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

OPERATIONAL PLAN

COMMUNITY BASED HEALTH CARE
(July 2011-June 2016)

HEALTH, POPULATION AND NUTRITION SECTOR DEVELOPMENT PROGRAMME (HPNSDP)

DIRECTORATE GENERAL of HEALTH SERVICES
Mohakhali, Dhaka
November 2011

Operational Plan

1.	**Name of the Operational Plan (OP):**	Community Based Health Care (CBHC)
2.	**Name of the Sector Program:**	Health, Population and Nutrition Sector Development Program (HPNSDP)
3.	**Sponsoring Ministry:**	Ministry of Health and Family Welfare (MOHFW)
4.	**Implementing Agency:**	Directorate General of Health Services (DGHS)
5.	**Implementation Period:**	a) Commencement: July 2011 b) Completion: June 2016
6.	**Objectives of the OP:**	

General objective

To improve the overall health status of the rural community by providing health, family planning and nutritional services with special emphasis to the poor.

Specific objectives

- To provide qualitative Primary Health Care services to the community people particularly to the poor, marginalized & vulnerable group;
- To institutionalize all community clinics under an integrated Upazila Health System (UHS) and District Health System (DHS) and channelizing effective referral linkage from Community Clinic to Union & Upazila facility for proper management of the cases.
- To improve Maternal, Newborn and Child care;
- To provide health care services to the senior citizens, adolescents, disabled and under privileged people of the community;
- To establish and maintain effective functional cooperation and coordination among all health, family planning and nutrition service providers;
- To contribute in improving the FP acceptance rate;
- To provide nutritional services to the community;
- To establish community clinic as a focal service delivery point on HPN;
- To strengthen BCC activities through Community Clinic;

- To introduce e-health in community clinics and introduce structured, effective and functional MIS and establish linkage with central MIS ;
- To establish functional linkage among the public facilities at union & upazila level for improving health, family planning & nutrition services through community participation.

7. Estimated Cost:

7.1 PIP and OP Cost:

(Taka in Lakh)

Description	Total	GOB	PA (RPA)	Source of PA
Approved cost of the PIP (Development)	22,176,66.00	8,603,50.00	13,573,16.00 (8,697,91.00)	Pooled (including JICA) & Non Pooled Fund
Estimated Cost of the OP.	1,657,19.12	413,91.00	1,243,28.12 (683,88.12)	Pool Fund (Including JICA), WHO, GAVI HSS, USAID & others
Cost of OP as % of PIP	7.47%	4.81%	9.16% (7.86%)	

7.2 Estimated Cost (According to Financing Pattern):

(Taka in Lakh)

	Financing Pattern	2011-12	2012-13	2013-14	2014-16	Total	Source of Fund
1	2	3	4	5	6	7	8
GOB	GOB Taka	21.56	1123.90	2615.44	37630.10	41391.00	
	(Foreign Exchange)	(-)	(-)	(-)	(-)	(-)	
	Total GOB	**21.56**	**1123.90**	**2615.44**	**37630.10**	**41391.00**	
PA	RPA (Through GOB)	5785.63	12224.81	4870.8	45506.88	68388.12	Pool Fund (Including JICA)
	DPA	279.40	6456.29	22913.76	26290.55	55940.00	WHO, GAVI HSS, USAID & others
	Total PA=	**6065.03**	**18681.10**	**27784.56**	**71797.43**	**124328.12**	
Grand Total=		**6086.59**	**19805.00**	**30400.00**	**109427.53**	**165719.12**	

8. OP Management Structure and Operational Plan Components (Attached Management set up at Annexure-I)

8.1. Line Director : Project Director, RCHCIB

8.2. Major Components of OP and their Program Managers / DPM: (As per Annex-1)

Major Components	Program Manager	Deputy Program Manager
HR Management	PM (HR Management) (APD Admin)	DPM (HR Management)
HR Development	PM (HR Development) (APD PRT)	DPM (HR Development)
Procurement of Goods and Services	PM (Procurement)	DPM (Procurement)
Mainstreaming the CC in the UHS	PM (Mainstreaming the CC in the UHS)	DPM (Mainstreaming the CC in the UHS)
Community mobilization	PM (Community mobilization)	DPM (Community mobilization)
E-health and MIS in CCs	PM (E-health and MIS)	DPM (E-health and MIS)
Infrastructure Maintenance, Monitoring & supervision	PM (Infrastructure maintenance, Monitoring & supervision)	DPM (Infrastructure maintenance, Monitoring & supervision)

8.3. Manpower in the development budget :

(Taka in Lakh)

Sl. No.	Name of the Post	Number of post	Pay Scale	Grade	Consolidated Pay per Person/ month (Taka)	Total Month	Festival Allowance	Total Pay	Grand Total (8 + 9)
1	2	3	4	5	6	7	8	9	10
	A. Officer								
1	Line Director	1	33500-39500	2	61450	24	1.34	14.75	16.09
2	Program Manager	7	29000-35600	¾	44225	24	8.12	74.31	82.43
3	Deputy Program Manager	7	22250-31250	5/6	34850	24	6.23	58.55	64.78
4	Communication Officer	1	18500-29700	6	29375	24	0.74	7.05	7.79
5	Programmer	1	18500-29700	6	29375	24	0.74	7.05	7.79
6	Accounts Officer	1	11000-20370	9	18200	24	0.44	4.37	4.81
7	Training Officer	1	11000-20370	9	18200	24	0.44	4.37	4.81
	B. Staff								
8	PA Cum Computer Operator	3	6400-14255	11	11090	24	0.77	7.98	8.75
9	Accountant	1	6400-14255	11	11090	24	0.26	2.66	2.92
10	Cashier	1	5200-11235	14	9350	24	0.21	2.24	2.45
11	Community Health Care Provider	13500	5200-11235	14	9350	24	2808.00	30294.00	33102.00
12	Data Entry Operator	8	5200-11235	14	9350	24	1.66	17.95	19.62
13	Store Keeper	1	4700-9745	16	8605	24	0.19	2.07	2.25
14	Driver	11	4700-9745	16	8605	24	2.07	22.72	24.79
15	MLSS	6	4100-7740	20	7750	24	0.98	11.16	12.14
	Total(A+B)=	**13550**					**2832.19**	**30531.23**	**33363.42**

Note: Posts 1- 4 & 6 on deputation, posts 5-15 (except 6) shifted from RCHCIB to HPNSDP.

9. Description:

a) Background Information, Current Situation and its relevance to policies, Sectoral Policy, MDG, Vision 2021, Sixth five Year Plan, MTBF etc.

Introduction:

The Government of Bangladesh recognized the importance of primary health care even before the Alma Ata Declaration in 1978 of universal primary health care. Just after independence in 1971, a setup of primary health care starting from sub-district hospitals, then district hospitals and successively tertiary hospitals were established. The Government signed the Alma Ata Declaration of "Health for All by the year 2000" and intensified the primary health care activities. Health and family welfare centers were established as low as at the union level. The government recognized that, as the population size of the country had been increased to a large extent; universal primary health care could not be possible without extending health care facilities to the grass root level. The urban areas had a concentration of both public and private health facilities but rural areas with thinner distribution of health care facilities. The community clinics program began in Bangladesh in 1998 with the implementation of 1st health and population sector reform program popularly known as Health and Population Sector Program (HPSP). The HPSP introduced from July 01, 1998 aimed to provide the countrymen a defined and standard package of health and family planning services through an integrated approach. On June 28, 1998, the Program Implementation Plan (PIP) of HPSP was approved in the meeting of the Executive Committee of the National Economic Council (ECNEC).

