

# WHO Country Cooperation Strategy 2008-2013

## Bangladesh



World Health  
Organization

Country Office for Bangladesh

**WHO**  
**Country Cooperation Strategy**  
**2008–2013**

**Bangladesh**



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## Preface

The collaborative work of WHO in the South-East Asia Region is aimed at improving health in its Member countries. It is recognized that WHO's contribution varies from country to country depending on the health situation, the needs of the Ministries of Health and the efforts of other health development partners. The Country Cooperation Strategy (CCS) is WHO's major instrument for identifying its strategic agenda for a country over the medium-term period. The efforts of all levels of the Organization then focus on the CCS when planning and implementing WHO's work in the country. At the same time, the CCSs for countries in the Region are used to develop regional and global priorities for WHO, as the Organization's work in countries is its main priority.

The South-East Asia Region was one of the first WHO regions to develop CCSs and the first region to develop a CCS for each of the countries in the Region. Working with headquarters, the Region has improved the quality of the CCSs to make them more strategic and provide a sharper focus for WHO's work in countries. This also involves closer participation of the Ministry of Health, other relevant ministries, and key development partners in drafting the CCS, ensuring that their inputs are a key consideration in developing WHO's strategic agenda in the country.

The first CCS for Bangladesh was for the period from 2004 to 2007. During that time Bangladesh made substantial progress in health development. This second CCS covers the years 2008 to 2013 and focuses on new challenges. The groundwork and development of this CCS were extensive, with close involvement of the Ministry of Health and Family Welfare, other relevant ministries and key health development partners in the country. Two stakeholder meetings were held in Bangladesh to discuss the work of WHO in the country and to review the proposed CCS draft. We appreciate the efforts of the Government and other partners made during this period, which have helped to guide the work of WHO in Bangladesh.

We recognize that a strong and capable WHO country office is a key to successfully achieving the strategic agenda of the CCS. Therefore, we will continue to strengthen the Bangladesh Country Office over the CCS period. I can assure all concerned that we are committed to this CCS and will provide support as needed.

Finally, I would like to thank all those who were involved in developing this CCS for Bangladesh. We expect that the work of WHO, along with the Ministry of Health and Family Welfare, other relevant ministries and our development partners will lead to further improvements in the health of the people of Bangladesh.



Samlee Plianbangchang, M.D., Dr.P.H.  
Regional Director

## Foreword

Since June 1972, WHO Bangladesh has been providing technical assistance to the Government of Bangladesh and its partners for health development, with a strong focus on strengthening the public health system. Its biennial budget and workplans are aligned with national plans and programmes, and are harmonized with activities of other development partners.

Over the decades Bangladesh has made considerable progress in improving the health status of its population. Life expectancy has increased while mortality, morbidity and fertility have decreased. Nevertheless, many challenges remain to be addressed. There are still unacceptably high levels of maternal and neonatal mortality. Communicable diseases continue to be a prevalent problem and noncommunicable diseases show a rising trend. Economic, social and environmental determinants of health need to be addressed effectively. Moreover, health systems are to be made responsive to provide equitable access to quality health care for the entire population.

This is the second WHO Country Cooperation Strategy for Bangladesh, which provides strategic directions for WHO collaborative work to address priority health and development challenges in the country during 2008-2013. It is well-attuned with the nation's health priorities and is designed to blend appropriately with the National Health, Nutrition and Population Sector Programme (NHNPS) 2003-2010. It also addresses health-related challenges of Bangladesh's Poverty Reduction Strategies and the Millennium Development Goals.

This document has been developed in consultation with the government, development partners and other key stakeholders. I would like to extend my sincere appreciation to all those within and outside WHO who have significantly contributed to the development of the WHO Country Cooperation Strategy for Bangladesh 2008-2013. It is envisaged that in implementing this CCS, WHO Bangladesh, together with government and development partners, will be able to make a meaningful difference to the nation's health status that will take the country ahead towards attaining "Health for All".



