United Nations Development Programme-Bangladesh

Project Completion Report

(Agreement No. ASIE/2008/165-839)

Improving Health, Nutrition and Population in the Chittagong Hill Tracts

(1 December 2008 – 29 February 2012)

Report prepared for the European Union

Chittagong Hill Tracts Development Facility (CHTDF)
IDB Bhaban (7th Floor), Shere-e-Bangla Nagar Agargaon, Dhaka-1207

August 2012

European Union

United Nations Development Programme-Bangladesh

Project Completion Report

(Agreement No. ASIE/2008/165-839)

Improving Health, Nutrition and Population in the Chittagong Hill Tracts

(1 December 2008 – 29 February 2012)

Prepared for the European Union

Chittagong Hill Tracts Development Facility (CHTDF)

IDB Bhaban (7th Floor), Shere-e-Bangla Nagar Agargaon, Dhaka-1207

August 2012

The document has been produced with the financial assistance of the European Union. The views expressed herein can in no way be taken to reflect the official opinion of the European Union

TABLE OF CONTENTS

Content	Page
ACRONYMS ……………………………………………………………………..	**4**
I. Description ……………………………………………………………………………	6
II. Assessment of Implementation of Action Activities ……………………………	7
2.1 Executive Summary of the Action ………………………………………………..	7
2.1.1 Background ……………………………………………………………………….	7
2.1.2 Project Area ….	7
2.1.3 Project Objectives ….	8
2.1.4 Overview of the Actions and Results… … … … … … … … …….. … … … … … … …	9
III. Activities and Results ……………………………………………………………….	12
3.1. Transitional Strategy for Providing Access to Community Health Services and Improving Access to Primary Health Care ……………………………………………….	**12**
3.1.1 Expanded Coverage of Community Based Health Services ………………………..	14
3.1.1.1 Health Services Provided through Community Health Service Workers (CHSWs) ……	15
3.1.1.2 Health Services Provided through Satellite Clinics…………………………………………	15
3.1.1.3 Access to Health Care Services Increased and Diseases Reduced ……………………	16
3.1.1.4 Improved Health Seeking Behavior through Health Education Sessions ………..	20
3.1.2 Referral System Established for Emergency Services …………………………………	21
3.1.3 Emergency Obstetric Care (EmOC) Services Provided ………………………………..	22
3.1.4 Expanded Program on Immunization ………………………………………………	23
3.1.5 Additional Health Services Delivered ……………………………………………………..	23
3.1.5.1 Emergency Responses for Malaria Outbreak………………………………………………	23
3.1.5.2 Health Camps Established in Most Remote and Hard to Reach Areas ………………..	24
3.2 Long Term Strategy for Strengthening CHT Health Systems …………………..	24
3.2.1. Enhanced Capacity of Health Authorities at District and Upazila Levels …………..	26
3.2.2. Strengthened Capacity of HDCs to Manage Community Health Services ………..	27
3.2.2.1 Health Staff Members in Place at HDCs …………………………………………………..	27
3.2.2.2 Health Guidelines Developed for HDCs and NGOs………………………………………	27
3.2.2.3 Health Information and Medicine Management Systems Developed ………………….	27
3.2.3 Training to Improve Quality of Healthcare ……………………………………………….	28
3.2.3.1 Curriculum and Guidebook for CHSWs Developed and Used ………………………….	28
3.2.3.2 Training of CHSW Trainers …………………………………………………………………	28
3.2.3.3 Capacity of CHSWs Strengthened …………………………………..…………………..	28
3.2.3.4 CHSWs Became Skilled Birth Attendants (SBA)………………………………………..	29
3.2.4 Coordination Improved for Health Service Delivery ……………………………….…..	30
3.2.5 Support to Infrastructure Development of Health Facilities ………………………….	31
3.2.6 Data Review, Studies and Surveys Prepared …………………………………………...	31
3.2.6.1 Health Studies………………………………………………………………………………	31
3.2.6.2 Immunization Coverage Survey …………………………………………………………..	32
3.2.6.3 Survey on Health Facility Mapping ……………………………………………………..….	33
3.2.7 Prioritization Workshops Conducted……………………………………………………	33
	34

Content	Page

3.2.8 CHT Health Plan Integrated in the National Health Plan ……………………………....

IV. Project Management, Monitoring and Evaluation…………………………….. 35

V. Challenges, Lessons Learnt and Sustainability…………………………………… 36

VI. Cross-cutting Issues ………………………………………………………………. 38

VII. Partnerships and Cooperation………………………………………..………….. 39

VIII. Communication and Visibility……………………………………………..……. 40

List of tables

Table-1: Upazilas and population coverage by the Health Project ………………………………. 14

Table-2: Community Health Services Workers (CHSWs) by district and year…………………… 15

Table-3: Total patients cases consulted and/or treated by SCs and CHSWs……………………. 16

Table-4: Patient cases treated by district and by diseases (Dec 2008-Feb 2012)………………. 18

Table-5: Health education session by district (Dec 2008-Feb 2012)……………………………… 20

Table- 6: Emergency referral cases dealt/referred (No.)……………………………………………. 21

Table-7: Immunization coverage by year, 2006-2010……………………………………………… 23

Table-8: Training received by CHSWs by district (as of February 2012)…………………………. 29

Table-9: Community-Based Skill Birth Attendant (CSBA) Trained by District……………………. 30

Table-10: Deliveries conducted by CSBA by district………………………………………………… 30

Table-11: Information on studies completed under the health project……………………………… 31

Table-12: Vaccination status by survey units……………………………………………………….. 33

List of Figures

Figure-1: Health Project Area ………………………………………………………………… 8

Figure-2: Indigenous people (patient cases) consulted by SC and CHSWs and by district and year ……………………………………………………………………………………………… 17

Figure-3: Non-indigenous people (patient cases) consulted by SC and CHSWs and by district and year……………………………………………………………………………………………….. 17

Figure-4: No. of patients consulted by per CHSW per month and by district…………………… 18

Figure-5: No. of patients cases treated by diseases and by district (Dec'08-Feb'12) ………… 18

Figure-6: Malaria patients consulted by months, December 2008- February 2012…………… 19

Figure-7: Proportion of malaria patients treated among total treated patient cases by the project by year (2006-2011) ……………………………………………………………………………….. 19

Figure-8: No. of ANC and PNC consulted by Satellite Clinic and by district (Dec'08-Feb'12) …. 20

Figure-9: Emergency referral cases dealt by Satellite Clinics and CHSWs, and by district …… 21

Figure-10: CHSWs received Basic and Refresher Training by district…………………………… 29

Annexes:

Annex-1: Training and Capacity Building …………………………………………………..……….. 42

Annex-2: Workshops/Conferences/Meetings Conducted …………………………………………..… 44

Annex-3 Knowledge Products ……………………………………………………………………… 49

Annex-4: List of LOA coordinated ……………………………………………………………………. 50

Annex-5: Communication and Visibility Materials………………………..…………………..….… 51

Annex-6: List of Assets ……………..…………..…………………….….……………………………. 58

Annex-7: Financial Report …………..…………………………..………………..………………... 59

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
ARI	Acute Respiratory Tract Infections
BBS	Bangladesh Bureau of Statistics
BCC	Behaviour Change Communication
BHDC	Bandarban Hill District Council
CEPZ	Chittagong Export Processing Zone
CHSW	Community Health Services Worker
CHT	Chittagong Hill Tracts
CHTDF	Chittagong Hill Tracts Development Facility
CSBA	Community-based Skilled Birth Attendant
DDFP	Deputy Director Family Planning
DGHS	Directorate General of Health Services
DH	District Hospital
DIMO	District Immunization Medical Officer
DPFC	District Project Facilitation Committee
EC	European Commission
EmOC	Emergency Obstetric Care
EPI	Expanded Programme on Immunization
ESD	Essential Service Delivery
EU	European Union
FWA	Family Welfare Assistants
FWC	Family Welfare Centre
GIS	Geographic Information System
GRAUS	Gram Unnayan Songothon
HDC	Hill District Council
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HNP	Health, Nutrition and Population
HPNSDP	Health, Population and Nutrition Sector Development Program
HNPSP	Health, Population, and Nutrition Sector Program
HSB	Health Seeking Behavior
KHDC	Khagrachhari Hill District Council
LoA	Letter of Agreement
MCWC	Maternal Child and Welfare centre
M&E	Monitoring and Evaluation
MoCHTA	Ministry of Chittagong Hill Tract Affairs
MoH&FW	Ministry of Health and Family Welfare
MOCS	Medical Officer-Civil Surgeon

NGO	Non Governmental Organization
OGSB	Obstetrical and Gynecological Society of Bangladesh
PHC	Primary Health Care
PIP	Project Implementation Plan
PNC	Post Natal Care
RHDC	Rangamati Hill District Council
SC	Satellite Clinics
SCMC	Satellite Clinic Management Committee
SMO	Surveillance Medical Officer
STI	Sexually Transmitted Illness
UHC	Upazila Health Complex
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UnFC	Union Facilitation Committee
UNV	United Nations Volunteer
UzAC	Upazila Advisory Committee
WHO	World Health Organization

I. Description

1.1 Name of beneficiary institution of grant contract	Chittagong Hill Tracts Development Facility (CHTDF), UNDP
1.2 Name and title of the Contact Person	Henrik Fredborg Larsen, Director, CHTDF, UNDP
1.3 Name of partner in Action	Ministry of Chittagong Hill Tracts Affairs (MoCHTA)
1.4 Title of the Action	Improving Health, Nutrition and Population in Chittagong Hill Tracts
1.5 Contract No.	ASIE/2008/165-839
1.6 Start Date and End date of Action	01 December 2008 and 29 February 2012
1.7 Target country(ies) or region(s)	Bangladesh
1.8 Target beneficiaries	The final beneficiaries are the people of the Chittagong Hill Tracts (CHT) of Bangladesh.

II. Assessment of Implementation of Action Activities

2.1 Executive Summary of the Action

2.1.1 Background

The characteristics of hilly terrains, difficult communications and scattered settlement patterns of ethnically diverse population of the Chittagong Hill Tracts (CHT) coupled with the region's emergence from a 25-year long armed conflict have resulted in under-staffed, inadequate and under-resourced health services in the CHT.

Most of the health indicators in the CHT are below the national standards and the levels of coverage and utilization of the basic health services are also significantly lower.

Under the 1997 CHT accord and subsequent legislation, provision was made to transfer 33 "subjects" including health and family planning (FP), to the Hill District Councils (HDCs). But the HDCs have had limited capacity and resources to manage these transferred subjects, especially health and FP. In this context, the Health Project implemented under the UNDP's Chittagong Hill Tracts Development Facility (CHTDF) proposed a transitional strategy for immediate health care in remote areas to be implemented directly, whilst also working on a longer term strategy of capacity building in health management and improved health systems and infrastructure with the relevant government institutions.

This project has been primarily funded by the European Union with co-financing from the UNDP. It started in December 2008 and was scheduled to end originally in November 2010. However, due to the need to address the remaining gaps and pave the way for the sustainability by the Government of Bangladesh, a no-cost extension up to February 2012 was approved by the European Union. Three interim reports were earlier submitted for the periods December 2008 to November 2009, December 2009 to June 2010 and July 2010-June 2011. This Project Completion Report (PCR) report covering the period from December 2008 to February 2012 provides detailed description of the activities undertaken and results achieved during the project period.

The project was implemented by UNDP, through the Chittagong Hill Tracts Development Facility in partnership with the Ministry of Chittagong Hill Tracts Affairs (MoCHTA). The project also worked closely with and implemented projects through the three Hill District Councils (HDCs), the Ministry of Health and Family Planning (MOH&FW) National and CHT based NGOs, Civil Society Organizations, local leaders and representatives from local community based organizations.

2.1.2 Project Area

The project had worked in 15 Upazilas in the three hill districts. In Rangamati, the project had been working in Barkal, Bilaichari, Jurachari, Baghaichari, Rajasthali and Langadu. In Bandarban, the project had worked in Rowangchari, Ruma, Thanchi, Lama and Alikadam. In Khagrachari, the project had worked in Matiranga, Mahalchari, Laxmichari and Panchari (Figure 1). Of these, Barkal and Baghaichari in Rangamati, Rowangchari and Lama in Bandarban, and Mohalchari and Matiranga in Khagrachari were the Upazilas where the project was operational from the very beginning. The others were added later, and by 2010, the project was operational in all 15 target Upazilas.

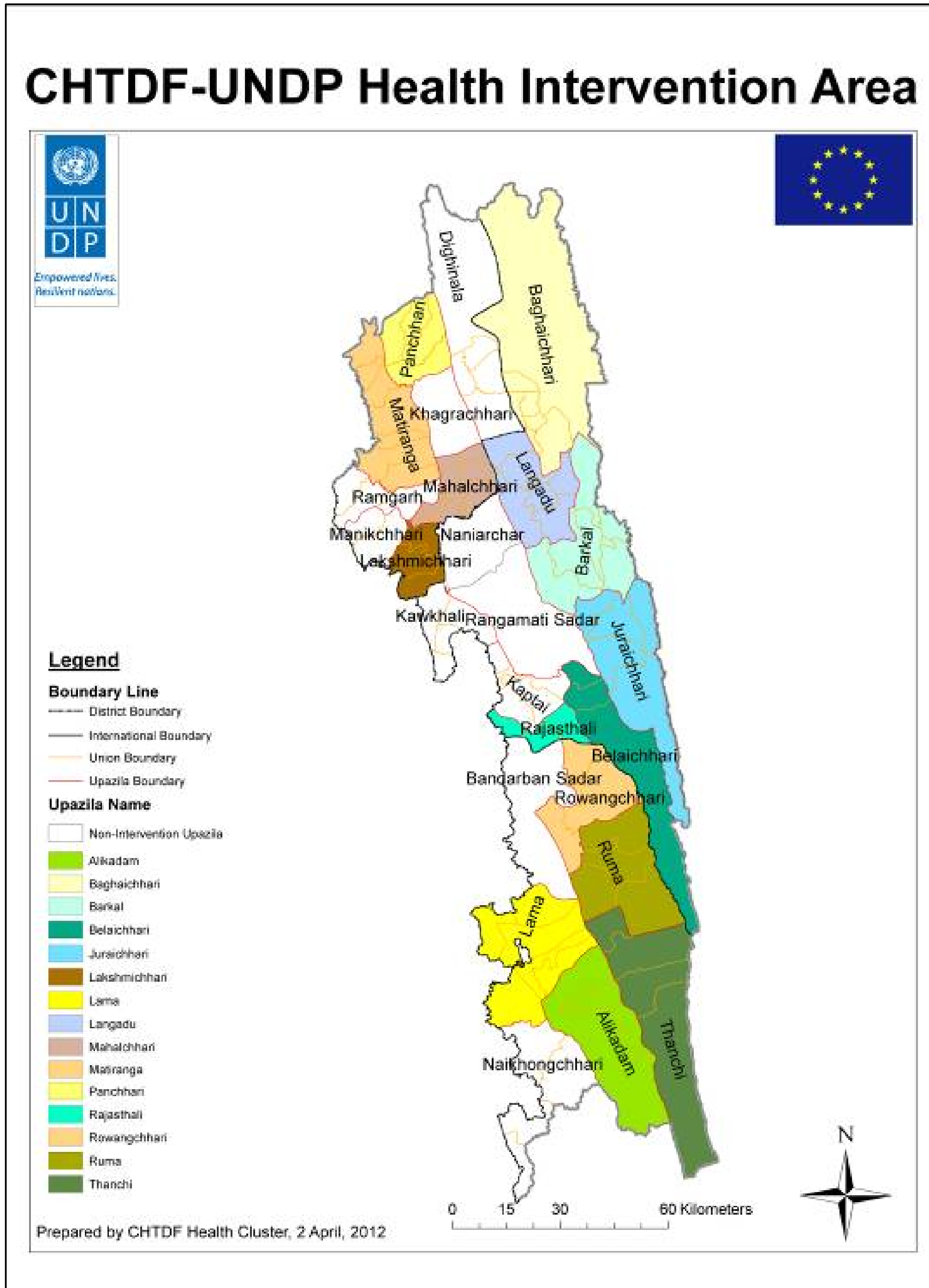


Figure-1: Health Project Area

2.1.3 Project Objectives

The main objective of the project was to improve access to quality health services in the Chittagong Hill Tracts (CHT) of Bangladesh and the specific objective was to connect a strengthened government health system with a strong system of community based health service.