The unique component of the HPSP was "Essential Service Package" to deliver to the rural people from a static community-based center. This center was termed as "Community Clinic". It was decided that one community clinic would be established for about 6000 people. It was also planned that a Community Clinic unit would be established in the existing government health facilities of Upazila and union level to provide services to the nearby people. The Gimadanga Community Clinic of Patgati Union under Tungipara Upazila of Gopalgonj district was the first CC to serve the people. It was inaugurated on 26 April 2000 by the Hon'ble Prime Minister of Govt. of Bangladesh.

It was planned to establish one CC for about 6,000 people. At the time at least one health facility in each old ward (the sub-union tier) should get priority for new construction. The community people welcomed the decision of the Government and assisted the program by donating lands required for constructing the facilities. They extended their hands in constituting the Community Group (CG) i.e. the Community Clinic Management Committee for maintenance, security, cleanliness, fund raising and utilization of the community clinics. A total of 10,723 community clinics were constructed and over 8000 of them commissioned till 2001. It should be mentioned that, the community clinic program was highly appreciated and became very popular among the rural people, and which was significantly contributing in meeting the essential primary health care needs of the population and also to improving the health indicators of the people. During 2001-2008 the activities of the community clinics were suspended.

The people massively accepted the idea of "Poverty Free Digital Bangladesh by 2021" of the present government and revitalization of CCs. The CCs can be a global model for primary health care in improving health status of rural people.

The aim of the community clinics is to provide comprehensive primary health care, family planning services and nutritional services to the people from a single center. The present government took the decision to provide services from CCs at door step of the rural people.

The implementation of the 2nd sector program (HNPSP) was not designed to address the community clinic concept. But the present Government recognized the essence of WHO's global call for revitalizing the Primary Health Care. Thus to revitalize the HPSP concept of CCs, Government planned to formulate a project titled "Revitalization of community health care initiatives in Bangladesh" in 2009. The implementation period for the project is July 2009-June 2014. The project aimed to revitalize the community health care system of Bangladesh through strengthening and/or re-establishing the community clinic system, which is one of the highest priority agenda of the government of Bangladesh. It is planned that a total of 13500 community clinics will be constructed by June 2012.

The ongoing project Revitalization of Community Health Care Initiatives in Bangladesh:

Present Govt. has taken initiatives for Revitalization of CC as the top-most priority project in Health Sector. The Project was approved by ECNEC on Sept. 2009 titled as "Revitalization of Community Health Care Initiatives in Bangladesh"(RCHCIB), with an estimated cost of BDT 26774.8 million of which BDT 21774.8 million is of GOB & 5000.00 million is PA. Implementation period of the project is from 1 st July 2009 - 30th June 2014. CC is a tiny clinic at the grass root level in the remotest and hard to reach area. It is basically meant for health education (on health, nutrition & FP), health promotion and treatment of minor ailments, first aid, and identification of emergency & complicated cases to establish an effective referral linkage with the higher facilities i.e. UHFWC & UHC for better management.

Basically CC is the first tier one stop service center for Primary Health Care with emphasis on Maternal & Neonatal Health. It is to be mentioned that normal delivery is being conducted in some CCs through SBA and CSBA (trained FW A/Female HA) particularly where DSF (Demand Side Financing) & MNH program is going on. Normal delivery is also being conducted in some areas where PLAN Bangladesh is working with RCHCIB. It needs to be mentioned that CC is a unique example of Public Private Partnership as all the CCs are constructed on community donated land, construction done by the govt. medicine & all necessary logistics are supplied by government including service providers but management is both by Govt. & community. Each CC has one managing body titled Community Group (CG) who represents different groups of people of the catchments area of Cc. Concerned Govt. staff provides technical & secretarial support to the CG for smooth functioning of Cc.

Mission

- To make 10624 existing (built during 1998-2001 but abandoned) CCs functional.
- To construct and functionalize 2876 new CCs (Including already demolished 99 CC).
- To establish CC unit at existing 4500 Health Facilities of Upazila (Sub-district) and Union level. To recruit 13500 Community Health care Provider(CHCP), 1 for each CC. To revitalize & establish 18000 CCs.

Objectives of OP:

- To strengthen 10624 existing community clinics located in the rural area of Bangladesh
- To introduce community clinic functions in 4500 existing government-owned union and Upazila health facilities
- To re-build 99 demolished Community Clinics
- To establish 2777 new community clinics in rural areas where community clinics are absent
- To institutionalize all the 18000 community clinics under an integrated Upazila and District health system and channelizing effective referral linkage.

Collaboration with NGOs :

For capacity development of CG, CSG, involvement of the community & for some operational research on CC, MoU has been signed with 8 NGOs and Some other agencies are coming Forward to work with RCHCIB;, GA VI-HSS is supporting for capacity development of CG, CSG, to establish solar panel, renovation for MNH services including conduction of normal delivery at CCs & many other CC a~tivities. Community Group (Management Body of Community Clinic): The most important driving force of CC Community Group (CG) : Members 09 to 13 (at least 04 will be female) President (0 I): Elected UP member . Vice President (02): Land donor or his/her representative and one is elected/elected by community people Among President and Vice-president one must be female Treasurer (0 I): Selected by community group members Member Secretary (OI):CHCP is be Member Secretary (without voting power). Members (08): Selected/elected from different group of people of the CC catchments area-poor, landless, freedom fighter, social worker, female Up member, religious leader, adolescents etc.

Services provided from CC :

It is a one stop service center for PHC at the rural area.

The major services are:

- Maternal and neonatal health care services
- Integrated Management of Childhood illness
- Reproductive Health and Family Planning services
- EPI, ARI, CDD

- Registration of newly married couple, pregnant women, birth & death, preservation of EDD
- Nutritional education and micro-nutrient supplements
- Health and Family Planning Education & counseling
- Identifications of other severe illnesses like TB, Malaria, pneumonia, life threatening influenza, obstetrical emergencies and refer to higher facilities
- Identification of emerging & reemerging diseases & refer to higher facilities.
- Other services as identified by GOB under HPNSDP to be provided
- Treatment of minor ailments

Establishing effective referral linkage with higher facilities

Reasons for separate Operational Plan:

The revitalization of Community Clinics activity started through the project "Revitalization of Community Health Care Initiatives in Bangladesh" since July 2009 & will continue till June 2014. The estimated cost of the project is 2677.48 crore taka with the provision of 500.00 crore taka as Project Aid (PA) support. Since the Ministry of Health & Family Welfare (MoHFW) is coordinating the PA support through the sector program approach, so most of the Development Partners (DPs) feel comfortable in supporting through the sector program. Till today the project got no PA support. Some of the important activities were planned to be implemented with the PA resource. Those activities could not be started. The foundation training for the Community Health Care Providers and other important training were also planned to be implemented under PA support. Thus it is essential to get the PA for implementing the project line activity.

The Community Clinic will act as a focal point to establish Upazila Health System where Health, Nutrition & Population services will be provided in a coordinated manner. DPs are interested to provide support to establish functional UHS keeping in view the Community Clinic as a focal point at the bottom tier of Health System.

