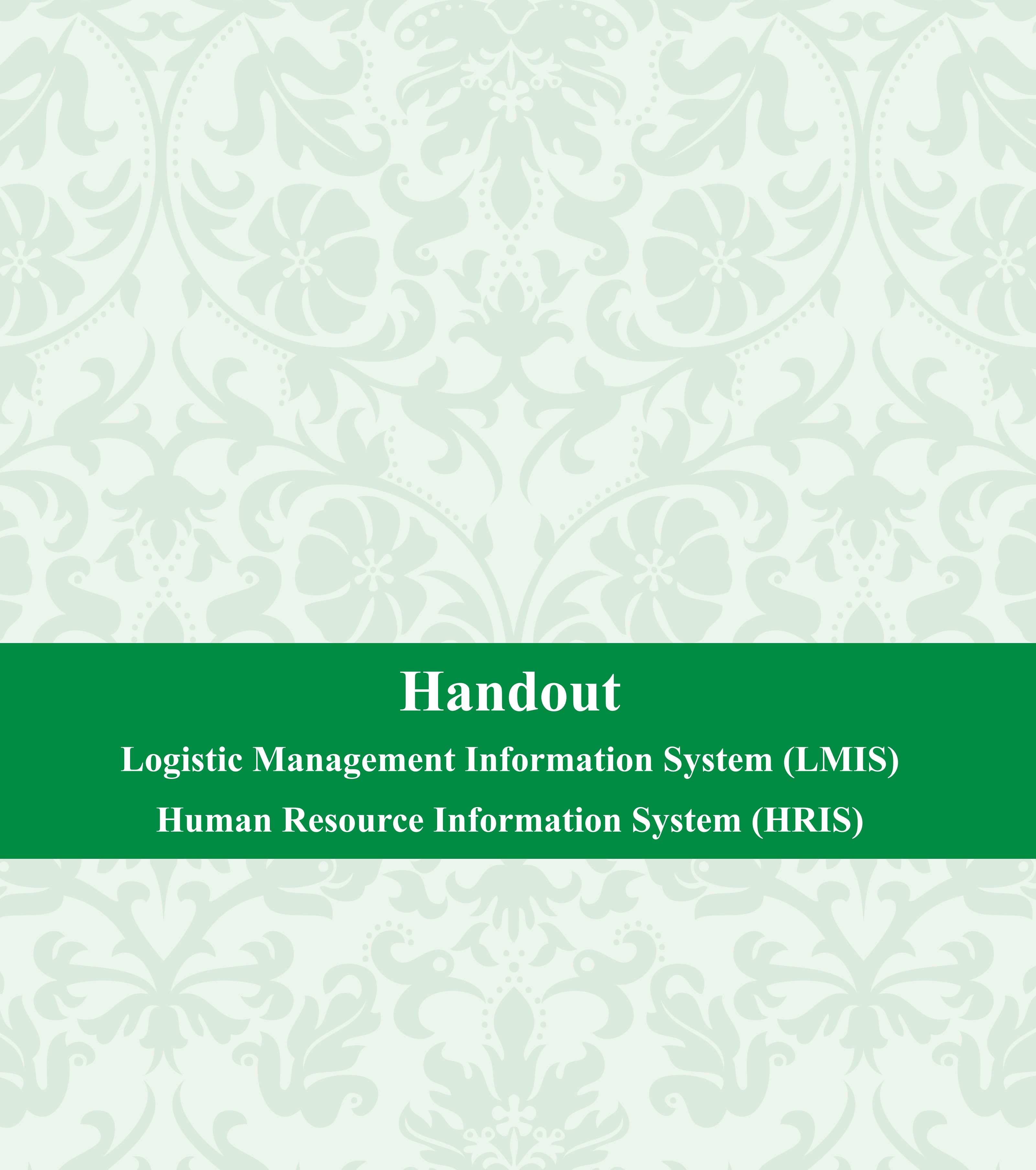
At the end of the session the participants will be able to

- Explain LMIS including e-LMIS
- Understand HRIS
- Describe the importance of LMIS and HRIS in planning and decision making
- Demonstration LMIS and HRIS

Time: 1 hour

Participant's note

- In this session participants will participate in a discussion
- They observe the live demonstration on use of e LMIS and HRIS



Handout

Logistic Management Information System (LMIS)

Human Resource Information System (HRIS)

Logistic Management Information System (LMIS)

Basic Logistics Management related information

Aspects of logistics:

Logistics:

Usually logistics means supplies, commodities, goods, materials, products etc. The supplies, commodities, goods, materials, products etc. which are procured, distributed/supplied, received and utilized for providing health services are called logistics for the health services**.**

For example: The logistics which are received, supplied/distributed and utilized are called logistics of the Directorate General of Health Service (DGHS).

Logistics Management:

Logistics Management is a system which starts from receiving logistics and ends in consumption of logistics by maintaining quality and supplying in an uninterrupted way.

Purpose of Logistics management:

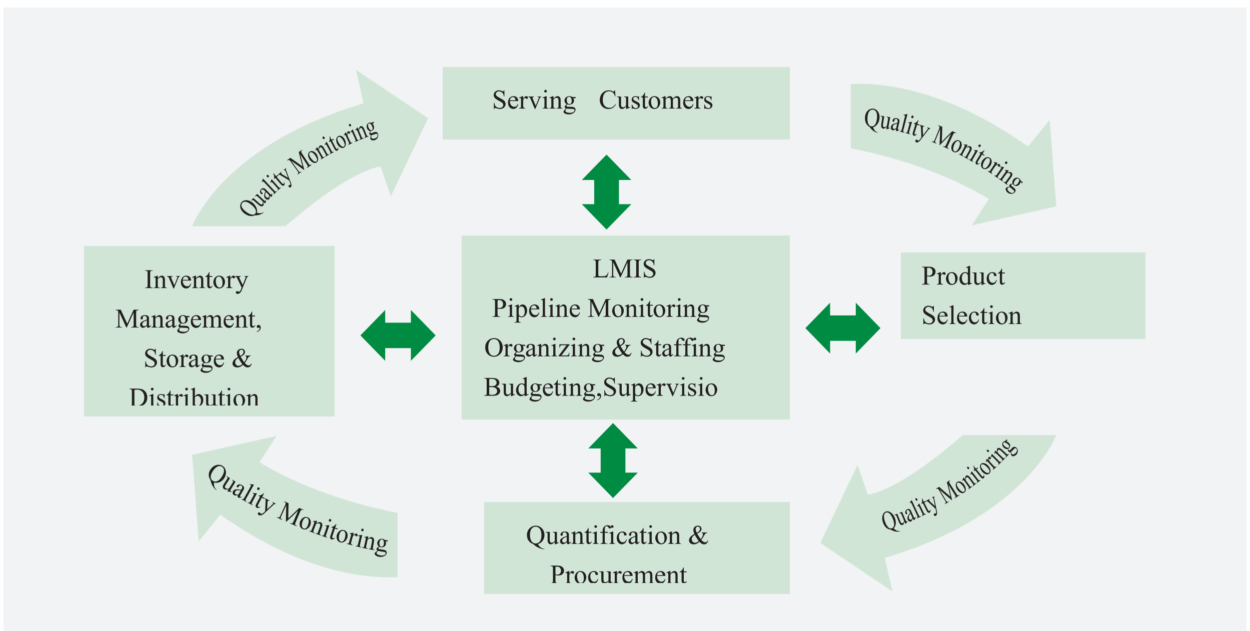
Logistics management is done to ensure the underlying six Rights**:**

- Right Products
- Right Quantity
- Right Destination
- Right Condition
- Right Time
- Right Cost

We have to remember "NO PRODUCT NO PROGRAM"

Key Logistics Terms

- **Supplies, commodities, goods, materials, products and stock:** Synonym for products which are in flow from first to last level of logistics system.
- **Users, clients, patients and customers:** English synonym for persons who receive services. The part of the population who receive different products, consume supplies and receive different types of services from health facilities.
- **Service Deliver Point (SDP):** Specific provider/facility from where health services are provided and medicine/commodities are supplied
- **Pipeline:** In logistics system, pipeline means the status of supply of a material/commodity which the organization/store is already informed about, but still the material/commodity did not reach the store. If any organization does not consider pipeline during issuing demand, would experience overstock situation.
- **Consumption, dispensed, dispensed to user, usage data and distribution:** Synonym for providing information about distributed commodities which are useable to the clients /patients.
- **Lead time:** Usually lead time means the time required from starting to ending of a task. In logistics, lead time means the time required from issuing demand to receiving the product. If any organization does not consider lead time during issuing a demand, would experience stock out of the product/commodities.



Adaptability

Inventory vs Physical Inventory

Inventory Management: Inventory Management is the process by which the products of logistics system is collected, stored, distributed and demand issued can be controlled.

Importance of inventory management: By this inventory management, necessary steps can be taken to ensure sufficient stock of that item and test whether they are of good quality and usable one. Inventory management helps to ensure the continuous flow of logistics in the system and also helps to take necessary steps to prevent damage of the logistics in the system.

Inventory management tools

- Balance Identification Notes (BIN) Card
- Inventory Control Register
- Issue Voucher
- Indent and Issue Voucher
- For hospital
- For store
- Logistics Reporting Form

Storage/Storing commodities

Store Layout: Store layout means keeping the storage equipment /furniture at the right place and keeping the goods/ commodities in a classified way to ensure the maximum utilization of the internal space of the store**.**

Principles of store layout:

- The goods/commodities which are frequently received and distributed, needs to be kept near the entrance of the store where it is easy to reach and takes minimum time.
- To keep different type of goods/products at different places according to classification. That means not to keep different types of products/goods together.
- To keep the slow moving items at inner side of the store.
- Unusable items needs to be kept at the back side of the store, so that can be easily separated from the usable items.

- To keep the valuable items in the Almirah.
- To keep sufficient space to within the store for movement.
- To fix a place for keeping refrigerator containing vaccine /temperature sensitive items.

Storage Guideline

- To clean the store at least once in a week.
- To store the items in First Expire first Out (FEFO) method. Also products needs to be kept in a classified way that can be easily identified, symbols can be easily seen and numbers can be easily counted.
- To keep the products/goods at dunnage, shelf and Almirah in a classified way.
- To ensure proper aeration /ventilation inside the store. The exhaust fan needs to be kept on for proper aeration/ventilation inside the store.
- To write the date of production and expire date if not mentioned on the carton and box.
- To keep the usable items/goods separately from unusable items and chemical products.
- To keep the products/goods 3 inches apart from the wall and 4 inches high from floor in a very small upazila store. To keep the products/goods 1 foot apart from the wall and 4 inches high from floor in a spacious store.
- To keep the product/goods away from direct sunlight and rain water.
- To keep the fire distinguisher/water bucket and bucket with sand in a space easy to be identified. To keep the telephone number of fire service in a visible place.
- To keep the sticker for not smoking on a visible place of the wall.
- To use insecticide in the store in every three months.
- To maintain the overall security of the store and to keep the telephone number of the nearby police station on a visible place of the wall.

Inventory vs Physical Inventory

Inventory: Inventory means the list of all the goods/items with specific quantity of a specific store on a specific day and time.

Physical Inventory: The process of counting the goods/items in a store on a specific day and time and comparing the data with the recorded data to identify if there is any difference**.**

Physical Inventory committee:

- District Reserve Store (DRS):
- Deputy Civil Surgeon-Chairman,
  Medical Officer (civil Surgeon)-Member
  Medical Officer (DRS)-Member Secretory
- Upazila Store
  Residential Medical Officer
  Medical Officer
- General Hospital
  Senior Consultant
  Junior Consultant
  Residential Medical Officer

Logistics Management Information System (LMIS)

A **Logistics Management Information System** (LMIS) is a system of **records** that supply chain managers use to collect, organize and present logistics data gathered across all levels of the system.

It also includes **reports** which are used to communicate logistics information from one level of the system to another

Logistics Management Information System of MOHFW:

- Supply Chain Management Portal(SCMP)
- Electronic Logistics Management Information System(e-LMIS) in DHiS 2

Basic logistics data:

- Opening balance
- Receive
- Issue/distribution
- Adjustment
- Closing balance

MNCH essential medicine and commodities

1. Ampicillin	9. itation device	16. Iron & Folic acid
2. Amoxicillin	10. ORS	17. Inj. 5% DNS
3. Gentamicin	11. Tab. Zinc	18.Hartmans's Solution
4. Cephradine	12. Oxytocin	19. Bupivacaine
5. Tab Metronidazole	13. Misoprostol	20. Ephedrine
6. Inj. Metronidazole	14.Magnesium Sulphate	21. Pethidine
7. Antenatal Corticosteroids	15.Sulbutamol respirator solu-	22. Inj. Furosemide
8. 7.1% Chlorhexidine	tions for use in nebulizer	23. Tab. Furosemide
		24. Ergometrine
		25. Plasmasol

MOHFW Supply Chain Management Portal (SCMP)

Ministry of Health & Family Welfare
MOHFW Supply China
Management Partal

The MOHFW Supply Chain Management Portal (SCMP) is a web-based portal accessible to the Ministry of Health and Family Welfare (MOHFW), Procuring Entities, Line Directors, Drug Administration, Hospitals and stakeholders.

This comprehensive system contains the features of product catalog, procurement planning of goods and services, package development, tracking of procurement packages and linkage with drug registration database.

1. Product catalog
2. Procurement plan
3. Procurement tracker
4. Drug registration database
5. Asset management System
6. DGFPLMIS
7. DGHSLMIS
8. Stock Status Report
9. DGFP Monthly Logistics Report
10. TB LMIS

1. Product Catalog

Product catalog module is the specification database of medicines, equipment's etc. in a structured and consistent way in the form of electronic catalogs. Each product is identified by unique code (Stock Keeping Unit – SKU) and can be accessed by the all stakeholders; conversely only authorized persons allowed to add or update product list with specifications

2. Procurement Plan

Line Directors will submit procurement requirements on online by selecting items from the approved product catalog, required quantities, expected delivery dates while consolidated procurement plan will be generated automatically in this system. On the other hand, desk officers of procuring entities (MOHFW, CMSD & DGFP-L&S) will review submissions, develop packages based on approved procurement plans

3.Procurement Tracker

This module will ensure to track the procurement packages through interactive dashboard. MOHFW, Line Directors & other stakeholders have immediate access to updated package status; thus the system will facilitate the efficient and effective procurement management in public sector. In addition, the system promotes good governance, transparency and competition in the bidding process.

4.Drug Registration Database

The module populates drugs/medicines list with detail specifications registered to Directorate General of Drug Administration. Procuring entities have the access to a list of registered drugs with Brand Names linked with Generic Name; thus this module guides the Line Directors in preparing their medicine procurement plan.

5. Asset Management System

Asset Management is a systematic process of deploying, operating, maintaining, upgrading, and disposing of assets cost-effectively. In this pilot implementation Asset Management System refers to a module within the MOHFW Supply Chain Management Portal having a wide range of features to manage assets from its registering stage to decommissioning as well as being accessible by the decision-makers at various levels of the MOHFW and other stakeholders.

6. DGFP LMIS:

DGFP LMIS is a web based tool to monitor DGFP national & regional level logistics data. Data entered at local levels and consolidated reports available in Dashboard

- Dash board
- LMIS report
- LMIS data
- SDP report
- WIMS report
- UIMS report

7.DGHS LMIS:

DGHS LMIS is a web based tool to monitor DGHS national & regional level logistics data. Data entered at local levels and consolidated reports available in Dashboard.

8.Stock status Report

Stock Status Report contains Stock status, shipment status & procurement status of contraceptives and DDS kits available in this report at a glance.

9.DGFP Monthly loggistics Report

DGFP Monthly Logistics Report containing logistics status of DGFP commodities from national to facility level. The report is generated automatically from SCMP and distributed to stakeholders.

10.TB LMIS :

TB LMIS is a web based tool to monitor the stock status of TB commodities in Central Ware House and TB stores in Bangladesh.

Human Recourse Information System (HRIS)

What is central HRIS

Central Human Resources Information System (HRIS) is an automated and systematic approach which collects and manages the HR information in a systematic, uniform as well as in consistent manner and provides decision makers (managers/policy makers/stakeholders) with the real-time information needed to assess HR problems and make effective plan accordingly.

Why HRIS is important

Central HRIS helps the policy makers to take decision based on the real-time, accurate and authentic data in terms of HR issues to ensure better service delivery at all level of facility. It supports the decision makers on the following aspects:

a. Assess the current scenario and HR gap as well as redistribute (one facility to another facility) to ensure better service

b. Project future HR gap and plan ahead for HR recruitment and deployment

c. Manage posting, leave, lien, attachment, deputation and retirement of all provider/ person's effectively, efficiently and accurately (who is on leave, lien or in deputation. HR can extract this information very easily and quickly)

d. Training management and capacity building of all providers / persons

A well-established central HRIS have the ability to generate the above information on time for the policy makers to take decision.

Role of facility managers

Central HRIS system is a continuous process to collect, regular update and manage HR data to plan the HR problems. A manager should be aware of the HRIS update status and monitor the activities. Among all the activities of HRIS, the followings are important which a manager should keep eyes on it:

a. Assign one focal person for the HRIS related activities and ensure his/her training. This person will be the Facility Admin

b. Ensure the submission of HR forms and check the data quality (completeness, correctness, human error, inconsistencies, ambiguity, duplication, authenticity)

c. Ensure computer/laptop and internet connection for the data entry

d. Ensure the completion of individual HR (provider/personal) profile data entry into the system

e. Ensure the update of transfer orders (move in / move out), deputation in or deputation out in the system on regular basis

f. Ensure the update of facility details information

g. Use support ticket for any query or any technical support or any logistic support and follow up

h. Ensure that the facility admin is getting informed about new joining, transfer, deputation for updating the HR data into the system

i. Monitor overall HRIS implementation at the facility level

Facility managers are the key role player in a facility for functioning the HRIS system at all level and get the benefits from the system.

Utilization of HRIS information

The ultimate goal of information is to be utilized for decision making process. Without utilization of information, it is meaningless. The facility managers can see the relevant reports from the HRIS system to get understand about the current HR status. The HRIS system has a list of reports with different types and categories from where a manager can extract any kind of information which he/she wants to see using permutation and combination method. Some of the utilization of HRIS information is as follows:

a. To know number of sanction post by category/ by class
b. To know number of filled post against the sanction post
c. To know number of vacant post for a sanction post
d. To know which doctor / nurse is working is in which facility
e. To know which providers are working in deputation or in attachment
f. To know who are on authorized leave from when to how long
g. To know number of facilities under one specific district or under one upazila

And many more……………….

The above are some example of reports from where a manager can get HR information and take decision accordingly.

Demonstration from live system

An overview of central HRIS will be given from live system. Useful links like report, dashboard, and others will also be demonstrated from live system.

DAY-5

Day-5 Schedule

Time	Sessions	Topics
9.00-9.45 (45 min.)	**Review of the previous day**	
9.45-11.15 (1 hour 30 minutes)	**Session-18**	**Budget Management** - Overview of Budget - IBAS system - Role of DDOs
11.15-11.30	**Tea Break**	
11.30-1.00 (1 hour 30 minutes)	**Session 19**	**Program Implementation Plan (PIP)** - Core components of PIP - PIP development cycle - Steps of PIP development
1.00-2.00 (1 hour)	**Lunch and prayer break**	
2.00-3.00 (1 hour)	**Session-20**	**Good governance and National Integrity Strategy** - Overview and principles
3.00-4.00 (1 hour)	**Posttest, Training course Evaluation, Closing**	

DAY-5

Session -18: Budget Management

Session objectives

At the end of the session the participants will be able to

- ➢ Understand budget, type of budget, budget monitoring
- ➢ Describe the role of DDOs
- ➢ Demonstrate Integrated Budget and Accounting System (IBAS)

Time: 1 hour 30 minutes

Participant's note

- In this session participants will participate in a discussion
- They will observe the live demonstration on IBAS

Handout

Budget Management

BUDGET

A **budget** is a financial plan for a defined period of time, usually a year. This plan includes approximate costs, revenues during a specific period and reflects future financial conditions. It may also include planned sales volumes and revenues, resource quantities, costs and expenses, assets, liabilities and cash flows. Budget is also used for analyzing, interpreting these calculations and comparing them to make decisions in the future. It is essential for managing spending, avoiding debts and properly allocating resources.

Companies, governments, families and other organizations use it to expresses strategic plans of activities or events in measurable terms

A budget is the sum of money allocated for a particular purpose and the summary of intended expenditures along with proposals for how to meet them. It may include a budget surplus, providing money for use at a future time, or a deficit in which expenses exceed income.

CommeSisyphe - Honoré Daumier (Brooklyn Museum)

Etymology

A budget (derived from old French word *bougette*, purse) is a quantified financial plan for a forthcoming accounting period.

Purpose

A budget helps in planning actual operations by forcing managers to consider how the conditions might change and what steps should be taken now, and by encouraging managers to consider problems before they arise. It also helps to co-ordinate the activities of the organization by compelling managers to examine relationships between their own operation and those of other departments. Other essentials of budget include:

- To control resources
- To communicate plans to various responsibility center managers
- To motivate managers to strive to achieve budget goals
- To evaluate the performance of managers
- To provide visibility into the company’s performance
- For accountability

In summary, the purpose of budgeting tools:

1. Tools provide a forecast of revenues and expenditures, that is, construct a model of how a business might perform financially if certain strategies, events and plans are carried out.
2. Tools enable the actual financial operation of the business to be measured against the forecast.
3. Lastly, tools establish the cost constraint for a project, program, or operation.

Budgeting Manager

Budgeting manager is responsible for managing the whole process of the planning and budgeting in the company. It is a very broad notion, and consists of several parts. Firstly, budgeting managers are responsible for appropriately spending and using resources in accordance with company's rules and regulations. Secondly, they must study previous budget and consider benefits and losses from previous years. In addition, budgeting managers are responsible for preparing business plans and make necessary updates of the plan according to any changes in business environment. These plans are essential for business, because resources are allocated in accordance with them. Another responsibility of budgeting manager is preparing detailed reports, which show any amendments that occurred in the budgets during financial year. These reports are usually submitted to higher management of the organization, so that they could track company's performance

Government Budget

The budget of a government is a summary or plan of the intended revenues and expenditures of that government. There are three types of government budget:

- The operating or current budget
- The capital or investment budget,
- The cash or cash flow budget.