2.1.4 Overview of the Actions and Results

The project deployed a network of community based health workers and mobile medical teams, thereby expanding the provision of medical services to the communities. People in remote communities, where government health programs were inadequate or not available previously, have been able to receive health care services as a result of the project interventions. The project also made progress towards institutionalizing the system of community-based health services, by transferring increasing responsibilities of managing these to Hill District Councils, and improving the capacities of HDC-led coordination and institutional arrangement in provision of health services.

a) Improved Access to Primary Health Care

As a result of the community based health services provided by this Health project, more than 450,000 people with access to health care services have increased. Through the weekly medical missions, health problems were treated immediately, which resulted in reduced mortality rates, particularly among children. As a result of the health awareness trainings and the work of Community Health Service Workers (CHSWs), the CHT population has become more health conscious. This is likely to have contributed to the recorded reduced prevalence of common diseases such as diarrhea and malaria in rural areas. The introduced referral system, which was used more towards the end of the project period, contributed to the reduction in maternal, neonatal and other mortalities.

b) Expanded Coverage of Community Based Health Services

The project established a strong network of the Community Health Services Workers (CHSWs) in the target 15 Upazilas of the three CHT districts and provided the capacity building support to the HDCs in managing it. During the project implementation period, it was proven that the network established was a very appropriate and effective means of providing basic health care particularly in hard-to-reach areas of the CHT, and HDCs had the necessary capacity to manage this network effectively. As a result of the project interventions, the number of CHSWs reached approximately 1,000 CHSWs in February 2012 from 300 CHSWs in 2008. All CHSWs are females. A total of 1,463,630 patients have been treated by the project-supported health teams and CHSWs, with an average of 30 patients treated by a CHSW per month, reflecting an increasing trend in the number of patients treated every year in the target localities. Of the total patients treated by the project health teams, more than 66% were treated by CHSWs. The number of patients treated at home increased over the years, indicating that CHSWs have become trusted health care providers in their communities.

During 2009-2010, a total of 80 satellite clinics were established by the project and have been operational in the 15 Upazilas of the three CHT districts. The project supported the capacity building of the HDCs to effectively manage NGOs in operating these satellite clinics with a view to increasing the sustainability. By the end of the project, the management of all satellite clinics and mobile medical teams supported by the project had been run by respective NGOs. For each of the satellite clinics, a Satellite Clinic Management Committee (SCMC) comprising of local community members was formed, thereby involving community members in the project and increasing their sense of ownership. In fact, it has been proved that the community participation was one of the most positive elements of satellite clinic management. The community members participated in the process of the clinics' establishment as they had the main responsibility of finding suitable infrastructure/ premises and/or land for the clinics and the materials required for the clinics' construction.

c) Improved Health Seeking Behavior and Awareness of Health Issues

CHSWs organized health education sessions on Acute Respiratory Tract Infections (ARI), diarrhea, malaria, Ante Natal Care (ANC), Post Natal Care (PNC) and safe water usage, immunization, sanitation and personal hygiene in their respective communities. In 2009, over 26,000 participants from the remote community participated in these sessions per month, which increased to around 36,000 participants in 2010 and over 40,000 participants per month in 2011 when CHSWs were fully on board[1]. As a result of health education sessions, health seeking behavior has improved among local CHT communities, as the community members are more willing to report to the SCs and government health facilities. The attendance of women at ANC and PNC clinics is steadily increasing and women have been following the vaccination schedule for their children.

d) Emergency Referral System

The project strengthened the linkage of satellite clinics and the network of CHSWs with the government health facilities and specialist medical services through the establishment of an effective and efficient referral system. During the project period, a total of 920 emergency patients were referred to, and received treatment in district health facilities based on the Emergency Patients Referral Guidelines developed by the project, where the majority of emergency referral cases were pregnancy/ delivery related (43%), thereby contributing to reducing maternal, neonatal mortalities and other mortalities. In addition, the HDC-CHTDF joint venture health programme which aimed at preventing obstetric related deaths under the proejct, introduced Emergency Obstetric Care (EmOC) services in Rangamati, Bandarban and Khagrachari in 2011, under which critically pregnant women were able to received services free of cost. During the reporting period, project supported 130 cesarean sections and 369 normal vaginal deliveries (NVD) in the target remote communities in the 3 hill districts.

e) Expanded Immunization Programme

The project provided technical, human resources and transport support to the routine Expanded Program on Immunization (EPI) sessions and other national immunization campaigns. Through the project facilitation, the immunization coverage of women and children was extended to hard-to-reach areas in the CHT, increasing community access to health services. Routine EPI sessions were conducted in all satellite clinics in coordination with MoH&FW's field workers. CHSWs in their communities have increased awareness of the community people to bring the eligible children and women to nearest immunization sessions for routine immunization. All these activities contributed to increasing vaccination coverage in the CHT. In 2006, the vaccination coverage was 67.5% in Bandarban, 70.0% in Khagrachhari and 63.8% in Rangamati which increased to 69.9% in Bandarban, 75.8% in Khagrachhari and 78.8% in Rangamati in 2010[2].

f) Strengthening CHT Health Systems

The project strengthened the overall CHT health system by introducing the referral system, increasing the health workforce and their service delivery capacity, particularly of the CHSWs, enhancing the capacity of the health authorities and local NGOs in the sector through provision of training and/or orientation sessions, and collecting and establishing health related indicators in the region for monitoring. The project also worked very closely with the relevant stakeholders including the HDCs, local NGOs, communities, and other aid agencies in the area, thereby contributing to increasing efficiency and effectiveness of the system put in place and avoiding the duplication of efforts.

---

[1] Community members might have participated more than one awareness session conducted at their communities, and they might have been counted more than once in the data.
[2] EPI Coverage Evaluation Survey 2010, Government of Bangladesh

g) Strengthened capacity of HDCs to Manage Community Health Services

The capacity of HDCs to manage the provision of health services has been strengthened through training, and new members of health staff were recruited in the HDCs. Orientation sessions were held to orient NGO and HDC-based health staffs on monitoring and evaluation processes, health management information systems (HMIS), medicine management and satellite clinic operation. The HMIS has been introduced and put in place by the project in all HDCs. The HDCs are adhering to the health programme implementation guidelines they developed while being supported by the project, and this is leading to more transparent and competency-based recruitment, transparent and efficient procurement of necessary medical supplies, participatory, timely, and efficient planning and monitoring of improved service delivery.

h) Training Provided to Improve Quality of Healthcare

The capacity of health service providers, including CHSWs, was strengthened through training and refresher training courses based on the curriculum and guidebooks developed under the project. Trainings were also organized for 18 CHSWs to become Community Skill Birth Attendant (CSBAs) in 2010. Additional 35 CHSWs are currently under CSBA training and will complete in two batches at the Institute of Mother and Child Health (ICMH) at Matuail, Dhaka by June 2012. The project provided basic training to 1,119 CHSWs and later to 1,906 CHSWs[3] through refresher training.

The project also supported in medical related infrastructure development with a view to increasing health facilities in the CHT. As a result, a total of 22 Upazila Health Complex were repaired and renovated and 2 Upazila Health Complex (Juraichari Upazila of Rangamati and Dighinala Upazila of Khagrachhari) were newly constructed.

i) Health Research to Improve Policy Making

A number of studies (please see Table 13 for details) were conducted under the project and provided with relevant information needed for situational analysis of the health sector in the CHT. The research aimed to inform policy making. The study results and analysis were also used or intended to be used as a base for further refinement and elaboration of the activities and interventions, including the development of a 5-Year district level Health National Plan (HNP) Plan in line with the national Health, Population and Nutrition Sector Development Program (HPNSDP).

j) CHT Health Plan Integrated in the National Health Plan

A separate budget line called 'Tribal Health in the CHT' under the Operational Plan on Essential Service Delivery (ESD) was included under the HPNSDP, which also calls for closer collaboration with the HDCs and MOCHTA.

[3] CHSWs who attended the training session more than once have been double-counted.

III. Activities and Results

The Health Project of the CHTDF aimed to increase people's access to quality health care. While sustaining and expanding the provision of medical services to the communities, the project has continuously enhanced the capacity of health workers and institutions in the CHT.

3.1. Transitional Strategy for Providing Access to Community Health Services and Improving Access to Primary Health Care

The objective of the transitional strategy of the project was to decrease morbidity and mortality due to vaccine preventable and common communicable diseases including malaria and obstetric complications in rural communities in 15 Upazilas through the provision of community-based health services and an improved access to primary health care.

The project has contributed to the achievement of this objective through the following:

- Community people have greater access to health services as a result of expanded coverage of community-based health services in 15 out of 25 upazilas in the CHT
- A network of Community Health Service Workers (CHSWs) was established which is completely managed by the Hill District Councils (HDC)
- 80 weekly satellite clinics were established and are all operational
- The immunization coverage of women and children was extended to hard-to-reach areas in the CHT resulting in increased immunization coverage rate in CHT. In 2006, this coverage rate was 67.5% in Bandarban, 70.0% in Khagrachari and 63.8% in Rangamati which increased to 69.9% in Bandarban, 75.8% in Khagrachri and 78.8% in Rangamati in 2010.
- 201 safe deliveries were conducted by Community Skilled Birth Attendants (CSBA) trained by the project, contributing to reducing maternal and new born mortality rate.
- 142,601 health education sessions were organized by satellite clinics (SCs) and CHSWs in communities, resulting in increased awareness on ARI, diarrhea, malaria, ANC, PNC and safe water usage, immunization, sanitation and personal hygiene.

Throughout the project implementation period, the linkages established between satellite clinics and the networks of CHSWs with government health facilities and other specialist medical services worked smoothly, and this contributed to the smooth functioning of referral services for the patients.

As the majority of referral cases were pregnancy/delivery related, the referral services contributed to reducing maternal mortality for achieving MDGs.

With respect to the indicators in the log frame under the Transitional Strategy, the project has achieved the following.

Objectively Verifiable Indicators	Achievements
Reduction in morbidity and mortality due to vaccine preventable diseases, CCD, Maternal mortality and Malaria.	During the reporting period, the project did not conduct health survey to measure morbidity and mortality in the CHT. However the project provided technical, human resources and transport support to the routine EPI sessions and other national immunization campaigns in the

Objectively Verifiable Indicators	Achievements
	CHT. Routine EPI sessions were conducted in all SCs and CHSWs supported increasing awareness of community members to bring their eligible children and women to the nearest immunization sessions for routine immunization, resulting in increased DPT1 and measles coverage rate. In 2006, DPT1 and measles coverage rate in Martiranga were 68% and 57%, while in Rowanchari they were 79% and 58%, and in Barkal 50% and 33% respectively. In 2008 DPT1 coverage was 78% in Martiranga, 103% (crude) in Rowanchari and 80% in Barkal. In 2008 measles coverage was 79% in Martiranga, 98% in Rowanchari and 79% in Barkal. During the period Dec 2008-Feb 2012, a total of 42,951 malaria cases were diagnosed and treated by CHSWs and SCs. Higher trend of treated malaria cases is found in CHSWs in comparison to SCs. In 2011, more than 66% malaria cases out of total 11,192 cases were diagnosed and treated by CHSWs.
Clear criteria established at regional level Same basic salaries. Package of activities provided by the CHSWs in the CHT Supervision system implemented in order to follow up performances of the CHSWs	Clear selection criteria for recruitment of health related staff was established in all three HDCs Salaries of CHSWs were paid through HDCs. All the CHSWs are regularly supervised and were assessed with a check list to enhance their capacities for better service delivery.
300 existing CHSWs receive support through training, guidance from mobile teams and kit resupply. 450 new CHSWs equipped and operational.	A total of 999 CHSWs including 300 existing CHSWs were recruited as well as trained in the three districts of CHT. Of them, 954 CHSWs have successfully continued their service in the three districts of CHT to date. 225 CHSWs were recruited and equipped in 2011.
6 existing mobile teams supported with transportation and supplies 30 existing satellite clinics supported with mobile teams and supplies 9 new mobile teams trained and deployed 45 new satellite clinics established	A total of 16 mobile medical teams including 6 existing medical teams were supported with supplies and transportation facilities by the project. All medical teams have been working through NGOs in 15 Upazilas to date. 80 Satellite clinics including 30 existing clinics have been strengthened by the mobile teams and medical supplies. The satellite clinics have been operational across the three hill districts to date.

Objectively Verifiable Indicators	Achievements
Standard curriculum implemented 300 existing CHSW receive additional training 450 new CHSWs trained	All the training program (basic and refresher) for CHSWs was conducted with the "Training Curriculum" developed in support of the project; Newly recruited 699 CHSWs received basic training, and existing 300 CHSWs received refresher training. Of them, 954 CHSWs have continued to work in their communities to date. 18 CSBAs (6 per district) have continued to serve their communities following the training provided under the project. In addition, 35 CHSWs who will have completed CSBA training at the Institute of Mother and Child Health (ICMH) at Matuail, Dhaka by June 2012 will commence work in their respective communities.
Monitoring system in place and functional in all 15 priority Upazilas	Monitoring system was developed and put in place at the target Upazila, district, and regional levels. Data/information on health situations of the target communities were collected, and findings were shared with the HDCs, district government, health authorities, and CHTDF, which helped the project to take decision for increasing accessibility of health services to the community people.
22 Vehicles deployed 6 Boats deployed	3 Fast Boat were deployed and ambulance services have started at Kaptai lake since 2011. (As the allocated funds for 6-fast boats were not sufficient, only 3 fast boats were deployed from this budget line.) In addition 39 motor bikes for Health Supervisor, 3 District Medical Officer (DMO) vehicles and 3 speed boats were purchased and have been deployed successfully to meet more appropriate means of services required on the ground.