During last two years of implementation of the project it was felt that some new activities/components need to be included for

i) effective service delivery,

ii) involvement of the community in Community Clinic activities and

iii) Sustainability of Community Clinic. Community Clinic concept is a very well taken concept to the experts who have been working in Primary Health Care. Community Clinics are the important facilities to render primary health care services at the door-step of the rural people. Such an important program should not run vertically in a projectile approach for an indefinite period. Thus the mainstreaming of the Community Clinic activities is also essential. But since the project is in the middle stage and some of the major activities are in process, both the project and the OP need to work together. After the project completion (June 2014) the activities of the Community Clinic will be mainstreamed and merged with the health system to serve the rural people.

To implement all these activities require additional resources. The new activities / components are planned to be implemented through the sector program. To complement, supplement and for better services from next fiscal year and for continuation of Community Clinic activities after June 2014 the new Operational Plan (OP) titled "Community Based Health Care" has been prepared under the Health Population & Nutrition Sector Development Program (HPNSDP) for the period from July 2011-June 2016.

Issues to be addressed:

The Community Based Health Care (CBHC) OP will maintain a good interlink with Maternal, Neonatal, Child & Adolescent Health (MNC&AH), Essential Service Delivery (ESD), Maternal, Child, Reproductive & Adolescent Health (MCRAH), Hospital Services Management (HSM), Physical Facilities Development (PFD), MIS & other relevant OPs. For proper functioning of the CBHC OP there would be need of direct support (such as TA, logistic supply, proper handling of referral system, construction and repair) from above mentioned OPs. Defining the composition and tasks/responsibilities of the district and upazila health management committee with tasks in planning, budgeting, priority setting, implementation, supervision and reporting would be ensured through proper coordination with the these OPs.

Coordination with UHS will be established through service providers, Community Group and Community Support Group. The coordination process and service delivery of Civil Surgeon (CS), Deputy Director-FP (DD-FP), Upazila Health &Family Planning Officer (UH&FPO), Medical Officer-Maternal & Child Health (MO-MCH) and

Upazila Family Planning Officer (UFPO), would be intimately involved and supervise the activities through their existing supervising authority.

Whenever the guideline on functional integration on MNC&AH services among DGHS and DGFP will be formulated, CC will follow the guideline for the implementation of its activities.

Referral linkage among Community Clinic, Union Sub-Center, Union Family Welfare Center (UFWC), Union Health & Family Welfare Center (UHFWC), Upazila Health Complex & other health facilities will be established with formulation of a referral guideline and referral slip. Regarding the referral process all the service providers of the field, Community Clinic and all other relevant health facilities of different levels will be well oriented and equipped. The Community Group, Community Support Group will be intimately involved in the referral system.

Referral and supervision linkages between the various levels of care (District, upazila, union and community) to be defined and the responsibilities of all the actors and stakeholders to be clearly spelled out in order to ensure the necessary 'unity of command'. Involving local government institutions and NGOs to support the Community Group, Community Support Group for stimulating informed demand, quality services and appropriate utilization along with accountability, particularly to the poor, women and elderly.

GO-NGO collaboration for better functioning of Community Clinic :

Community Group (CG) comprising 9-13 members has been formed and there is Terms of Reference (TOR) of the group. In the catchments area of each CC there are three community support group (CSG) comprising of 10-15 members. Activities have been taken to orient the CG on their responsibility. For proper functioning of the CG & CSG there is need of collaborative effort both from govt. and NGOs in different aspects such as monitoring and supervision of the Community Group performance. A well structured monitoring and supervision plan will be formulated with assigned responsibility and time frame. Government and NGOs will be actively involved to formulate the plan and establish a supportive environment for proper functioning of the Community Group so that the community clinic will be a sustainable health, population and nutrition service delivery center.

In the mean time Revitalization of the Community Health Care Initiatives in

Bangladesh (Community Clinic Project) has signed Memorandum of Understanding (MOU) on Strategic Partnership with a number of NGOs like PLAN, CARE,VSO, Eminence etc. who aim to improve access to basic health care and treatment at facility and community level through their programs and research. In relation to Community engagement & monitoring and supervision of the community clinics that Memorandum of Understanding (MOU) would be used for better performance of the CC. NGOs will be allowed to implement the activities as per TOR and prior permission from the appropriate authority.

Feasibility

The pragmatic operational research for community clinic model was done between June 1998 and April 1999. Its various alternative models were tested in 6 unions of 4 districts under Thana Functional Improvement Pilot Project (TFIPP) of the Ministry of Health and Family Welfare. Besides, on small scale, same type of research has been done by some organizations such as Bangladesh Red Crescent Society. A GTZ-supported pragmatic research has also been done regarding alternate service delivery system by ICDDR,B. These research-based experiences helped the Ministry of Health and Family Welfare to introduce programs of community clinics. The experiences obtained from various health programs such as Satellite Clinics, EPI Outreach Centers, etc. conducted at field levels helped to finalize the idea and plan for community clinics.

b) Related Strategies:

The Poverty Reduction Strategy Paper (PRSP) states that the government is committed to ensure quality health, nutrition and family welfare services, which are affordable, attainable and acceptable to its citizens. The government's focus is on improving health status, reducing health inequalities, expanding access to social safety net and encouraging affordable service delivery systems for everybody. For the poor and vulnerable, existing safety nets will be further expanded and consolidated not only to ensure access of the poor to public health care services but also to raise their voices and establish ownership through community participation.

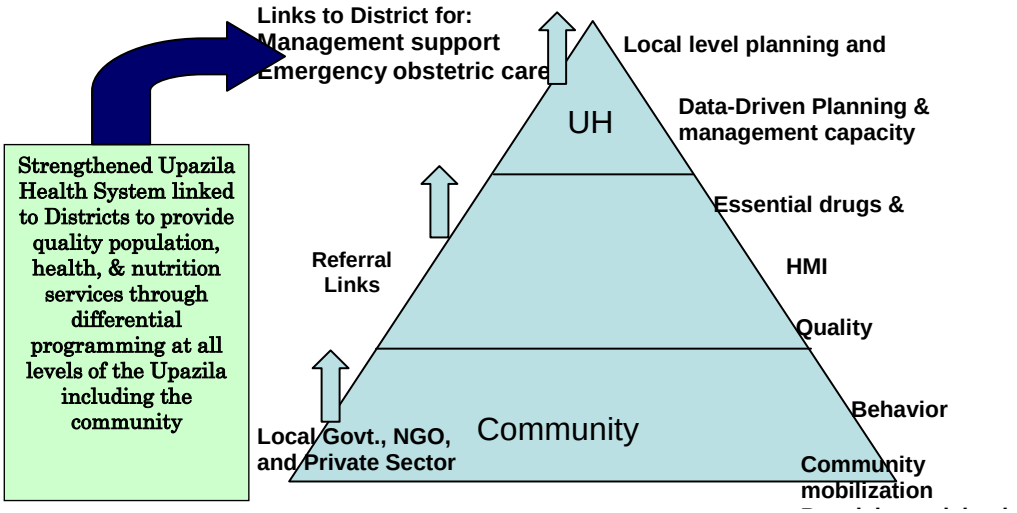
The Millennium Development Goals 4 and 5 is the call for reduction of child and maternal mortality. These two goals can be achieved if the primary health care services are ensured. Without focusing to rural communities, where

around 3/4th of the country's population lives, much improvement in this regard is not possible. The community clinics will be important milestones towards achieving the health related MDGs.