Personal or family Budget

A personal budget or home budget is a finance plan that allocates future personal income towards expenses, savings and debt repayment. Past spending and personal debt are considered when creating a personal budget. There are several methods and tools available for creating, using and adjusting a personal budget. For example, jobs are an income source, while bills and rent payments are expenses.

Types of Budget

- **Sales budget –** an estimate of future sales, often broken down into both units and currency. It is used to create company sales goals.
- **Production budget -** an estimate of the number of units that must be manufactured to meet the sales goals. The production budget also estimates the various costs involved with manufacturing those units, including labor and material. Created by product oriented companies.
- **Capital budget -** used to determine whether an organization's long-term investments such as new machinery, replacement machinery, new plants, new products, and research development projects are worth pursuing.
- **Cash flow/cash budget** – a prediction of future cash receipts and expenditures for a particular time period. It usually covers a period in the short-term future. The cash flow budget helps the business to determine when income will be sufficient to cover expenses and when the company will need to seek outside financing.
- **Marketing budget** – an estimate of the funds needed for promotion, advertising, and public relations in order to market the product or service.
- **Project budget** – a prediction of the costs associated with a particular company project. These costs include labour, materials, and other related expenses. The project budget is often broken down into specific tasks, with task budgets assigned to each. A cost estimate is used to establish a project budget.
- **Revenue budget** – consists of revenue receipts of government and the expenditure met from these revenues. Tax revenues are made up of taxes and other duties that the government levies.

- **Expenditure budget** – includes spending data items..
- “Flexibility budget **- it is established for fixed cost and variable rate is determined per activity measure for variable cost.**
- ‘ *Appropriation budget* - a maximum amount is established for certain expenditure based on management judgment.
- **Performance budget** - it is mostly used by organization and ministries involved in the development activities .This process of budget takes into account the end results.
- **Zero based budget -** It has clear advantage when the limited resources are to be allocated carefully and objectively

Budget Monitoring:

1. What to Monitor?

- **Progress of revenue collection:**
- Whether revenue is being collected in line with the target? If not, what are the reasons for shortfall in revenue collection?
- **Actual expenditure:**
- Whether the actual expenditure is in the line with the approved budget?
- Is there any incidence of over expenditure or is the expenditure is abnormally low?

2. Purposes of Monitoring:

- To achieve the target of revenue collection;
- To prevent over expenditure;
- To ensure that expenditure trend is consistent with the normal revenue collection trend.
- To ensure that no unauthorized expenditure is incurred.
- To make a realistic projection for revised budget.

3. Who are responsible for budget monitoring?

- Respective organization;
- Respective ministry/division;
- Respective chief accounts office;
- Finance division.

4. Tool for budget monitoring:

- Monthly accounts produced by respective CAO;
- Monthly management report produced by respective CAO;
- Budget variance report;
- Budget database;

Power, Functions and Responsibilities of Drawing and Disbursing Officer (DDO)

In every government office the head of the office or program appoint a gazetted officer as drawing and disbursing officer. He or she performs work on behalf of the head of the office or program. Generally drawing and disbursing officer directly responsible to head of the office or program.

Power, Functions and Responsibilities of DDO

Definition of DDO:

DDO is an officer empowered to draw from treasury and expend it.

Source of Power of a DDO:

1. According to Subsidiary Rule (65) all office head is empowered to draw money from the treasury.

   So the office head is the DDO or he can do the work of DDO.
2. He may authorize any gazetted officer serving under him to sign a bill for him. In that case the name and signature of the officer concerned should be communicated to the disbursing officer (SR 66). This authorization does not relieve the head of the office from his ultimate responsibility.
3. In rare occasions in the absence of gazetted officer the head of the office may authorize a non-gazetted government servant to draw bills who is senior among them. It shall be done under prior authority of the head of the department (SR 66 note 1).

Functions and responsibilities:

1. Budgetary control:

DDO should look into some important issues in case of payment from govt. fund to ensure budgetary control.

i) Budgetary allocation in the concerned head.

ii) Existence of sanction from the competent authority.

iii) Compliance of concerned rules and regulations.

iv) Money should not be spent for his own or at the interest of any group.

v) Money should not be withdrawn from government fund to avoid lapse of budget.

vi) Budget should be utilized to achieve the objective for which it was allocated.

2. Preparation of bill:

During preparation of bill DDO should consider the following points:

i) Bill should be prepared in proper form.

ii) It should be signed by ink.

iii) Amount of bill should be written both in number and in word.

iv) In case of correction full signature should be given, initial is not accepted.

v) Use proper seal.

vi) Over writing is not acceptable. If needed correction can be done by using red ink and putting signature.

vii) Proper payment code should be written in the bill form.

viii) Except pay bill, all other bills must be attached with the sanction letter and relevant vouchers.

3. After preparing the bill:

- DDO must entry it into the bill register with his signature.
- In case of receipt in cash or cheque against the bill, entry should be given in the cash book and
- In case of pay and allowances the DDO must keep a pay roll register.

Compliance of rules and regulations by a DDO:

A DDO should be well aware of:

i) Financial rules;

ii) Service rules;

iii) Fundamental rules and supplementary rules;

iv) Treasury rules and subsidiary rules;

v) Accounts code;

vi) Government orders;

vii) Budgeting and classification of accounts;

The duties of the DDO are-

- To ensure economy by following relevant rules and regulations.
- To ensure security, payment and accounts of government money.
- To ensure proper payment of pay and allowances, payment of traveling allowances, bills and payment of bills for Supply and Services.

Payment of TA bills:

Before payment DDO will ensure that:

- The bill is prepared in the proper form;
- Travel was commenced in the shortest and cheapest way;
- In case of transfer TA, family members are shown according to relevant rule;
- Basic pay is shown rightly;
- Budget is shown in the bill form properly;
- Signature is also given properly;
- Proper code number is used in the bill;
- Tour diary is attached with the bill;
- Controlling officer has countersigned the bill (where applicable).

Payment for Supply and Services:

Before placing the bill to the CAO office DDO should check that:

- Budgetary allocation is present;
- Proper sanction is present;
- Applicable rules and regulations are properly followed;
- Delegation of financial power is properly observed;
- Items were supplied according to specification mentioned in the tender schedule/document;
- Items are in good condition, entered into stock register and certificate is given in the bill;
- Bills are attached with proper voucher. Example: relevant voucher, tender notice, comparative state-

ment prepared by the Tender Evaluation Committee (TEC) etc are attached;

- In case of procurement of consultancy services Expression of Interest (EOI), Short listing Evaluation Report, Proposal Evaluation Committee (PEC) report and contract should be attached;
- The Public Procurement Regulation 2003/Donor regulation is followed properly.
- Income Tax and VAT should be deducted properly.

Maintenance of cash book, other registers and books by the DDO:

DDO should maintain the following registers:

1) Cash book;
2) Petty-cash register;
3) Advance register;
4) TA bill register;
5) Supply and services register;
6) Receipt and disbursement register;
7) Bank control register;
8) Payroll register - for officers and staff;
9) Cheque registers;
10) VAT register;
11) Income Tax (IT) register;
12) Inventory Register;
13) Delegation of Financial Power;
14) Revenue and Development Budget book and
15) Annual Development Program (ADP)

In case of development projects:

DDO needs to keep the following books and registers along with the others:

1) Fund releasing procedure for the development projects;
2) Delegation of financial power for the development Projects;
3) Project Proforma /Proposal (PP) or Technical Assistance Project Proforma /Proposal (TAPP);
4) Copy of Development Credit Agreement (DCA)/Development Grant Agreement (DGA) with the donor;
5) Booklet for revision procedure of PP/TAPP issued by Planning Commission;
6) Project accounting manual for keeping accounts properly, which will help him to prepare various kinds of reports for Administrative Ministry, Finance Division, Implementation Monitoring and Evaluation Division (IMED) and Economic Relations Division (ERD) (for donor funded projects).

DDO's responsibility in keeping accounts, relation with accounts offices & other responsibilities:

- Keeping accounts of all transactions properly
- Receipts should be deposited into govt. account without delay
- Monthly and annual accounts should be prepared in time
- DDO should reconcile the monthly accounts with the CAO and

- He/she should maintain very close liaison with his/her respective CAO offices for smooth functioning of his/her responsibilities.

Other responsibilities of DDO:

- DDO can strengthen internal control by reducing misuse of govt. money.
- Any irregularity, fraud or defalcation should be communicated to the higher authority without delay.
- Adequate measures should be taken to solve audit observations promptly.

A Good DDO:

A good DDO will keep following books in hand:

1) Establishment manual Vol. 1 & Vol. 2
2) Personnel manual
3) Compilation of financial orders issued by Ministry of Finance (MOF).
4) TO &E manual
5) ERD hand book
6) The Public Procurement Regulation 2003 and Procurement procedure issued by Central Procurement Technical Unit (CPTU). Donor guidelines for procuring goods and services.
7) Delegation of financial power booklet issued by MOF

References

- *Module on Financial management training, NIPORT*
- *https://en.wikipedia.org/wiki/Budget*

DAY-5

Session -19: Program Implementation Plan

Session objectives

At the end of the session the participants will be able to

- ➢ Understand core components of program implementation
- ➢ Explain the cycle of decentralized planning and management and it's benefit
- ➢ Describe the steps of program implementation planning approach

Time: 1 hour 30 minutes

Participant's note

- In this session participants will participate in a discussion
- They will observe a video clip

Handout

Program Implementation Plan

Implementation Plan

What is Program Implementation?

Implementation is the carrying out, execution, or practice of a plan, a method, or any design, idea, model, specification, standard or policy for doing something. As such, implementation is the action that must follow any preliminary thinking in order for something to actually happen.

Six Components Necessary for Effective Public Health Program Implementation

Public health programs succeed and survive if organizations and coalitions address 6 key areas.

(1) **Innovation** to develop the evidence base for action;

(2) A **technical package** of a limited number of high-priority, evidence-based interventions that together will have a major impact;

(3) Effective **performance management**, especially through rigorous, real-time monitoring, evaluation, and program improvement;

(4) **Partnerships** and coalitions with public- and private-sector organizations;

(5) **Communication** of accurate and timely information to the health care community, decision makers, and the public to effect behavior change and engage civil society; and

(6) **Political commitment** to obtain resources and support for effective action.

Programs including smallpox eradication, tuberculosis control, tobacco control, polio eradication, and others have made progress by addressing these 6 areas.

Innovation

Innovation is essential to all aspects of public health strategy and program development and is critical to developing the evidence base needed to establish and refine the technical elements of successful program implementation.

Innovations need not be limited to science or medicine. Innovations in information systems, data collection, communication techniques, and issue framing can increase political commitment and also be essential for progress. Innovations in operations can facilitate refinement of and improvements in programs based on actual experience. Innovations in program evaluation can further build the evidence base for interventions by better identifying those that are not working as expected and those that are effective and ripe for scale-up.

Innovation can help improve program management to scale up, disseminate, and sustain high-impact interventions. Smallpox was eradicated through continuous introduction and implementation of innovation.

Technical package

The most effective public health programs are based on an evidence-based technical package: a selected group of related interventions that, together, will achieve and sustain substantial and sometimes synergistic improvements in a specific risk factor or disease outcome. A technical package of proven interventions sharpens and focuses what otherwise might be vague commitments to "action" by committing to implementation of specific interventions known to be effective. It also avoids a scattershot approach of using a large number of interventions, many of which have only a small impact.

Simplicity is key to success. The Integrated Management of Childhood Illness initiative, intended as an integrated approach that focuses on the well-being of the whole child to reduce mortality among children younger than 5 years, can improve the quality of clinical care for sick children.

Managing Performance

For many public health programs, implementation is essentially a management problem. Even if political commitment, resources, and a technical package are in place, effective management may not be. Management of public health

activities is particularly difficult because, unlike in the private sector where metrics such as product sales provide prompt feedback on performance, there is often no automatic, accurate, and affordable way to track public health program performance in real time. In addition, the impact of public health programs may not be evident for months or years, further complicating measurement of performance.

Partnership

Public health is increasingly complex, with key roles played by public- and private-sector partners that are critical to sustaining and improving the population's health. Coalitions are often essential to progress. Getting many organizations to collaborate can be slow and frustrating but is often crucial to create the advocacy needed to support budgetary, legislative, or regulatory change and to implement new or improved programs. Government programs are more likely to succeed—and to be sustained—when organizations outside of government advocate for them.

Partners can supplement available human or financial resources and can support and undertake critical activities. Helping disparate groups agree on and take action to achieve a common agenda can build effective long-term coalitions that extend beyond a specific issue. Schools, businesses, law enforcement, transportation, agriculture, labor, and many other sectors in society can contribute greatly to, and benefit greatly from, public health programs, policies, and priorities.

Communication

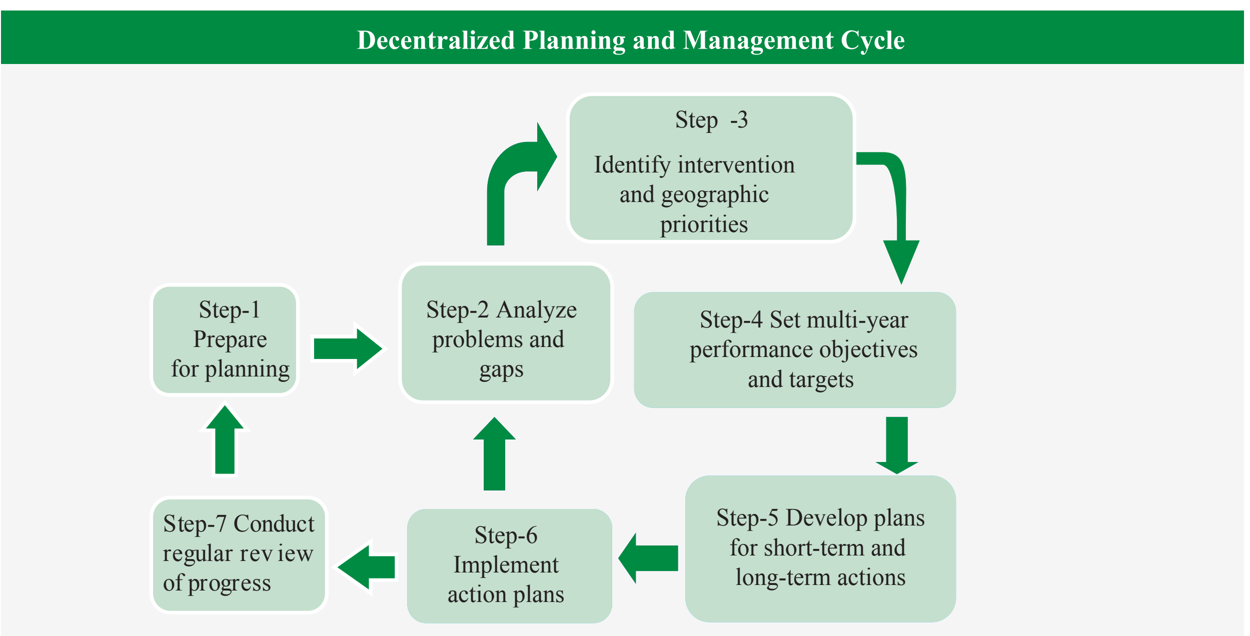
Effective communication can lead to behavior change, but, more importantly, it can lead to increased political commitment and program effectiveness by engaging a wide range of civil society sectors and by contributing to a change in the public perception of an issue. With the advent of the Internet, social media, and other communication technologies, more information is available from more sources than ever, although some is incorrect or potentially harmful. New communication tools and technologies facilitate interactive conversations, giving public health practitioners the ability to have dialogues with people from affected communities and other stakeholders. With the increase in communication channels and voices, public health communications can be drowned out unless communication strategies are timely, well defined, well executed, and sustained to meet specific objectives.

Political Commitment

Political commitment is built on and supported by the components described thus far, all of which are critical to provide government with a strong foundation for action. Effectively engaged political commitment leads to the resources and support needed to coordinate, implement, and sustain public health interventions, including policy change where needed. Change is often controversial, and the entities that implement public health programs—usually led by public health departments or other government agencies—may have less ability to influence budget and policy decisions than other groups within government and civil society.

The benefits of decentralized planning

- Identification of low performing geographies and underserved populations
- Identification the most critical interventions to accelerate implementation
- Identification supply- and demand-side bottlenecks
- Identification and prioritization of area-specific strategies to improve the performance
- Setting realistic and achievable performance targets
- Providing a platform for ongoing review, monitoring and evaluation of progress and take regular actions for improvement



Step 1: Prepare to Plan……….

- Mapping of District level stakeholders and their programs
- Situation Analysis

Step 2: Analyze problems and gaps…………

Managers are using different data for problem and gap analysis

- Population based survey data
- Service readiness data
- Service utilization data
- Quality of care data

Managers analyze MNCH-FP-N tracer indicator

- ANC, SBA, PNC, ENC, Misoprostol, CPR
- Analyze inequities: socio-economic inequities in the utilization of MNCH-FP-N services, Variations in coverage

Analyze bottle necks of problems and their root causes

Access and availability of services, Care-seeking preferences, Quality of services, Human resources, Infrastructure and equipment ,Supplies, Logistic, Social and cultural factors, Tracking systems and MIS , Coordination among provider etc

Step 3: Identify intervention and geographic priorities…..

- Assessment of performance of interventions across upazilas
- Identify the weakest unions for intensified and more targeted support.
- Identification of well performing areas to use as best practices for cross learning.

Step 4: Set multi-year performance targets

- Setting upazila level performance targets for each tracer intervention.
- Setting numerical performance targets for each of the interventions

Step 5: Plans for short term and long term actions……….

- Categorization of problems in long term and short term solutions
- Identify what actions are required to be undertaken in which of the Unions.
- Separate action plans developed for selected unions.
- Combination of actions taken by managers, providers, supervisors and stakeholders
- Supervision and quality improvement plans.

Step 6: Implementation of action plan

- Mobilization of local resources for implementation of the action plan:eg Equipment & Supplies mobilized from Regional Warehouse of Family planning
- Mobilization of Local government recourses eg. Support provided by UPs in several union Temporary staff – Aya, night guard ,Furniture, Water pumps, Medicines Waste management pits et.

Step7: Program and Performance review

Improvement in performance and success can only be achieved if there is active engagement, participation and alignment of all stakeholders including communities, civil society organizations, private sector and development partners around one results-focused district plan and one monitoring system.

Performance reviews, completed monthly at upazila level and quarterly at the district level, provide the impetus to adjust implementation plans as necessary. Recognizing that changes to the plans often have technical and financial implications, consensus-building among key stakeholders is required as well as a commitment by all to provide additional resources to support implementation to achieve common goals and targets.

The monthly upazila level reviews and quarterly district reviews (QPRM) are the main opportunities to make substantive changes in the district programming cycle. The decision to make changes will be informed by the strength of implementation as well as the performance of activities on the achievements of outputs and performance objectives. New initiatives often require the addition or modification of performance objectives, outputs and activities. These changes should be made in a way that ensure complementarities, build synergy and strengthen existing plans without displacing attention, funding and human resources. During upazila and district level reviews, the main focus should be to assess whether the district/upazila is on track with the implementation of activities and the achievements of outputs and performance objectives.

Session -20: Good Governance and National Integrity Strategy

Session Objectives

At the end of the session the participants will be able to

- Discuss the principles of good governance in health systems
- Explain National Integrity strategy
- Discuss how can upazila health system governance be strengthened (Tackling corruption, transparency and enhancing community accountability)?

Time: 1 hour

Participant's note

- In this session participants will participate in discussion on good governance and NIS

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Handout

Good Governance
National Integrity Strategy

Good Governance

Good governance is an indeterminate term used in the international development literature to describe how public institutions conduct public affairs and manage public resources. Governance is "the process of decision-making and the process by which decisions are implemented (or not implemented)". The term governance can apply to corporate, international, national, local governance or to the interactions between other sectors of society.

The concept of "good governance" often emerges as a model to compare ineffective economies or political bodies with viable economies and political bodies. The concept centers on the responsibility of governments and governing bodies to meet the needs of the masses as opposed to select groups in society. Because countries often described as "most successful" are Western liberal democratic states, concentrated in Europe and the Americas, good governance standards often measure other state institutions against these states. Aid organizations and the authorities of developed countries often will focus the meaning of "good governance" to a set of requirements that conform to the organization's agenda, making "good governance" imply many different things in many different contexts.

Good governance in national governments

Good governance in the context of countries is a broad term, and in that regards, it is difficult to find a unique definition. According to Fukuyama (2013), there are two dimensions to qualify governance as good or bad: the capacity of the state and the bureaucracy´s autonomy. They both complement, in the sense that when the state is more capable, for instance through the collection of taxes, there should be more autonomy because the bureaucrats are able to conduct things well without being instructed with a lot of details. In less capable states, however, less discretion and more rules setting are desirable.

Another way to think about good governance is through outcomes. Since governments carry out with goals like the provision of public goods to its citizens, there is no better way to think about good governance other than through deliverables, which are precisely the one demanded by citizens, like security, health, education, water, the enforcement of contracts, protection to property, protection to the environment and their ability to vote and get paid fair wages.

Similarly, good governance might be approximated with provision of public services in an efficient manner, higher participation given to certain groups in the population like the poor and the minorities, the guarantee that citizens have the opportunity of checks and balances on the government, the establishment and enforcement of norms for the protection of the citizens and their property and the existence of independent judiciary systems.

Lawson (2011) in his review of Rothstein´s book "The quality of government: corruption, social trust, and inequality in international perspective" mentions that the author relates good governance to the concept of impartiality, which is basically when the bureaucrats perform their tasks following the public interest rather than their self-interest. Lawson differs with him in that this impartial application of law ignores important factors like the economic liberalism, which matters due to its relation with economic growth.

Making distinctions between good governance and other related concepts

It is important to distinguish good governance from other concepts that look similar, such as development and economic growth. Instead of considering them as equal, many scholars refer to them as features that are likely to be related in different ways. In fact, the importance that authors give to good governance is due to the impact it may have on development and economic growth.

According to Grindle (2004), the relevance of getting good governance comes precisely from its relationship with the development of a country and the reduction of poverty. Setting an agenda for reaching good governance is of the huge interest but also a complex task, which makes this author to propose rather a "good enough governance" agenda as a starting point. In the construction of this "simpler" agenda, the idea is to revisit policies that have worked in the past, set priorities in a strategically way, consider policies with greater impact in alleviating poverty and reaching development, and look for innovative ways of implementing such policies.