3.1.1 Expanded Coverage of Community Based Health Services

The project expanded the coverage of satellite clinics and Community Health Services Workers (CHSWs) from 9 to 15 upazilas in three hill districts in 2010. The new 6 upazilas added for coverage by the project are Rajsthali and Jurachari of the Rangamati district, Panchari of Khagrachhari district, Ruma, Thanchi, and Alikadam of the Bandarban district. The following table reflects the geographical coverage of the project.

Table-1: Upazilas and population coverage by the Health Project

District	Upazilas (No.)	Paras/Communities covered (No.)	Population served (No.)
Bandarban	5 (Rowangchari, Lama, Ruma, Thanci, Alikadam)	1,115	121,818
Khagrachari	4 (Matiranga, Mahalchari, Laxmichari, Panchari)	722	156,048
Rangamati	6 (Barkal, Baghaichari, Belaichari, Rajsthali, Jurachari, Langadu)	1,108	174,065
Total	**15 Upazilas**	**2,945**	**451,931**

The locations for satellite clinics were selected based on the recommendations made by the Union Facilitation Committees (UnFC), which followed the endorsement of the Upazila Advisory Committees (UzAC), as well as the approval of the District Project Facilitation Committees (DPFC). The DPFC also approved the additional 6 target Upazilas of the project. The elected members of the local government institutions, MoH&FW authorities, local leaders, NGOs, Community Based Organizations and Hill District Councils are represented in these committees.

3.1.1.1 Health Services Provided through Establishment of Community Health Service Workers (CHSWs) Network

The project established a strong network of village-based Community Health Service Workers (CHSWs) and provided support to the HDCs in managing the network with a view to ensuring the sustainability beyond the lifespan of the project. The network established has continued to be managed by the HDCs to date. The project also ensured that the services of the CHSWs were catered to the needs of the communities and linked with the project component which addressed the strengthening of the selected government facilities such the Upazila health complex and district health facilities, thereby contributing to also establishing a strong referral system. On average, each CHSW supported covers around 100 households. More specifically, the basic health care packages / services provided by the CHSWs included diagnosis and treatment of malaria, acute respiratory tract infection (ARI), diarrhoea, treatment of common ailments, basic health education, and emergency referrals and ante and / or post natal care of pregnant women.

The project was able to increase the number of CHSWs by around 55% from 2009 to 2010 and by a further 7% from 2010 to 2011, thereby expanding the coverage of medical services particularly in the remote areas. To date, a total of 954 CHSWs have continued to serve the communities.

Table-2: Community Health Services Workers (CHSWs) by district and year

District	No. of CHSWs				CHSWs per 1,000 population (as of Feb 2012)
	2009	2010	2011	2012 (Feb)	
Bandarban	181	273	265	265	2.0
Khagrachari	203	289	288	288	1.8
Rangamati	191	331	403	401	2.0
All	**575**	**893**	**956**	**954**	**1.9**

The CHSWs work under the regular supervision of 3 supervisors in each Upazila. In addition to referring patients to the clinics, the CHSWs attend their nearest clinic on a weekly basis to provide support to manage the clinic, and receive technical orientation from the Medical Officer and other technical staffs. This has provided them with an opportunity to share their experience with other CHSWs and also to obtain in-service training and technical support required from the mobile team members.

3.1.1.2 Health Services Provided through Satellite Clinics

The number of weekly satellite clinics established by the project reached 80 in 2009-2010 from 30 in 2008. The satellite clinics are served by mobile medical teams across the 3 hill districts. Each Upazila is served by one mobile team (except in Baghaichari where two teams were deployed). Each mobile team comprises of one medical doctor, one pharmacist, one laboratory technician, one nurse and one health promoter. In 9 Upazilas, the project supported the capacity building of the HDCs to effectively manage NGOs in operating satellite clinics in 2010. In the remaining 6 Upazilas, mobile teams were managed directly by the project until December 2010, and thereafter, the HDCs have taken over the management role of operating the NGOs as of January 2011. The mobile teams worked at controlling diseases by providing immediate diagnosis and treatment of cases and ensured appropriate follow-ups. The mobile teams have

also ensured timely referrals of complicated cases to other hospitals and institutions in the districts. The services provided by the mobile teams included ANC/PNC, EPI, malaria, ARI, malnutrition, diarrhea, other general treatments and laboratory tests.

Community participation was one of the most positive elements of satellite clinic management. To achieve ownership and sustainability of these health services, community involvement and appreciation has proved essential. The community members were mobilized to be mainly responsible for finding out suitable infrastructure/ premises and/or land for the clinics and the procurement of construction materials required for the establishment of the facilities / premises where these materials were available. Unutilized and/or under-utilized government facilities have been transformed to satellite clinics under the project, including 16 Community Clinics and 16 Family Welfare Centers (FWCs).

For each satellite clinic supported by the project, a Satellite Clinic Management Committee (SCMC) was formed to be responsible for setting up, maintaining and managing the premises of the satellite clinic. The SCMCs consists of local community members who work on voluntary basis, and function as a platform for voicing the needs, demands and perspectives of community members that are meant to be served by the network of CHSWs and satellite clinics.

In addition to the NGOs managing mobile teams/ clinics, the project partnered with three NGOs (one for each district) which worked with the SCMCs for reformation of the committees and provided training to their members for a period of one year (10 May 2011- 29 February 2012). These NGOs were mainly engaged in community mobilization and helped to articulate the needs, demands and perspectives of local communities served by CHSWs and mobile medical teams

3.1.1.3 Access to Health Care Services Increased and Diseases Reduced

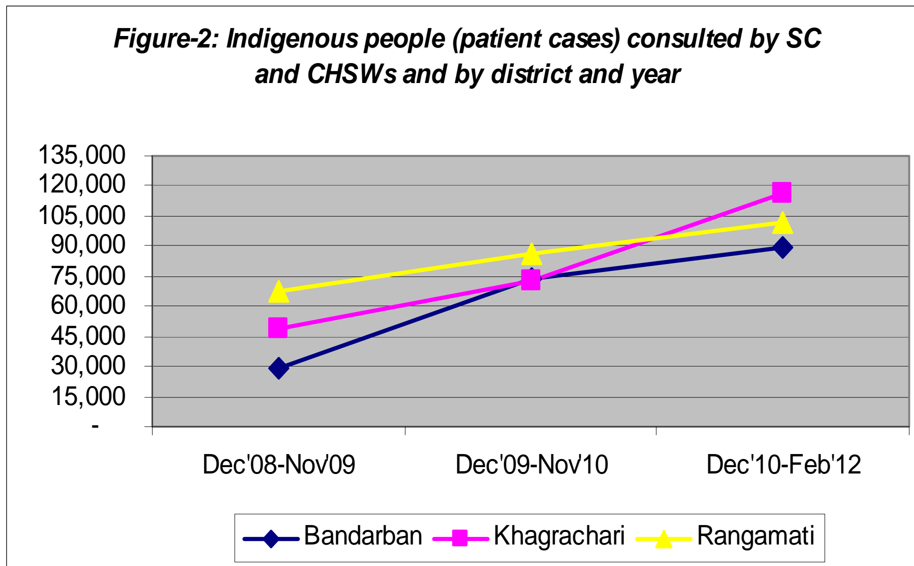
During the project period, a total of 1,463,630 patients (cases) have been treated by the project-supported health teams and CHSWs, reflecting an increasing trend in the number of patients treated from year to year. Of the total patients, more than 66% were treated by CHSWs. On average, each CHSW treated around 30 patients per month during the reporting period. The number of patients treated at home increased over the years, indicating that CHSWs have become trusted health care providers in their communities. On an average 47 patients were treated daily by each mobile team at respective satellite clinics.

From December 2008 to February 2012, a total of 683,451 indigenous origins patients were treated, while Bengalis patients were 780,179. The highest portion of patients was treated in Khagrachhari.

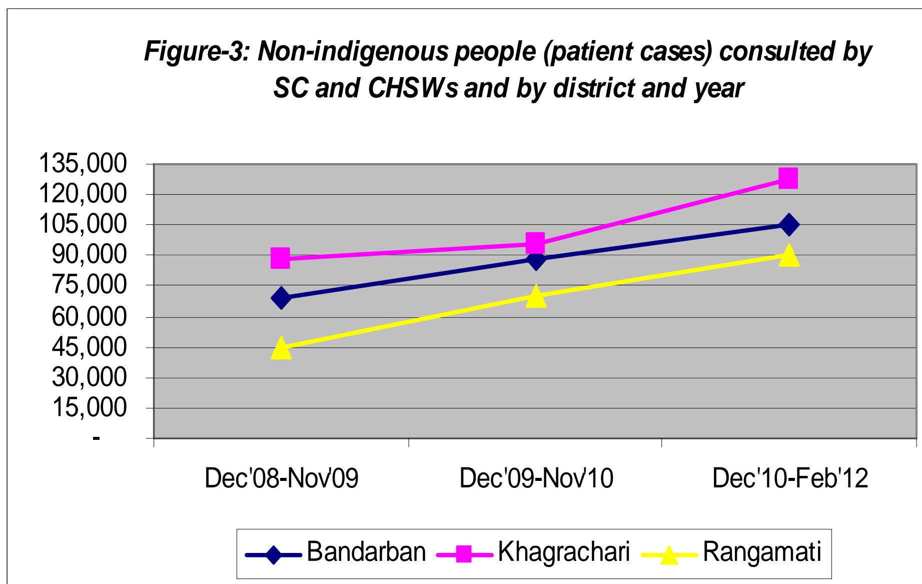
The following table and figures (Table 3, Figures 2 & 6) show the number of cases consulted / treated by the project during the reporting period.

Table-3: Total patients cases consulted and/or treated by SCs and CHSWs

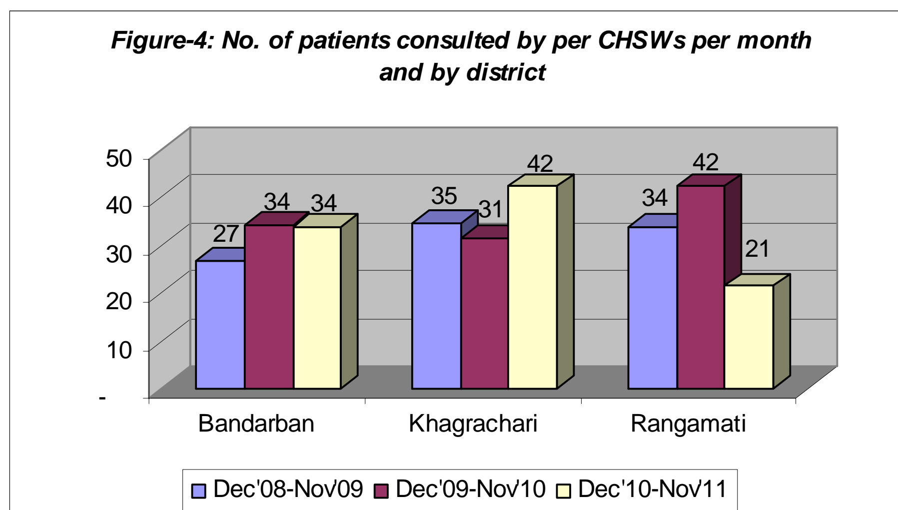
District	Dec'08- Nov'09		Dec'09- Nov'10		Dec'10- Nov'11		Dec'11- Feb'12	
	SC	CHSW	SC	CHSW	SC	CHSW	SC	CHSW
Bandarban	40,229	58,016	50,554	111,876	51,785	107,750	11,090	24,044
Khagrachari	52,827	84,058	59,067	108,977	58,943	145,767	12,102	27,400
Rangamati	37,978	73,853	60,676	95,375	57,343	103,348	10,884	19,688
Total	**131,034**	**215,927**	**170,297**	**316,228**	**168,071**	**356,865**	**34,076**	**71,132**



Note: The third period covered additional 3 months as the project was concluded on 29 Feb 2012



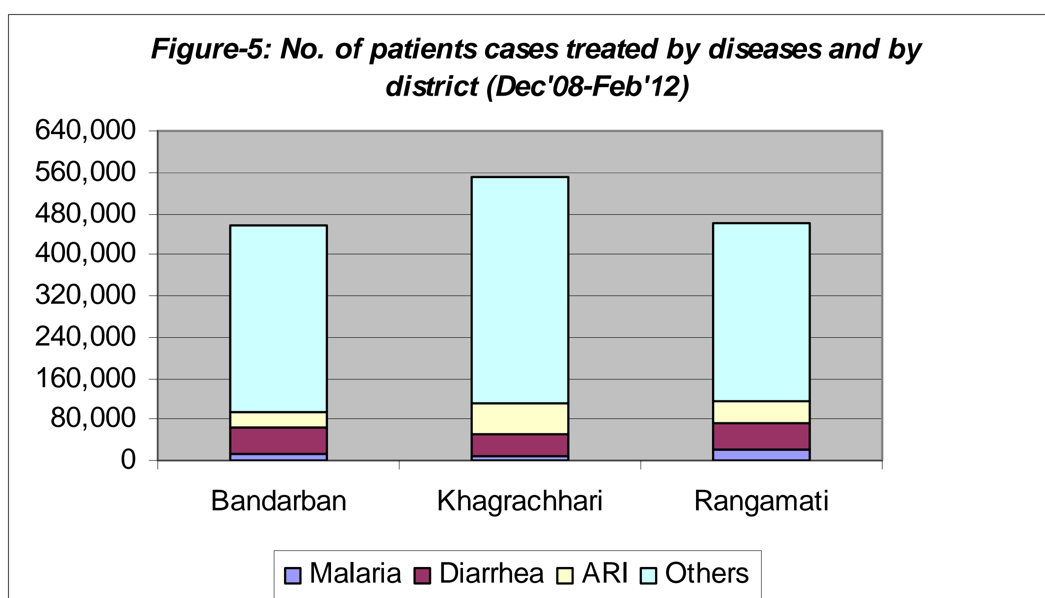
Note: The third period covered additional 3 months as the project was concluded on 29 Feb 2012



Malaria, diarrhoea and ARI were given priority by the project-supported health teams. During the project period, a total of 42,951 patients with malaria, 144,749 with diarrhoeal disorders and 130,765 with ARI were consulted at the SC and by CHSWs. In addition, there were also 1,145,165 other cases of diseases treated in the three hill districts.