The PRSP specifically states for strengthening and expansion of community and facility based IMCI, maternal and reproductive health. It is mentioned that Upazila Health Complexes (UHCs), Union Health & Family Welfare Centers (UHFWCs) and the Community Clinics (CCs) would be strengthened and further consolidated through providing adequate manpower, drugs and other medical & non medical supports. There would be involvement of local government bodies and NGOs for greater participation of the community with a view to ensuring community driven health, family planning and nutritional services.

UHS will be the transformation of the fragmented, inefficient, centralized, separated curative from preventive care and apartheid health system existing at the Upazila level into a coherent unified national health system capable of addressing the health needs of the population, especially those living in the poverty. The goal of UHS is the provision of an equitable, efficient and effective health service that is based on the primary care approach.

Figure- 1



Communities and

The community based and the facility based HPN activities would be

implemented under a single HPN plan for a given population and area. It will also comprise the relationship of the UHS and the respective roles of each spheres of the government particularly local government, NGOs, Private sector and district health services and lower level UHFWCs as well as CCs. In the first 2-3 years of the next sector program, MOHFW would start piloting the UHS with a limited number of selected Upazilas, where the required staff (doctors, nurses, paramedics, etc) and equipment is available for caesarians and other surgical interventions. After successful piloting, the UHS will gradually be scaled up countrywide.

Service providers of CCs will also identify the complicated, serious & emergency cases. Service providers will refer those patients to Union Health & Family Welfare Centre & Upazila Health Complex for better management. The patients will be provided with referral slips mentioning patient's condition & pre-referral management, reasons of referral. This information will be kept in the register of Community Clinic. These referred patients will be managed in the respective facilities on priority basis & all the information will be kept there. Periodically information on referral will be disseminated with all concern.

It is to be noted that Medical Officer, Sub Assistant Community Medical officer (SACMO), FWV of union level will visit & provide services from Community Clinic once in a week/decided by the Upazila managers. They will support the service providers of Community Clinic for improvement of services.

Community Group & Community Support Group will perform their responsibility intending to improve quality of services & to make the program sustainable. Community Group & Community Support Group will be involved & empowered to make the CC full functioning and acceptable to the community. CBHC OP will take initiative to increasing the capacity of the community group & the community support group through training & motivation.

The service of all the Community Clinic s of respective Upazila will be supportively supervised on regular basis & monitored by the Upazila managers of both health & family planning using formulated check list. The findings will be shared with the service providers & immediate superior supervisors with a view to indentify the

problems, find out possible causes & recommend reasonable solution. Upazila managers will also monitor proper functioning of Community Clinic & ensure optimum utilization of drugs & other inputs with special emphasis to the poor & vulnerable people.

Nutrition Service Delivery at Community Clinic Level

The delivery of nutrition services in community clinics will be under the supervision of the Medical Officer of the Union facility/union who would be assigned the responsibility of overseeing the implementation of nutrition activities through the service providers, Community Group & Community Support Group in the community clinic catchments area. Community Health Care Provider (CHCP), Health Assistant (HA) & Family Welfare Assistant (FWA) and other relevant personnel working at that community clinic will have the responsibility of delivering the nutrition services.

The main activities to be implemented in community clinic will include:

- IYCF: Counseling to all women with children who come to OPD and community for exclusive breast feeding until 6 months of age including positioning and attachment, supporting for trouble-shooting for any breastfeeding problem, proper complementary foods and advice on adequate nutrition after six months of age, weight and height measurements.

- Management of Acute Malnutrition: Screening for malnutrition (MUAC, growth monitoring), nutrition advice for all children, classification and categorization of referred children by level of malnutrition, treatment of uncomplicated cases of moderate malnutrition, referral for complicated cases to primary level care facility, follow-up of referrals from the community and monitor follow-up visits to children under treatment.

- Behavior Change Communication (BCC): In addition to BCC messages on IYCF nutrition education and counseling will be provided to adolescents, pregnant and lactating women on topics such as, personal hygiene and cleanliness especially during preparation of food and feeding of infants and young children, general nutrition, health and nutritional importance of de-worming and consumption of micronutrient supplements (Vit A, Iron, Folate etc).

- **Micronutrients:** Provide advice, guidance to households on iodine, iron, and vitamin A, advocacy and monitoring, follow-up and compliance of use of iron folic acid by pregnant women; provision of zinc in addition to ORS during treatment of diarrhea, provision of de-worming medication, iron-folic acid supplements, post-partum vitamin A supplementation.
- Growth Monitoring:

  It is to be done in the Community Clinic using the prescribed chart. Children of < 5 age of the catchments area will be under this program. Growth of the children will be monitored & accordingly mothers will be advised to take necessary steps for the proper growth & development of their children. CHCP & other service providers of CC will be trained in this regard.

  - Community clinics will be the main contact points for nutrition services. Nutrition services will be provided in all community clinics in an integrated way with EPI, Satellite clinic and other health and family planning programs.
  - All Health and Family Planning workers will be trained in nutrition to strengthen nutrition services.
  - Nutrition Services/activities will be implemented in coordination with NNS, ESD, MNC&AH, & MCRAH.

Nutrition Service Delivery at Community Level

The community level will be the focus of all area based Community Nutrition activities/ interventions. At the community level, nutrition services will be delivered by Health Assistants, Family Welfare Assistants and CHCP in addition to their usual duties. These activities will be supervised by their respective supervisors and will be carried out through group counseling; one-to-one counseling during home visits to pregnant women, new mothers, growth falters (that is, pregnant women, infants and young children). The HAs, FWAs and CHCPs will receive supervision and guidance from Health/Family Planning Inspectors and Family Welfare Visitors to carry out nutrition services along with other health and family planning responsibilities. In addition, services of Community Group & Community Support Group will be achieved wherever they are available and whenever necessary.

Inter-OP Coordination within Agency:

The three OPs under DGHS such as MNC&AH, ESD and CBHC focus on delivery of

the primary health care services particularly at the Upazila and below level. This in fact divides the PHC implementation into three separate LDs where coordination during implementation will be critical. Through the office of the Director-PHC, DGHS, the gap between MNC&AH and ESD–OP will be minimized during implementation. To synchronize the inter-OP operation and maximize coordination, Director-PHC will be made LD of MNC&AH and a senior level DD will be assigned to a post under Director-PHC, DGHS who will be given the responsibility of the LD for the ESD-OP thus ensuring these two OPs' implementation under the Director-PHC. The coordination of CBHC with those two OPs will be ensured through Upazila Health System, with referral linkages to service delivery issues such as BCC, Nutrition etc. A technical committee will be formed to guide coordination among these OPs with defined TORs to improve coordination in these regards.

On 22.02.2011 a circular was issued which states the services to be rendered from community clinics and the TORs of the service providers including CHCP, HA and FWA. The circular is annexed at Annexure-XI.

An inter-wing coordination mechanism among the PFD, HSM, HRM and SWPMM–OPs for making health facilities functional a High Level Committee to be formed to ensure synchronization of new/upgraded facilities within time provision of manpower, supplies and logistics.