In terms of economic growth, there are several authors relating that variable with good governance, but in the sense of "being related to" instead of "being part of". In other words, scholars have been intrigued by the relationship between good governance and economic or political development. Grindle (2007) mentions there are many relations to be found between indicators of good governance and economic growth, however those associations are difficult to measure and even harder to be attributed as causal. Nevertheless, she mentions the work of Kauffman (2002), who found a causal and positive relationship between different dimensions of good governance and the GDP per capita in the long run, i.e. good governance makes development possible.

These dimensions are how the government is elected and over sighted, the accountability power of citizens, the credibility in the government, the respect for institutions, both from government and citizens, and the effective delivery of public goods. He found that the relation between these two variables does not hold in the reverse direction, meaning that higher levels of economic growth do not lead to better governance. For example, Quain (2003) points out that China and Vietnam are frequent examples of countries that have made remarkable leaps in economic development and poverty reduction, but nevertheless retain many characteristics of poor governance.

National Integrity Strategy

An Inclusive Approach to Fight Corruption

Preamble: In 2007, the Government of Bangladesh acceded to the United Nations Convention against Corruption (UNCAC) and prepared a comprehensive report on the domestic institutions that could support implementation of the Convention. This report on UNCAC highlighted that corruption thrives on systemic weaknesses. In Bangladesh, just as in other countries, anti-corruption strategies can only be effective if they proactively address the need for prevention through the eradication of the causes of corruption as well as its detection and prosecution. Both public and private sectors have key roles to play here and the task of eliminating the causes of corruption will only be successful if a multi-disciplinary approach is undertaken. National Integrity Strategy (NIS) is a comprehensive set of goals, strategies and action plans aimed at increasing the level of independence to perform, accountability, efficiency, transparency and effectiveness of state and non-state institutions in a sustained manner over a period of time.

Government commitment: The Government of Bangladesh is committed to establish democracy, the rule of law, human rights, freedom of citizens as embodied in the Constitution, equality and justice in the country. The Government believes that it is necessary to create productive opportunities for citizens to lead better lives. The Government is also committed to ensuring that citizens have improved access to basic resources, education, health, food, housing, employment and fair distribution of income as well as providing an enabling environment for the active role of women in the development process.

Corruption as a major deterrent: The Government recognizes that corruption has emerged as a major deterrent against growth and development in the country, and is inhibiting the achievement of the commitment. In Bangladesh, low levels of transparency and accountability characterize the functioning of institutions in both the public and private sectors. The Government believes that the fight against corruption cannot be won by prosecution alone, an inclusive approach based on values, morals, ethics and integrity is necessary. The NIS captures this approach to help prevent corruption and enhance transparency and accountability.

Institutions in the integrity system: The integrity system comprises both State and non-state institutions. In facilitating application of the NIS, the Government wishes to engage not only the State institutions such as Parliament, the Executive, the Judiciary, Public Services, Local Government, Attorney Services, Public Service Commission, Election Commission, Anti-Corruption Commission, Office of the Comptroller and Auditor General, and Office of the Ombudsman but also the non-State institutions including civil society, political parties, NGOs, private sector, and the media. Furthermore, State and non-State educational and religious institutions will also be key players of NIS.

Bangladesh has established almost all of the required institutions for strengthening good governance and accountability and encouraged by experiences from other countries, the Government has opted for the NIS as a policy and strategy document that deals with a rational choice of vision-driven and goal-oriented strategies across institutions, making use of good practices tested elsewhere.

NIS Vision and Mission: The Government's **vision** for the country, as contained in the NIS, is **'A Bangladesh free from corruption'**. To that end, the Government is committed to implement the NIS to achieve the **Mission** that **'People and institutions embrace values and principles of integrity, and increasingly practice them as part of their individual and institutional activities'**.

How to attain the Vision and Mission: The Government envisages the following institution-specific broad measures to achieve the NIS goals:-

1. NIS foresees that the Parliament will emerge as a place for fair and rational debate for law-making and through the effective functioning of the Parliamentary Committee system demand greater accountability from the executive.

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2. The Executive – will be transparent, responsive, and accountable to people and the Parliament. NIS requires that the public servants working under the political executive are impartial, efficient, effective, and accountable. At the local level, NIS demands that the local governments are people-oriented, accountable, transparent and independent.
3. NIS envisages that the Government will ensure by providing all necessary support that the Judiciary functions as an independent, transparent, efficient, and effective organ of the State.
4. The Public Service Commission, which recruits public servants, will be transformed into an efficient, modern, and professional institution. The Election Commission will be strengthened as a fully independent constitutional body capable of organizing free and fair elections. The Office of the Attorney General and the Attorney Services will offer objective and impartial advice to the Executive without political considerations. The Office of the Comptroller and Auditor General will be strengthened as an effective institution ensuring financial accountability from all public institutions.
5. The Anti-Corruption Commission will be strengthened to be an effective agency to prevent corruption and prosecute those who are corrupt.
6. NIS envisages that the Office of the Ombudsman will be established and made operational as embodied in the constitution.
7. NIS ensures that civil society remains articulate, non-partisan, and an active campaigner for national integrity so that citizens can effectively demand transparency and accountability from public institutions. NIS will also strive to ensure that political parties be transformed into democratically-run institutions pursuing the interests of their constituencies. NIS also demands that NGOs strengthen their internal accountability, and have policies, systems, and procedures for effective service delivery for the extremely poor and disadvantaged groups. The Strategy will also enable the private sector to increase compliance with regulatory requirements for the sustained improvement of the business environment. NIS will also support a media that is free, truthful, accountable, and impartial.
8. Finally, NIS will help improve the educational system at various levels, creating a conducive environment for individuals and families to realize opportunities within an ethical framework.

NIS implementation: The Cabinet Division will affect the implementation of NIS through relevant line ministries and in collaboration and concurrence with the constitutional bodies and other institutions. A policy-making body, the National Integrity Advisory Committee (NIAC), headed by the Prime Minister/Chief Advisor and comprising members from the Cabinet and major institutions of the national integrity system will provide policy guidance.

The Cabinet Division will also facilitate the establishment of an Ethics Committee composed of the heads of the institutions. Each institution will nominate an Ethics Focal Point to maintain liaison with the Cabinet Division and manage implementation of NIS activities within the institution.

The Government of Bangladesh believes that the issue of integrity should not stop at the top level of institutions. Rather, each institution is expected to find mechanisms to implement institution-specific strategies at different tiers. The idea is to let the obligations of integrity reach down to each individual of the institutions. In that respect, every citizen will be part of the NIS.

The Government will monitor and evaluate the outcomes and impact of the strategies periodically and invite suggestions for any possible change of strategies and institutional arrangements.

To ensure that NIS is implemented effectively across the country, an immediate action plan has been prepared which accompanies this document. A more detailed document that operationalizes the NIS is being prepared which will be discussed continuously with all stakeholders so that the NIS becomes a living document.

Immediate Action Plan for Implementation of Framework NIS					
Serial	**Action points**	**Performance indicator**	**Time**	**Budget**	**Responsibility**
1	The Government approves the Frame-work NIS	Government approval is circulated	October 2008	-	Cabinet Division
2	The Government forms NIAC and Ethics Committees across institutions	Notify and inform Cabinet Division	March 2009	Good Gover-nance Program	Cabinet Division
3	Cabinet Division to communicate NIS to respective institu-tions and citizens	Institution og National Integrity System and citizen know about NIS and how it is implemented	March 2009	GoB, ADB, DANIDA	Cabinet Division & respective institu-tion
4	Cabinet Division develops and intro-duces a coordina-tion, monitoring and reporting system	Guidelines for commu-nication, monitoring tools and reporting formats are available for use	December 2008	GoB, ADB, DANIDA	Cabinet Division
5	Cabinet Division maintains ongoing consultations with all institutions repre-sented in the NIAC to review and update NIS	Action plan is continu-ously updated	Continuous	GoB, ADB, DANIDA	Cabinet Division
6			October 2008	GoB	Cabinet Division, Ministry of Infor-mation, Ministry of Law, justice and Parliamentary Affairs
7			November 2008	GoB	Local Government Division
8			December 2008	Good Gover-nance Program	Cabinet Division

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References

- *https://en.wikipedia.org/wiki/Good_governance*
- *National Entirety Strategy, GOB*

Annex- I

কমিউনিটি গ্রুপ এর কাঠামো ও গঠন প্রক্রিয়া

(Source: Community Group Oparetional & Training Manual 2012, Session 3 & 4)

৩.১ কমিউনিটি গ্রুপ

কমিউনিটি ক্লিনিক স্থাপন এবং ক্লিনিকের ব্যবস্থাপনা, পরিচালনা ও রক্ষাণাবেক্ষণ, স্বাস্থ্য সেবায় জনগণের অংশগ্রহণ ও বিদ্যমান স্বাস্থ্য সেবাপ্রাপ্তি নিশ্চিত করার জন্য কমিউনিটি ক্লিনিকের আওতাভুক্ত গ্রামসমূহের জনগোষ্ঠীর মধ্য হতে মনোনীত প্রতিনিধিদের সমন্বয় গঠিত ব্যবস্থাপনা কমিটি 'কমিউনিটি গ্রুপ' নামে অভিহিত হবে। কমিউনিটি গ্রুপ গঠনের রূপরেখা নিম্নরূপ ঃ

৩.২ কমিউনিটি গ্রুপ গঠন প্রক্রিয়া

সংশ্লিষ্ট এলাকায় কর্মরত কমিউনিটি হেলথ কেয়ার প্রোভাইডার স্বাস্থ্ সহকারী ও পরিবার কল্যাণ সহকারীদের সহযোগিতায় সহকারী স্বাস্থ্য পরিদর্শক এবং পরিবার পরিকল্পনা যৌথভাবে সংশ্লিষ্ট ইউনিয়ন পরিষদের সাথে যোগাযোগ করে কমিউনিটি গ্রুপ গঠনের উদ্যোগ গ্রহণ করবেন।

কমিউনিটি গ্রুপ গঠন কল্পে নিম্নোক্ত পদ্ধতি/ধাপ অনুসরণ করা হবেঃ

ধাপ ১ : কমিউনিটি হেলথ কেয়ার প্রোভাইডার সহকারী স্বাস্থ্য পরিদর্শক পরিবার পরিকল্পনা পরিদর্শক ও মাঠকর্মীদের (স্বাস্থ্য সহকারী ও পরিবার কল্যাণ সহকারী) সহয়তা নিয়ে ইউনিয়ন পরিষদ এর সাথে কমিউনিটি গ্রুপ গঠনের উদ্দেশ্য ও তাদের দায়িত্ব কর্তব্য সম্বন্ধে আলোচনা করবেন।

ধাপ ২ : এলাকার নেতৃস্থানীয় ব্যাক্তিবর্গ, সমাজসেবা কাজে আগ্রহী স্ব-উদ্যোগী জনগণ, শিক্ষক ও বিভিন্ন শ্রেণী/পেশার প্রতিনি-ধিত্বকারী ব্যক্তিবর্গের সাথে কমিউনিটি গ্রুপ গঠনের উদ্দেশ্যে ও তাদের দায়িত্ব কর্তব্য সম্বন্ধে আলোচনা করবেন এবং তাদেরকে কমিউনিটি গ্রুপ গঠনের সভায় উপস্থিত হওয়ার জন্য উৎসাহিত করবেন।

ধাপ ৩ : কমিউনিটি হেলথ কেয়ার প্রোভাইডার সহকারী স্বাস্থ্ পরিদর্শক, পরিবার পরিকল্পনা পরিদর্শক ও মাঠকর্মীদের (স্বাস্থ্ সহকারী ও পরিবার কল্যাণ সহকারী) সহযোগিতায় কমিউনিটা গ্রুপের সদস্য হতে পারেন এমন ব্যক্তিবর্গের একটি খসড়া তালিকা প্রণয়ন করবেন এবং সভায় যোগদানের জন্য আহবান জানাবেন।

ধাপ ৪ : ইউনিয়ন পরিষদের চেয়ারম্যান, উপজেলা স্বাস্থ্য ও পরিবার পরিকল্পনা বিভাগের কর্মকর্তা/তাদের পতিনিধিসহ এলা-কাবাসীর উপস্থিতিতে অনুষ্ঠিত সভায় প্রতিটি ক্লিনিকেরর জন্য ১টি করে কমিউনিটি গ্রুপ গঠন করা হবে।

ধাপ ৫ : কমিউনিটি গ্রুপ গঠন শেষে কমিউনিটি গ্রুপের সকল সদস্যের দায়িত্ব-কর্তব্য সম্বন্ধে আলোচনা করবেন।

কমিউনিটি গ্রুপ গঠনের পর গ্রুপের সদস্য-সচিব তা ইউনিয়ন পরিষদের অনুমোদনপূর্বক উপজেলা স্বাস্থ্য ও পরিবার পরিকল্পনা কর্মকর্তা, উপজেলা পরিবার পরিকল্পনা কর্মকর্তা এবং উপজেলা পরিষদকে অবহিত করবেন।

৩.৩ কমিউনিটি গ্রুপের সদস্য

৩.৩.১ নিয়মিত সদস্য

প্রস্তাবিত কমিনিটি গ্রুপ নিম্নেবর্ণিত ৯-১৩ জন নিয়মিত সদস্যের সমন্বয়ে গঠিত হবে (তন্মধ্যে কমপক্ষে ৪ জন মহিলা থাকা অবশ্যক)। সদস্য মনোয়নের ক্ষেত্রে মনে রাখতে হবে যে, সদস্যগণ যেন কোন একটা বিশেষ অংশের বাসিন্দা না হন, বরং তারা যেন প্রকৃতপক্ষে সমগ্র এলাকার প্রতিনিধিত্বকারী হতে পারেন। এই কমিটিতে এলাকার মহিলা, দরিদ্র/হতদরিদ্র, বি-ধবা/স্বামী পরিত্যক্তা, পতিবন্ধী, ভূমিহীন ও নিম্নআয় সম্পন্ন জনগোষ্ঠী, কিশোরী/কিশোরদের প্রতিনিধিত্বের বিষয়টি বিশেষ বিবেচনায় রাখতে হবে।

ক. কমিউনিটি ক্লিনিকেরর আওতাভুক্ত এলাকায় বসবাসকারী সংশ্লিষ্ট ইউনিয়ন পরিষদের ওয়ার্ড সদস্যগণ (বর্তমান পরিষদের নির্বাচিত সদস্য) পদাধিকার বলে কমিউনিটি গ্রুপের সদস্য হিসাবে অন্তর্ভুক্ত থাকবেন। সাধারণভাবে ১ জন ইউনিয়ন পরিষদ সদস্য ১টি গ্রুপের সদস্য থাকবেন, তবে ঐ সদস্য সর্বোচ্চ ২ টি কমিউনিটি গ্রুপের সদস্য থাকবে পারবেন।

খ. জমিদার কিংবা তার ১জন প্রতিনিধি সদস্য হিসাবে অন্তর্ভুক্ত হবেন;

গ. কমিউনিটি গ্রুপের ১ জন মুক্তিযোদ্ধা সদস্য হিসাবে অন্তর্ভুক্ত হবেন;

ঘ. শিক্ষক (উক্ত এলাকায় অবস্থিত শিক্ষা প্রতিষ্ঠানের একজন অভিজ্ঞ ও সমাজসেবায় আগ্রহী শিক্ষক) বা স্থানীয় সামাজিক ও সাংস্কৃতিক গোষ্ঠী বা ধর্মীয় নেতা প্রতিনিধি হিসাবে ২ জনকে গ্রুপের সদস্য হিসাবে অন্তর্ভুক্ত করতে হবে। এদের মধ্যে অন্ততঃ ১ জন হবেন মহিলা;

ঙ. এলাকায় দরিদ্র/ভূমিহীন বা নিম্ন আয় সম্পন্ন জনগোষ্ঠীর প্রতিনিধি হিসাবে ২ জনকে গ্রুপের সদস্য হিসাবে অন্তর্ভূক্ত করতে হবে। এদের মধ্যে একজন মহিলা/কিশোরী/প্রতিবন্ধী হওয়ার বাঞ্চনীয়;

চ. কমিউনিটি হেলথ কেয়ার প্রোভাইডার ভোটদানের অধিকার ব্যতীত কমিউনিটি গ্রুপের সদস্য-সচিব হিসাবে অন্তর্ভূক্ত থাকবে;

ছ. এলাকায় বসবাসরত ন্যূনতম ৪ জন মহিলা এই গ্রুপের সদস্য হিসাবে অন্তর্ভুক্ত থাকবেন। ইউনিয়ন পরিষদের মহিলা সদস্য যদি সংশ্লিষ্ট কমিউনিটি ক্লিনিকের আওতার্ভুক্ত এলাকার বাসিন্দা হন তবে তিনি অবশ্যই পদাধিকার বলে এই গ্রুপের সদস্য হি-সাবে অন্তর্ভুক্ত থাকবেন। সদস্য হিসাবে অন্তর্ভুক্তির ক্ষেত্রে স্বেচ্ছায় ও নিঃস্বার্থে এলাকার উন্নয়নে স্বাস্থ্যসেবার সাথে প্রত্যক্ষ বা পরোক্ষভাবে জড়িত মহিলাদের অগ্রধিকার দিতে হবে।

৩.৩.২ পর্যবেক্ষক সদস্য

কমিউনিটি ক্লিনিকে কর্মরত স্বাস্থ্য সহকারী ও পরিবার কল্যাণ সহকারী ভোটদানের অধিকার ব্যতীত পর্যবেক্ষক সদস্য হিসাবে অন্তর্ভুক্ত থাকবেন।

৩.৩.৩ অতিরিক্ত (কো-অপ্ট) সদস্য

কমিউনিটি ক্লিনিকের কাজ সুষ্ঠুভাবে পরিচালনা এবং কোন বিশেষ কাজ সম্পাদনের লক্ষে কমিউনিটি গ্রুপ প্রয়োজনবোধ সেরূপ যোগ্য সর্বোচ্চ ২ জন ব্যক্তিকে গ্রুপের অতিরিক্ত (কো-অপ্ট) সদস্য হিসাবে অন্তর্ভুক্ত করতে পারবেন। কো-অপ্ট সদস্য ২ জন হলে তার মধ্যে ১ জন মহিলা হওয়া আবশ্যক। তাদের কোন ভোটাধিকার থাকবে না।

৩.৩.৪ আজীবন সদস্য

কেবলমাত্র জমিদাতা কিংবা তার প্রতিনিধি কমিউনিটি গ্রুপের আজীবন সদস্য হিসাবে গণ্য হবেন।

৩.৪ কমিউনিটি গ্রুপের কাঠামো

গ্রুপ গঠনের পরবর্তী ৩০ দিনের মধ্যে সংশ্লিষ্ট ইউনিয়ন পরিষদের চেয়ারম্যানের আহবানে গ্রুপের ১ সভা অনুষ্ঠিত হবে। উক্ত সভায় গ্রুপ সদস্যদের পর্যালোচনা ও অনুমোদন সাপেক্ষে সদস্যদের দায়িত্ব ও কর্তব্য নির্ধারণ করতে হবে।

সভাপতি : সংশ্লিষ্ট কমিউনিটি ক্লিনিক এলাকার নির্বাচিত জনপ্রতিনিধি (ইউনিয়ন পরিষদের সদস্য) পদাধিকার বলে কমিউনিটি গ্রুপের সভাপতি হিসাবে মনোনীত/নির্বাচিত হবেন। যদি এক্ষেত্রে উক্ত কমিউনিটি ক্লিনিক এলাকায় একের অধিক নির্বাচিত জনপ্রতিনিধি থাকেন তবে সে ক্ষেত্রে ইউনিয়ন পরিষদের চেয়ারম্যান ও কমিউনিটি গ্রুপের অন্যান্য সদস্যদের মধ্যে আলোচনার ভিত্তিতে সভাপতি নির্বাচন হওয়া আবশ্যক। যে ইউনিয়ন পরিষদ সদস্য এর বাড়ী কমিউনিটি ক্লিনিক ভবনের নিকটবর্তী তাকে কমিউনিটি গ্রুপের সভাপতি হিসাবে মনোনীত/নির্বাচিত করা উত্তম।

সহ-সভাপতি-১ ও ২ : গ্রুপের সদস্যদের মধ্যে থাকে ২ জনকে সহ-সভাপতি হিসাবে মনোনীত/নির্বাচিত করতে হবে। ১ জন জমিদাতা কিংবা তার প্রতিনিধি এবং ২য় গ্রুপের সদস্যদের মধ্যে আলোচনার ভিত্তিতে মনোনীত/নির্বাচিত হবেন। সভাপতি ও সহ-সভাপতি এই ৩ জনের মধ্যে কমপক্ষে ১জন মহিলা হওয়া আবশ্যক।

কোষাধ্যক্ষ : সভাপতি, সহ-সভাপতি ও সদস্য-সচিব ব্যতীত অন্য ১জন নিয়মিত সদস্যকে কোষাধ্যক্ষ হিসাবে মনোনীত/ নির্বাচিত করতে হবে।

সদস্য-সচিব : কমিউনিটি হেলথ কেয়ার প্রোভাইডার সদস্য-সচিব হিসাবে দায়িত্ব পালন করবেন। সদস্য-সচিব কমিউনিটি গ্রুপকে সকল বিষয়ে দাপ্তরিক সহায়তা প্রদান করবেন। তার ভোট দানের অধিকার থাকবে না। সিএইচসিপি এর বর্তমানে স্বাস্থ্য সহকারী/পরিবার কল্যাণ সহকারী দায়িত্ব পালন করবেন যা কমিউনিটি গ্রুপ নির্ধারণ করবেন।

পর্যবেক্ষক সদস্য (২) ঃ কমিউনিটি ক্লিনিকে কর্মরত স্বাস্থ্য সহকারী এবং পরিবার কল্যাণ সহকারী এই ২ জন ৯-১৩ নিয়মিত সদস্যের অতিরিক্ত পর্যবেক্ষক সদস্য হিসাবে অন্তর্ভূক্ত হবেন। তাদের ভোটাধিকার থাকবে না।