Table-4: Patient cases treated by district and by diseases (Dec 2008-Feb 2012)

District	**No. of cases Treated (by disease type)**				
	Malaria	**Diarrhea**	**ARI**	**Others**	**Total**
Bandarban	11,350	51,214	32,298	360,482	455,344
Khagrachhari	10,045	43,147	56,690	439,259	549,141
Rangamati	21,556	50,388	41,777	345,424	459,145
Total	**42,951**	**144,749**	**130,765**	**1,145,165**	**1,463,630**



Malaria continues to be an important area of focus for the project-supported health services, with the CHSWs providing the bulk of the early diagnosis and treatment. The overall patients flow trend for malaria disease fluctuated each month, usually the patients flow was the highest during June, July and August, and the lowest in the months of December, January and February. During the project reporting period, the SC's consultation for malaria patients was higher when compared to the CHSWs' consultation except the period of June-August 2011. The early detection and treatment of malaria was a contributing factor to a reduced incidence of malaria death cases in the project area. In 2008, about 22 malaria related death cases were recorded whereas it was 3 cases in 2009, 5 cases in 2010 and 9 cases in 2011 (September) recorded in the CHTDF health intervention areas.

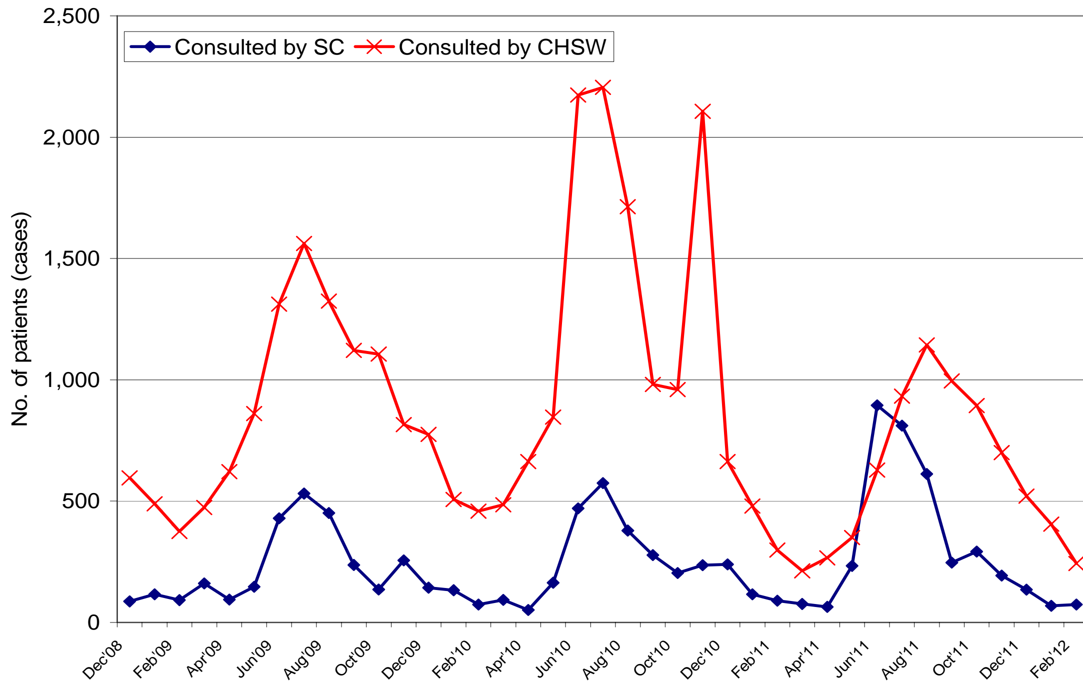


Figure-6: Malaria patients consulted by months, December 2008- February 2012

The proportion of malaria patients among total treated patients by the project-supported health facilities shows a declining trend.

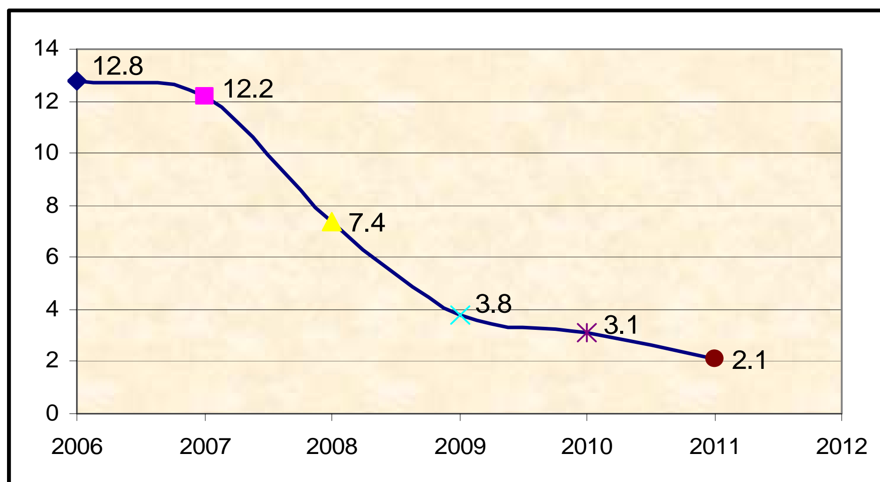


Figure-7: Proportion of malaria patients treated among total treated patient cases by the project by year (2006-2011)

3.1.1.4 Improved Health Seeking Behaviour through Health Education Sessions

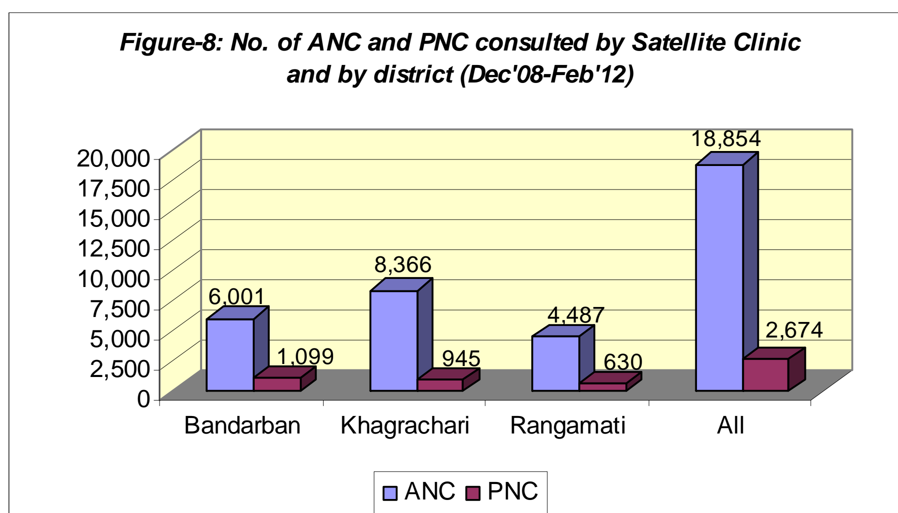
CHSWs organized health education sessions on ARI, diarrhea, malaria, ANC, PNC and safe water usage, immunization, sanitation and personal hygiene for community members. Each month, a series of sessions were held in various locations across the three districts. During the project period, SC conducted approximately 25,969 health sessions, while CHSWs conducted 116,632 sessions. In 2009, over 26,000 participants from the remote community participated in these sessions per month, which increased to around 36,000 participants in 2010 and over 40,000 participants per month in 2011 when CHSWs were fully on board[4].

Table-5: Health education session by district (Dec 2008-Feb 2012)

District	Health education session conducted by providers		
	SC	CHSWs	Total
Bandarban	10,475	32,529	43,004
Khagrachhari	8,897	43,667	52,564
Rangamati	6,597	40,436	47,033
Total	**25,969**	**116,632**	**142,601**

The health education sessions contributed to improving health seeking behavior of local communities in the CHT. For example, the number of people seeking treatment for common ailments has increased. The attendance of women at ANC and PNC clinics has steadily increased, and women have been following up on the vaccination schedule for their children. These observations point to the high likelihood of a continued increase in demand for health services in the future.

As part of maternal, neonatal and child health care services, the project health teams provided a total of 18,854 ante-natal care (ANC) and 2,674, post-natal care (PNC) services. The data shows that 8,366 ANC services were provided in Khagrachari which was higher than in the other two hill districts. On the other hand, Bandarban was the highest to provide the PNC related services (1,099).



[4] Community members might have participated more than one awareness session conducted at their communities, and they might have been counted more than once in the data

3.1.2 Referral System Established for Emergency Services

The project has strengthened the linkage of Satellite Clinics (SC) and the network of CHSWs with the government health facilities and specialist medical services through the establishment of an effective and efficient referral system. With the Emergency Patients Referral Guidelines developed under the project, the project ensured that the CHSWs and mobile medical teams followed the guidelines to refer patients to appropriate medical institutions. During the project period, a total of 920 emergency patients were supported and referred to, and received treatment in the district health facilities based on the above Guidelines. Majority of the emergency referral cases were pregnancy/delivery related complicacies (43%), while the other emergency referral cases were respiratory diseases, severe diarrhea, accidents/injuries including snake bites, severe malaria etc.

Table- 6: Emergency referral cases dealt/referred (No.)

Period	Particular	Bandarban	Khagrachari	Rangamati	All
Dec'08-Nov'09	**Total emergency cases**	**25**	**23**	**25**	**73**
	Maternal cases	6	5	14	25
	% of Maternal cases	**24.0**	**21.7**	**56.0**	**34.2**
Dec'09-Nov'10	**Total emergency cases**	**22**	**82**	**82**	**186**
	Maternal cases	12	41	30	83
	% of Maternal cases	**54.5**	**50.0**	**36.6**	**44.6**
Dec'10-Nov'11	**Total emergency cases**	**245**	**155**	**178**	**578**
	Maternal cases	74	94	71	239
	% of Maternal cases	**30.2**	**60.6**	**39.9**	**41.3**
Dec'11-Feb'12	**Total emergency cases**	**33**	**28**	**22**	**83**
	Maternal cases	14	19	11	44
	% of Maternal cases	**42.4**	**67.9**	**50.0**	**53.0**
Overall	**Total emergency cases**	**325**	**288**	**307**	**920**
	Maternal cases	**106**	**159**	**126**	**391**
	% of Maternal cases	**32.6**	**55.2**	**41.0**	**42.5**

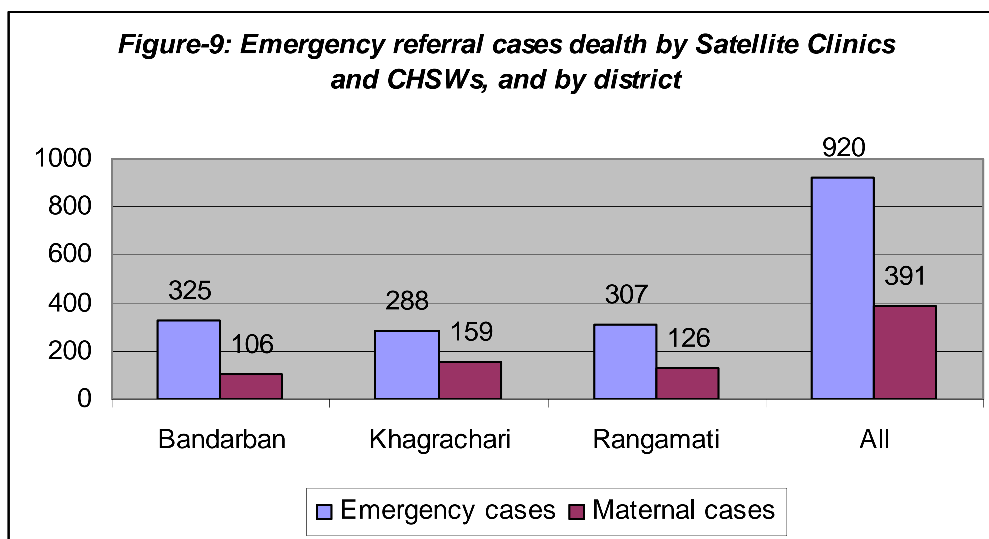


Figure-9: Emergency referral cases dealth by Satellite Clinics and CHSWs, and by district

The HDCs under the project procured 3 fast boat ambulances for referral of patients. These speed boat ambulances are stationed at various locations of Kaptai Lake in order to enable

speedy transportation of patients in all project area. Through the interventions, the boats have been proved crucial in providing those in remote areas with access to referral emergency care.

A Successful Ending to a Complicated Delivery

Thiuma Marma (25 years old) lives in the Grokhyong para, Allekyoung union of Rowangchori upazila, Bandarban district and her family's main income source is Jum cultivation. During her pregnancy, she had been under a care by the project-supported Community-Based Skill Birth Attendant (CSBA). When her labor came, however, she faced complications and was hospitalized by to the Sadar Hospital in Bandarban as an emergency patient. No sooner, she received the emergency referral support from the joint health initiative of Bandarban HDC and CHTDF through the partner NGO SCUK-GRAUS.

As Thiuma's condition was critical and there were signs of fetal distress, the CSBA urgently requested the District Medical Officer (DMO) of Bandarban HDC to assist her with the delivery. The District Medical Officer responded instantly and coordinated the provision of assistance to Thiuma including liaising with all the relevant personnel and focused in particular on finding an anesthetist. Thanks to the coordinated efforts, two doctors were found and agreed to conduct the caesarian section within the day. In the late night of the same day, Dr. Aung Tha Loo and his team helped Thiuma deliver a healthy boy. Despite the constraints in infrastructure, the health team managed to save the lives of both the mother and a child.

Thuima Marma and her boy baby

3.1.3 Emergency Obstetric Care (EmOC) Services Provided

Under this project, the HDC-CHTDF joint venture health program started EmOC services in Bandarban Khagrachri and Rangamati in 2011 with a view to preventing obstetric related death. The introduction of EmOC has contributed to saving lives of the mothers and newborns in these remote localities by providing critically pregnant women with the EmOC services free of cost. Under the program, 130 cesarean sections were conducted in the three hill districts, of which 48-ceaserean sections were conducted in Rangamati, 12 in Bandarban and 70 in Khagrachari. The project also supported the 369 normal vaginal deliveries (NVD) during the same period, of which 148 were conducted in Rangamati, 91 in Bandarban and 130 in Khagrachri. Two committees were formed by the Chairman of the Rangamati Hill District Council (RHDC) to implement the EmOC services smoothly in collaboration with MOH&FW. Namely, the Coordination Committee headed by the CEO of the RHDC with the Civil Surgeon and Deputy Director Family Planning (DDFP) acting as coordinators, guided, monitored and supervised the

EmOC services for 24/7 hours. The Implementation Committee headed by the DCS, Consultant Gynecology, and anesthesiologist from General Hospital worked under the guidance of the Coordination Committee.

3.1.4 Expanded Programme on Immunization

The project provided the technical, human resources and transport support to the routine EPI sessions and other national immunization campaigns. Through the project, the immunization coverage of women and children was extended to hard-to-reach areas in the CHT, thereby contributing to increasing their access to health services as well as reducing the incidences of diseases.