Rational linkage:

Globally it is recognized that Bangladesh has a good health care network extending from the national to community level. But, one weakness often referred to Bangladesh's health care network is poor organization of the referral linkages. If a mathematical analysis is drawn, it will reveal that each community clinic catchments area will have about 1200 to 1300 families considering average family size of about 4.7 (BBS 2008). If every community clinic is organized in such a way that it will strongly oversee health matters of all community people ensuring active community participation, then the community clinics can be really hubs for making breakthrough in health and social development. The community clinic approach may initiate the first step in referral linkage in health care with gradually leading the patients to higher levels of health care facilities viz. union health facility, upazila health facility, district health facility and ultimately tertiary health care facilities.

It is estimated that there would be a need for about 18000 rural health facilities

through which all rural people can get their health, population and nutritional services. About 4500 Upazila and union health facilities, viz. Upazila Health Complexes, Union Sub-Centers, Union Family Welfare Centers, Union Health & Family Welfare Centers, etc could provide the necessary health, population and nutritional services for the adjacent rural people. Thus there is a crucial need to establish at least 13500 CCs which would cover all the rural citizens of Bangladesh. The number might increase considering the geographical area (char, haor, hill, hard to reach etc.) ethnic priorities and increase in population.

10. Priority activities of the OP:

1) HR Management

- Pay & Allowances for the program manpower assign job responsibility, deployment of Community Health Care Provider and improve capacity development of HPN services.
- Institutionalization of community clinics under an integrated Upazila Health System and District Health System
- Establish and maintain effective functional cooperation and coordination of all health, family planning and nutrition service provider (GO and NGO) in the rural area;

2)**Procurement of goods and services**

- Procurement of medicine, furniture, Medical and Surgical Requisites (MSR), equipments, printed materials, vehicle etc. to ensure supplies and services in the Community Clinic;
- Provide one three wheeler (VAN) to 500 Community Clinic for piloting: (the three wheeler will be given to a poor family by the Community Group with the condition that the poor man will provide free service to the Community Clinic through transferring the patient to the UHFWC/UHC when necessary);
- Provide one motorcycle to one MO in the UHC to ensure monitoring and supervision of CC activities.

3) Establish e-health and MIS in the CC

- Training of Community Clinic Service Providers on IT to support the introduction of e-health of rural people through Community Clinics;
- Establish Strong MIS in the Community Clinic and linking it with the UHS
- Establish online reporting system with support of MIS OP of DGHS;

4) HR Development

- Provide training to the CHCP, HA, FWA and other public providers to ensure services;

5) Community mobilization

- Provide training to the Community Group, Community Support Group, Local Government Representatives and other stakeholders for the community participation and mobilization;
- BCC for MNC&AH activity promotion in the Community Clinic to reduce maternal and child mortality;

6) Mainstreaming the Community Clinic in the UHS

- Establish Community Clinic as the basic HPN services and the total PHC services will be built up on Community Clinic services;
- Establish well functional coordinated HPN services at the grass root level based on Community Clinic;
- Mainstreaming the Community Clinic Approaches in the HNP sector though establishing a regular GOB set-up;
- Institutionalization of community clinics under integrated upazila and district health system and channelizing effective referral linkage ;
- Introduction of Family Health Card to maintain complete data of every individual in the family;
- Introduction of Growth monitoring chart for monitoring the growth of children;

7) Infra-structure Maintenance and Monitoring & supervision of Community Clinic:

- Repair & Maintenance of the Community Clinic building with support of Community Group
- Establish solar panel in the community clinic where electric supply is not available
- Electric line installation where ever possible;
- Ensure monitoring, supervision (as per annex-X plan) and evaluation to ensure services in the community clinics.
- Monitoring would be done by the Community Clinic management committee, upazila, district and national level supervising authority.
- Monitoring will be done on regular basis and with the help of checklist on performance and supply of logistic, and activities of the Community Clinic management committee.
- Functional linkage of domicile and static Health, Family Planning and Nutritional Services in the rural Health system.

11. Relevant Result Frame Work Indicators (s): Base line, Projected Target for the planned year:

11.1. Relevant PIP Indicators

The activities under this OP contribute to ensuring the quality and equitable health care for all citizens of Bangladesh. More specifically, the activities planned contribute to all the results under Component 1 (Result 1.1, increased utilization of essential HPN services, Result 1.2 improved equity in essential HPN utilization, Result 1.3 improved awareness of health behavior) and, in particular, Result 1.4 improved primary health care-community clinics systems.

Result	Indicator	Means of verification & Timing	Baseline	Target 2016
Result 1.4 Improved PHC-CC systems	# of Community Clinics (CC) with increasing number of service contacts over time.	CC Project /MIS/ MOHFW	NA	13500

11.2. OP level indicators (Output/Process)

	Indicators	Unit of Measurement	Base line (with Year and Data Source)	Projected Target	
				Mid-2014	Mid-2016
(1)	(2)	(3)	(4)	(5)	(6)
1.	Community Clinics (CC) are available (in terms of number of CCs functional)	Number	10,624 (RCHCIB-study 2010)	13,500	Sustain
2.	Community Clinics (CC) utilized	Number	10323	13,500	Sustain
3.	Number of community clinic functional with trained staff and medicines	Number trained CHCP available	None with CHCP	13,500	Sustain
4.	Number of community clinic management committee meeting held	Meeting held in each quarter	500	13,500	18,000
5.	% of community clinic with medicines available	% of CC with medicine available	60%	100 %	100 %
6.	Number of CHCP trained	Number	Nil	13,500	sustained
7.	Training of the community group (CG)	Number of CG trained	1000	13,500	18,000

11.3. Source and methodology of data collection to measure/preparation of annual progress report:

Routine report:

Report in respect of services provided from all Community Clinics (Health, Nutrition & Family Planning) will be collected monthly through Upazila & District. It will be compiled at Head Quarters. It has been planned that the monthly report of huge number of community clinics will be compiled automatically through soft ware.

Report in respect of Drugs, MSR, Logistics, Infrastructure, CG& CSG meetings with community engagement will be collected periodically & compiled.

Progress report will be collected from the NGOs who will work with Community Clinics. Quarterly meeting will be held with them to review the progress for future plan of action

It has also been planned to conduct survey to find out the status of implementation, strength, weakness etc. for future action plan

MIS report of DGHS, DGFP, other study/ survey, reports etc.will also be reviewed & will be accommodated in future plan of action to improve the services of community clinics.