** কিশোর/কিশোরীর ভোটাধিকার থাকবে না ।

৩.৫ কমিউনিটি গ্রুপের মেয়াদ

কমিউনিটি গ্রুপের কার্যকালে মেয়াদ হবে গ্রুপ গঠনেরর তারিখ থেকে পরবর্তী ২ বৎসর । তবে মেয়াদ শেষ হবার পরেও নবগঠিত গ্রুপের ১ম সভা অনুষ্ঠিত না হওয়া পর্যন্ত পূর্বতন গ্রুপ তাদের কাজ চালিয়ে যাবেন এবং নবগঠিত গ্রুপের ১ম সভায় নতুন গ্রুপের নিকট তাদের দায়িত্বভার হস্তান্তর করবেন । এ দায়িত্বভার হস্তান্তর প্রক্রিয়া সংশ্লিষ্ট ইউনিয়ন পরিষদ চেয়ারম্যানের তত্ত্বাবধানে অনুষ্ঠিত হবে, অন্যথায় তা বৈধ হিসাবে গণ্য হবে না । কমিউনিটি গ্রুপের দায়িত্ব হস্তান্তর প্রক্রিয়ায় উপজেলা স্বাস্থ্য ও পরিবার পরিকল্পনা কর্মকর্তা, উপজেলা পরিবার পরিকল্পনা কর্মকর্তা এবং উপজেলা নির্বাহী কর্মকর্তা অথবা তাদের প্রতিনিধিবৃন্ধ উপস্থিত থাকবেন ।

৩.৬ নতুন গ্রুপ গঠন প্রক্রিয়া

১টি কমিউনিটি গ্রুপের কার্যকালের মেয়াদ শেষ অনুচ্ছেদ ৩.২, ৩.৩ এবং ৩.৪ অনুযায়ী নতুন গ্রুপ হবে এবং সদস্য- সচিব তা যথারীতি ইউনিয়ন পরিষদের অনুমোদনপূর্বক উপজেলা স্বাস্থ্য ও পরিবার পরিকল্পনা কর্মকর্তা ও উপজেলা চেয়ারম্যানকে অবহিত করবেন ।

৩.৭ কমিউনিটি গ্রুপ সদস্যের পদত্যাগ

কমিউনিটি গ্রুপের যে কোন সদস্য ব্যক্তি গত বা শারীরিক কারণে সভাপতির নিকট আবেদনের মাধ্যমে পদত্যাগ করতে পারবেন । এই পদত্যাগের বিষয়টি গ্রুপের পরবর্তী সভায় আলোচনা করতে হবে এবং পদত্যাগপত্র গৃহীত হলে পদটিকে শূণ্য ঘোষণাপূর্বক ইউনিয়ন পরিষদকে অবহিত করতে হবে । সভাপতির পদত্যাগের ক্ষেত্রে ইউনিয়ন পরিষদের চেয়ারম্যান বরাবর আবেদন করতে হবে । সংশ্লিষ্ট পদটি শূন্য ঘোষিত হওয়ার পর কমিউনিটি গ্রুপ ইউনিয়ন পরিষদের অনুমোদনক্রমে ঐ শূন্যপদে উপযুক্ত কোন ব্যক্তিকে মনোনীত করবেন । এই মনোনয়নের জন্য ৩.৩ অনুচ্ছেদ বর্ণিত শর্তসমূহের যেটি প্রযোজ্য সেটি অনুসরণ করতে হবে ।

৩.৮ কমিউনিটি গ্রুপ সদস্যের সদস্যপদ বাতিল/শূন্য

নিম্ন বর্ণিত কারণে কমিউনিটি গ্রুপ সদস্যদের সদস্যপদ বাতিল/শূন্য বলে গণ্য হবে:

(ক) মৃত্যু;

(খ) শারীরিক অক্ষমতার কারণে দায়িত্ব পালনে অপারগতা/অক্ষমতা;

(গ) এলাকা ত্যাগ করে অন্যত্র বসবাস (জমিদাতার ক্ষেত্রে তা প্রযোজ্য হবে না);

(ঘ) তহবিল তসরূপ বা অন্য কোন শৃঙ্খলাজনিত কারণে;

(ঙ) ফৌজদারী মামলায় সাজাপ্রাপ্ত হলে এবং

(চ) কার্যকালের মেয়াদ শেষে ।

এছাড়াও কোন সদস্য পর পর ৩টি মাসিক সভায় উপস্থিত না হলে তার সদস্যপদ বাতিল বলে বিবেচিত হতে পারে । তবে এ ক্ষেত্রে সংশ্লিষ্ট সদস্যকে পত্রের মাধ্যমে কমিউনিটি গ্রুপের কাজে উৎসাহী হওয়ার আহবার জানিয়ে সক্রিয় অংশগ্রহণের সুযোগ দান করা বাঞ্ছনীয় । পত্র প্রদানের পর পরবর্তী ১ মাস সংশ্লিষ্ট সদস্য মাসিক সভায় অংশগ্রহণ না করলে কমিউনিটি গ্রুপ আলো-চনাপূর্বক তার সদস্যপদ বাতিল করতে পারবে । সদস্যপদ বাতিলের বিষয়টি অবশ্যই সংশ্লিষ্ট ব্যক্তিকে এবং সংশ্লিষ্ট ইউনিয়ন পরিষদকে পত্রের মাধ্যমে অবহিত করতে হবে । উল্লেখিত ৩.৮ (ঘ) এবং ৩.৮ (ঙ) ধারার যে কোন কারণে যদি কোন সদস্যের সদস্যপদ বাতিল হয়ে যায় তবে পরবর্তীতে তিনি কমিটিতে অন্তর্ভূক্ত হতে পারবেন না ।জমিদাতা মারা গেলে/শারীরিক ভাবে অক্ষম হলে তার পরিবার থেকে ১ জন প্রস্তাবিত সদস্যকে কমিটির অনুমোদন সাপেক্ষে আজীবন সদস্য হিসাবে অন্তর্ভূক্ত করা হবে ।

৩.৯ নতুন/শূন্য পদে সদস্য অন্তর্ভূক্তি

নিয়মিতভাবে মনোনীত সদস্যদের মধ্যে হতে কারো সদস্যপদ ৩.৭ এবং ৩.৮ ধারা অনুসারে শূন্য/বাতিল হলে তা শূন্য পদ হিসাবে পরিগণিত হবে এবং ঐ শূন্য পদের জন্য এলাকর জনগণের মধ্য হতে সদস্য মনোনয়ন করতে হবে । শূন্যপদে নতুন কোন ব্যক্তিকে সদস্য হিসাবে অন্তর্ভূক্ত করা হলে তা অবশ্যই গ্রুপ সভার সিদ্ধান্ত মোতাবেক সংশ্লিষ্ট ইউনিয়ন পরিষদ বরাবর অনুমোদনেরর জন্য প্রেরণ করতে হবে । ইউনিয়ন পরিষদের অনুমোদনেরর পর তার সদস্যপদ কার্যকর হবে । সভাপতি,

সহ-সভাপতি ও কোষাধ্যক্ষের পদ যদি শূন্য হয় সে ক্ষেত্রে মনোনীত নতুন কোন সদস্য সরাসরি সে পদের অধিকারী হতে পারবেন না। নতুন সদস্য অন্তর্ভুক্তির পর কমিউনিটি গ্রুপ পুনরায় সভা করে নিজেদের মধ্যে আলোচনাক্রমে সেই পদের (সভাপতি, সহ-সভাপতি ও কোষাধ্যক্ষ) জন্য যোগ্য বলে বিবেচিত ব্যক্তিকে মনোনয়ন করে ইউনিয়ন পরিষদের নিকট অনুমোদনের জন্য প্রেরণ করবেন। সভাপতি ও সহ-সভাপতির পদ শূন্য থাকা অবস্থায় যদি কোন সভা করতে হয় তাহলে সভার দিন অন্যান্য সদস্যদের মতানুযায়ী ১ জন সদস্য ঐ সভার ভারপ্রাপ্ত সভাপতি হিসাবে দায়িত্ব পালন করবেন। কোন সদস্যপদ শূন্য হলে ৩০ দিনের মধ্যে ইউনিয়ন পরিষদের অনুমোদনসহ সেই পদ পূরণের প্রক্রিয়া সম্পন্ন করতে হবে।

৩.১০ কমিউনিটি গ্রুপের অবলুপ্তি

৩.১০.১ কমিউনিটি গ্রুপ বিলুপ্তের কারণ

(ক) কমিউনিটি গ্রুপ সঠিকভাবে নিজেদের দায়- দায়িত্ব পালন না করলে;

(খ) পর পর ৩ মাস নিয়মিত মাসিক সভা না করলে;

(গ) কোন আর্থিক অসঙ্গতি বা তহবিল তসরূপ করলে এবং

(ঘ) সংশ্লিষ্ট সরকারী নির্দেশনাবলী পালন না করলে বা নির্দেশনাবলী পরিপন্থী কার্যক্রম পরিচালনা করলে।

উপরোল্লিখিত এক/একাধিক সমস্যা উদ্ভূত হলে ইউনিয়ন পরিষদ চেয়ারম্যান তা সরেজমিনে পর্যবেক্ষণ করবেন এবং নিম্নোক্ত পদক্ষেপ গ্রহণ করবেন;

(১)পর্যাবেক্ষণে পরিক্ষিত ত্রুটিসমূহ উল্লেখ করে সতর্কতামূলক পত্র জারি করবেন এবং পরবর্তী ১ মাস গ্রুপের কার্যক্রমে পর্যবেক্ষণ করবেন;

(২) সতর্কতামূলক পত্র প্রাপ্তির ১মাস মধ্যে যদি কমিউনিটি গ্রুপের সদস্যগণ উক্ত ত্রুটিসমূহ সংশোধনপূর্বক পুনরায় এ গ্রুপের কার্যাবলী সঠিকভাবে পরিচালনা করতে উৎসাহিত হন তাহলে তিনি গ্রুপের কার্যক্রম পুনরায় চালু করার জন্য পত্রজারির প্রয়োজনীয় ব্যবস্থা গ্রহণ করবেন এবং

(৩) সতর্কতামূলক পত্র জারির ১ মাসের মধ্যে যদি কমিউনিটি গ্রুপ কার্যক্রম পরিচালনায় উদ্যোগী না হয় তাহলে সংশ্লিষ্ট ইউনিয়ন পরিষদ কমিউনিটি গ্রুপ অবলুপ্তির জন্য উপজেলা স্বাস্থ্য ও পরিবার পরিকল্পনা কর্মকর্তার নিকট প্রস্তাব প্রেরণ করবেন। প্রস্তাবের অনুলিপি সংশ্লিষ্ট কমিউনিটি গ্রুপের সভাপতিকে নোটিশের মাধ্যমে জানিয়ে দেবেন।

৩.১০.২ অবলুপ্তি ঘোষণা

ইউনিয়ন পরিষদের প্রস্তাবপ্রাপ্তির পর উপজেলা স্বাস্থ্য ও পরিবার পরিকল্পনা কর্মকর্তা এর উদ্যোগে উপজেলা নির্বাহী কর্মকর্তা এবং উপজেলা পরিবার পরিকল্পনা কর্মকর্তা বিষয়টি যৌথভাবে অনুর্ধ্ব ১৫ দিনের মধ্যে তদন্তপূর্বক অভিযোগের সত্যতা প্রমাণিত হলে সংশ্লিষ্ট গ্রুপের অবলুপ্তি ঘোষণার সুপারিশ লিখিতভাবে উপজেলা পরিষদকে অবহিত করবেন। উপজেলা পরিষদ কর্তৃক অনুমোদিত হলে অবলুপ্তির ঘোষণা ইউনিয়ন পরিষদ চেয়ারম্যানকে অবহিত করা হবে। ইউনিয়ন পরিষদের নিকট থেকে কোন গ্রুপ অবলুপ্তির প্রস্তাব প্রাপ্তির পরবর্তী ১ (এক) মাসের মধ্যে উপজেলা পরিষদ কর্তৃক এ বিষয়ে চূড়ান্ত সিদ্ধান্ত গ্রহণ এবং তা ইউনিয়ন পরিষদ চেয়ারম্যানকে অবহিত করবেন। বিলুপ্তি ঘোষণার পরবর্তী ১ (এক) মাসের মধ্যে সংশ্লিষ্ট ইউনিয়ন পরিষদ চেয়ারম্যান নতুন কমিউনিটি গ্রুপ গঠন প্রক্রিয়া সম্পূন্নপূর্বক নতুন গ্রুপের সক্রিয় করবেন।

৩.১১ অবলুপ্তি ঘোষণান্তে নতুন গ্রুপের মেয়াদ

অবলুপ্তি ঘোষিত কমিউনিটি গ্রুপ গঠনেরর তারিখ হতে ২ বছর (অনুচ্ছেদ ৩.৫ দৃষ্টব্য)।

৩.১২ কমিউনিটি গ্রুপের জবাবদিহিতা

নির্বাচিত জনপ্রতিনিধি ও স্থানীয় সরকার প্রধান হিসাবে সংশ্লিষ্ট ইউনিয়ন পরিষদের চেয়ারম্যান কমিউনিটি গ্রুপের সরাসরি তত্ত্বাবধায়কের দায়িত্ব পালন করবেন। ইউনিয়ন পরিষদ চেয়ারম্যানের তত্ত্বাবধান প্রতিবেদন উপজেলা পরিষদ চেয়ারম্যান উপজেলা নির্বাহী অফিসার, উপজেলা স্বাস্থ্য ও পরিবার পরিকল্পনা কর্মকর্তা এবং উপজেলা পরিবার পরিকল্পনা কর্মকর্তাকে অবহিত করবেন। স্থানীয় মাননীয় সংসদ সদস্য, উপজেলা চেয়ারম্যান এবং ভাইস-চেয়ারম্যান ও কমিউনিটি ক্লিনিকের কাজ তত্ত্বাবধান করবেন এবং ক্লিনিকের উন্নয়নে প্রয়োজনীয় দিক নির্দেশনা প্রদান করবেন। মাননীয় সংসদ সদস্যের মতামত ও দিক-নির্দেশনাসমূহ এবং উপজেলা

চেয়ারম্যান ও ভাইস-চেয়াম্যানের পরামর্শ কমিউনিটি গ্রুপকে গুরত্বের সাথে বিবেচনা করাসহ বাস্তবায়নের পদক্ষেপ গ্রহণ করতে হবে।

নিম্নোক্ত কর্মকান্ডের মাধ্যমে কমিউনিটি গ্রুপ ইউনিয়ন পরিষদেরে নিকট দায়বদ্ধ থাকবে ঃ

(ক) কমিউনিটি গ্রুপ তাদের কার্যকলাপ সম্পর্কে নিয়মিতভাবে ইউনিয়ন পরিষদকে অবহিত রাখবেন। এ লক্ষে গ্রুপের সভার কার্যবিবরণী সমূহের অনুলিপি ইউনিয়ন পরিষদ চেয়ারম্যানের নিকট প্রেরণ করবেন এবং উপজেলা স্বাস্থ্য ও পরিবার পরিকল্পনা কর্মকর্তা এবং উপজেলা পরিবার পরিকল্পনা কর্মকর্তা বরাবর অনুলিপি দেবেন;

(খ) ইউনিয়ন পরিষদ চেয়ারম্যান নিয়মিতভাবে তার কার্যক্রমের অংশ হিসাবে সংশ্লিষ্ট ইউনিয়নভুক্ত কমিউনিটি ক্লিনিকসমূহ পরিদর্শন করবেন এবং ক্লিনিকসমূহ সুষ্ঠুভাবে পরিচালনার জন্য প্রয়োজনীয় উপদেশ/পরামর্শ প্রদান করবেন;

(গ) ইউনিয়ন পরিষদের মাসিক সমন্বয় সভায় আলোচ্যসূচিতে কমিউনিটি ক্লিনিক বিষয়টি নিয়মিতভাবে অন্তর্ভূক্ত করবেন এবং কমিউনিটি গ্রুপের সভাপতি এবং সদস্য-সচিব উপস্থিত থেকে সার্বিক কর্মকান্ডের অগ্রগতি আলোচনা করবেন;

(ঘ) প্রতি ৩ মাস অন্তর ইউনিয়ন পরিষদের চেয়ারম্যানের সভাপতিত্বে ইউনিয়ন পরিষদ কার্যালয়ে ইউনিয়নে আওতাধীন সকল কমিউনিটি গ্রুপের সভাপতি, সহ-সভাপতি, কোষাধ্যক্ষ ও সদস্য-সচিবের উপস্থিতিতে ও অংশগ্রহণে ১টি আলোচনা সভা অনুষ্ঠিত হবে। উক্ত সভায় কমিউনিটি ক্লিনিকের সার্বিক ব্যবস্থাপনা ও কাজের অগ্রগতি বিশদভাবে আলোচনা করবেন। এ আলোচনার মাধ্যমে বিভিন্ন কমিউনিটি গ্রুপের সদস্যগণ একে অপরের কাজ সম্পর্কে অবহিত হবেন। এ পর্যালোচনা সভায় উপজেলা চেয়ারম্যান, উপজেলা নির্বাহী সদস্যগণ একে অপরের কাজ সম্পর্কে অবহিত হবেন। এ পর্যালোচনা সভায় উপজেলা চেয়ারম্যান, উপজেলা নির্বাহী অফিসার, উপজেলা স্বাস্থ্য ও পরিবার পরিকল্পনা বিভাগের কর্মকর্তাবৃন্দ উপস্থিত থেকে উৎসাহ এবং প্রয়োজনীয় দিক নির্দেশনা দিবেন।

কমিউনিটি গ্রুপ ও এর সদস্যবৃন্দের দায়িত্ব ও কার্তব্য

৪.১ কমিউনিটি গ্রুপের দায়িত্ব

কমিউনিটি ক্লিনিক সুষ্ঠুভাবে পরিচালনা, রক্ষণাবেক্ষণ, স্বাস্থ্য সেবায় জনগনের অংশগ্রহণ ও বিদ্যমান স্বাস্থ্য সেবা প্রাপ্তি নিশ্চিত করার লক্ষ্যে কমিউনিটি গ্রুপ নিম্নবর্ণিত দায়িত্ববলী পালন করবেন;

৪.১.১ কমিউনিটি ক্লিনিকের নিরাপত্তার বিধান

কমিউনিটি ক্লিনিক ভবন, আসবাবপত্র, যন্ত্রপাতি ও নানাবিধ সরঞ্জামাদির নিরাপত্তা বিধানকল্পে কমিউনিটি ক্লিনিকের নিকটবর্তী বসবাসরত গ্রুপ সদস্যদেও মধ্যে ১ জন আগ্রহী ও উপযুক্ত সদস্যদেও নেতৃত্বে ১টি নিরাপত্তা উপ-কমিটি গঠন করতে হবে। এই কমিটিতে ইউনিয়ন পরিষদেও চৌকিদার, গ্রাম পুলিশ, আনসার-ভিডিপি, কমিউনিটি ক্লিনিক সংলগ্ন আধিবাসী এবং এলাকার যুব সম্পৃক্ত করা যেতে পারে। তবে ১ জন নৈশ প্রহরী নিয়োগ করাই সর্বোত্তম। কমিউনিটি গ্রুপের নিজস্ব তহবিল থেকে এই নৈশ প্রহরীর ভাতা প্রদানের ব্যবস্থা করা যেতে পারে।

৪.১.২ কমিউনিটি ক্লিনিকের পরিস্কার-পরিচ্ছন্নতা

কমিউনিটি গ্রুপ ও এলাকাবাসী (স্বেচ্ছাশ্রমের) কমিউনিটি ক্লিনিকের পরিস্কার পরিচ্ছন্নতা নিশ্চিত করবেন। এ ক্ষেত্রে নিয়মিতভাবে ক্লিনিক ভবনের ছাদ পরিস্কারের বিষয়টি বিশেষভাবে খেয়াল রাখতে হবে। নিয়োগকৃত প্রহরীকে কমিউনিটি ক্লিনিকের পরিস্কার পরিচ্ছন্নতার দায়িত্বে নিয়োজিত করা যেতে পারে।

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৪.১.৩ কমিউনিটি ক্লিনিকের রক্ষণাবেক্ষণ

(ক)দৈনন্দিন রক্ষণাবেক্ষণ

কমিউনিটি গ্রুপ কমিউনিটি ক্লিনিকের দৈনন্দিন কাজ পরিচালনার জন্য প্রয়োজনীয় সকল সামগ্রী এবং স্বাস্থ্য, পরিবার টিউবওয়েলের অন্যন্য মেরামত, কেরোসিন স্টোভের তেলের সংস্থান, প্রযোজ্য ক্ষেত্র বিদ্যুৎ ও গ্যাস বিল প্রদান, আসবাবপত্র মেরামত ইত্যাদি। সরবরাহকৃত কোন যন্ত্রপাতি অকেজো বা নষ্ট হলে কমিউনিটি গ্রুপ সংশ্লিষ্ট কর্মীর মাধ্যমে তা উপজেলা স্বাস্থ্য কমপ্লেক্স থেকে মেরামত করিয়ে নেওয়া বা পুনরায় সংগ্রহের উদ্যোগ গ্রহণ করবেন অথবা স্থানীয়ভাবে মেরামতের ব্যবস্থা নিবেন। এক্ষেত্রে গ্রুপের তহবিল থেকে ব্যয় নির্বাহ করা যেতে পারে।

(খ) দীর্ঘ মেয়াদী রক্ষণাবেক্ষণ

কমিউনিটি ক্লিনিকের দেয়াল রং করা, ছাদ, মেঝে ও দেয়ালের সংস্কার ইত্যাদি দীর্ঘ মেয়াদী রক্ষণাবেক্ষণ কাজের ব্যয় কমিউনিটি গ্রুপ তাদেও তহবিল থেকে নির্বাহ করতে পারেন। প্রয়োজনবোধে কমিউনিটি গ্রুপ এসব কাজে ইউনিয়ন পরিষদেও সহায়তা নেবেন। তবে বড় ধরণের কোন সম্প্রসারণের জন্য কমিউনিটি গ্রুপ প্রয়োজনবোধ সরকারী আর্থিক সাহায্য ও এলাকার জনগণের স্বেচ্ছাশ্রম এবং/অথবা অনুদানের মাধ্যমে তা সম্পাদনের উদ্যোগ গ্রহণ করবেন। এ ছাড়া ইউনিয়ন পরিষদ অথবা উপজেলা প্রশাসনের সাথে যোগাযোগের মাধ্যমে প্রয়োজনীয় সরকারী আর্থিক সহায়তার প্রচেষ্ঠা চালাবেন।