The project organized workshops to share the findings of the survey on the EPI coverage with all target Upazilas, based on which these Upazilas had developed detailed micro plans on EPI. Subsequently, intensive crash programs were conducted in all low coverage areas to increase immunization coverage. Routine EPI sessions were conducted in all satellite clinics in coordination with MoH&FW's field workers. The CHSWs have also assisted in raising awareness of the community members on preventable diseases and bringing the eligible children and women to the nearest immunization sessions for routine immunization.

The project also provided support to the HDCs in organizing and launching the National Immunization Day and other national campaigns through the satellite clinics and CHSW network. Table 7 shows the findings of the Coverage Evaluation Survey 2010 on vaccination coverage of the year 2009 and 2010. Vaccination coverage increased from the year 2006 to 2009 and it then decreased in 2010. The reason for the decrease can be attributed to the shortage of human resources (e.g. Upazila Health & Family Planning Officials: UH&FPO) and/or many other vacant posts in 2010 at upazila level in CHT area.

Table-7: Immunization coverage by year, 2006-2010

District	Full Vaccination Coverage (%)		
	2006	2009	2010
Bandarban	67.5	81.4	69.9
Khagrachari	70.0	80.1	75.8
Rangamati	63.8	79.9	78.8
Chittagong Division	71.3	77.5	80.0

(Source: EPI Coverage Evaluation Survey 2010, Bangladesh)

3.1.5 Additional Health Services Delivered

3.1.5.1 Emergency Responses for Malaria Outbreak

The project mobile teams also rolled out emergencies/special responses during the malaria outbreak occurred in Farua Union (Bilaichori Upazila) in July 2010. Their swift and appropriate response contributed to controlling the situation within a short period of time. The visit of a civil surgeon along with HDC officials to the Union during the outbreak also made aware of the community members that they would act jointly to manage such occurrences in the future when required.

Health staff providing medical support to community people

3.1.5.2 Health Camps Established in Most Remote and Hard to Reach Areas

Sajek Union is one of the most remote and hard-to-reach unions of Baghaichari Upazila of the Rangamati district where people are living in extremely difficult conditions and have been marginalized from the mainstream of development services. Under the project, with a view to providing better health care services to such remote communities, the Khagrachari Hill District Council (KHDC) established two health camps in Ruilui and Konglak of Sajek Union for 4 days in August 2010. The health team comprised of District Medical Officer, CHSW Supervisor and 2 CHSWs were dispatched to the communities, where they treated approximately 310 patients including 10 malaria patients. The local community provided support to the team while also expressing satisfaction upon receiving such services.

3.2 Long Term Strategy for Strengthening CHT Health Systems

The long term strategy of the project aimed to strengthen the existing heath system in CHT and to ensure that the community-based services are strongly anchored in the formal health care system. The project has made considerable progress in operationalizing the strategy.

The project strengthened the capacity of health service providers and HDCs with a view to providing proper health services to the community members. The intervention ensured that the planning system was in place in all HDCs. As a result, the HDCs began and have continued to monitor the health activities and conduct regular monthly and quarterly meetings with relevant stakeholders. HDCs also organized basic and refresher training for CHSWs. The project initiated the training program on the Community Skill Birth Attendant (CSBA) which has contributed to reducing maternal mortality and ensuring safe delivery at the community level. The project also supported the rehabilitation and/or construction of health facilities. The project organized participatory discussion on community health issues that helped to enhance the coordination of different stakeholders and create a platform for stakeholders to discuss different issues such as strategies to control the spread of communicable diseases. Based on different study findings, specific plan of actions were developed and implemented at various levels to provide community health services. In addition, a Health Management Information System (HMIS) was put in place under the project, and has been operational in all HDCs. An initiative was also taken to integrate the CHT health plan in the national health plan. As part of this initiative, HDCs with the support of CHTDF submitted a proposal to MoH&FW through MoCHTA to continue health services activities at the community level in the CHT.

With respect to the indicators in the log frame the project has achieved the following:

Objectively Verifiable Indicators	Achievements
Surveys completed, data analysed and final reports submitted.	Health Seeking Behavior (HSB) Study was completed Study on Perception of Illness and Health Seeking Behavior among 5 additional ethnic groups was completed. Baseline survey on HIV/AIDS was completed in 2010, as part of the mapping exercise. EPI Coverage Survey in CHT was completed.
Surveys completed, data analysed and final reports submitted.	The above mentioned surveys were completed and database (geographic information system: GIS) was put in place and has continued to be functional. Upazila and district-wise GIS maps have been produced.

Objectively Verifiable Indicators	Achievements
Prioritisation workshop completed and final report with recommendations accepted by key partners.	Findings of different surveys were reviewed and a series of workshops were held to development health related interventions, leading to the development of the HDCs' health proposals.
The 5 year plan exists	HDCs' health proposal (for the period from January 2012 – June 2016) was submitted to MOHFW through MoCHTA.
The annual development planning process exists	Planning process was put in place as part of the HDCs health proposal.
1 Senior Technical Advisor placed at National Level 8 Management Advisors placed at RC and HDC Level Coordination systems functional MIS/M&E system functional Planning system functional	1 National Senior Technical Advisor was placed; Management advisors were placed in all HDCs (1-IUNV in each HDC placed); HMIS system was introduced and has been functional in 3 HDCs HDC-led planning and coordination mechanism was strengthened.
The HNP Consultative Group is implemented	National Steering Committee and Technical Advisory Committee (TAC)-Health were put in place and have been conducting regular meetings. The meeting minutes have been disseminated to all concerned stakeholders.
A HNP Working Group is established	
Upazila and Union level coordination is established in all Upazilas	A coordination mechanism has been established and planning and coordination capacity of the Upazilas and Unions has been strengthened.
MIS & M&E systems and structures established and functional. MIS information available for decision makers	The M&E and MIS mechanisms have been established and operational. CHTDF-Health M&E system is established and the M&E system for HDCs is also established and operational. Through this established system, data have been collected on a monthly basis from the field while the MIS has been updated accordingly both at the HDCs and CHTDF. Data and its findings were used in different reports.
Install hardware and software for MIS and provide training	GIS software was installed in two computers, and the trainings were provided to key personnel of the CHTDF, HDCs and RC. Several maps related to health were produced through analyzing data in GIS.
Operational systems developed	Health staff members were recruited and have been in place, and the capacity of the HDCs was strengthened, which enabled expanding the coverage of satellite clinics and Community Health Services Workers (CHSWs) in 15 upazilas of the CHTs.
Bills of Quantity developed and approved Contracts issued and completed M&E Reports	Community infrastructure support (both district and and community levels) were implemented in partnership with the 3 HDCs. The outputs have been reported in the M&E reports.
5-Year Plan	A health proposal from the HDCs was submitted to

Objectively Verifiable Indicators	Achievements
15 upazilas have started implementation of Service Packages	MOH&FW to be included in the HPNSDP (2012-2016)
Policy review completed and final report with recommendations submitted	Resource allocation included in the HPNSDP (2011- 2016). A Tribal Health and Nutrition Plan cell established in the DGHS to implement the plan.
Strategic Review completed and final report with recommendations accepted by key partners.	Review completed and recommendations included in the proposal submitted to MOH&FW by HDCs

3.2.1. Enhanced Capacity of Health Authorities at District and Upazila Levels

The project shared the survey data at district and upazila levels and based on the survey findings, the detailed micro plans have been developed by the district and Upazila health authorities with UNDP's technical support to increase immunization coverage in the low performing areas. Under the project, the health authority at the Upazila level was able to identify low coverage areas and intervene accordingly.

As a result of the project interventions, health authorities at district and upazila levels began and have continued to conduct coordination meetings regularly with all service providers by month and on a quarterly basis. The project also supported them to manage the communicable diseases outbreaks (malaria, diarrhoea etc) at the community level in coordination with the CHSWs network and mobile medical teams. District and upazila health facilities manage the emergency referral cases from communities.

Monthly morbidity and mortality reports submitted by the satellite clinics and CHSWs to the upazila health authorities are now regularly shared in the government MIS.

3.2.2. Strengthened Capacity of HDCs to Manage Community Health Services

As reported above, the project provided technical support to strengthen the capacity of the HDCs and partner NGOs. A series of training sessions on the Health Management Systems (MIS), Satellite Clinic Management and logistic management (where Medicine Management System: MMS was introduced and reporting files were updated), monitoring and evaluation, and GIS were conducted for the HDCs and partner staffs. As a result, the HDC and NGO staffs have improved the organizational capacity and begun recording data on patients and cases served properly, and continued to monitor the quantity of medicines available, thus improving the efficiency of service delivery. In addition, the HDCs have improved the management of satellite clinics and assisted the mobile teams in managing clinics in a better way, thereby contributing to ensuring quality service delivery to patients.

They collect data on a monthly basis, analyze data and generate reports and share findings which are then utilized to improve implementation. The HMIS Officers in the three HDCs are able to manage the database smoothly and monitor the health activities.

3.2.2.1 Health Staff Members in Place at HDCs

The project provided support to the HDCs to recruit staffs for implementing the Health project. The HDC-based health staff members supported by the project included the following positions:

- District Medical Officers (DMO) (1 per HDC)
- CHSW Supervisors (3 per Upazila in each of the target 15 Upazilas and one additional for Sajek Union of Baghaichari Upazila)
- Health Trainer (1 per HDC)
- Two training assistant for each HDC
- HMIS Officer (1 per HDC)
- Logistics Officer (1 per HDC)
- Store Assistant (1 per upazila)
- Network of CHSWs (All HDCs) 954 as of February 2012
- One vehicle driver for each HDC and one speed boat driver for RHDC

3.2.2.2 Health Guidelines Developed for HDCs and NGOs

The project reviewed and provided support in updating the guidelines followed by the HDCs in the implementation of the health programme in the district in 2010. The guidelines supported included: CHSW recruitment guidelines, coordination mechanisms, satellite clinic node selection criteria, satellite clinic management committee (SCMC) guidelines, and guidelines for the management of medical supplies, pharmaceuticals storage plan, guidelines for information and documentation, training guidelines and emergency patients' referral guidelines.

The project also ensured that the relevant stakeholders adhere to these guidelines, with a view to enabling more transparent and competency-based recruitment, transparent and efficient procurement, participatory planning and monitoring, timely and efficient monitoring of medical supplies and improved service delivery.

3.2.2.3 Health Information and Medicine Management Systems Developed

The HMIS Officer and Logistics Officer recruited in the HDC enabled information on medicine inventory to be more accurate and up-to-date. Data storage system is now well understood; monthly data formats were improved and found to be consistent. Program coverage information at Union level was also updated. Data collected through the project supported surveys were the key source of information for the development of the HMIS systems.

Technical training on the HMS was provided to the HDCs and NGOs including medical officers, nurses, laboratory technicians, health promoters, pharmacists, district coordinator, project coordinator and CHSW trainers. In addition, training on M&E was provided to a similar group of participants.

3.2.3 Training to Improve Quality of Healthcare

The project organized trainings for CHSW's trainers, CHSWs and CSBAs. The trainings aimed to enhance their capacity to provide proper health services to the community members. During the project period, one Training of Trainers (ToT) for CHSW's trainers in each district, 47 basic trainings and 76 refresher trainings were conducted in the 3 districts of the CHT.

3.2.3.1 Curriculum and Guidebook for CHSW Developed and Used

The project developed a curriculum and guidebook for the CHSW training in collaboration with the HDCs and MoHFW. Each CHSW has a copy of the guidebook which enabled the workers to keep up-to-date with knowledge on basic health care management. This guidebook has continued to be in use to facilitate the knowledge transfer beyond the time span of the project.

3.2.3.2 Training of CHSW Trainers

During the project period, three (one for each district) ToT courses were conducted in the three hill districts. In each of the ToT courses, about 22 participants including Chief Executive Officer, Executive Officer, Civil Surgeon, Deputy Director-Family Planning, Consultants of District Hospital, Maternal Child and Welfare centre (MCWC), Medical Officer-Civil Surgeon (MOCS), Surveillance Medical Officer (SMO) - World Health Organization (WHO), District Immunization Medical Officer (DIMO), Chief Lab Technician Health Education Officer, and HDC based DMO, Trainer, Assistant Trainer participated. This has built their capacity to train CHSWs on the management of different diseases. Through this training, the CHSWs were oriented on update of current health management techniques and processes to provide basic health services to the community people.

3.2.3.3 Capacity of CHSWs Strengthened

The CHSWs played a very important role to ensure the availability of health facilities across the three hill districts. The project provided basic training to 1,119 CHSWs and later 1,906 CHSWs received refresher training (one CHSW who participated in the training more than once have been double-counted). The contents of the trainings included the management of malaria, the prevention of other diseases, child health care and general practice. The refresher training also included new guidelines, such as modules on additional diseases and preventative measures of certain health problems that were developed by the project in coordination with MOH&FW authorities.

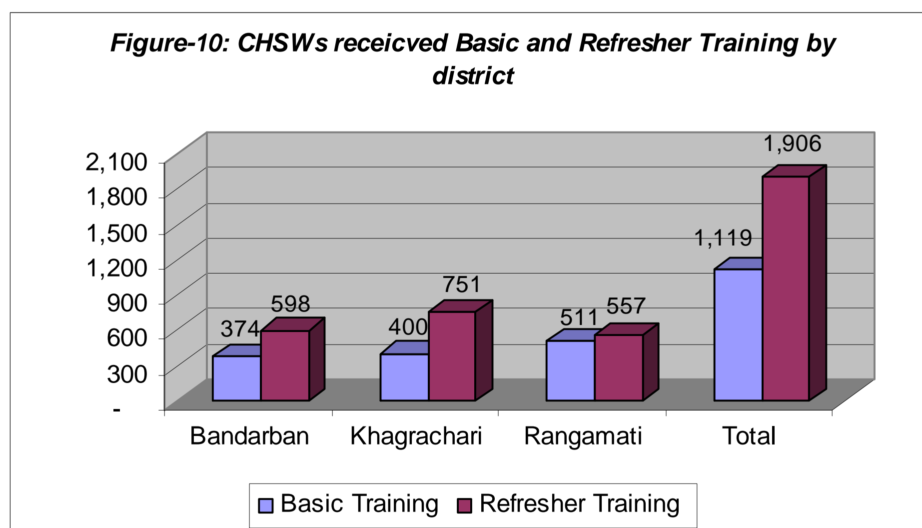
CHSWs in basic training exam in Rangamati

CHSWs in refresher training in Rangamati

Table-8: Training received by CHSWs by district (as of February 2012)

District	Basic training				Refresher training			
Year	2008	2009	2010	2011*	2008	2009	2010	2011*
Bandarban	64	186	99	25	0	72	168	358
Khagrachari	102	207	90	1	0	99	202	450
Rangamati	99	97	221	94	0	96	100	361
Total	**265**	**324**	**410**	**120**	**0**	**267**	**470**	**1,169**

**including up to Feb'12*



In addition, CHSWs received training on leadership and motivational skills focusing on development of interpersonal communication while handling the referral of cases to the tertiary hospital.