12 Estimated Budget :

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12.1. Estimated summary of development budget: (Taka in Lakh)

Inputs	Activities	Economic Code	Total(July 2011-June 2016)						% if the total cost
			GOB	PA				Total	
				Sub-total PA	RPA (GOB)	RPA (others)	DPA		
A. Revenue Component									
Pay of Officers	Pay & Allowances	4500	1900.00					1900.00	1.15
Pay of Establishment	Pay & Allowances	4600	16000.00					16000.00	9.65
Allowances	Pay & Allowances	4700	11191.20					11191.20	6.75
Supplies and Services	Operational and other Expenses,	4800	11599.8	111104.52	64764.52		46340.00	122704.32	74.04
Repairs & Maintenance	Maintenance & Repairs	4900		8100.00			8100.00	8100.00	4.89
Sub total (A)			***40691.00***	***119204.52***	***64764.52***		***54440.00***	***159895.52***	**96.49**
B. Capital Component									
Acquisition of Assets		6800		3623.60	3623.60			3623.60	2.19
Works		7000	700.00	1500.00			1500.00	2200.00	1.33
Sub total (B)			**700.00**	**5123.60**	**3623.60**		**1500.00**	**5823.60**	3.51
Total(C=A + B)			**41391.00**	**124328.12**	**68388.12**	**00.00**	**55940.00**	**165719.12**	**100**

12.2 Estimated Detailed Budget (Input wise) :

12.2 Estimated Detailed Budget (Input wise)

13. Year-wise physical and financial Target during OP period:

13. Year-wise physical and financial Target during OP period:

14. Location-wise break-up of the components :

Name of the components	National	Estimated Cost	Name of Division	Estimated Cost	Name of District	Estimated Cost	Name of Upazilla	Estimated Cost
Pay, Allowances & Others	Project Office	1000.00						
Pay, Allowances of CHCP, Supply & Services and Others							All Upazila	164719.12

15. Organogram for Community Based Health Care (Annexure- I)
16. Log Frame (As per Annexure- II):

17. Annual Procurement Plan for Goods, Works, Services (Separate table for a. Goods, b. Works, c. Services): (As per Annexure- III a, b, c)

18. List of Machinery & MSR (Annexure-IV a, b):

19. List of Furniture-Fixture (Annexure-V):

20. Vehicle (Annexure- VI):

22. Training program for human resource development (Annexure- VII)
23. CHCP Training Related work plan (Annexure- VIII)

24. Monitoring Mechanism for CCs (Annexure- IX)

25. GO on CC services & Co-ordination among service providers -(Annexure-X)
26. Meeting Minutes of Manpower Selection Committee, Ministry of Finance - (Annexure-XI)
27. Name & Designation of officers responsible for the preparation of this OP:

a. Dr. Makhduma Nargis, PD, RCHCIB & LD, CBHC

b. Dr. Md. Firoz Miah, Addl. PD, RCHCIB & PM, CBHC

c. Dr. Barendara Nath Mandal, Addl. PD, RCHCIB & PM, CBHC

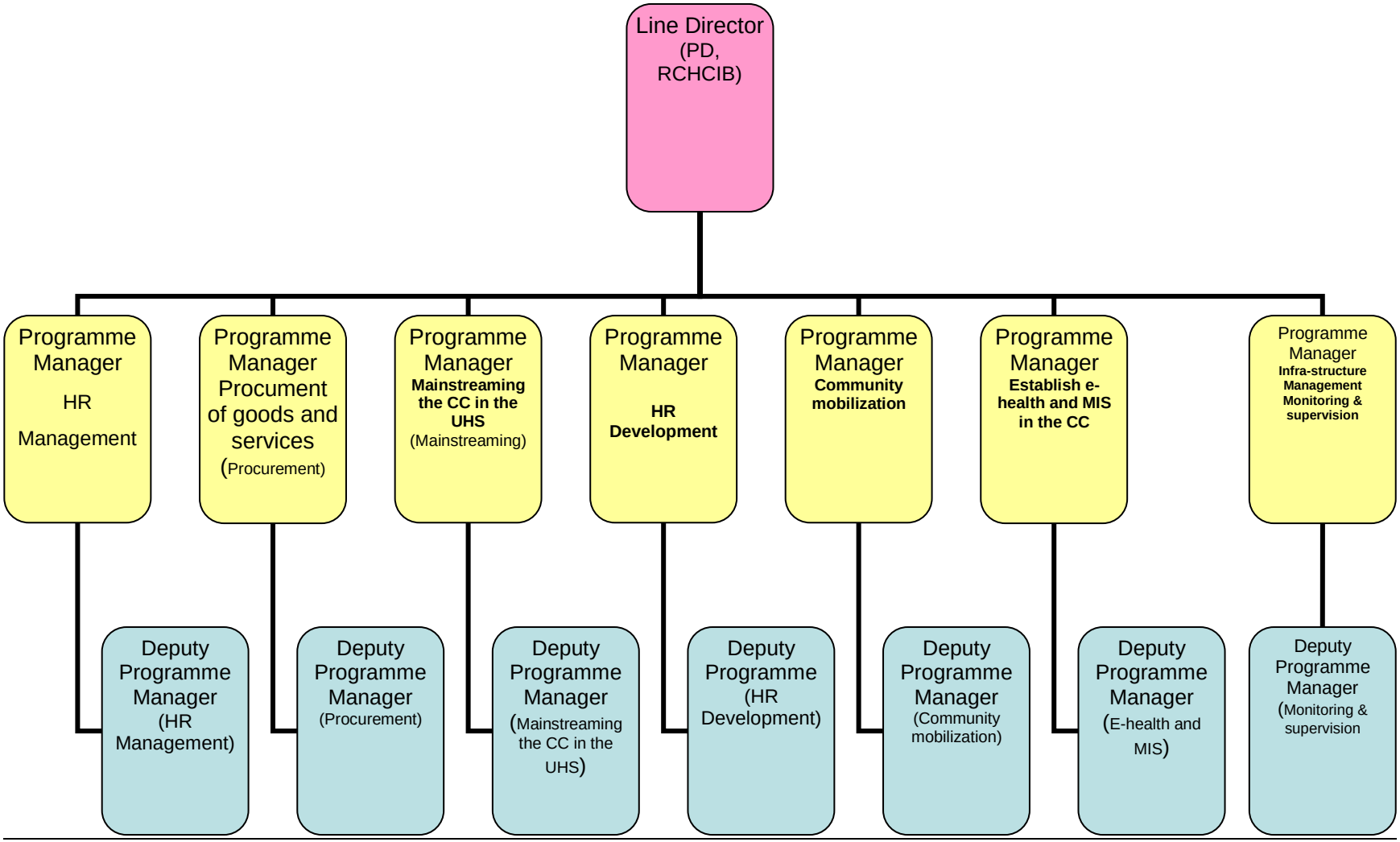
d. Dr. K M Azad, Communication Officer, RCHCIB and DPM, CC