৪.১.৪ কমিউনিটি ক্লিনিক কর্মএলাকায় তথ্য সংগ্রহ, সমস্যা চিহ্নিতকরণের মাধ্যমে বার্ষিক কর্মপরিকল্পনা প্রণয়ন

সরকার দেশের গ্রামীণ জনগণের দোরগোড়ায় একটি নির্দিষ্ট মানসম্মত স্বাস্থ্য, পরিবার পরিকল্পনা ও পুষ্টি সেবা প্রদানের পূর্বশর্ত হচ্ছে একটি কার্যকরী স্থানীয় পর্যায়ের পরিকল্পনা প্রণয়ন ও তার সঠিক বাস্তাবায়ন। একটি কার্যকরী স্থানীয় পর্যায়ের পরিকল্পনার সঠিক বাস্তবায়নের জন্য স্থানীয় সমস্যা ও সম্পদ চিহ্নিতকরণ এবং সম্পদের সঠিক ব্যবহার নিশ্চিতকরণ অতীত জরুরী। সংযুক্ত পদ্ধতিগুলো ব্যবহার কওে কমিউনিটি ক্লিনিক কর্মএলাকায় ১টি বার্ষিক কর্মপরিকল্পনা তৈরি করা হবে যা পরবর্তীতে উপজেরা পর্যায়ে সমন্বয়ের মাধ্যমে উক্ত উপজেলার বার্ষিক কর্মপরিকল্পনা হিসাবে বিবেচিত হবে।

৪.১.৫ কমিউনিটি সাপোর্ট গ্রুপ তৈরী করা

বিস্তারিত অধিবেশন ৬-এ বর্ণিত আছে।

৪.১.৬ কমিউনিটি ক্লিনিক সম্পর্কে জনগণকে উবুদ্ধকরণ

কমিউনিটি গ্রুপ এলাকার জন্ম ও মৃত্যুও তথ্য, রোগের তথ্য, অপুষ্ট শিশুদেও তথ্য, টিকা গ্রহণ থেকে বাদ পড়া শিশু ও মহিলাদেও তথ্য, গর্ভবতী ও প্রসবোত্তর মহিলা যারা স্বাস্থ্য প্রতিষ্ঠানের সেবা নিচ্ছেন না বা যারা প্রতিবন্ধী তাদেও তথ্য, যক্ষ্মা, কুষ্ঠ, ম্যালেরি-য়া, রোগ, আর্সেনিকোসিস রোগের ঔষধ গ্রহণ থেকে বিরত থাকা রোগীদেও তথ্য দিয়ে মাঠকর্মীদেও সহযোগিতা করবেন। জটিল রোগীদেও সেবা প্রদানকারীদেও কাছে যেতে উদ্বুদ্ধ করবেন। মনেরাখতে হবে যে, কমিউনিটি ক্লিনিকের সর্বোচ্চ ব্যবহার নিশ্চিত হলেই জনগণের স্বাস্থ্য সেবা নিশ্চিত হবে।

৪.১.৭ কমিউনিটি ক্লিনিকের তহবিল গঠন

কমিউনিটি গ্রুপ কমিউনিটি ক্লিনিকের কার্যক্রম পরিচালনা এবং রক্ষণাবেক্ষণের ব্যায়ভার নির্বাহের জন্য একটি তহবিল গঠন করবেন। এই তহবিলের অর্থ সংগ্রহের উপায় সম্পর্কে সংশ্লিষ্ট কমিউনিটি গ্রুপ প্রয়োজনীয় সিদ্ধান্ত নেবেন।

৪.১.৭.১ তহবিল সংরক্ষণ

কমিউনিটি গ্রুপের তহবিলের অর্থ স্থানীয় একটি ব্যাংক/পোষ্ট অফিস-এ জমা রাখতে হবে। উক্ত জমাকৃত অর্থ সংশ্লিষ্ট কমিউনিটি ক্লিনিকের নামে জমা থাকবে। সভাপতি, সহ-সভাপতি-১ অপারগতায় সহ-সভাপতি-২ এবং কোষাধ্যক্ষ এই ৩ জন উক্ত তহবিল পরিচালনার দায়িত্বে থাকবেন। এই হিসাব থেকে অর্থ উত্তোলনের জন্য কোষাধ্যক্ষসহ সভাপতি অথবা সহ-সভাপতি যে কোন ২ জনের স্বাক্ষরের প্রয়োজন হবে। কোষাধ্যক্ষ সর্বোচ্চ ১,০০০ (এক হাজার) টাকা পর্যন্ত নগদ অর্থ কমিউনিটি গ্রুপ/ক্লিনিকের কাজ পরিচালনার জন্য নিজের কাছে রাখতে পারবেন।

৪.১.৭.২ হিসাব নিরীক্ষা

প্রতি অর্থ বছর শেষে (অর্থবছর-১লা জুলাই থেকে ৩০শে জুন) প্রয়েজনবোধে সংশ্লিষ্ট ইউনিয়ন পরিষদ কমিউনিটি গ্রুপের হিসাব নিরীক্ষা করবেন এবং প্রতিবেদন উপজেলা পরিষদে দাখিল করবেন। সেই সাথে প্রতিবেদনের অনুলিপি উপজেলা স্বাস্থ্য ও পরিবার পরিকল্পনা কর্মকর্তা ও উপজেলা পরিবার পরিকল্পনা কর্মকর্তার নিকট পাঠাবেন।

৪.১.৭.৩ আপত্তি নিস্পত্তির ব্যবস্থা

হিসাব সংক্রান্ত বিষয়ে কোন আপত্তি উত্থাপন করতে হবে এবং পরিষদেও সিদ্ধান্তই চূড়ান্ত বলে গণ্য হবে।

৪.১.৮ কমিউনিটি গ্রুপের সাংগঠনিক দায়িত্ব

* নিয়মিত মাসিক সভা:

কমিউনিটি গ্রুপ প্রতি মাসে অন্তনঃ ১ বার সভায় মিলিত হবেন। সভা কমিউনিটি ক্লিনিকে অথবা কমিউনিটি গ্রুপ কর্তৃক নির্বাচিত কোন স্থানে অনুষ্ঠিত হবে। উক্ত সভায় কমিউনিটি ক্লিনিকের পরিচালনা, রক্ষণাবেক্ষণ, ব্যবস্থাপনা, সেবার মান, দেয় সেবা ও সুবিধাদিও সর্বোত্তম ব্যবহার ইত্যাদি বিষয়ে পর্যালোচনা করা হবে। কমিউনিটি ক্লিনিকের মাসিক অগ্রগতি এবং উদ্ভূত সমস্যাসমূহ উক্ত সভায় আলোচনা করা হবে। এই আলোচনার ভিত্তিতে পরবর্তী মাসের প্রধান করণীয় ও অন্যান্য করণীয় কার্যাবলী নির্ধারণ করা হবে।

৪.১.৯ কমিউনিটি ক্লিনিকের সুষ্ঠু পরিচালনা ও ক্লিনিক থেকে কার্যকর সেবা প্রদান নিশ্চিত করার জন্য কমিউনিটি গ্রুপের সাথে স্বাস্থ্য ও পরিবার পরিকল্পনা মাঠ পর্যায়ের সেবাপ্রদানকারী, ইউনিয়ন পর্যায়ের তত্ত্বাবধায়ক এবং উপজেলা পর্যায়ের ব্যবস্থাপ-কবৃন্দেও সাথে সু-সম্পর্ক থাকা বাঞ্ছনীয়।

৪.২ কমিউনিটি গ্রুপ সদস্যদের দায়িত্ব ও কর্তব্য

(ক) সভাপতি

(১) সভাপতি সদস্য-সচিবের সাথে আলোচনা কওে নিয়মিতভাবে মাসিক সভাসহ যাবতীয় সভা আহবান করবেন এবং সভায় সভাপতিত্ব করবেন;

(২) কোন বিশেষ সভার প্রয়োজন হলে তা আয়োজনের উদ্যোগ গ্রহণ করবেন;

৩) কমিটি কর্তৃক গৃহীত সিদ্ধান্ত সমূহ বাস্তবায়নের প্রয়োজনীয় পদক্ষেপ গ্রহণ করবেন;

৪) কমিউনিটি ক্লিনিক পরিচালনায় কোন সমস্যা উদ্ভূত হলে তা নিরসন বা সমাধান কল্পে প্রয়োজনীয় উদ্যোগ গ্রহণ করবেন;

৫) কমিউনিটি গ্রুপের আয়ের ব্যাপাওে সহায়তা দিবেন এবং আয় ও ব্যায়ের হিসাব তদারকী করবেন;

৬) কমিউনিটি ক্লিনিক পরিচালনা সংক্রান্ত বিষয়ে প্রয়োজনমত ইউনিয়ন পরিষদ ও ইউনিয়ন স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্র, উপজেলা স্বাস্থ্য কমপ্লেক্স ও অন্যান্য স্বাস্থ সেবাপ্রদানকারী সংস্থা/সংগঠনের সাথে যোগাযোগ রক্ষা করবেন;

৭) কমিউনিটি ক্লিনিক ব্যবস্থাপনা সংক্রান্ত বিষয়ে প্রয়োজনমত ইউনিয়ন পরিষদ ও উপজেলা পরিষদেও সাথে যোগাযোগ রক্ষা করবেন;

৮) কমিউনিটি ক্লিনিক ব্যবস্থাপনা সংক্রান্ত সকল কাজ তদারক করবেন;

৯) নিয়মিতভাবে কমিউনিটি ক্লিনিক পরিদর্শনপূর্বক সেবাগ্রহণকারীদেও মতামত নিয়ে সে অনুসাওে ব্যবস্থা নিবেন;

১০) কোষাধ্যক্ষের সাথে যৌথভাবে ব্যাংকের আর্থিক বিষয়দি পরিচালনা করবেন;

১১) সদস্যদের দ্বায়িত্ব পালনের ক্ষেত্রে দক্ষতাবৃদ্ধি ও বিকল্প নেতৃত্ব তৈরিতে সহায়তা করবেন।

খ) সহ-সভাপতি ১-২

১) সহ-সভাপতি নিয়মিতভাবে সভায় অংশগ্রহণ করবেন এবং কমিউনিটি ক্লিনিক সুষ্ঠভাবে পরিচালনার জন্য প্রয়োজনীয় সিদ্ধান্ত প্রহণে সভাপতিকে সাহায্য ও সহযোগিতা করবেন;

২) স্বাধীনভাবে নিজের মতামত দিবেন ও সমস্যার সমাধানে উদ্যোগী হবেন;

৩) সভাপতির অবর্তমানে সহ-সভাপতি-১, তার অবত্যামানে সহ-সভাপতি-২ সভাপতির যাবতীয় দায়িত্ব পালন করবেন;

৪) সহ-সভাপতি-১ এর অপারগতায় সহ-সভাপতি-২ কোষাধ্যক্ষের সাথে যৌথভাবে ব্যাংকের আর্থিক বিষয়াদি পরিচালনা করবেন; এবং

৫) সভাপতি কর্তৃক অর্পিত যে কোন দায়িত্ব পালন করবেন।

গ) কোষাধ্যক্ষ

১) কমিউনিটি গ্রুপের তহবিলের আয় ও ব্যায়ের হিসাব রাখবেন;

২) ক্যাশ বই ও অন্যান্য রেজিস্টারের মাধ্যমে এই হিসাব রক্ষণাবেক্ষণ করবেন;

৩) ব্যাংক একাউন্ট ও ব্যাংকের হিসাবপত্র যথাযথভাবে রক্ষণাবেক্ষণের দায়িত্বে থাকবেন;

৪) নিয়মিতভাবে আয় ব্যায় সংক্রান্ত মাসিক/ত্রৈমাসিক/ষাণ্মাসিক/বাৎসরিক প্রতিবেদন তৈরি করবেন; এবং

৫) সভাপতি কর্তৃক অর্পিত অন্যান্য যে কোন দায়িত্ব পালন করবেন।

ঘ) সদস্য

১) সদস্যবৃন্দ নিয়মিতভাবে সভায় অংশগ্রহণ করবেন এবং কমিউনিটি ক্লিনিক সুষ্ঠুভাবে পরিচালনার জন্য প্রয়োজনীয় সিদ্ধান্ত গ্রহণে সভাপতিকে সাহায্য ও সহযোগিতা করবেন;

২) সভায় আলোচনা সাপেক্ষে সভাপতি কর্তৃক প্রদত্ত যে কোন দায়িত্ব সুচারুরূপে ও নিষ্ঠার সাথে সম্পন্ন করবেন;

৩) স্বাধীনভাবে নিজেদেও মতামত প্রদান ও সমস্যার সমাধানে উদ্যোগী হবেন; এবং

৪) সাপোর্ট গ্রুপ তৈরি ও তার কার্যক্রম পরিচালনায় সহায়তা প্রদান করবেন।

(ঙ) সদস্য-সচিব

১) সদস্য-সচিব সভাপতির সাথে আলোচনাক্রমে বা তার অনুমোদনক্রমে মাসিক সভা ও প্রয়োজনমত অন্যান্য সভা আহবান এবং অনুষ্ঠানের ব্যবস্থা করবেন;

২) মাসিক সভায় উপস্থাপনের জন্য কমিউনিটি ক্লিনিকের কার্যক্রমের অগ্রগতির প্রতিবেদন প্রস্তুত করবেন;

৩) সভার কার্যবিবরণী প্রস্তুত করবেন এবং তার অনুলিপিসমূহ যথাযথ কর্তৃপক্ষ বরাবর প্রেরণের ব্যবস্থা করবেন;

৪) সভার কার্যবিবরণী ও অন্যান্য রেকর্ডপত্র সংরক্ষণ করবেন;

৫) সভাপতি, সহ-সভাপতি ও কোষাধ্যক্ষকে কমিউনিটি ক্লিনিকের কার্যক্রম পরিচালনায় সহযোগিতা প্রদান করবেন;

৬) সভাসমূহের আলোচনায় অংশগ্রহণ করবেন এবং মতামত রাখবেন। তবে দাপ্তরিক কর্মী বিধায় তার ভোট প্রয়োগের ক্ষমতা থাকবে না;

৭) নিয়মিতভাবে সেবাগ্রহণকারীদের মতামত নিয়ে তদানুযায়ী ব্যবস্থঅ গ্রহণ করবেন।

(চ) পর্যবেক্ষক সদস্য

পর্যবেক্ষক সদস্যগণ কমিউনিটি গ্রুপ কর্তৃক প্রদেয় দায়িত্ব পালন করবেন; তাদেও ভোটাধিকার থাকবে না।

(ছ) কো-অপ্ট সদস্য

কো-অপ্ট সদস্যগণ কমিউনিটি গ্রুপ কর্তৃক প্রদেয় দায়িত্ব পালন করবেন; তাদেও ভোটাধিকার থাকবে না।

DAY-5

কমিউনিটি সাপোর্ট গ্রুপ এবং জনগণকে উদ্বুদ্ধকরণ

(Source: Community Group Oparetional & Training Manual 2012, Session 6)

৬.১ কমিউনিটি সাপোর্ট গ্রুপ (সিএসজি)

কমিউনিটি সার্পোট গ্রুপ গঠনের প্রেক্ষাপট ঃ

বাংলাদেশের বেশির ভাগই (প্রায় ৭০ ভাগ) গ্রামে বসবাস করে যার শতকরা ৩০-৪০ ভাগ এর অবস্থান দারিদ্রসীমার নীচে। এ বিশাল জনগোষ্ঠী তাদের অর্থনৈতিক অসচ্ছলতা ও অন্যান্য সামাজিক ভৌগলিক সমস্যার কারণে সকল জরুরি স্বাস্থ্য সেবা যথাযথভাবে পৌছানো যাচ্ছে না। সরকার ও উন্নয়ন সহযোগী সংস্থাসমূহ বিভিন্ন প্রকল্পের মাধ্যমে এ জনগোষ্ঠীকে সেবার আওতায় আনার চেষ্ঠা করে যাচ্ছে।

সবিধাবঞ্চিত এই জনগোষ্ঠীকে সকল জরুরি স্বাস্থ্য সেবার আওতায় আনতে হলে প্রয়োজন কমিউনিটি ক্লিনিক কর্মএলাকার জনগে-াষ্ঠী সমন্বয়ে "কমিউনিটি সাপোর্ট গ্রুপ" তৈরি করা, যারা উক্ত সুবিধাবঞ্চিতদের প্রয়োজনীয় সহায়তা দিবেন। এ সাপোর্ট গ্রুপ কমিউনিটি গ্রুপের কর্মকান্ডে সহায়তা করবেন।

কমিউনিটি সাপোর্ট গ্রুপ হচ্ছে কমিউনিটি গ্রুপকে গতিশীল করা ও এলাকার জনগণের স্বাস্থ্য, পরিবার পরিকল্পনা ও পুষ্টি সেবা নিশ্চিত করার জন্য স্বেচ্ছাপ্রণোদিত উদ্বুদ্ধ মহিলা, পুরুষ, কিশোর/কিশোরী, হতদরিদ্র, পতিবন্ধীসহ সমাজের সর্বস্তরের প্রতি-নধিত্বকারী ব্যক্তিদের সমন্বয়ে গঠিত একটি গ্রুপ। এই গ্রুপ কমিউনিটি ক্লিনিক এর মাধ্যমে এলাকার জনগোষ্ঠীকে সেবাদান ও পরিচালনার ক্ষেত্রে 'কমিউনিটি গ্রুপ' কে সার্বিকভাবে সহায়তা করবেন।

বর্তমানে সরকার এবং উন্নয়ন সহযোগী ও বেসরকারী সংস্থা বিভিন্ন স্থানে কমিউনিটি সাপোর্ট গ্রুপের মাধ্যমে কার্যক্রম বস্তাবায়ন করছে। ফলে সংশ্লিষ্ট এলাকায় দরিদ্র ও সুবিধাবঞ্চিত জনগণের সেবাগ্রহণের হার বৃদ্ধি পেয়েছে। এ সকল কার্যক্রমের শিখণ ব্যবহার করে কমিউনিটি সাপোর্ট গ্রুপ তৈরি এবং কমিউনিটি ক্লিনিক কার্যক্রমে সাপোর্ট গ্রুপের সক্রিয় অংশগ্রহণ নিশ্চিত করা সম্ভব।

৬.২ কমিউনিটি সাপোর্ট গ্রুপ এর উদ্দেশ্য

- মা ও শিশু স্বাস্থ্য, পরিবার পরিকল্পনা পদ্ধতি, পুষ্টি, কমিউনিটি ক্লিনিকসহ বিভিন্ন সেবাকেন্দ্র হতে প্রাপ্ত সেবা সম্পর্কে জনগণের মধ্যে সচেতনতা তৈরি এবং জরুরি সেবা প্রাপ্তিতে সেবা কেন্দ্রে সময়মত প্রেরণে সহযোগিতা করা।
- স্বাস্থ্য শিক্ষা প্রসারের মাধ্যমে স্বাস্থ্য সম্মত জীবন-যাপন উদ্বুদ্ধ করা।
- শিক্ষার প্রসারের মাধ্যমে স্বাস্থ্যসহ সকল সামাজিক উন্নয়ন এবং কুসংস্কার দূরীকরণ।
- স্থানীয় সম্পদ আহরণের মাধ্যমে কমিউনিটি গ্রুপের জন্য একটি তহবিল তৈরিতে সহায়তা করা যা ব্যবহার করে কমি-উনিটি ক্লিনিকের রক্ষণাবেক্ষণসহ উক্ত এলাকার অবহেলিত ও দরিদ্র জনগণকে জরুরি চিকিৎসা সেবাপ্রাপ্তিতে সহায়তা করা সম্ভব।

৬.৩ কমিউনিটি সাপোর্ট গ্রুপের গঠন প্রক্রিয়া ও তৈরির ধাপ সমূহ

৬.৩.১ কমিউনিটি সাপোর্ট গ্রুপ গঠন প্রক্রিয়াঃ

১টি কমিউনিটি ক্লিনিকের কর্মএলাকায় ৩টি কমিউনিটি সাপোর্ট গ্রুপ তৈরি করা হবে। এই লক্ষ্যে ৩টি এলাকায় সাপোর্ট গ্রুপ তৈরির সকল কর্মকান্ড পরিচালনা ও পর্যবেক্ষণ করার জন্য কমিউনিটি গ্রুপের সদস্যদের মধ্যে দায়িত্ব বন্টন করতে হবে। এক্ষেত্রে যে এলাকায় কমিউনিটি সাপোর্ট গ্রুপ তৈরি করা হবে, সে এলাকার ২/৩ জন কমিউনিটি গ্রুপের সদস্যের মধ্যে দায়িত্ব বন্টন করা বাঞ্ছনীয়। দায়িত্বপ্রাপ্ত কমিউনিটি গ্রুপের সদস্যগণ তাদের কাজের সুবিধার্থে এবং কমিউনিটি সাপোর্ট গ্রুপ তৈরি ও এর কর্মকান্ড বাস্তবায়নে জন্য উক্ত এলাকা হতে কিছু স্ব-উদ্যোগী লোকজনকে চিহ্নিতপূর্বক তাদের অংশগ্রহণ নিশ্চিত করবেন।

কমিউনিটি সাপোর্ট গ্রুপের কাঠামো নিম্নরূপঃ

আহবায়ক	ঃ	১ জন
• যুগ্ন-আহবায়ক	ঃ	২ জন
• সদস্য সচিব (তিনি অবশ্যই সংশ্লিষ্ট কমিউনিটি সাপোর্ট গ্রুপ কর্ম এলাকায় বসবাসকারী কমিউনিটি গ্রুপের ১ জন সদস্য হবেন)	ঃ	১ জন
• নিয়মিত সদস্য (সদস্য বলতে সদস্য/সদস্যা উভয়কে বুঝাবে)	ঃ	অবশিষ্ট ০৯ থেকে ১১ জন
• কো-অপ্ট সদস্য (প্রয়োজন সাপেক্ষে)	ঃ	২ জন
(অর্থাৎ কমিউনিটি সর্বোচ্চ ১৭ সদস্যবিশিষ্ট হবে)		