Ms Minu, CHSW from Baghaichari quoted, "*I was a simple housewife two years ago. Today, I am a PDC member, PNDG member and SMC member. My contribution is greatly valued in my community. I feel proud to become a CHSW for my community.*"

3.2.3.4 CHSWs Became Skilled Birth Attendants (SBA)

Under the project, a total of 53 CHSWs will have received training on Community Skill Birth Attendant (CSBA). The CSBA course, supported by the Directorate General of Health Services (DGHS), Director-Nursing Council, the Obstetrical and Gynecological Society of Bangladesh (OGSB) and UNFPA aims to improve the rate of safe deliveries in the community. The training course for the first 18 CHSW was conducted over 6 months from 2nd December 2009 to 7th June 2010. All participants satisfied their exam requirements. Preliminary evidence indicates that the CHSWs applied what they learned from the training and are now fully capable to assist patients in giving birth. After completion of the training, they have assisted in 201 deliveries in three upazilas. At the time of reporting, 18 CSBAs were providing their services (6 in each district). In addition 35 CHSWs will complete CSBA training in two batches at the Institute of Mother and Child Health (ICMH) at Matuail, Dhaka by June 2012.

Community Skilled Birth Attendants (CSBAs)

Khumi Woman, one of the smallest and most vulnerable ethnic communities in the CHT, receiving a certificate after the successful completion of a Special Training on Reproductive Health, from Honorable State Minister for CHT Affairs, Govt. of Bangladesh

Table-9: Community-Based Skill Birth Attendant (CSBA) Trained by District

District	CSBAs Trained (No.)	CSBAs participated in ongoing training (No.)	
		Batch 1 (Nov'11-April'12)	Batch 2 (Dec'11- June'12)
Bandarban	6	6	6
Khagrachari	6	6	6
Rangamati	6	6	5
Total	**18**	**18**	**17**

Table-10: Deliveries conducted by CSBA by district

District	No. of deliveries			Total
	Jun- Nov'10	Dec'10-Nov'11	Dec'11-Feb'12	
Bandarban	18	19	6	43
Khagrachari	40	62	26	128
Rangamati	14	15	1	30
All	**72**	**96**	**33**	**201**

3.2.4 Coordination Improved for Health Service Delivery

A coordinated approach to delivery of health services increased efficiency and avoided a duplication of efforts. Meetings were organized in the three HDCs with the participation of civil surgeons, CHTDF representatives, HDC health staffs and NGO staffs on a monthly and quarterly basis. In order to achieve program coordination at Upazila level, district health coordination meetings were organized during which monthly activities and achievements were reviewed. The meetings helped to enhance the coordination in health service delivery of different stakeholders and created a platform of stakeholders to discuss different issues, for example, strategies to control the spread of communicable diseases. Moreover these coordination meetings established linkages among different agencies. Quarterly review meetings and monthly SCMC meetings were held to discuss issues related to health project activities and the management of health activities in the clinics. Key agreements or decisions were reached during the meetings and knowledge was shared and updated. The series of meetings on infrastructure resulted in the greater utilization of health infrastructure facilities by community people.

3.2.5 Support to Infrastructure Development of Health Facilities

The project provided support to the rehabilitation and/ or construction of health facilities. This included construction of new infrastructure (hospital, EmOC), equipments support (generators, refrigerators, bio-chemical analyzers etc), water supply plants in the Upazila Health Complex (UHC), repairing and maintenance in the UHCs, district hospitals & MCWCs. The infrastructure support was provided by the HDCs under their Memorandum of Understanding (MOU) with Upazila Parishad, district and upazila health authorities and a detailed need base requirement approved by project implementation committees. In addition, the HDCs established new storage facilities for medicine in their own premises which is in line with the WHO guidelines as existing storage facilities were considered to be inadequate. The project has also provided support to the HDCs to introduce new procedures and charts for monitoring temperatures in storage areas and expiry dates for medicines, and to establish safe procedures for the disposal of outdated medicines and supplies.

3.2.6 Data Review, Studies and Surveys Prepared

3.2.6.1 Health Studies

The project has conducted a number of studies that provided relevant information needed for situational analysis of the health sector in the CHT. Along with the analysis of the data, the reports contained recommendations to address the current problems and issues of the health sector in the hill districts. The survey results were used as a basis for further refinement and elaboration of the activities and interventions outlined in this proposal, including the development of a 5-Year district level HNP Plan in line with the national HNPSP.

Table-11: Information on studies completed under the health project

SL	Name of Study	Objectives	Key Recommendations and Actions Taken
1	Study on Perception on illness and Health Seeking Behavior of the Mru	To gather information and provide an analytical report on the perception of illness and health seeking behavior of communities belonging to ethnic groups	As per recommendations more CHSWs from Mru communities were recruited, trained and are now working in their communities. Many Satellite Clinics reorganized near Mru communities in the intervention areas.
2	Studies on Perception of illness and Health Seeking Behavior among 5 ethnic groups in CHT	Same as above	The survey findings and policy recommendations shared with all stakeholders in a workshop in Rangamati
3	Baseline Survey and Mapping of Health & Education Providers and Facilities in CHT	To establish a database to be expanded and updated over time; the database will be used to provide maps to graphically display and visualize selected layers of data	Baseline information on health and education facilities and service providers are ready in GIS at central level of CHTDF. All the HDCs HMIS system will be fully developed by the end of 2012 and the HDCs will be able to use the GIS and HMIS for planning and management of health services in the CHT
4	EPI Coverage Survey in CHT	To determine the EPI coverage in the CHT	National EPI coverage survey results were published by the districts. CHTDF

SL	Name of Study	Objectives	Key Recommendations and Actions Taken
		(survey covering 17 Upazilas)	conducted EPI coverage survey by Upazila. This result was shared at the EPI Headquarters DGHS with all stake holders for making supplementary activities for low performing Upazilas in the CHT. At the local level in all Upazilas the results of the survey disseminated in workshop and micro plan has been designed to increase the coverage in low performing areas.
5	Comprehensive Situation Assessment of various high risk groups vulnerable to HIV and AIDS in CHT and Chittagong Export Processing Zone (CEPZ)	To gain a more accurate understanding of Sexually Transmitted Illnesses (STI) prevalence patters, risk behaviors, knowledge and service availability in order to analysis of sexual/reproductive health issues relating to HIV/AIDS	Survey findings were shared with the district health and family planning authorities, HDCs and NGOs working on HIV/AIDS and specific plan of action has been taken to prevent and control HIV/AIDS in the CHT and CEPZ
6	STI Situation Analysis and STI Prevalence Patters, Risk Behaviour, Knowledge and Service Availability in order to inform sexual/reproductive health issues relating to HIV & AIDS in CHT region.	-Do-	The report was shared with stakeholders to design a health program within the government health structure that effectively target the people of these areas for enhancing awareness, especially amongst youth, about the risk factors and their risky behavior in sexuality, causes and symptoms of STI, and importance of health services.

3.2.6.2 Immunization Coverage Survey

The CHTDF health cluster conducted an Upazila-level individual EPI coverage survey, based on joint consultations by the HDCs, the EPI Program Manager and the UNICEF in 2009. The survey covered 15 Upazilas.

The contractor undertook the field work and data analysis and submitted the final reports in July 2010. The overall results for all Upazilas surveyed point to several conclusions:

- The situation differs greatly among upazilas, but particularly in several Upazilas, the common issue in Thanchi, Juraichari, Ruma and Belaichari was the overall limited access to the health services.
- Other Upazilas have gaps between crude and valid coverage (in Lama, among others) inviting the vaccinators to decrease the too early doses and revise their screening and delivering practices
- A few Upazilas have a limited loss a quality between crude and valid, even with a relatively low crude coverage.

Table-12: Vaccination status by survey units

Survey Units	Crude Coverage	Valid Coverage by 23 months	Valid Coverage By 12 months	Never Vaccinated
Barkal **	62.9	59.4	49	20
Rowangchari	73.3	66.8	59.1	10
Matiranga	89.5	69.4	62.3	1.4
Bagaichari **	81.4	76.4	73.9	15.2
Lama	79.0	65.0	57.6	8.6
Mahalchari	84.8	69.3	65.3	7.6
Rajasthali	74.8	72.1	64.1	7.1
Belaichari ***	49.5	44.0	38.5	26.2
Juraichari ***	45.7	25.3	23.7	35.7
Langadu	74.3	70.8	54.7	10.0
Ruma ***	43.3	32.1	29.9	29.5
Alikadam ***	62.9	56.8	53.4	31.9
Thanchi ***	25.7	24.6	19.4	59.5
Panchari	88.1	74.9	71.7	2.9
Laxmichari **	58.6	51.8	48.4	29
Sadar	90.0	77.1	74.1	1
Other Upazila	83.3	70.9	69.0	5.2

*** Need serious attention right now; ** Need attention now

3.2.6.3 Survey on Health Facility Mapping

In 2010, the project conducted a Health Facility Mapping Survey in the CHT by hiring local consulting firm, the Geographical Research and Solution Centre (GRSC). The survey collected information on available health facilities in 21 upazilas of the CHT and the. The final report showed information on available health services using the geographical maps of para (villages) at 21 upazilas of the CHT.

Through this survey, the GIS database was established containing Para level information, allocation of health facilities and services among the CHT communities and monitoring of the outcomes of development programs have been improved. The project produced maps on health services and used in different reports.

3.2.7 Prioritization Workshops Conducted

A prioritization workshop was originally designed to define programmatic and geographic priorities for HNP service and infrastructure packages on the basis of data review and surveys. A number of workshops, meetings and seminars were organized which were considered as a substitute for the prioritization workshop. A project proposal was developed based on the recommendations of these workshops and findings of the surveys conducted. The proposal was submitted to the MoHFW for continuation of the community based health services in CHT.

3.2.8 CHT Health Plan Integrated in the National Health Plan

The services provided by the CHSWs and the mobile teams are widely appreciated at different levels throughout the CHT as well as by high level officials in Dhaka (in MOCHTA and MOHFW) who are familiar with the project. However, sustaining these services beyond the lifetime of the project remains a challenge. In this context, the UNDP and the three HDCs held several rounds of discussion, including three workshops organized jointly by the UNDP and the HDCs, to explore ways of sustaining the gains already made by their joint health program.

Based on all the above discussions, a draft proposal was developed by/ for HDCs. The outline of the concept paper was presented at the first meeting of the Technical Advisory Committee on Health held on June 15, 2010. The committee endorsed the idea of the proposal, the main elements of which were proposed to be incorporated within the upcoming Health, Population and Nutrition Sector Development Programme (HPNSDP), which was supposed to be implemented in July 2011 and yet pending. The original proposal was submitted to the Ministry of Health and Family Welfare (MoHFW) through the MoCHTA in August 2010. Subsequently a revised proposal was submitted by the HDCs in March 2011. In response, the MOHFW included a separate budget line called 'Tribal Health in the CHT' under the Operational Plan on Essential Service Delivery (ESD) of the HPNSDP. The Project Implementation Plan (PIP) of HPNSDP also calls for closer collaboration with HDCs and MOCHTA.

IV. Project Management, Monitoring and Evaluation

4.1 CHTDF Management and Technical Support Team

The CHTDF Health Cluster which implemented the EU funded Health project had been fully staffed and operational. The cluster, under the guidance of Chief-Service Delivery (and more generally, the Project Director and UNDP Country Director), led the implementation of the project. The CHTDF project management reports periodically to the National Steering Committee.

In addition to the staff members under the health cluster of the CHTDF, during the reporting period, 3 International UNVs were placed at the HDCs to serve as management advisors and capacity building specialists.

4.2 Monitoring and Evaluation

The project has introduced a Health Information System both at the CHTDF and HDCs where information on project outputs indicators and the number of cases and patients served were recorded on a monthly basis with gender-disaggregated data. An M&E work plan was developed to ensure proper M&E data collection on project indicators from the field.

Special surveys were conducted as mentioned under Health Research/Studies to capture the health and nutrition status and behavior of the population in the CHT.

Likewise, the project management and the technical staff conducted regular field visits and monitored progress and issues. During August-September 2010, an assessment of NGO-run clinics (operating in 9 Upazilas) was conducted by a team led by the international Technical Specialist of the CHTDF health cluster, The decision to outsource the management of mobile teams/ clinics in remaining 6 Upazilas was made on the basis of the findings of this assessment.

On a monthly basis, the project held a Regional Coordination meeting where the District Managers and Cluster Leaders presented progress reports to and discussed challenges and recommendations with the HDCs, and representatives from the MoCHTA etc.

In September 2010, the Project National Steering Committee was convened to discuss the achievements, issues and way forward actions, with special attention to the issue of inclusion of CHT-specific provision under the next HNP Sector Programme. The NSC endorsed the health proposal prepared for submission to the MOHFW.

The Technical Advisory Committee-Health comprising of the government has been established and functional to date. The Committee visited the project sites in Rangamati and provided feedback on refining the HDCs health proposals.

There was a Results Oriented Monitoring (ROM) mission, which took place during February-March 2011, commissioned by the EU. The observations of the mission highlighted the need to focus on the sustainability of the project.

V. Challenges, Lessons Learnt and Sustainability

5.1 Challenges and Lessons Learnt

The main challenges of project implementation were to reach remote communities, and to develop and roll out a locally appropriate system of community-based health services within the given timeframe. Particularly, it was a challenging task to manage and improve a health program with wide terrain geographical area coverage of 15 Upazilas. In addition, the signing process with HDCs was often time-consuming, and in some instances resulted in putting pressures on implementation of project activities. During the implementation, issues on relatively high dropout/turnover of CHSWs and mobile team staffs have been discussed. It was felt that external support (particularly funding) was needed for a longer period to achieve sustainability of the system which was put in place by the project. However, some challenges faced were addressed including maintaining staff morale at some levels among mobile medical teams in the face of uncertainties.

The efficient coordination between all partners also mitigated some of the problems encountered. The CHTDF health cluster from the beginning developed a strong coordination mechanism with the MOH&FW field staffs and other health services providers. The coordination mechanism played a crucial role in ensuring the control of acute disease outbreaks such as malaria and diarrhea and facilitated the expansion of the immunization coverage.

During the implementation period, it became clear that the network of community health services workers in the CHT, backed up with mobile medical teams, was an appropriate and very effective means of providing basic health care services to hard-to-reach communities, and that HDCs were able to manage this network quite effectively as supported by the project. It also became evident that this system needed continued support to be integrated under the government health system adapted for the CHT with sustainability.

5.2 Sustainability

Ensuring the provision of health services in the CHT beyond the lifespan of the project remained a challenge. It is clearly understood that there were common interests among the stakeholders to ensure the provision of community based health services in the CHT beyond the project timeframe, and that appropriate actions should be taken in time. In this context, a reviewed draft proposal was developed by the HDCs and submitted to the Ministry of Health and Family Welfare (MoH&FW) through the MoCHTA in March 2011. In response, MoH&FW included a separate budget line called 'Tribal Health in the CHT' under the under the new Health, Nutrition and Population Sector Development Program (HNPSDP).