28. Recommendation and Signature of the Head of the Implementing Agency with seal & date:

29. Recommendation of the Signature of the Secretary of the sponsoring Ministry with seal & date:

Annexure- I

Organogram for Community Based Health Care



Annexure-II

Log-frame

(i) Planned date completion: June 2016

(ii) Date of summary preparation: November 2011

Logical Framework of Community Based Health Care, DGHS, July 2011- June 2016

Narrative summary	Objectively Verifiable Indicators	Means of verification	Important Assumptions
Goal: Improved health status of the rural people through ensuring comprehensive health care, family planning and nutritional services	- Reduced Infant mortality rate from 52 – 31 (per 1000 live births) by 2016 - Reduced Neonatal mortality rate from 37– 21 (per 1000 live births) by 2016 - Reduced prevalence of underweight children from 41% to 34% by 2016	BDHS UESD BMMS	
Purpose: Increased utilization of community clinic to improve Maternal, Child Health and Reproductive Health services through quality services rendered and informed choice of the people	- Increased utilization of Community Clinic by about 200% by 2016 (from 19 patients per day to 40 patients per day) - Increased number of patients referred to higher level health services with valid reason by about 160% by 2016 (47 patients per month to 75 patients per month) - Increased percentage of children 6-24 months fed with all infant and young child feeding (IYCF) practices/CF from 41.5% to 52% by 2016	Quarterly OP report CC MIS BDHS	Constructed community clinic as per plan Successfully integrated with HPNSDP
Outputs: 1) Establishment of Community clinic with adequate manpower and medicines 2) Functional of Community Clinic with services of maternal and child health, ESD, nutrition, family planning, geriatric care by the participation of community people	By 2016: - Established 13500 Community Clinics located in the rural area of Bangladesh with at least 1 trained Community Health Care Provider (CHCP) and requisite medicines - 13500 Community Clinics rendered services of maternal and child health, ESD, nutrition, family planning, geriatric care by the participation of community people - 13500 Community Clinic Management committee meeting held per quarter (at least 4 meetings per year) with participation of nominated local community, meeting minutes recorded and implemented - 100% community clinics provided Growth monitoring services - At least 10 pregnant women received ANC (4th visit) per month per community clinic - At least 10 mother and new born children received PNC visit per month per community clinic - At least 10 pregnant women received iron and folate supplementation per month per community clinic - At least 140 eligible couples received family planning methods per month per community clinic	Quarterly OP report MIS report Meeting minutes	Availability of medicines Support received from community and local representatives Support received from Family Planning
Input/ Activities • Service delivery froom the Community Clinic • Monitor regular repair and renovation of community clinics • Formation of CG for all CCs • Ensure supply of medicines to the community clinics • Train service providers to ensure quality of services • Monitor and supervise to ensuring quality services	By 2016: - Ensure service delivery from all 13500 community clinics in rural areas - Introduce community health system in 4500 existing union and Upazila health facilities and functional linkage with them; - Ensure CHCP deployment and training- 13500 - IEC material production, supply medicines and MSR to all Community Clinics (13500) - Formation and training of Community Group for the CC Management – 13500 - Ensure regular meeting(t least 4 meeting/year) of CG – 13500 x 4 = 54,000 / year - Community Group meeting held in each month- 75% - Establish regular reporting including online reporting - Regular monitoring of the CC services from different level	Quarterly OP report Periodic MIS report	Need based IEC planned and implemented Filled up vacant positions of Community Health Care providers (CHCP) and Community Health Volunteers (CHV)

Annexure- III (a)

PROCUREMENT PLAN OF GOODS FOR OPERATIONAL PLAN

Ministry/Division	Ministry of Health and Family Welfare
Agency	CMSD / LD
Procuring Entity Name & Code	Line Director, CBHC
OP Name & Code	Community Based Health Care (CBHC)

OP Cost (in lakh Taka)	
165719.12	Total :
41391.00	GOB
124328.12	PA

Package No.	Description of procurement	Unit	Quantity	Procurement method and type	Contact Approving authority	Source of Fund	Estd. Cost (Lakh Taka)	Indicative Dates			
								Not used in Goods	Invitation for tender	Signing of contact	Completion of contact
1	2.1	3	4	5	6	7	8	9	10	11	12
GD1	Bi-cycle		13500	NCB / ICB	MOHFW	RPA	867.52		Nov-11	Jan-12	Dec-12
GD2	Three Wheeler Van for Patient carrying	Lot	500	NCB	MOHFW	RPA	100.00		Nov-11	Jan-12	Jun-12
GD3	Motor Cycle(for 1 MO in each Upazila)	Lot	500	NCB	MOHFW	RPA	750.00		Nov-11	Jan-12	Dec-12
GD4	Vehicle (1 Jeep, 1 Double Cabin Pick-up)	Lot	2	NCB	MOHFW	RPA	100.00		Nov-11	Jan-12	Jun-12
GD5	Furniture (Steel Almirah) to old CCs	Lot	10624	NCB / ICB	MOHFW	RPA	1806.08		Nov-11	Jan-12	Dec-12

Package No.	Description of procurement	Unit	Quantity	Procurement method and type	Contact Approving authority	Source of Fund	Estd. Cost (Lakh Taka)	Indicative Dates			
								Not used in Goods	Invitation for tender	Signing of contact	Completion of contact
GD6	Carrying Bag for CHCP	Lot	13500	NCB	LD	RPA	135.00		Nov-11	Jan-12	Jun-12
GD7	MSR	Lot	13500	NCB	LD	RPA	2616.98		June - 14	Oct-14	Feb-15
GD8	Stationary for the CCs(11500-13500)	Nos	Need Based	NCB / ICB	LD	GoB – 1193.00 RPA – 890.12 DPA – 2181.00	4129.12		July-12	Oct.-12	June-16
GD9	Printing of Register, forms, outdoor tickets etc.	Nos	Need Based	NCB / ICB	LD	GoB – 520.71 RPA – 1181.26 DPA – 2320.71	4022.68		July-12	Oct.-12	June-16
GD10	Family Health Card	Nos	Need Based	NCB / ICB	LD	RPA – 1904.96 DPA – 22890.88	24795.84		Nov-11	Jan-12	June-16
GD11	Growth monitoring chart	Nos	Need Based	NCB	LD	GoB – 110.42 RPA – 608.75 DPA -1445.71	2164.88		Nov-11	Jan-12	June-16
GD12	Procurement of Medicine	Nos	Need Based	Direct Procurement	MOHFW	GoB – 1460.52 RPA – 39688.25 DPA – 15456.27	56605.04		July-14	Oct.-12	June-16
Total (A)=							**98093.14**				

Annexure- III (b)

PROCUREMENT PLAN OF WORKS FOR OPERATIONAL PLAN

Ministry/Division	Ministry of Health and Family Welfare
Agency	HED
Procuring Entity Name & Code	Line Director, CBHC
OP Name & Code	Community Based Health Care (CBHC)

OP Cost (in lakh Taka)	
165719.12	Total :
41391.00	GOB
124328.12	PA

Package No.	Description of procurement	Unit	Quantity	Procurement method and type	Contact Approving authority	Source of Fund	Estd. Cost (Lakh Taka)	Indicative Dates			
								Invitation for proposal	Invitation for tender	Signing of contact	Completion of contact
1	2.1	3	4	5	6	7	8	9	10	11	12
W1	Electric line installation where ever possible	Nos	8000	NCB / ICB	MOHFW	GoB	700.00		Jul-11	Oct-11	June-16
W2	Establishment of solar panel in CC	Nos	2000	NCB / ICB	MOHFW	DPA	1500.00		Dec-11	Feb-12	June-16
Total (B)=							2200.00				

PROCUREMENT PLAN OF SERVICES FOR OPERATIONAL PLAN **Annexure- III (c)**

		OP Cost (in lakh Taka)	
Ministry/Division	Ministry of Health and Family Welfare	165719.12	Total :
Agency	LD	41391	GOB
Procuring Entity Name & Code	Line Director, CBHC	124328.12	PA
OP Name & Code	Community Based Health Care (CBHC)		