৬.৩.২ কমিউনিটি সাপোর্ট গ্রুপ তৈরির ধাপঃ

কমিউনিটি সাপোর্ট গ্রুপ তৈরির শুরুতে সিএইচসিপি'র উদ্যোগে সংশ্লিষ্ট স্বাস্থ্যসহকারী এবং পরিবার কল্যাণ সহকারীর সহায়তায় এবং ইউনিয়নের AHI ও FPI এর তত্ত্বাবধানে দায়িত্বপ্রাপ্ত কমিউনিটি গ্রুপের সদস্যগণ এলাকার চিহ্নিত স্ব- উদ্যোগী লোকজনকে সাথে নিয়ে সংশ্লিষ্ট এলাকার মাতৃ বা শিশুমৃত্যুর বিষয়গুলিসহ অন্যান্য স্বাস্থ্য ও সামাজিক বিষয়ক সমস্যাসমূহ পর্যালোচনা করবেন এবং ১টি গ্রাম সভায় আয়োজন করে সেই গ্রাম সভায় তা উপস্থাপন করবেন। সিএইচসিপির অনুপস্থিতে দায়িত্বপ্রাপ্ত স্বাস্থ্য সহকারী/ পরিবার কল্যাণ সহকারী উদ্যোগকারীর ভূমিকা পালন করবেন।

এ বিষয়ে সংশ্লিষ্ট এলাকার সহকারী ও বেসরকারী মাঠ কর্মীগণ সিএইচসিপিকে সার্বিক সহায়তা দিবেন। উপজেলা হতে তত্ত্বাব-ধায়ক পর্যায়ের কোন প্রতিনিধি উপস্থিত থাকলে এটি অধিকতর ফলপ্রসূ হবে।

ধাপ ১ ঃ সংশ্লিষ্ট এলাকায় ১টি করে গ্রাম সভার আয়োজন করতে হবে। সভায় উক্ত এলোকার সকল শ্রেণী ও পেশার মানুষের উপস্থিতি নিশ্চিত করতে হবে। গ্রাম সভায় অন্যান্য তথ্য উপস্থাপনের পাশাপাশি মাতৃ বা শিশুমৃত্যুর ঘটনাবলী পর্যালোচনার ফলাফল ও অন্যান্য গুরুত্বপূর্ণ স্বাস্থ্য ও সামাজিক বিষয়ক সমস্যাসমূহ উপস্থাপন করতে হবে। কি করলে মাতৃ বা শিশু মৃত্যু কম-ানো যায়, অবহেলিত ও দরিদ্র মানুষের স্বাস্থ্যসেবা নিশ্চিত করা যায় ইত্যাদি ব্যাপারে উপস্থিত সকলের সাথে কার্যকরী আলোচনা করতে হবে।

ধাপ ২ ঃ উক্ত গ্রাম সভায় ১টি কমিউনিটি সাপোর্ট গ্রুপ গঠন করতে হবে যার সদস্য সংখ্যা হবে ১৩-১৫ জন। নির্ধারিত কর্ম-এলাকার সবগুলি পরিবার কমিউনিটি ক্লিনিক সংক্রান্ত কার্যক্রমের আওতাধীন থাকবে। গ্রাম সভায় মৌখিক ভোটের মাধ্যমে কমিউনিটি সাপোর্ট গ্রুপ গঠন করা হবে এবং একই ভাবে অর্থাৎ মৌখিক ভোটের মাধ্যমে নবগঠিত কমিউনিটি সাপোর্ট গ্রুপের সদস্যগণ তাদের মধ্য হতে ১ জন আহবায়ক, ২ জন যুগ্ম-আহবায়ক ও ১জন সদস্য-সচিব মনোনীত/নির্বাচিত করবেন। সদস্য সচিব অবশ্যই সংশ্লিষ্ট সাপোর্ট গ্রুপ কর্মএলাকার বাসিন্দা এবং কমিউনিটি গ্রুপের সদস্য হওয়া আবশ্যক।

ধাপ ৩ ঃ কমিউনিটি সাপোর্ট গ্রুপ গঠন হবার পর উক্ত এলাকার কমিউনিটি গ্রুপ তাদের সভার সিদ্ধান্তের মাধ্যমে নবগঠিত কমিউনিটি সাপোর্ট গ্রুপের অনুমোদন দিবেন এবং নবগঠিত কমিউনিটি সাপোর্ট গ্রুপের তালিকায় কমিউনিটি গ্রুপ এর সভাপতি ও সদস্য সচিব স্বাক্ষর করে তালিকাটি ইউনিয়ন পরিষদের চেয়ারম্যান এবং উপজেলা স্বাস্থ্য ও পরিবার পরিকল্পনা কর্মকর্তার নিকট প্রেরণ করবেন। তালিকায় কমিউনিটি সাপোর্ট গ্রুপের নাম ও নম্বর, সদস্যের নাম, পিতা/স্বামীর নাম, মাতার নাম, বয়স, পদবী, মোবাইল নম্বরা, ন্যাশনাল আইডি নং ও পেশার উল্লেখ করতে হবে।

* কমিউনিটি সাপোর্ট গ্রুপ গঠনের নমুনা ছক সংযুক্তি-খ এ দেওয়া হল (পৃষ্ঠা ঃ ২)।

কমিউনিটি সাপোর্ট গ্রুপ আলোচনা সাপেক্ষ তাদের সাপোর্ট গ্রুপের নাম ঠিক করবেন এবং ১টি নম্বর দিবেন। ১টি কমিউনিটি ক্লিনিকের আওতায় যেহেতু ৩টি কমিউনিটি সাপোর্ট গ্রুপ তৈরি হবে এ জন্য কমিউনিটি সাপোর্ট গ্রুপ এর নম্বর লেখার সময় কমিউনিটি ক্লিনিকের নাম লেখার পর সাপোর্ট গ্রুপের নাম লিখে ১, ২ বা ৩ লিখতে হবে। ইতি মধ্যে উপজেলা স্বাস্থ্য ও পরিবার পরিকল্পনা কর্মকর্তা কর্তৃক কমিউনিটি সাপোর্ট গ্রুপ কর্মএলাকা নির্ধারিত করা হয়েছে।

৬.৩.৩ কমিউনিটি সাপোর্ট গ্রুপ ও এর সদস্যগণের দায়িত্ব ও কর্তব্য

কমিউনিটি সাপোর্ট গ্রুপ গঠনের পরবর্তী ৩০ দিনের মধ্যে গ্রুপের ১ম সভা অনুষ্ঠিত হবে। উক্ত সভায় কমিউনিটি সাপোর্ট গ্রুপের সদস্যগণ গ্রুপ সদস্যদের দায়িত্ব ও কর্তব্য সর্ম্পকে আলোচনা করে নিজ নিজ নির্ধারিত দায়িত্ব-কর্তব্য বুঝে নেবেন ও তা পালনের অঙ্গীকার করবেন।

৬.৩.৪ কমিউনিটি সাপোর্ট গ্রুপের সদস্য ও কাঠামো

৬.৩.৪.১ কমিউনিটি সাপোর্ট গ্রুপের সদস্যঃ

প্রস্তাবিত কমিউনিটি সাপোর্ট গ্রুপ নিম্নেবর্ণিত শ্রেণীসমূহ (ক্যাটাগরী) হতে ১৩-১৫ জন নিয়মিত সমন্বয়ে গঠিত হবে। এই সদস্যদেরে মধ্যে ন্যূনতম এর তৃতীয়াংশ সদস্য মহিলা হতে হবে। সদস্য মনোনয়নের ক্ষেত্রে খেয়াল রাখতে হবে যে, সদস্যগণ যেন কোন একটা এলাকার বিশেষ বিবেচনায় রেখে নিম্নবর্ণিত জনগোষ্ঠীর সমন্বয়ে কমিউনিটি সাপোর্ট গ্রুপ গঠন করতে হবেঃ

- মুক্তিযোদ্ধ ও প্রবীণ গুণীজন, অবসরপ্রাপ্ত চাকুরীজীবী;
- শিক্ষক (উক্ত এলাকায় অবস্থিত শিক্ষা প্রতিষ্ঠানের ১ জন অভিজ্ঞ ও সমাজসেবায় আগ্রহী শিক্ষক) বা স্থানীয় সামাজিক ও সাংস্কৃতিক গোষ্ঠী বা ধর্মীয় নেতা বা সাংবাদিককে সাপোর্ট গ্রুপের সদস্য হিসাবে অন্তভূক্ত করতে হবে;
- এলাকার দরিদ্র/ভূমহীন বা নিম্ন আয় সম্পন্ন জনগোষ্ঠীর প্রতিনিধি হিসাবে ২ জনকে গ্রুপের সদস্য হিসাবে অন্তর্ভূক্ত করতে হবে। এদের মধ্যে একজন মহিলা হওয়া বাঞ্ছনীয়;
- কিশোর/কিশোরী (কমপক্ষে ৯ম শ্রেণী থেকে উর্দ্ধে), শারীরিকভাবে প্রতিবন্ধী, স্থানীয় এলাকার ক্লাব/সমিতির প্রতিনিধি, স্থানীয়ভাবে স্বাস্থ্যসেবায় নিয়োজিত ব্যক্তি (পল্লি চিকিৎসক/ধাত্রী), গ্রাম পুলিশ/চৌকিদার;
- ইউনিয়ন পরিষদের মহিলা সদস্য যদি সংশ্লিষ্ট কমিউনিটি সাপোর্ট গ্রুপের আওতাভুক্ত এলাকার বাসিন্দা হন তবে তিনি এই গ্রুপের সদস্য হিসাবে অন্তর্ভুক্ত থাকতে পারেন;
- এলাকার বাজার/বণিক সমিতির সবাপতি বা প্রতিনিধি এবং প্রান্তিক জনগোষ্ঠী (জেলে/কামার/কুমার ইত্যাদি) এবং
- সদস্য হিসাবে অন্তর্ভুক্তির ক্ষেত্রে স্বেচ্ছায় নিঃস্বার্থে এলাকার উন্নয়নে স্বাস্থ্যসেবার সাথে প্রত্যক্ষ ভাবে জড়িত মহিলাদের অগ্রাধিকার দিতে হবে।

৬.৩.৪.২ কমিউনিটি সাপোর্ট গ্রুপের কাঠামো

আহবায়ক (১ জন) ঃ নবগঠিত কমিউনিটি সাপোর্ট গ্রুপের সদস্যগণ আলোচনা সাপেক্ষে তাদের মধ্যে হতে ১ জন যোগ্য মলিা বা পুরুষকে আহবায়ক হিসাবে মনোনীত করবেন। আহবায়ক নির্বাচনের ক্ষেত্রে স্ব-উদ্যোগী, স্বেচ্ছায়, নিঃস্বার্থে এলাকার উন্নয়নে এবং স্বাস্থ্যসেবার সাথে জড়িত আছেন বা জড়িত থাকতে আগ্রহী এবং স্বেচ্ছাপ্রণোদিত হয়ে পর্যাপ্ত সময় দিতে সক্ষম এমন কাউকে বিবেচনা করা আবশ্যক।

যুগ্ম-আহবায়ক-১ ও ২ (২ জন) ঃ সাপোর্ট গ্রুপের সদস্যদের মধ্য থেকে ২ জনকে যুগ্ম-আহবায়ক হিসাবে মনোনীত/নির্বাচিত করতে হবে।

(আহবায়ক এবং ২ যুগ্ম-আহবায়ক এই ৩ জনের মধ্যে কমপক্ষে ১ জন মহিলা হওয়া আবশ্যক)।

সদস্য, সচিব (১ জন) ঃ সংশ্লিষ্ট কমিউনিটি সাপোর্ট গ্রুপ কর্মএলাকায় বসবাসকারী ১জন কমিউনিটি গ্রুপ সদস্যকে সদস্য সচিব করা আবশ্যক। কর্মএলাকায় একাধিক কমিউনিটি গ্রুপ থাকলে অধিকতর যোগ্য ব্যক্তিকে মনোনীত করতে হবে। তিনি কমিউনিটি গ্রুপের সাথে সেতুবন্ধ হিসাবে কাজ করবেন।

বি.দ্র.ঃ কমিউনিটি সাপোর্ট গ্রুপে আহবায়ক/যুগ্ম-আহবায়ক/সদস্য-সচিব নির্বাচনের ক্ষেত্রে তথ্য প্রযুক্তি সম্পর্কে জ্ঞান রাখেন (কম্পিউটার চালানো) এমন কাউকে মনোনয়ন করলে ভাল।

সদস্য (৯-১১)ঃ উপরোক্ত ৩টি পদের ব্যক্তিবর্গ অন্য সকলে কমিউনিটি সাপোর্ট গ্রুপের সদস্য হিসেবে দায়িত্ব পালন করবেন। ৫.১ এ বর্ণিত জনগোষ্ঠির প্রতিনিধিগণকে কমিউনিটি সাপোর্ট গ্রুপের সদস্য হিসেবে অন্তর্ভুক্ত করতে হবে। এই সদস্য সংখ্যা ১১ জনের মধ্যে সীমাবদ্ধ রাখতে হবে; তন্মধ্যে ১ জন কিশোর ও ১ জন কিশোরী হওয়া আবশ্যক। (কিশোর-কিশোরীদের ভোটা-ধিকার থাকবে না)

অতিরিক্ত (কো-অপ্ট) সদস্য ঃ কমিউনিটি ক্লিনিকের কাজ সুষ্ঠুভাবে পরিচালনা এবং কোন বিশেষ কাজ সম্পাদনের লক্ষ্যে কমিউ-নিটি সাপোর্ট গ্রুপ প্রয়োজনবোধে সেরূপ যোগ্য সর্বোচ্চ ২ জন ব্যক্তিকে গ্রুপের অতিরিক্ত (কো-অপ্ট) সদস্য হিসাবে অন্তর্ভুক্ত করতে পারবেন। কো-অপ্ট সদস্য ২ জন হলে তার মধ্যে ১ জন মহিলা হওয়া অবশ্যক। তাদের ভোটাধিকার থাকবে না। কমিউ-নিটি গ্রুপের অনুমোদনক্রমে এরূপ অতিরিক্ত সদস্য গ্রুপভুক্ত করা যাবে।

৬.৪ কমিউনিটি ক্লিনিক সম্পর্কে জনগণকে উদ্বুদ্ধকরণ ঃ

কমিউনিটি সাপোর্ট গ্রুপ এর সকল সদস্যের মূল দায়িত্ব ঃ কমিউনিটি গ্রুপের সাথে সার্বক্ষণিক সমন্বয়, সুষ্ঠুভাবে সাপোর্ট গ্রুপ পরিচালনা এবং এলাকার মা ও শিশুদের স্বাস্থ্য, পরিবার পরিকল্পনা পদ্ধতি, পুষ্টি, বিভিন্ন সেবাকেন্দ্র বিশেষ করে কমিউনিটি ক্লিনিক হতে প্রাপ্ত সেবা সম্পর্কে জনগণের মধ্যে সচেতনতা তৈরি করা এবং জরুরী স্বাস্থ্য সেবাপ্রাপ্তিতে সময়মত উচ্চতর পর্যায়ের সেবা কেন্দ্রে প্রেরণের ব্যবস্থা করা । স্থানীয় সম্পদ আহরণের মাধ্যমে কমিউনিটি গ্রুপের তহবিল গঠন এবং তা ব্যবহার করে কমিউনিটি ক্লিনিকের রক্ষণাবেক্ষণসহ উক্ত এলাকার অবহেলিত, দরিদ্র জনগণকে জরুরি চিকিৎসা সেবাগ্রহণে সহায়তা প্রদান করা । এছাড়াও স্বাস্থ্য সেবায় জনগণের অংশগ্রহণ ও বিদ্যমান স্বাস্থ্য সেবায় জনগণের অংশগ্রহণ ও বিদ্যমান স্বাস্থ্য সেবাপ্রাপ্তি নিশ্চিত করার লক্ষ্যে কমিউনিটি সাপোর্ট গ্রুপের উল্লেখযোগ্য কয়েকটি দায়িত্ব নিম্নরুপ ঃ

প্রতি ২ মাস অন্তর কমিউনিটি সাপোর্ট গ্রুপ একটি সাধারণ সভার আয়োজন করবেন । আহবায়কের অনুমতিক্রমে সদস্য-সচিব এ সভার আয়োজন করবেন;

প্রতি ৬ মাস অন্তর কমিউনিটি ক্লিনিকের আওতাভুক্ত ৩টি কমিউনিটি সাপোর্ট গ্রুপের অংশগ্রহণে ১টি সমন্বয় সভা আয়োজনের জন্য কমিউনিটি গ্রুপকে আহবান জানানো এবং সে সমন্বয় সভায় অংশগ্রহণ করা । এই সমন্বয় সভায় কমিউনিটি সাপোর্ট গ্রুপ ও কমিউনিটি গ্রুপের সকল সদস্য উপস্থিত থাকবেন;

- কমিউনিটি ক্লিনিক সম্পর্কে জনগণকে উদ্বুদ্ধকরণ;
- কমিউনিটি ক্লিনিক কর্মএলাকার তথ্য সংগ্রহ, সমস্যা ও সম্পদ চিহ্নিতকরণের মাধ্যমে বার্ষিক কর্মপরিকল্পনা প্রণয়ন;
- এলাকার জনগণ বিশেষ করে মা ও শিশু এবং সুবিধাবঞ্চিত জনগোষ্ঠীকে কমিউনিটি ক্লিনিক হতে প্রদেয় সেবা সমূহ সম্পর্কে অবহিতকরণ ও উক্ত সেবাগ্রহণে সকলকে উদ্বুদ্ধকরণ;
- এলাকার গর্ভবতী মা চিহ্নিতকরণ, চেকআপ ও প্রসব-পরিকল্পনা নিশ্চিতকরণ এবং প্রসব সংক্রান্ত জটিলতা আক্রান্ত মহিলাদের জরুরি প্রসূতি সেবাকেন্দ্রে প্রেরণে সহযোগিতা করা;
- ১ বছরের নীচে সকল শিশুদের সময়মতো সকল টিকা নিশ্চিতকরণে সহযোগিতা করা;
- পুষ্টি, ডায়রিয়া, যক্ষ্মা, কৃমি, কুষ্ঠ, ম্যালেরিয়া, রাতকানা, এইচআইবি/এইডস ইত্যাদি রোগ সম্পর্কে জনগণকে সচেতন করা ও কমিউনিটি ক্লিনিকে/হাসপাতালে প্রেরণে সহায়তা করা;
- পরিবার পরিকল্পনা সেবা গ্রহণে জনগণকে আগ্রহী করে তোলা;
- অপুষ্টিতে আক্রান্ত মা ও শিশুদেরকে চিহ্নিত করা এবং তাদেরকে কমিউনিটি ক্লিনিকে প্রেরণে সহায়তা করা;
- স্থানীয় সম্পদ আহরণের মাধ্যমে সাপোর্ট গ্রুপ ও কমিউনিটি গ্রুপের জন্য তহবিল গঠনে সহযোগিতা করা;
- প্রতিবন্ধী, অটিষ্টিক, নিঃস্ব ও হতদরিদ্র এবং সুবিধা বঞ্চিত জনগণকে চিকিৎসা গ্রহণে সর্বতোভাবে সহযোগিতা করা;
- ধূমপান, নেশা, মাদক ইত্যাদির বিরুদ্ধে গণসচেতনতা এবং প্রতিরোধ তৈরি করা;
- নিয়মিত সাধারণ সভা করা ও কমিউনিটি গ্রুপের মাসিক সভায় সাপোর্ট গ্রুপের প্রতিনিধির উপস্থিতি নিশ্চিত করা;
- অন্তজ/প্রান্তিক জনগোষ্ঠীর মধ্যে আধুনিক স্বাস্থ্য সেবাগ্রহণে বিভিন্ন কুসংস্কার দূরীকরণে কার্যকরী পদক্ষেপ নেয়া;
- স্বাস্থ্য শিক্ষা প্রসারের মাধ্যমে স্বাস্থ্য সম্মত জীবণ যাপন উদ্বুদ্ধ করা এবং
- এলাকার জনগণের শিক্ষা প্রসারে উৎসাহ প্রদান করে শিক্ষার হার বাড়ানো ।

ইউনিয়ন স্বাস্থ্য ও পরিবার কল্যান কেন্দ্রের ব্যবস্থাপনা কমিটি ও তার কার্যাবলী

(Source: UH&FWC Oparetional Manual 2014,Chapter 4)

গ্রামীণ জনগোষ্ঠির মধ্যে পরিবার পরিকল্পনা, মা ও শিশুস্বাস্থ্য, পুষ্টি সেবা, কিশোর-কিশোরী স্বাস্থ্য সেবা, স্বাস্থ্য শিক্ষা ও সাধারণ স্বাস্থ্য সেবা/পরামর্শ প্রদান করার ক্ষেত্রে ইউনিয়ন স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্র এক গুরুত্বপূর্ণ ভূমিকা পালন করে। এই কেন্দ্রের সার্বিক কার্যক্রম পরিচালনায় স্থানীয় নেতৃবর্গ বিশেষ করে মহিলাদের সম্পৃক্ত করা হলে উল্লেখিত সেবা সমূহ প্রদান করা সহজ হবে। এতে করে এ কেন্দ্রের ও সেবাদানকারীর সামাজিক গ্রহণযোগ্যতা বৃদ্ধি পাবে।

তাই প্রতিটি কেন্দ্র সুষ্ঠু ভাবে পরিচালনার জন্য স্থানীয় প্রতিনিধি বিশেষ করে মহিলা সদস্যদের নিয়ে একটি পরিচালনা কমিটি গঠন করা অত্যাবশ্যক। স্মরণ রাখা প্রয়োজন যে, প্রাথমিক অবস্থায় কমিটি সদস্য/সদস্যদেও নিয়ে সম্মিলিত ভাবে দায়িত্ব পালন করতে নানাবিধ অসুবিধা হতে পারে। এই বিষয়ে কমিটি থেকে যথাযথ উপদেশ, নির্দেশনা এবং সহযোগিতা পেলে কেন্দ্রের কর্মকর্তা ও কর্মীগণ কেন্দ্র পরিচালনা ও মানসম্মত সেবা দান করায় সফলকাম হবেন।

বর্তমানে, কেন্দ্র পরিচালনার জন্যে নিম্নে বর্ণিত সদস্যদের নিয়ে একটি ব্যবস্থাপনা কমিটি গঠন করা আছে।