Since the project ended on 29 February 2012, and further funding has not been ensured, a special arrangement has been made by UNDP-Bangladesh to continue the HDC-based health services beyond February 2012, initially up to June 2012 with UNDP funds. Then beyond this timeframe, it is expected that the MoCHTA take forward until an arrangement is finalized to finance these services.

The following are the avenues available for the continuation of the health services currently being implemented by the project;

- To include community health services in the HPNSDP (2011 – 2016), a proposal has been submitted by the HDCs to the MoH&FW

- HDCs as per their Letter of Agreement (LOAs) with the UNDP to absorb CHSWs in the vacant HA&FWA positions
- Continuation of programme activities through UN agencies/other donor, international and national NGOs.
- Strengthening the CHSWs network through the HDCs.

VI. Cross Cutting Issues

6.1 Gender

The project recruited only women as Community Health Services Worker (CHSW), thereby diversifying their income and career avenues.

In addition, Health Promoters and CHSWs promoted health strategies for women in the satellite clinics and in their respective communities, with a view to improving physical and mental health of women in the CHT.

CHSWs regularly attended Para Development Committee meetings to raise health issues especially women's health. They also conducted two health sessions in every month which were participated by 20-25 community members with majority of them being women.

The project provided ToT to 18 women CHSW Facilitators (CHSW Trainers) along with 48 male facilitators. The project initiated training program on the Community Skill Birth Attendant (CSBA) for 53 CHSWs which has contributed to reducing maternal mortality.

Exchange visits were also organized to provide CHSWs with the opportunity to share their experiences and observe how things were practiced differently in other places.

The project also supported the HDCs and MoHFW to organize rallies and seminars in the three CHT districts to celebrate the International Day on "Safe Motherhood" and the routine EPI sessions and other national immunization campaigns, resulting in expanded immunization coverage for women and children particularly in hard-to-reach areas of the CHT.

6.2 Human Rights

The project worked closely with the 3 HDCs to build their capacities for delivering improved health services particularly to marginalized and disadvantaged communities in the CHTs. As a result of the intervention, community members who were previously less aware on their health issues and had no or limited access to the health services have become more aware on their rights to receive services.

VII. Partnerships and Cooperation

The three Hill District Councils (HDCs) have been actively involved in the implementation of the health component of the CHTDF. In 2006, Letters of Agreement (LoA) were signed between the UNDP and each of the HDCs, to support the implementation of a community-based health programme in the CHT. These were subsequently updated in each year up to February 2012.

The LoA mechanism was established to strengthen the management capacity and financial resources of the HDCs. The HDCs executed the planned activities within this agreement. The strategies of LoA are similar to CHTDF key policies in the implementation of health initiatives in the CHT.

In accordance with the LoA, the HDCs were responsible for recruitment, training, and supervision of the CHSWs in remote areas. The HDCs were also responsible in establishing medicine stores and facilities for the safe disposal of medicines.

Government ministries provided services to the CHT institutions and communities in the implementation of their own specific sectoral programs. Thus, it was an important strategy for the project to establish and sustain institutional linkages with these stakeholders. For the health project, the Ministry of Health and Family Welfare (MoHFW) and MoCHTA have been regular participants in the workshops and dialogues conducted to discuss issues and possible solutions. Monthly coordination meetings were held involving various stakeholders at the community level. For example, the selection of new working Upazilas and locations for satellite clinics was based on the recommendations of the Union Facilitation Committee (UnFC) and the endorsement of the Upazila Advisory Committee (UzAC). Elected members, local leaders, NGOs and Community Based Organizations are represented on these committees.

Since the beginning, the project has been working in partnership with local NGOs to implement the programme activities and it also helped enhancing the capacities of the NGOs to manage development projects.

In 9 new Upazilas where the project was extended during the second half of 2009, the project contracted NGOs to run the Satellite Clinics and Mobile Medical Teams. The NGOs contracted, which came on board by February 2010, are Sajida Foundation for upazilas in Khagrachari and Rangamati districts with ALAAM and Hill Flower as local partners in the respective districts; and Save the Children UK in Bandarban with GRAUS (Gram Unnayan Songothon) as local partner.

The health cluster is a member of the Technical Committee on Malaria Control Program of the DGHS, Government of Bangladesh and regularly attends the technical meetings organized by DGHS. The health cluster also attends the regular meetings of the development of national health policy with DGHS and MOH&FW.

VIII. Communication and Visibility

The visibility plan was in place. The visibility of the EU and UNDP was ensured through workshops, trainings, campaigns and various publications and other materials used/disseminated by the project, e.g. the EPI Survey Report, CHSWs Training Curriculum, Registration Book, Family Health Card, apron for technical staffs, satellite clinic sign boards etc. and other materials used during observation days, and workshops.

The CHTDF website (www.chtdf.org) has been launched since 2010 and providing regular updates on CHTDF activities, best practices and data on CHT, as well as events where donors are participating.

Regular CHTDF promotional materials with appropriate donor information were disseminated. Examples were leaflets of cluster activities, CHTDF brochure, monthly newsletter, CHTDF pen, CHTDF annual diary and calendar etc.

In consultation with Donor focal points, visits to the CHT by high officials and donors were given press coverage when and where possible.

Awareness on health issues and particularly on child health and primary healthcare has been raised through observing national and international health related events, such as the NID, World Health Day etc.

A good number of knowledge products were developed (listed in Annex-3). These include training materials, reports, bulletins, banners, leaflets, family health card, bags, T-shirts, caps, signboards, etc.

The project has ensured the following communication actions as per visibility plan:

- 1,200 CHSW guidebook and Curriculum distributed among CHSWs;
- 2,000 CHSW Reporting Register Books distributed among CHSWs;
- 80,000 Family Health card printed and distributed to the patients;
- 2,200 apron for mobile team technical staffs and for CHSWs distributed;
- 85 Sign boards for satellite clinics developed and hung in the satellite clinic;
- 2 documentary films (one with 7 minutes, and another one with 20 minutes; duration) both in Bengali & English version shared with all stakeholders and main communication Medias in 200 CDs;
- 50 sets CD and 20 sets hard copies of EPI Coverage Survey in the CHT printed and distributed;
- 3,000 Leaflets and brochures distributed;
- 1,200 flip charts for CHSWs printed and distributed;
- 1,200 shoulder Bag printed distributed to the CHSWs and Project staffs during training;
- 6,000 promotional items such as T-shirts, caps and umbrellas distributed;
- 500 banner printed and displayed in different trainings and workshops in three hill districts;

- 142,601 health education sessions on ARI, diarrhea, malaria, ANC, PNC and safe water usage, immunization, sanitation and personal hygiene with community people conducted in three hill districts.

Examples of visibility materials are provided in Annex 5.

Annex-1: Training and Capacity Building

SL	Training title	Beneficiaries / participants	Duration (day/month)	Participants (No.)			Outcomes
				Total	Male	Female	
1	Basic Training	CHSW	2 months	1,119	0	1,119	The participants learnt about the primary healthcare including treating communicable diseases (malaria, pneumonia, diarrhea) and safe delivery, and referral process of emergency patients from remotest community to district health facilities
2	Refresher Training	CHSW	5/6/7 days	1,906	0	1,906	All the participants refreshed and updated their primary healthcare knowledge including malaria diagnosis and pneumonia treatment at community level.
3	Training of Trainers	CHSW Facilitators	1 day	66	48	18	Improved the quality of training
4	CHSWs Supervisor Training	CHSWs Supervisors	10 days	15	13	2	Oriented on the whole HDC-CHTDF health program and developed the Supervision and monitoring skill.
5	Training on CSBA	CHSW	6 months	18	0	18	Capacitated to improve safe deliveries in the community through providing
6	Evaluation of CSBA Activity	Government workers	1 day	10	0	10	Knowledge on delivery was assessed, field base problems were discussed and coordination was improved with the government line department
7	CSBA Refresher	Community skill birth attendants (CSBAs)	3 days	6		6	CSBA gathered delivery related knowledge and practical experience at hospital.
8	TOT on Basic Training for Community Health Services Workers	CHSWs, Facilitators	1 day	180	150	30	Improved the quality of basic training of CHSWs.
9	Technical Support to HDC & NGO Health Management System	Medical officer, Nurse, Lab. Technician, Health Promoter, Pharmacist, District coordinator, Project Coordinator,	1 day	37	26	11	The Mobile Teams were able to manage mobile clinic better and provided services to patients.

SL	Training title	Beneficiaries / participants	Duration (day/month)	Participants (No.)			Outcomes
				Total	Male	Female	
		CHSW Trainer					
10	Training on Satellite Clinic Management	Medical officer, Nurse, Lab. Technician, Health Promoter, Pharmacist, District coordinator, Project Coordinator, CHSW Trainer	2 days	42	27	15	The participants were able to manage the satellite clinic effectively. Satellite clinics were being run following prescribed guidelines.
11	Training on M&E	Medical officer, Nurse, Lab. Technician, Health Promoter, Pharmacist, District coordinator, Project Coordinator, CHSW Trainer, CHS Supervisors, HMIS, Training Assistant	2 days	70	20	50	The participants were able to perform their responsibility and submitting report and documents as required.
12	Malaria Training of Health Staff	Medical Officer and Lab Technician	2 days	10	8	2	The participants were experienced and efficient on the updated malaria diagnosis and treatment.
13	Logistic Management Training	Government and NGO worker	2 days	25	21	4	Medicine management system was introduced and the reporting files were updated.
14	Leadership Training	CHSWs	5 days	49		49	Improved skills and capacity in conduction of meeting, workshop
15	Technical support to HDC, MOH and NGO health management system on MIS	NGO Medical Mobile team member (doctor, pharmacist)	1 day	17	13	4	Participants gathered updated knowledge on malaria diagnosis and treatment.
16	Technical support to HDC,MOH and NGO health management system on MIS	Tacticians of GOB and HMIS of BHDC	2 days	10	8	2	All participants refreshed and updated on Health MIS system and were able to operate software for reporting efficiently.

Annexure -2: Workshops/Conferences/Meetings Conducted

SL	Workshop/ meeting Title	Beneficiaries / participants	Participant organization	Duration (day)	Participants (No.)			Key agreements/ decisions
					Total	Male	Female	
1	Strategic planning workshop	Stakeholders		03-day	66	58	8	Strengthen of HDC capacity and identified the risk for sustainability
2	NGO orientation workshop	GoB, NGOs etc.	HDC,CSO,DDFP, SK-USA, Local NGOs, Sajeda foundation, CHTDF	5 days	70	50	20	Oriented on HMIS, M&E, node selection, referral facility, etc.
3	Workshop on Sustaining Community-Based Health Services currently supported by UNDP and HDCs.	GoB, NGOs, Upazila chairman etc	HDC,CSO,DDFP, SK-USA, Local NGOs, Sajeda foundation, CHTDF, Unicef, other local NGOs etc	1 day	40	37	3	Explored the possibility of preparing a proposal on behalf of the HDCs to get additional funds to support community-based health services.
4	EPI survey result dissemination workshop	MOH&FP, HDCs & NGOs.	DGHS, UNICEF, WHO, HDC, CS, DDFP, UH&FPOs, NGOS	1 day	250	200	50	Shared the EPI coverage findings and details plan for micro planning at Upazila level to increase immunization coverage.
5	Workshop on Health Policy & HNPSP	MOHFPs, HDCs, CHTDF & NGOs	MOH&FW, DGHS, CS, DDFP, HDC	1 day	65	50	15	National health policy and HNPSP implementation in the CHT.
6	CSA (Comprehensive Situation Analysis) Study Result Dissemination Workshop	MOH&FP, HDCs, CHTDF & NGOs.	DGHS, MOHFW, HDC, CS, DDFP, UH&FPOs, NGOS, Journalists, Local leaders and YPSA experts	1day	40	25	15	Shared the CSA study findings and a tentative plan to finalize the report to increase the understanding of HIV/AIDS awareness in the CHT region.
7	District Monthly Meeting (NGOs,)	Representative of PNGO, HDCs & CHTDF	GRAUS & Save the Children-UK & CHTDF	1 day	59	52	7	Better coordination & cooperation ensured based on this meeting and performance analysis to monitor the progress
8	District monthly meeting with health authorities and NGO.	LG, NGOs, CHTDF	BHDC, CHTDF, SC-UK, GRAUS.	1 day	28	21	6	1) Joint field visit programs with UHFPO and UFPO.2) Increasing supportive supervision of weak CHSWs. 3) Identifying nonresident and absentee CHSWs.

SL	Workshop/ meeting Title	Beneficiaries / participants	Participant organization	Duration (day)	Participants (No.)			Key agreements/ decisions
					Total	Male	Female	
9	District Monthly Meeting	NG (CS,DCS,MO-CS, UH&FPOs), NGO& RHDC	Dept. of health, Family Planning, BRAC, MSF, Hill Flower & RHDC health program	1 day	190	38	152	Coordination increased with NGOs and others.
10	District monthly meeting with Health Authorities and NGO in BHDC	LG, NGOs, CHTDF	BHDC, CHTDF, GRAUS.	1 day	22	20	2	Coordination of health services Improved. District MSA will keep additional stock register and use short report format provided by DHF. Further coordination will be made from HOPE 87 on report sharing.
11	District coordination meeting in RHDC	Civil Surgeon, DDFP, CHTDF representative from district & Uz, RHDC based health staff & NGO Hill Flower	NG, RHDC, CHTDF, Hill Flower and MoH	01 day	159	93	66	Shared information about ongoing health services and increased coordination with relevant stakeholders
12	District coordination meeting in KHDC	Civil Surgeon, DDFP, CHTDF representative from district & Uz, KHDC based health staff, NGO ALAM & HAMARI	NG, KHDC, CHTDF,ALAM, HAMARI and MoH	01 day	77	40	37	Shared information about ongoing health services and increased coordination with relevant stakeholders
13	TAC-Health Meeting	Representative of MoCHTA, MOHFW, CHTRC, Three HDCs, UNICEF & CHTDF of UNDP	MoCHTA, MOHFW, CHTRC, Three HDCs, UNICEF & CHTDF of UNDP	01 day	26	20	6	TAC provided required guidelines.
14	District Health Coordination Meeting	CHSW supervisor, NGO partners, DMO, UC, DHF, DM, CEO, Member	KHDC, ALAAM, HAMARI, UNDP, Zabarang	01 day	35	25	10	Team work in the field strengthened and coordination Increased.