Package No.	Description of procurement	Unit	Quantity	Procurement method and type	Contact Approving authority	Source of Fund	Estd. cost	Indicative Dates			
								Invitation for proposal	Invitation for tender **(Indicative starting Period)**	Signing of contract	Completion of contract **(Indicative Completion Period)**
1	2	3	4	5	6	7	8	9	10	11	12
SP1	Training of CHCP	persons	13500			RPA	4914.00		12-Jan		September-12
SP2	Training of CG	persons	162000			RPA	1935.00		11-Dec		September-12
SP3	Training of UP Chairman & Members	persons	63000			RPA	2010.00		12-Jul		12-Dec
SP4	Training of Community Support Group	persons	607500			RPA	3888.00		12-Jul		12-Dec
SP5	Refreshers Training of CHCP	persons	13500			RPA	700.00		13-Jul		13-Dec
SP6	Training of CHCP on IT	persons	13500			RPA	756.00		12-Jul		12-Dec
SP7	Foreign Training /Study Tour	persons	370			RPA	1400.00		Agust-12		16-Jun
Total (C)=							**15603.00**				

**** All the training will be implemented by Line Director.**

Annexure-IV(a)

List of Machinery

Sl.No	Name of Machinery	Unit	No	Rate	Total Cost

Annexure-IV(b)

List of MSR for 2 Years

Sl. No	Name of Items	Unit	No	Rate	Cost in BDT
1	Aluminum saucepan (2 liter including cover)	Number	2	350	700
2	Bandage	Sheet	24	40	960
3	Blood slide (72 pc.)	box	2	45	90
4	Bucket(Balti) with cover	Set	1	250	250
5	Clinical thermometer	Number	6	30	180
6	Clothed duster	Number	12	20	240
7	Cotton	250gm	50	24	1200
8	Cutting needle	Pkt. of 6 unit	5	50	250
9	Disposable lancet (box of 200pcs.)	box	2	300	600
10	Disposable Syringe 3ml	100pc Box	5	700	3500
11	Forceps Artery - 6"	Number	2	110	220
12	Forceps Tissue - 6"	Number	2	110	220
13	Gauge	Sheet	20	80	1600
14	Medicated/Adhesive Tape 2"	Roll	5	150	750
15	Mug for Measuring saline (Marked)	set	5	60	300
16	Needle holder- 8"	Number	1	120	120
17	Plastic Water-pot (1.0 liter)	Number	4	50	200
18	Plastic Water-pot (1.5 liter)	Number	3	60	180
19	Rubber sheet	Number	2	90	180
20	Savlon /Dettol	1 liter	20	200	4000
21	Scissors-(9-12 inch)	Number	2	120	240
22	Silk thread	Roll	4	40	160
23	Soap case Plastic	Number	5	30	150
24	Sphygmomanometer (Japan)	Number	1	900	900
25	Stethoscope (Japan)	Number	1	450	450
26	Test tube (6”)	Dozen	5	35	175
27	Test tube holder	Number	2	20	40
28	Tourniquet	Number	4	20	80
29	Uric 3B(For testing urine sugar & albumin)	Pkt of 100 Strip	5	290	1450
	Total (Per CC) =				**19385**
	Grand Total for 13500 CC (Taka in Lakh) =				**2616.98**

Annexure-V

List of Furniture and Fixtures

(Taka in Lakh)

Name of Furniture	Number	Unit Cost	Total cost for 1 clinic	Total cost
1. Steel almirah	10624	0.17	0.17	1806.08

* List may be changed according to need.

Annexure-VI

List of Vehicles with Estimated Cost

Sl. No.		DPP		
		Quantity	Unit Cost (in Lakh)	Total (in Lakh)
1	Jeep (2400-2550cc)	1	60.00	60.00
2	Pick-Up (Double Cabin)	1	40.00	40.00
3	Motor Cycle (for 1 MO in each upazila)	500	1.500	750.00
4	Bi-Cycle	13500	0.64	867.52
Total		**14002**		**1717.52**

Annexure-VII

Training program for Human Resource Development

	Total (2011-16)		2011-12		2012-13		2013-14		2014-16	
	Physical	Financial	Physical	Financial	Physical	Financial	Physical	Financial	Physical	Financial
1	2	3	4	5	6	7	8	9	10	11
a) Local										
Short Course	821000	9289.00	136884	1635.00	670616	6954.00	13500	700.00	-	-
Medium Course	13500	4914.00	11168	4065.00	2332	849.00	-	-	-	-
Long Course	-	-	-	-	-	-	-	-	-	-
Subtotal(a)	834500	14203	148052	5700.00	672948	7803	13500	700.00	-	-
b) Foreign										
Short Course	370	1400.00	-	-	93	350.00	93	350.00	185	700.00
Medium Course	-	-	-	-	-	-	-	-	-	-
Long Course	-	-	-	-	-	-	-	-	-	-
Subtotal(b)	370	1400	-	-	93	350	93	350	185	700
Grand Total(a+b)=	834870	15603	148052	5700.00	671041	8153.00	13593	1050.00	185	700.00

- Short Course :

CG, CSG, UP Chairman & Members, CHCP (IT & Refreshers) Training.

- Medium Course :

CHCP Training (12 weeks training).

Estimated Allocation for Training:

Year	Total (=3+4)	GOB	PA (=5+6+7)	RPA through GOB	RPA others	Other than RPA (DPA)
1	2	3	4	5	6	7
2011-12	5700.00	-	5700.00	5700.00	-	-
2012-13	8153.00	-	8153.00	8153.00	-	-
2013-14	1050.00	-	1050.00	1050.00	-	-
2014-16	700.00	-	700.00	700.00	-	-
TotaL (2011-16)=	15603.00		15603.00	15603.00		

* Rates of different activities should be uniform with other OPs.

Annexure-Vlll

CHCP Training Related work plan

Annexure-IX

Monitoring Mechanism for CCs:

Community Clinic is a new concept for our country. The concept has not yet been mainstreamed. Thus it is very much essential to establish a strong monitoring mechanism from the central level to ensure the expected level of service for rural people. It is essential to involve all stake holders including the MOHFW officials in the monitoring and recommend about the activities of CC

Local Level:

One medical officer of each UHC will be given responsibility to monitor, supervise and coordinate the activities relating to CC. He/she will be provided with a motor cycle and from the OP he/she will get total of 1500.00 Taka (Fuel Tk.1200.00 + Motor cycle maintenance Tk. 300.00) per month. He/she will ensure visit to 50% of the total CC in every month and will coordinate with the concern HI/AHI/FWV/FPI/SACMO/MA and also with the Medical Officer of the respective Union. The UHFPO and UFPO of the concerned upazila will ensure their visit at least 10% in a month and 100% in each six month of the CCs. He will get a sum of 1500 BDT a month for performing the effective supervision. To get the honorarium he must ensure all sorts of reports to the Project Office or OP implementation authority.

National Level:

It is proposed that all concern officials of the MOHFW, officials of the RCHCIB project including DPDs in the division, Directors of DGHS/DGFP or their nominees, Director or their nominees of the concerned Division of both DGHS and DGFP, Civil Surgeon/DD/AD of the concerned District or their nominee will ensure their visit/inspection and visit/ inspection report to the project/OP authority. This will be a routine activity of the officials.

To claim the inspection related expenditure all officers must submit and inspection report to the implementation authority of the OP and also write their comments in the inspection register of the CC. The CHCP/HA/FWA will report to the implementation authority about the inspection and the action taken after the suggestions during inspection of the official. The project authority will produce a format for inspection which should have a paragraph containing the recommendation.