ইউনিয়ন স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্রের ব্যবস্থাপনা কমিটি গঠন

১। ইউনিয়ন পরিষদ চেয়ারম্যান	সভাপতি
২। সংশ্লিষ্ট ওয়ার্ডের ইউনিয়ন পরিষদ নির্বাচিত মহিলা সদস	সহ সভাপতি
৩। ইউনিয়ন পরিষদের অন্যান্য মহিলা সদস্য	সদস্য -২জন
৪। স্থানীয় কলেজের অধ্যক্ষ/উচ্চ বালিকা বিদ্যালয়ের প্রধান শিক্ষিকা/প্রাইমারী স্কুলের প্রধান শিক্ষক/শিক্ষিকা	সদস্য -১জন
৫। মহিলা ভিডিপি দলনেত্রী/বিআরডিবি/মাদার্স ক্লাব মহিলা বিষয়ক অধিদপ্তর/ সমাজ সেবা অধিদপ্তরের ইউনিয়ন পর্যায়ের মহিলা কর্মী	সদস্য -১জন
৬। বেসরকারী স্বেচ্ছাসেবী সংস্থার প্রতিনিধি	সদস্য -১জন
৭। ফার্মাসিষ্ট	সদস্য -১জন
৮। পরিবার কল্যাণ কেন্দ্রের পরিবার কল্যাণ পরিদর্শিকা	সদস্য -১জন
৯। কমিউনিটি হেলথ কেয়ার প্রভাইডার (সিএইচিসিপি) (সংশ্লিষ্ট ইউনিয়নের অর্ন্তভুক্ত কমিউনিটি ক্লিনিকের সেবাদানকারী)	সদস্য -১জন
১০। ইউনিয়ন পরিবার পরিকল্পনা পরিদর্শক	সদস্য -১জন
১১। ইউনিয়নে কর্মরত পরিবার কল্যাণ সহকার	সদস্য -১জন
১২। স্বাস্থ্য অধিদপ্তরের ইউনিয়ন পর্যায়ের কমী	সদস্য -১জন
১৩। কিশোর ও কিশোরী প্রতিনিধি	সদস্য -১জন
১৪। সুবিধাবঞ্চিত যেমন প্রতিবন্ধী, ক্ষুদ্র নৃ-তাত্ত্বিক জনগোষ্ঠীর/গ্রুপের নারী প্রতিনিধি	সদস্য -২জন
১৫। ইউনিয়ন স্বাস্থ্য পরিবার কল্যাণ কেন্দ্রের মেডিকেল অফিসার/উপ-সহকার কমিউনিটি মেডিকেল অফিসার	সদস্য সচিব

সদস্য নির্বাচনের নীতিমালা

পরিবার কল্যাণ কেন্দ্রের ব্যবস্থাপনা কমিটির সদস্য নির্বাচন করার ক্ষেত্রে নিম্নরূপ নীতিমালা অনুসরণ করে পদ ভিত্তিতে মনোনয়ন বা নির্বাচন করে নির্ধারিত করতে হবে।

- ক্রমিক নং ৪-এ বর্ণিত সদস্য নির্ধারণের ক্ষেত্রে যদি ইউনিয়নে কোন কলেজ/বালিকা উচ্চ বিদ্যালয় থাকে এবং উক্ত বিদ্যালয়ের প্রধান শিক্ষক যদি মহিলা হন তবে তাকে এবং যদি তিনি মহিলা না হন তবে উক্ত বিদ্যালয়ের একজন শিক্ষিকাকে মনোনীত করা হবে। যদি কোন উচ্চ বালিকা বিদ্যালয় না থাকে তবে প্রাইমারী স্কুলের প্রধান শিক্ষিকা/

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শিক্ষিকাকে সদস্য মনোনীত করা হবে।

- যে সব ইউনিয়নের ক্রমিক নং ৫ এ বর্ণিত সংস্থা একের অধিক, সে ক্ষেত্রে অন্যান্য সদস্যদের মতামতের ভিত্তিতে সদস্য নির্বাচন করা হবে।
- ক্রমিক নং ৪,৫ ও ৬ এ বর্ণিত শ্রেনির সদস্যদের স্থানীয় ইউনিয়ন পরিষদের চেয়ারম্যান মনোনীত করবেন।
- কমিটি ইচ্ছা করলে স্থানীয় মহিলা সমাজ কর্মীদের মধ্যে থেকে ২ জনকে কো-অপ্ট সদস্যরূপে মনোনীত করতে পারবেন।
- কমিটি সদস্য নির্বাচনের ক্ষেত্রে দুই সন্তানের মাতা/পিতাদের অগ্রাধিকার দিবেন।
- সদস্য সচিব, কিশোর ও কিশোরী নির্বাচনে অংশ গ্রহণ করতে পারবেনা।
- উপরোক্ত নীতিমালা অনুযায়ী গঠিত কমিটিতে সদস্য সংখ্যা সর্বোচ্চ ২১ হতে পারে।

কমিটির দায়িত্ব ও কর্তব্য

১। ইউনিয়নের গর্ভবতী মা ও পাঁচ বছর বা তা নিম্ন বয়সের শিশুরা যাতে পরিচর্যা পায় তার জন্য প্রতি কেন্দ্রে পরিবার পরিকল্পনা, মা ও শিশুস্বাস্থ্য, পুষ্টি ও কিশোর স্বাস্থ্য সেবার জন্য নির্ধারিত লক্ষ্যমাত্রা বাস্তবায়নে ব্যবস্থা গ্রহণ করা।

২। ইউনিয়নের সক্ষম দম্পতি যারা পরিবার পরিকল্পনা পদ্ধতি গ্রহণ করেছেন তাদের নিয়মিত সেবা প্রদান এবং যারা এখনও কোন পদ্ধতি গ্রহণ করেন নাই তাদের পদ্ধতি গ্রহণে উদ্ধুদ্ধ করার ব্যবস্থা গ্রহণ।

৩। যে সকল কেন্দ্রে ২৪ ঘন্টা প্রসবের ব্যবস্থা আছে সেখানে প্রসবের জন্য জনগণকে উদ্ধুদ্ধকরণ এবং কেন্দ্রের রক্ষণাবেক্ষণে প্রয়োজনীয় ব্যবস্থা গ্রহণ।

৪। পরিবার কল্যাণ কেন্দ্রের জন্য সরবরাহকৃত ডিডিএস কিট্‌স এবং এমসিএইচ ঔষধপত্রের বিভিন্ন সরঞ্জাম ও উপকরণের সুষ্ঠু ব্যবহার নিশ্চিত করা।

৫। বিভিন্ন জন্মনিয়ন্ত্রণ সামগ্রীর বিতরণ এবং ব্যবহার সুষ্ঠুভাবে হচ্ছে কিনা পর্যালোচনা করে প্রয়োজনীয় ব্যবস্থা গ্রহণ।

৬। গর্ভবতী মা ও পাঁচ বছরের নিম্ন বয়সের শিশুদের টিকাদান কর্মসূচী বাস্তবায়নে সহায়তা প্রদান।

৭। ইউনিয়নে সিএসবিএ দের কাজের অগ্রগতি পর্যালোচনা এবং সহায়তা প্রদান।

৮। কেন্দ্রের কর্মরত এফডব্লিউবি এবং এসএসিএমও প্রত্যেকে যাতে সপ্তাহে দুইদিন স্যাটেলাইট ক্লিনিক করেন সে বিষয়ে সহায়তা প্রদান।

৯। পরিবার কল্যাণ কেন্দ্রকে ইউনিয়নে মহিলাদের স্বাস্থ্য ও পরিবার পরিকল্পনা বিষয় শিক্ষা এবং স্বাস্থ্য শিক্ষা কেন্দ্ররূপে প্রতিষ্ঠিত করা।

১০। পুষ্টি সেবা প্রদান নিশ্চিত করতে হবে।

১১। বিভিন্ন জাতীয় দিবস যেমন, স্বাধীনতা দিবস, বিশ্ব জনসংখ্যা দিবস, বিশ্ব স্বাস্থ্য দিবস, আর্ন্তজাতিক নারী ও শিশু দিবস, নিরাপদ মাতৃত্ব দিবস, মাতৃদুগ্ধ সপ্তাহ, মাদকাশক্তি প্রতিরোধ দিবস উপলক্ষে আলোচনা অনুষ্ঠান এবং শোভাযাত্রার ব্যবস্থা গ্রহণ।

১২। প্রতিনিয়ত পরিবার কল্যাণ কেন্দ্র পরিদর্শনের ব্যবস্থা করা এবং সমস্যা সমাধানে উদ্যোগ নেয়া কেন্দ্রের সুষ্ঠু পরিচা-লনার ক্ষেত্রে স্থানীয়ভাবে সমাধান করা যায় না এমন সব সমস্যা উপজেলা পরিষদ এবং পরিবার পরিকল্পনা ও স্বাস্থ্য অধিদপ্তরের সংশ্লিষ্ট কর্মকর্তার নজরে নিয়ে আসার ব্যবস্থা গ্রহণ।

১৩। কেন্দ্রের সুষ্ঠু ব্যবস্থাপনা ও দরিদ্র রোগীদের চিকিৎসা নিশ্চিত করার জন্য রোগী কল্যাণ তহবিল গঠন ও নীতিমালা প্রণয়ন।

দ্রষ্টব্যঃ বিশেষ সদস্য যেমন- সভাপতি, সহ সভাপতি, সদস্য সচিব ও ক্যাশিয়ারের দায়িত্ব নির্দিষ্ট হতে হবে।

কার্যপ্রণালী

- কমিটি ২ মাসে অন্ততঃ একবার সভায় মিলিত হবে।
- কমিটির সভাপতি কোন সভায় উপস্থিত থাকতে না পারলে সহ সভাপতি মিটিং পরিচালনা করবেন।
- কমিটির সভাপতি এবং অপর স্থায়ী মেম্বারের উপস্থিতিতে সভার কোরাম হবে।
- সভার কার্যবিবরণী কমিটির সদস্য সচিব কর্তৃক একটি রেজিষ্টারে লিপিবদ্ধ করা হবে। প্রত্যেক সভায়
- পূর্ববর্তী সভার সিদ্ধান্ত উপস্থিত সদস্যদেরকে পড়ে শোনানো হবে এবং তাদেও সম্মতিক্রমে তা চূড়ান্ত হবে।
- কমিটির সভায় গৃহীত সিদ্ধান্ত সংশ্লিষ্ট ইউনিয়ন পরিষদ, উপজেলা পরিষদ এবং পরিবার পরিকল্পনা ও স্বাস্থ্য অধিদপ্তরের সংশ্লিষ্ট কর্মকর্তার নিকট ব্যবস্থা গ্রহণের জন্য প্রেরণ করা হবে।

মেডিকেল অফিসার (এমসিএইচ-এফপি), উপজেলা পরিবার পরিকল্পনা কর্মকর্তা, সহকারী পরিবার পরিকল্পনা

কর্মকর্তা এবং এএফডব্লিওও (এমসিএইচ-এফপি) এই কমিটির সভায় পর্যবেক্ষরূপে যোগদান করতে পারবেন।

- প্রতিটি কমিটি কার্যবিবরণী লিপিবদ্ধ করার জন্য উপজেলা পরিবার পরিকল্পনা কর্মকর্তা একটি রেজিষ্ট্রার সরবরাহ করবেন।
- কমিটির আনুসাংগিক ব্যয় বহন করার জন্য উপজেলা বা ইউনিয়ন পরিষদকে কিছু আর্থিক সহায়তা প্রদান করার জন্য অনুরোধ করা হবে। উপজেলা পরিবার পরিকল্পনা কর্মকর্তা এ বিষয়ে উদ্যোগ গ্রহণ করবেন।

ব্যবস্থাপনায় উর্ধ্বতন কর্মকর্তাদের ভূমিকা

উপজেলা পরিবার পরিকল্পনা কর্মকর্তা ঃ

উপজেলা পরিবার পরিকল্পনা কর্মকর্তা সংশ্লিষ্ট উপজেলা/ইউনিয়ন পরিষদকে এই কমিটির গঠন এবং কার্যক্রম সম্পর্কে অবহিত করবেন। তিনি উপজেলায় এবং ইউনিয়নে কর্মরত সকল কর্মকর্তা ও কর্মীকে এ সম্পর্কে অবহিত করবেন। তিনি ইউনিয়ন পরিষদের চেয়ারম্যানের সাথে যোগাযোগ করে কমিটি গঠনের ব্যবস্থা নিবেন।

মেডিকেল অফিসার (এমসিএইচ-এফপি)/এডিসিসি/এমওসিসি/এডিএফপি/আঞ্চলিক সুপারভাইজার (এফপিসিএসটি/কিউএটি) ঃ

উপরোক্ত কর্মকর্তাগণ কমিটির সভায় পর্যবেক্ষকরূপে যোগদান করবেন এবং প্রয়োজনীয় পরামর্শ প্রদান করবেন। তারা এ বিষয়ে উপ-পরিচালককেও অবহিত করবেন।

উপ-পরিচালক (পরিবার পরিকল্পনা) ঃ

প্রত্যেক উপ-পরিচালক (পরিবার পরিকল্পনা) এই কমিটির কার্যক্রম ও বিষয়বস্তু সম্পর্কে জেলা পরিবার পরিকল্পনা সমন্বয় কমিটিকে অবহিত করবেন।

বিভাগীয় পরিচালক (পরিবার পরিকল্পনা) ঃ

বিভাগীয় পরিচালক তার বিভাগের অন্তর্ভূক্ত জেলা সমূহে যথা সময়ে এই কমিটি গঠনের নিশ্চয়তা বিধান করবেন।

(একই স্মারক ও তারিখে প্রতিস্থাপিত)

গণপ্রজাতন্ত্রী বাংলাদেশ সরকার
স্থানীয় সরকার বিভাগ
ইউনিয়ন পরিষদ-২ শাখা

নং- ৪৬.০১৮.০৩১.০০.০০.০০২.২০১১.৬০৮ তারিখঃ-১৪.০৩.২০১৩ ইং

সংশোধিত পরিপত্র

বিষয়ঃ ইউনিয়ন উন্নয়ন সমম্বয় কমিটি ।

স্থানীয় সরকার (ইউনিয়ন পরিষদ) আইন, ২০০৯ এর ৯৫ ধারায় প্রদত্ত ক্ষমতাবলে নিম্নরূপ ইউনিয়ন উন্নয়ন সমম্বয় কমিটি গঠন করা হলঃ

২। ইউনিয়ন উন্নয়ন সমম্ব কমিটি (UDCCs) এর গঠন ঃ

১	চেয়ারম্যান, ইউনিয়ন পরিষদ	সভাপতি
২	ইউনিয়ন পরিষদের সকল সদস্য	সদস্য
৩	ইউনিয়ন পরিষদের স্থায়ী কমিটিসমূহের সভাপতিগন	সদস্য
৪	উপ-সহকারী প্রকৌশলী, স্থানীয় সরকার প্রকৌশল অধিদপ্তর	সদস্য
৫	সহকারী উপজেলা প্রাথমিক শিক্ষা কর্মকর্তা	সদস্য
৬	উপ- সহকারী কৃষি কর্মকর্তা, কৃষি সম্প্রসারণ অধিদপ্তর	সদস্য
৭	ভেটেরেনারী ফিল্ড এ্যাসিসট্যান্ট, প্রাণী সম্পদ অধিদপ্তর	সদস্য
৮	ভেটেরেনারী ফিল্ড এ্যাসিসট্যান্ট (কৃত্তিম প্রজনন), প্রাণী সম্পদ অধিদপ্তর	সদস্য
৯	ফিল্ড এ্যাসিসট্যান্ট, মৎস্য অধিদপ্তর	সদস্য
১০	উপ-সহকারী কমিউনিটি স্বাস্থ কর্মকর্তা, স্বাস্থ্য অধিদপ্তর	সদস্য
১১	স্বাস্থ্য পরিদর্শক, স্বাস্থ্য অধিদপ্তর	সদস্য
১২	সহকারী স্বাস্থ্য পরিদর্শক, স্বাস্থ্য অধিদপ্তর	সদস্য
১৩	পরিবার কল্যাণ পরিদর্শক, পরিবার পরিকল্পনা অধিদপ্তর	সদস্য
১৪	পরিবার কল্যাণ সহকারী, পরিবার পরিকল্পনা অধিদপ্তর	সদস্য
১৫	ইউনিয়ন সমাজকর্মী, সমাজসেবা অধিদপ্তর	সদস্য
১৬	ইউনিয়ন দলনেতা, আনসার ও ভিডিপি	সদস্য
১৭	টিউবওয়েল মেকানিক, জনস্বাস্থ্য প্রকৌশল অধিদপ্তর	সদস্য
১৮	কমিউনিটি অর্গানাইজার, স্থানীয় সরকার প্রকৌশল অধিদপ্তর	সদস্য
১৯	মাঠ সংগঠক, বাংলাদেশ পল্লী উন্নয়ন বোর্ড	সদস্য
২০	ম্যারেজ রেজিস্ট্রার (কাজী) [আইন, বিচার ও সংসদ বিষয়ক মন্ত্রণালয় কর্তৃক নিয়োগপ্রাপ্ত]	সদস্য
২১	বিদ্যালয় ব্যবস্থাপনা কমিটির প্রতিনিধি (মাধ্যমিক বিদ্যালয়ের ১ জন, প্রাথমিক বিদ্যালয়ের ১ জন)	সদস্য
২২	ইউনিয়ন এলাকার মাঠ পর্যায়ে কর্মরত এনজিও প্রতিনিধি (১জন)	সদস্য
২৩	গ্রাম সংগঠনের একজন প্রতিনিধি	সদস্য
২৪	স্থানীয় ব্যবসায়ী প্রতিনিধি (১ জন)	সদস্য
২৫	ইমাম ও ধর্মীয় নেতাদের প্রতিনিধি (১ জন)	সদস্য
২৬	নারী প্রতিনিধি (২ জন)	সদস্য
২৭		

২৮	হেডম্যান (১ জন) শুধুমাত্র পার্বত্য জেলাসমূহের জন্য প্রযোজ্য	সদস্য
২৯	কারবারী (১ জন) শুধুমাত্র পার্বত্য জেলাসমূহের জন্য প্রযোজ্য	সদস্য
৩০	ইউনিয়ন পরিষদ সচিব	সদস্য- সচিব

২.ক. উপজেলা পর্যায়ের দপ্তর প্রধানগণ ইউনিয়ন উন্নয়ন কমিটিতে ইউনিয়নওয়ারী সদস্য মনোনয়ন প্রদান করবেন। অন্যান্য ক্ষেত্রে ইউনিয়ন পরিষদ সাধারণ সভায় আলোচনা করে সদস্য মনোনীত করবে। সকল সদস্য মনোনীত হওয়ার পর ইউনিয়ন পরিষদ এ কমিটি সংক্রান্ত একটি অফিস আদেশ জারি করবে এবং সংশ্লিষ্ট সকলকে অবাহিত করবে।

৩. ন্যূন্যপক্ষে প্রতি দু'মাসে একবার ইউনিয়ন উন্নয়ন সমন্বয় কমিটির সভা অনুষ্ঠিত হবে।

৪. ইউনিয়ন উন্নয়ন সমন্বয় কমিটিতে সভার সকল সিদ্ধান্ত উপস্থিত সংখ্যাগরিষ্ঠ সদস্যগণের মতামতের ভিত্তিতে গৃহীত হবে।

৫. ইউনিয়ন উন্নয়ন সমন্বয় কমিটির কার্যাবলীঃ

(১) ইউনিয়ন উন্নয়ন সমন্বয় কমিটি সাধারণভাবে ইউনিয়নের সকল আর্থ-সামাজিক উন্নয়ন কর্মকান্ডের পরিকল্পনা প্রণায়ন, বস্তাবায়ন ও সমন্বয় করবে;

(২) ইউনিয়নের আইন-শৃঙ্খলা রক্ষায় এবং আইন-শৃঙ্খলা পরিস্থিতি উন্নয়নে প্রয়োজনীয় ব্যবস্থা গ্রহণ করবে;

(৩) ইউনিয়ন পর্যায়ে কর্মরত সকল বিভাগীয় উন্নয়ন কর্মকা- বাস্তবায়ন অগ্রগতি পর্যালোচনা করবে এবং প্রয়োজনীয় ক্ষেত্রে সুপারিশ প্রদান ও সহায়ক পরিবেশ সৃষ্টিতে সহায়তাপ্রদান করবে;

(৪) সংশ্লিষ্ট ইউনিয়ন বিদ্যমান সেবা প্রদান পরিস্থিতি পর্যালোচনা করবে; বাস্তবভিত্তিক চাহিদা নিরূপণ বা ইউনিয়নে কর্মরত সকল উন্নয়ন সহযোগীর মাধ্যমে নিরূপিত চাহিদা পূরণে কর্মপরিকল্পনা প্রণয়ন ও সমন্বয় সাধন করবে;

(৫) সংশ্লিষ্ট ইউনিয়নের জনসাধারণের জীবনমান উন্নয়নে সকল উন্নয়ন সহযোগী থেকে প্রাপ্ত সম্পদ ব্যবহারে সমন্বয়ে সাধন করবে;

(৬) স্থানীয় জনসাধারণের সাথে বিভিন্ন উন্নয়ন সহযোগী, সেবা সরবরাহ কেন্দ্র, উপজেলা পরিষদ ইত্যাদি প্রতিষ্ঠান/ব্যক্তিবর্গের ঘনিষ্ঠ যোগাযোগ স্থাপন ও সমন্বয় সাধন করবে;

(৭) স্থানীয় সম্পদের সদ্ব্যবহারে বাস্তব পদক্ষেপ গ্রহণ করবে;

(৮) ইউনিয়ন এলাকায় কর্মরত বিভিন্ন সংস্থা/ব্যাক্তিবর্গ কর্তৃক সম্পাদিত কার্যক্রমের মুল্যায়নের ভিত্তিতে পুরস্কার প্রদানের ব্যবস্থা গ্রহণ করবে;

(৯) স্থানীয় উন্নয়নে উদাহরণ সৃষ্টিকারী ভাল শিক্ষণসমূহের তথ্য সংগ্রহ এবং নিজ এলাকায় বাস্ত বায়নযোগ্য শিক্ষাণসমূহ পারস্পরিক শিখনের মাধ্যমে যাচাই ও বাস্তবায়নের পদক্ষেপ গ্রহণ করব;