SL	Workshop/ meeting Title	Beneficiaries / participants	Participant organization	Duration (day)	Participants (No.)			Key agreements/ decisions
					Total	Male	Female	
15	District monthly meeting with Health Authorities and NGOs	Civil Surgeon, DDFP, CHTDF representative from district & Uz, KHDC based health staff, NGO ALAM & HAMARI	NG, KHDC, CHTDF,ALAM, HAMARI, Sajida Foundation and MoH	01 day	112	87	25	Linkage strengthened with department of health and other relevant stakeholders
16	Meeting on Infrastructure	Doctors and development workers	CS office, UH and FPO, RMO	01 day	35	25	10	Top priority needs were addressed by HDCs. Reviewed need assessment.
17	Quarterly Coordination meeting	Doctors and development workers	CS office, UH and FPO, RMO, NGO KHDC	01 day	50	42	8	Health partners should work under leadership of HDC. Reporting was improved through coordination
18	Workshop on GIS	All staff from 3 HDCs and CHTDF-Health	CHTDF, KHDC,RHDC and BHDC	5 days	20	18	2	Application of ArcGIS software to analyze the project's dataset by three districts. A workgroup on GIS was formed.
19	Health coordination meeting	CHTDF staff	CHTDF	01 day	5	1	4	Agreed for conducting the GIS training and informing the higher authority about CSBA training.
20	Upazila Monthly Meeting-Rangamati	NG(UH&FPO), NGO & RHDC (CHSWs, supervisors & Store Assistant)	Dept. of health, Family Planning, RHDC & Hill Flower.	01 day	1203	299	904	Coordination increased with NGOs and others.
21	Upazila monthly meeting-Khagrachari	UH&FPO, UFPO, CHTDF representative from district & Uz, KHDC based health staff from Upazila & district, CHSW, NGO ALAM & HAMARI	NG, KHDC, CHTDF,ALAM, HAMARI, Sajida Foundation and MoH	01 day	958	137	821	Linkage strengthened with department of health and other relevant stakeholders

SL	Workshop/ meeting Title	Beneficiaries / participants	Participant organization	Duration (day)	Participants (No.)			Key agreements/ decisions
					Total	Male	Female	
22	Upazila monthly health coordination meeting with CHSWs and UHC-Bandarban.	NG, LG, NGOs, CHTDF	BHDC, UHFPO office, CHTDF, NGOs.	01 day	292	18	274	Effective patient referral. Timeliness & completeness of reporting Discussing treatment of common diseases and ANC-PNC.
23	Upazila coordination meeting monthly-Rangamati (6)	UH&FPO, UFPO, CHTDF representative from district & Upazila, RHDC based health staff from Upazila & district, CHSW & NGO Hill Flower	NG, RHDC, CHTDF, Hill Flower and MoH	01 day	864	167	697	Updated on basic PHC knowledge. Linkage with service providers enhanced. Discussion held on effective patient referral, timeliness & competences of reporting, treatment of common diseases and ANC-PNC.
24	Upazila coordination meeting bi-monthly-Khagrachhari	UH&FPO, UFPO, CHTDF representative from district & Uz, KHDC based health staff from Uz & district, CHSW, NGO ALAM & HAMARI	NG, KHDC, CHTDF,ALAM, HAMARI and MoH	01 day	344	48	296	-Do-
25	Upazila monthly health coordination with CHSW & UHC-Bandarban	NG,LG,NGO CHTDF	BHDC, UHFPO office, CHTDF, NGOs.	01 day	247	13	234	-Do-
26	Workshop on project management and evaluation	KHDC health staffs and NGO officials	KHDC ALAAM, HAMARI	01 day	41	30	11	Self monitoring of running project ensured.
27	Seminar on World AIDS day 2011	Designated staff from health department and district offices	Civil surgeon office, DC office, SP officer, ALLAM, HAMARI, Smiling sun, FPAB, BRAC, KHDC, IMAM shamity	01 day	150	50	100	Disseminated HIV information
28	Quarterly progress review meeting	MoH, CHTDF, Partner NGO,	NG, KHDC, CHTDF,ALAM, HAMARI,		75	34	41	All concerned became aware of implementation status for further

SL	Workshop/ meeting Title	Beneficiaries / participants	Participant organization	Duration (day)	Participants (No.)			Key agreements/ decisions
					Total	Male	Female	
		District+ Upazila admin officer, public representatives & Community leaders, KHDC health staff and CHSW representatives	Sajida Foundation, SCMC and MoH					suggestion
29	Quarterly review meeting with health authorities and NGOs.	NG, LG, NGOs, CHTDF	BHDC,CS office, UHFPO office, CHTDF,.BRAC,WV, CCDB,GRAUS, Humanitarian foundation, CARITAS, BNKS, Leprosy mission, ICDDRB, SURJERHASHI, SCUK, ICDP-CHTDB.	01 day	90	85	5	1) Quarterly progress presentation. 2) Extended detailed report sharing with UHFPO & UFPO office. 3) Infrastructure support formal delivery by Honorable MP.
30	Support Eye campaign at Upazila level	BHDC,LG,NGO CHTDF	BHDC, UHFPO office, Upazila administration office, CHTDF, NGOs.	01 day	47	34	13	Diagnosed the eye related diseases, and selected the patient for eye surgery
31	Support International day	GoB, BHDC, NGO CHTDF	BHDC, CS office, Family planning office, CHTDF, NGOs.	01 day	70	45	25	Increased awareness
32	Health coordination meeting	CHTDF staff, 3 HDCs staff, NGOs staff	CHTDF, HDC, Partner NGOs	2 days	25	21	4	Draft budget for joint initiatives of health program in 15 Upazila was discussed for agreement.
33	Joint GoB-UN MNHI Meeting	Representative of MOHFW, UNICEF, LAMB, BRAC, Save the children, CLP, ICDDRB, UNFPA, CHTDF of UNDP, etc	MOHFW, UNICEF, LAMB, BRAC, Save the children, CLP, ICDDRB, UNFPA, CHTDF of UNDP, etc	2 days	100	85	15	Contributed to develop National strategy on MNHI for the disadvantaged people lived in heard-to-reach areas. A plan will be developed based on existing program on MNHI (CHTDF and Save the children) targeting the people lived in heard-to-reach areas.

Annex-3 Knowledge Products

SL	Knowledge products title	Author(s)	Completion date	No. of copies disseminated	Key results/ outcomes/ recommendations
1	CHSW Guidebook and Curriculum	Health Cluster	31 Aug, 2010	1200	Basic and refresher training of CHSWs were held as per guideline and curriculum.
2	EPI Coverage Survey in the CHT	The Nielsen Company, Bangladesh Ltd.	15 Jul, 2010	50 sets on CD and 20 sets Hard copies	Each intervention Upazilas had micro planning workshop. Detailed plan was implemented to increase the EPI coverage.
3	Baseline Survey and Mapping of Health and Education Providers and Facilities in the Chittagong Hill Tracts	Geographical Solutions Research Center	30 Sep, 2010	Data base is available in GIS Computer at CHTDF Rangamati office	These data base was used by HDCs through HMIS for planning and implementation of health services in the remotest un-serve areas of CHT.
4	Study on STI Situation Analysis in the Chittagong Hill Tracts (CHT) and in the CEPZ	Development Support Link (DSL)	14 Oct, 2010		Contributed to gain accurate understanding of STI prevalence, risk behaviors, able to analysis sexual/reproductive health issues relating to HIV/AIDS.
5	Study on Comprehensive Situation Assessment (CSA) for HIV/AIDS in the Chittagong Hill Tracts (CHT) and in the CEPZ	YPSA (Young Power in Social Action)	31 Oct, 2010		Contributed to gain understanding on the risk behaviors, acquiring g knowledge on HIV and sexual/ reproductive health and building awareness.
6	Perception of Illness and Health Seeking Behavior Among 5 Different Ethnic Groups In the CHT	Human Development Research Center (HDRC)	15 Oct, 2010		Helped in gathering information, analytical reporting on perception, and health seeking behavior of different ethnic communities in the CHT.
7	Study on The Performance of the CHTDF Medical Mobile Team Members in 6 Upazilas of the CHT Region in 2006-2010	Showkat Gani, Prashanta Tripura and Rabiul Alam			Helped in estimating performance of medical mobile team worked under the project.

SL	Knowledge products title	Author(s)	Completion date	No. of copies disseminated	Key results/ outcomes/ recommendations
8	Documentary Film-2 (one with 7 minutes, and another with 20 minutes duration)- Both in Bengali & English version)		March, 2012	2 Films disseminated to GoB, UN and medias.	Suggested to sustain the health project in the context of disadvantaged people in CHT.
9	Flip Chart for CHSWs	CHTDF	2009	1200	
10	CHT Health Publication References	Doftori, Mojibur	May, 2009		
11	Perception of Illness and Health-seeking Behaviour among the Mru of the Chittagong Hill Tracts of Bangladesh	Dorgabekova, Moumina	October,2009		
12	Report on Assessment of Prescribing Practices of Medicines in CHTDF Project Areas of UNDP	Ali, S M Younus	November, 2009		
13	Report on Medicines and Supplies Management of UNDP-CHTDF Health Cluster	Endailalu, Shimelis	November, 2009		

Annex-4: List of LOA* Coordinated

SL	Project Initiative	Location / Place	Total Budget			
			2009	2010	2011	All
1	Rangamati Hill District Council (RHDC)	Rangamati (USD)	297,623	545,125	1,024,976	1,867,724
		EURO	213,693	392,490	737,983	1,344,166
2	Khagrachhari Hill District Council (KHDC)	Khagrachhari (USD)	299,101	335,592	616,547	1,251,240
		EURO	214,755	241,626	443,914	900,295
3	Bandarban Hill District Council (BHDC)	Bandarban (USD)	314,213	401,447	734,863	1,450,523
		EURO	225,605	289,042	529,101	1,043,748
4	**Total**	**USD**	**910,937**	**1,282,164**	**2,376,386**	**4,569,487**
		EURO	**654,053**	**923,158**	**1,710,998**	**3,288,209**

*Purpose of LOA: Strengthening capacity of HDC to manage health program.

*Key Results /Outcomes: Quality preventive and curative health services are accessible, equitable and effective in improving the health status of the people in the remotest communities of CHT.

Annex 5: Communication and Visibility Materials

CHSW Training Guidebook

CHSW Register Khata

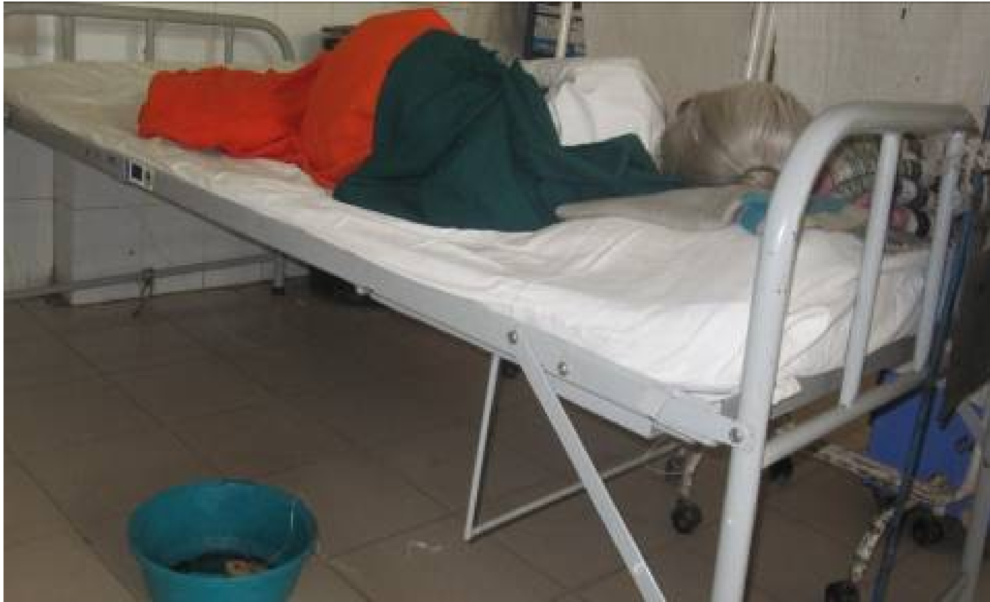
The CHSWs poster distributed to the community health facilities

Family Health Card

Infant Pediatric Scales

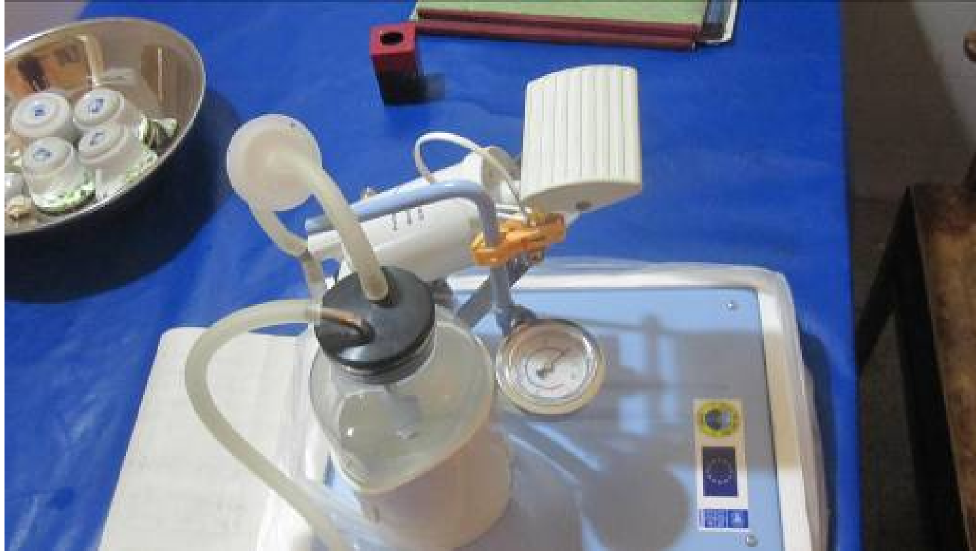
Wheelchair for the Patients

Oxygen Cylinder



Patients Bed

Delivery Bed



Nebulizer Machine

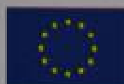
World Health Day 2011 Rally

Report on Seventeen 30-Cluster EPI Coverage Evaluation Survey in the CHT

Barkal Upazila

Chittagong Hill Tracts Development Facility (CHTDF)

United Nations Development Programme, Bangladesh



Coverage of EPI Evaluation Report

Annex 6: List of Assets Purchased

SL	Asset Name	Quantity
1	Motor Car/Jeep	3 Nos.
2	Ambulance	1 No.
3	Motorbike	39 Nos.
4	Speed Boat	1 No.
5	Fast Boat	3 Nos.
6	Speed Boat	2 Nos.

SL	Asset Name	Quantity
01	GIS Computers	02 Nos.
02	Plotter Printers	01 No.
03	GIS Software	02 Nos.
04	Laptop/Computers	65 Nos.
05	Furniture	Bulk

SL	Asset Name	Quantity
01	Medicine & Lab items	Bulk

SL	Asset Name	Quantity
01	CHSWs medical kits	3,000

Note: All the assets, as listed above, purchased under the agreement No. ASIE/2008/165-839 will remain with CHTDF, and will be transferred to government/non-government institutions, and/ or beneficiaries at the end of the CHTDF project cycle as per CHTDF project document.

Annex 7: Financial Report

Please be referred to attachment.