(১০) ইউনিয়নবাসীর জীবনমান উন্নয়নে প্রয়োজনীয় ব্যবস্থা গ্রহণ করবে।

৬. সভা অনুষ্ঠানের ০৩ কার্যদিবসের মধ্যে সভার কার্যবিবরণী প্রস্তত করতে হবে এবং ০৭ কার্যাদিবসের মধ্যে উক্ত কার্যাবিবরী উপজেলা চেয়ারম্যান, উপজেলা নির্বাহী অফিসারসহ সংশ্লিষ্ট সকল কর্মকর্তা ও সদস্যদের বরাবরে প্রেরণ করতে হবে। কার্যাবিবরণী প্রস্তুতে নিম্নোক্ত "ছক" ব্যবহার করা যেতে পারেঃ

ক্রমিক নং	আলোচ্যসূচী	আলোচনা	সিদ্ধান্ত	দায়িত্বপ্রাপ্ত সংস্থা/ব্যক্তি

৭. প্রতিটি সভার অন্ততঃ ০৭ কার্যাদিবস পূর্বে বিগত সভার সিদ্ধন্তসমূহের বাস্তবায়ন অগ্রগতির প্রতিবেদনসহ সংশ্লিষ্ট সকলকে সভায় উপস্থিত থাকার জন্য বিজ্ঞপ্তি জারি করা যেতে পারে।

৮.　কমিটি নিম্নলিখিত বিষয়সমূহ সভার আলোচ্যসূচীতে অন্তর্ভূক্ত করতে পারেঃ

ক) বিগত সভার কার্যবিবরণী পাঠ ও অনুমোদন;

খ) বিগত সভার সিদ্ধান্তসমূহ বাস্তবায়ন অগ্রগতি;

গ) বিভিন্ন বিভাগ/সংস্থাওয়ালী কার্যক্রম বাস্তবয়ান অগ্রগতি পর্যালোচনা;

ঘ) ইউনিয়ন এলাকার সেবা সরবরাহ পরিস্থিতি পর্যালোচনা, উন্নয়ন সহযোগী কর্তৃক বাস্তবায়নাধীন কর্মকান্ডের অগ্রগতি আলোচনা এবং পরিকল্পনা প্রণয়ন;

ঙ)পরবর্তী সভার আলোচ্যসূচী নির্ধারণ;

চ) বিবিধ ।

৯.　পতিবেদনঃ

প্রতি ০৩ টি সভার প্রধান প্রধান আলোচনা, সিদ্ধান্তসমূহ এবং বাস্তাবায়ন অগ্রগতি সম্বলিত একটি প্রতিবেদন উপজেলা পর্যায়ের সকল অফিস প্রধান, উপজেলা নির্বাহী অফিসার এবং জেলা প্রশাসকের নিকট প্রেরণ করতে হবে ।

১০　জনস্বার্থে এ পরিপত্র জারী করা হল এবং এই পরিপত্রের বিধানাবলী অবিলম্বে কার্যকর হবে ।

(শামীমা নার্গিস)

যুগ্ম-সচিব

ফোনঃ ৯৫১৪৬৩২

বিতরণঃ

১ ।　বিভাগীয় কমিশনার (সকল), বিভাগ...................... ।

২ ।　জাতীয় স্থানীয় সরকার ইনস্টিটিউট, আগারগাঁও, ঢাকা ।

৩ ।　জেলা প্রশাসক (সকল), জেলা.................................... ।

৪ ।　উপজেলা নির্বাহী অফিসার (সকল), উপজেলা................... ।

৫ ।　ইউনিয়ন পরিষদ চেয়ারম্যান (সকল), উপজেলা.......................................জেলা......................... ।

৬ ।　.. ।

গণপ্রজাতন্ত্রী বাংলাদেশ সরকার

স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রনালয়

হাসপাতাল-২ শাখা

বাংলাদেশ সচিবালয়,ঢাকা ।

স্বারক নং-হাস-২/তদারকি কমিটি-১/২০০৭/১৯০ তারিখ-০৫/০৪/০৯

প্রজ্ঞাপন

হাসপাতাল সুষ্ঠ ব্যবস্থাপনা ও চিকিৎসা সেবার মান উন্নয়নের লক্ষে উপজেলা হাসপাতালসমূহে সরকার নিম্ন বর্ণিত ব্যবস্থাপনা কমিটি গঠণ করবেন ।

উপজেলা হাসপাতাল ব্যবস্থাপনা কমিটিঃ

১. সংশ্লিষ্ট নিবাচনী এলাকার মাননীয় সংসদ সদস্য	সভাপতি
২. চেয়ারম্যান,নির্বাচিত,উপজেলা পরিষদ	সহ-সভাপতি
৩. উপজেলা নির্বাহী অফিসার	সদস্য
৪. মেয়র,পৌরসভা (যদি থাকে)	সদস্য
৫. একজন মহিলা ভাইস চেয়ারম্যান, উপজেলা পরিষদ	সদস্য
৬. ভারপ্রাপ্ত কর্মকর্তা, থানা	সদদ্য
৭. উপজেলা সমাজ সেবা কর্মকর্তা	সদস্য
৮. আবাসিক মেডিকেল অফিসার, উপজেলা হাসপাতাল	সদস্য
৯. মেডিকেল অফিসার, এমসিএইচ,	সদস্য
১০. উপজেলা পরিবার পরিকল্পনা কর্মকর্তা	সদস্য
১১. নাসিং সুপারভাইজার, উপজেলা হাসপাতাল	সদস্য
১২. কাউন্সিলর পৌরসভা(যদি থাকে)	সদস্য
১৩. উপজেলা মুক্তিযোদ্ধা কমান্ড কাউন্সিল	সদস্য
১৪, একজন ইউনিয়ন পরিষদ চেয়ারম্যান, মহিলা চেয়ারম্যান, অথবা উপজেলা নির্বাহী অফিসার কতৃক মনোনীত.অগ্রাধিকার	সদস্য
১৫. একজন এনজিও প্রতিনিধি, উপজেলা নির্বাহী অফিসার কতৃক মনোনীত.	সদস্য
১৬. সভাপতি,প্রেসক্লাব (যদি থাকে)	সদস্য
১৭. একজন বিশিষ্ট গণ্যমান ব্যক্তি	সদস্য
১৮. নার্সিং এর প্রতিনিধি,সংশ্লিষ্ট প্রতিষ্টান	সদস্য
১৯. ৩য় শ্রেণীর একজন প্রতিনিধি,সংশ্লিষ্ট প্রতিষ্টান	সদস্য
২০. ৪র্থ শ্রেণীর একজন প্রতিনিধি,সংশ্লিষ্ট প্রতিষ্টান	সদস্য
২১. উপজেলা স্বাস্থ্য ও পরিবার পরিকল্পনা কর্মকর্তা,	সদস্য সচিব ।

কার্যপরিধিঃ

১. কমিটির সভাপতির অনুমতি সাপেক্ষে সদস্য সচিব সভা আহবাণ করবেন ।
২. কমিটি ন্যূনতম প্রতিমাসে একবার সভায় মিলিত হবেন ।
৩. কমিটি প্রয়োজনবোধে সদস্য অন্তর্ভুক্ত করতে পারবে,তবে তার সংখ্যা তিন জনের বেশী হবেনা ।কমিটিতে মহিলা সদস্যা অন্তর্ভুক্ত প্রচেষ্টা করতে হবে ।
৪. কমিটির সভায় ন্যূনতম মূল কমিটির সাতজন উপস্থিত থাকতে হবে ।

৫. কমিটি উপজেলা হাসপাতাল হতে প্রদত্ত সেবা (নিবাময় ও প্রতিষেধক) পরিমানগত ও গুনগতমান উন্নয়নের লক্ষে অগ্রাধিকার ভিক্তিতে প্রদক্ষেপ গ্রহণ করবেন। বিশেষত বীর মক্তিযোদ্ধা, হতদরিদ্র মহিলা,প্রতিবন্ধি ও সুবিধা বঞ্চিতদের সেবা সুনিশ্চিত করবে।
৬. কমিটি স্থানীয়ভাবে সম্পদ আহরণ,রক্ষণ ও ব্যবহার করতে পারবে। সরকার কতৃক বরাদ্ধ (মালামাল,সম্পদ,ঔষধ,যন্ত্রপাতি,আসবাব স্থাপনা ইত্যাদি) সুষ্ঠু ব্যাবহার নিশ্চিত করন।
৭. কমিটি সংশ্লিষ্ট হাসপাতালের অনুমোধিত বাজেট এর মধ্যে বাৎসরিক পরিকল্পনা গ্রহণ ও বাস্তবায়নের লক্ষে প্রয়োজনীয় উদ্যোগ গ্রহণ করবে।
৮. কমিটি প্রযোজন বোধ বিশেষ দায়িত্ব পালনের লক্ষে নিদিষ্ট সময়ের জন্য কমিটির অন্তভুক্তি/ উপ-কমিটি গঠন করতে পারবে।
৯. উপজেলা ও তার নিম্নস্তরের চিকিৎসা/ স্বাস্থ্য সেবা প্রদানকারী অন্যান্য প্রতিষ্ঠানের সাথে সমন্বয় সাধন এবং পর্যবেক্ষণ করবে।
৩. স্বারক নং স্বাপকন/হাস-১/ক্লিনিক-৫/২০০১ ।অংশ ৯৬, তারিখ-১৭/৪/০৭ এর প্রজ্ঞাপন বাতিল করা হল।
৪. এই আদেশ জনস্বার্থে জারী করা হলা এবং অবিলম্বে কার্যকর হবে।

রাষ্ট্রপতির আদেশক্রমে স্বাক্ষরিত/

০৫/৪/০৯ইং

(সাগরিকা নাসরিন)

সিনিয়র ....

ফোন-৯৫৫৬৯৮৯

স্বরণঃ
১. সচিব, মন্ত্রিপরিষদ বিভাগ/ সংসদ সচিবালয়/ সংস্থাপন মন্ত্রনালয়/ স্থানীয় সরকার বিভাগ।
২. মহা পরিচালক, স্বাস্থ্য অধিদপ্তর, মহাখালী,ঢাকা।
৩. ************************** ।

শিক্ষা, স্বাস্থ্য ও পরিবার পরিকল্পনা বিষয়ক স্থায়ী কমিটির গঠন ও কার্যাবলী

(সোর্স: বাংলাদেশ গেজেট, অতিরিক্ত, ডিসেম্বর ১৯, ২০১৬ ১৮৩৬৩)

(১) শিক্ষা, স্বাস্থ্য ও পরিবার পরিকল্পনা বিষয়ক স্থায়ী কমিটি নিম্নরুপে গঠিত হইবে, যথা :-

(ক)	পরিষদ সদস্য (পুরুষ বা মহিলা)	সভাপতি
(খ)	স্থানীয় ১ (এক) জন ডাক্তার বা প্যারামেডিস্ক বা অবসরপ্রাপ্ত	সদস্য
(গ)	স্থানীয় ১ (এক) জন অবসরপ্রাপ্ত শিক্ষক বা শিক্ষিকা	সদস্য
(ঘ)	স্থানীয় ১ (এক) জন শিক্ষানুরাগী (পুরুষ)	সদস্য
(ঙ)	স্থানীয় ১ (এক) জন শিক্ষানুরাগী (মহিলা)	সদস্য
(চ)	স্থানীয় ১ (এক) জনসমাজকর্মী বা বেসরকারি সংস্থার প্রতিনিধি	সদস্য
(ছ)	পরিষদ সচিব বা কর্মচারী	সদস্য-সচিব

(২) শিক্ষা, স্বাস্থ্য ও পরিবার পরিকল্পনা বিষয়ক স্থায়ী কমিটির কার্যাবলী হইবে নিম্নরুপ, যথা :-

(ক) মহামারি নিয়ন্ত্রন বিষয়ক কার্যাদি:

(খ) প্রাথমিক চিকিৎসা কেন্দ্রের ব্যবস্থা গ্রহণ সংক্রান্ত কার্যাদি;

(গ) ইউনিয়ন স্বাস্থ্য কমপ্লেক্স, ইউনিয়ন স্বাস্থ্য ও পরিবার পরিকল্পনা কল্যাণ কেন্দ্র, ইউনিয়ন সাব সেন্টার ও কমিউনিটি ক্লিনিকে প্রয়োজনীয় স্বাস্থ্য সেবা নিশ্চিতকরণে অবলোকন, পর্যবেক্ষণ এবং এতদ্‌সংক্রান্ত সুপারিশ পরিষদে দাখিল;

(ঘ) ইউনিয়ন পর্যায়ে সকল স্বাস্থ্য সেবা প্রতিষ্ঠান বা কেন্দ্রের মেরামত, রক্ষণাবেক্ষণ, নিরাপত্তা, পরিষ্কার পরিচ্ছন্নতা, ইত্যাদি কার্যক্রমের জোরদারের লক্ষ্যে সুপারিশ প্রণয়ন;

(ঙ) শিশু স্বাস্থ্য এবং দরিদ্র-সুবিধাবঞ্চিত জনসাধারণের স্বাস্থ্য সেবা নিশ্চিতকরণের লক্ষ্যে প্রয়োজনীয় সুপারিশ দাখিল;

(চ) ভেজাল খাদ্য, স্বাস্থ্য উপকরণ ঔষধ সরবরাহকারীদের বিরুদ্ধে আইনানুগ ব্যবস্থা গ্রহণের জন্য পরিষদ ও যথাযথ কর্তৃপক্ষের নিকট সুপারিশ পেশ;

(ছ) ইউনিয়নের শিক্ষার উন্নয়নে একটি দীর্ঘমেয়াদী দৃষ্টিভঙ্গি সৃষ্টি এবং উহা ইউনিয়ন পরিষদের উন্নয়ন পরিকল্পনায় অন্তর্ভুক্তির উদ্যোগ গ্রহণ;

(জ) মাধ্যমিক স্কুল ও মাদ্রাসাসমূহের ছাত্র-ছাত্রীর সংখ্যা, শিক্ষকদের উপস্থিতি, পাঠদান পদ্ধতি, পরীক্ষার ফলাফল, শিক্ষার গুণগতমান, ছাত্র-অভিভাবক-শিক্ষক, সমন্বয়, ইত্যাদি বিষয়ে তথ্য ভান্ডার সৃষ্টি এবং তদ্‌সম্পর্কে প্রয়োজনীয় সুপারিশ পরিষদে উপস্থাপন;

(ঝ) কৃতি ও মেধাবী ছাত্র-ছাত্রীদের জন্য সংবর্ধনা প্রদান ও শ্রেষ্ঠ অভিভাবগণকে পুরষ্কৃতকরণের ব্যবস্থা গ্রহণ;

(ঞ) দরিদ্র ছাত্র-ছাত্রী ও ঝরে পড়া ছাত্র-ছাত্রীদের জন্য বিশেষ শিক্ষা বৃত্তির ব্যবস্থা গ্রহণের জন্য যথাযথ কর্তৃপক্ষের নিকট সুপারিশ দাখিল;

(ট) প্রতিটি বিদ্যালয়ের ব্যবস্থাপনা কমিটিগুলোকে সক্রিয়করণে সহায়তাদান এবং শিক্ষক-অভিভাবক সভা, বার্ষিক ক্রীড়া ও সাংস্কৃতিক অনুষ্ঠান উদযাপনে সহায়তা করা;

(ঠ) প্রাথমিক শিক্ষার বর্তমান অবস্থার পর্যালোচনা ও প্রাথমিক শিক্ষার একটি রেখচিত্র প্রণয়ন এবং উহা পরিষদে উপস্থাপন;

(ড) ইউনিয়নের প্রাথমিক শিক্ষার সকল সরকারি ও বেসরকারি বিদ্যালয়ভিত্তিক সরকারি বরাদ্দ ও ব্যয়ের একটি সার্বিক চিত্র সংরক্ষণের সুপারিশমালা পরিষদে দাখিল;

(ঢ) ছাত্র-ছাত্রীদের বিনামূল্যে বইসহ শিক্ষা উপকরণ সম্পর্কিত চাহিদা নিরুপণে সহযোগিতা, সংগ্রহ ও বিতরণ রেজিস্টার, ইত্যাদি পর্যবেক্ষণ করিয়া সুষ্ঠু বন্টনের ব্যবস্থায় সহায়তা করা;

(ণ) ইউনিয়ন এলাকার প্রাথমিক বিদ্যালয়সমূহের সংস্কার, মেরামত, পুননির্মান, বিদ্যুৎ সুবিধা, উন্নত তথ্য-প্রযুক্তির সুবিধা, ইত্যাদি বিষয়ে প্রয়োজনীয় পদক্ষেপ গ্রহণের জন্য পরিষদে সুপারিশ দাখিল;

(ত) শিক্ষার মান উন্নয়ন বিশেষ করিয়া বিজ্ঞান, বাংলা, গণিত ও ইংরেজি শিক্ষার মানোন্নায়নে বিশেষ ব্যবস্থা গ্রহণের সুপারিশ;

(থ) স্থানীয় শিক্ষা প্রতিষ্ঠানসমূহে সুপেয় পানি সরবরাহ ও স্যানিটেশন ব্যবস্থা নিশ্চিতকরণে প্রয়োজনীয় সুপারিশ দাখিল;

(দ) প্রাথমিক ও গণশিক্ষার সহিত সংশ্লিষ্ট বেসরকারি সংস্থা ও সকল ব্যক্তি উদ্যোগের সমন্বয় সাধনের উদ্যোগ গ্রহণ;

(ধ) প্রতিটি প্রাথমিক বিদ্যালয়ে ব্যবস্থাপনা কমিটি গঠনে সহায়তা প্রদান;

(ন) প্রাথমিক শিক্ষার গুণগত মানোয়ন্নের লক্ষ্যে উপজেলা শিক্ষা কর্মকর্তাদের সঙ্গে একত্রে বিদ্যালয় পরিদর্শন;

(প) সংশ্লিষ্ট খাত ও খাতসমূহের উপর তথ্য ভান্ডার তৈরি, নবায়ন ও সংরক্ষণ;

(ফ) ওয়ার্ড সভার প্রস্তাব বা মতামত বিবেচনা;

(ব) ইউনিয়ন পরিষদের সদৃশ কাজে নিয়োজিত অন্যান্য সংস্থার সহিত সহযোগিতা সম্প্রসারণে পরিষদে প্রয়োজনীয় সুপারিশ দাখিল; এবং

(ভ) পরিষদে বিভিন্ন সময় যে সব দায়িত্ব পালনের নির্দেশ প্রদান করিবে, সে সকল দায়িত পালন করা ।

Annex- II

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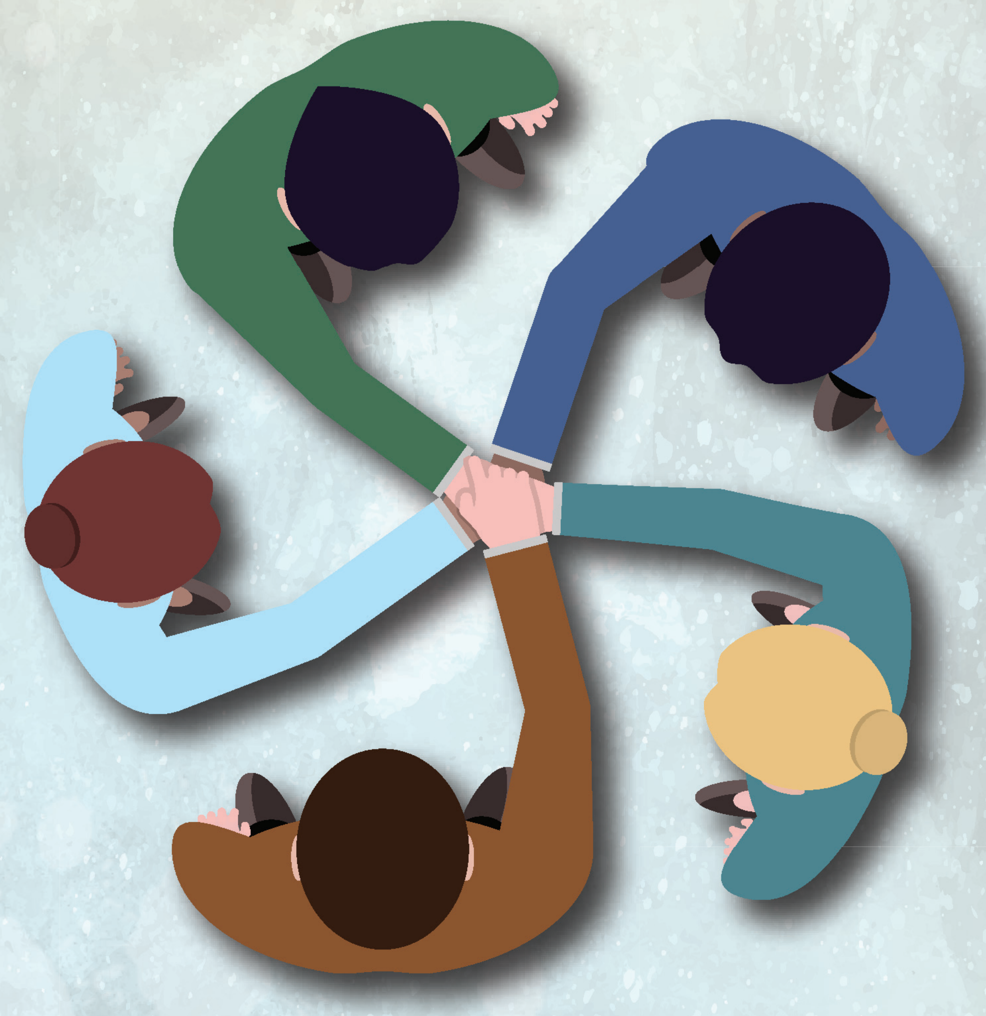

Design: Kabirul Abedin

Disclaimer : The manual is developed as a part of MaMoni Health Systems Strengthening (HSS) initiative with generous support of the American people through the United States Agency for International Development (USAID); Associate Cooperative Agreement No. AID-338-LA-13-00004 - MaMoni Health Systems Strengthening (HSS). The contents are the responsibilities of the authors and do not necessarily reflect the views of USAID or the United States Government.