Dr Duangvadee Sungkhobol  
WHO Representative to Bangladesh

## Acronyms

AC	assessed contribution
ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
AusAID	Australian Agency for International Development
BBS	Bangladesh Bureau of Statistics
BCG	Bacillus Calmette-Guerin
BDHS	Bangladesh Demographic and Health Survey
CCS	Country Cooperation Strategy
CDS	Communicable Diseases and Surveillance
CIDA	Canadian International Development Agency
DfID	Department for International Development (of United Kingdom)
DGHS	Directorate-General of Health Services
DP	development partners
EC	European Commission
EHA	Emergency and Humanitarian Action
EPI	Expanded Programme of Immunization
EU	European Union
FAO	Food and Agriculture Organization of the United Nations
FCH	Family and Community Health
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoB	Government of Bangladesh
GMP	good manufacturing practices
GSM	Global Management System
GTZ	<i>Gesellschaft für Technische Zusammenarbeit</i> (of Germany)
HIV	Human Immunodeficiency Virus
HNP	health, nutrition and population
HNPSP	Health, Nutrition and Population Sector Programme
HPSP	Health and Population Sector Programme
HSD	Health Systems Development
IMCI	Integrated Management of Childhood Illness (IMCI)



IVD	Immunization and Vaccine Development
JICA	Japan International Cooperation Agency
KfW	<i>Kreditsanstalt für Wiederaufbau</i> (of Germany)
MDG	Millennium Development Goals
MIS	management information system
MoHFW	Ministry of Health and Family Welfare
MoLGRDC	Ministry of Local Government, Rural Development and Cooperatives
NCD	noncommunicable diseases
NGO	Nongovernment organization
NIPORT	National Institute of Population Research and Training
NIPSOM	National Institute of Preventive and Social Medicine
NMH	Noncommunicable Diseases and Mental Health
NSAPR	National Strategy for Accelerated Poverty Reduction
OPV	oral polio vaccine
PHC	primary health care
RB	Regular budget
SBA	skilled birth attendant
SDE	Sustainable Development and Environmental Health
SEAR	South-East Asia Region
SEARO	Regional Office for South-East Asia (of WHO)
SIDA	Swedish International Development Agency
SSA	Special Service Agreement
SVRS	sample vital registration system
SWAp	sector-wide approach
TB	tuberculosis
TT	tetanus toxoid
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VC	voluntary contribution
WB/IDA	World Bank/International Development Association
WHO	World Health Organization

## Executive summary

The World Health Organization (WHO) has been providing technical assistance to the Government of the Peoples' Republic of Bangladesh for the development and strengthening of the country's public health systems since 1972. In 1999 WHO initiated the formulation of Country Cooperation Strategies (CCS) to further strengthen its performance at the country level. The CCS is a medium-term framework that establishes the strategic directions for the organization, and provides country-specific guidance for planning, budgeting and resource allocation. The CCS for 2008-2013 was developed in consultation with government officials, development partners, and other key stakeholders. The primary inputs to the CCS 2008-2013 were a comprehensive analysis and review of the country's health and development priorities, current and expected development assistance, the impact of recent WHO collaborative work, and the directions given in the WHO global and regional policy frameworks.

There are clear indications that considerable progress is being made to improve the health of the people of Bangladesh. Over the last decade life expectancy at birth has increased, and both infant and child mortality rates have decreased. Signs of a beginning of a demographic transition suggest that strategies aimed at reducing fertility are taking effect, though this also implies that the health system must plan its response to an increasingly older population with accompanying specific health needs. Nevertheless, there remain many areas of concern over health development. For example, maternal mortality remains unacceptably high. Lowering maternal mortality is contingent upon improving the management of pregnancy, though underlying causes including maternal malnutrition must also be addressed.

Child health in general has improved, though the neonatal mortality rate remains high and contributes disproportionately to overall infant mortality. The immunization programme has been recognized for its sustained high coverage; however, only 71% of infants are fully immunized. Measles presents an additional challenge to the immunisation programme with an estimated 20000 children dying from the disease each year. Efforts must be intensified to ensure access to safe immunization and strengthen surveillance of all vaccine-preventable diseases. Malnutrition continues to be a serious problem with nearly half of the children being moderately underweight, one-third suffering from stunting and a large number of adolescents, girls in particular, being malnourished. Adolescent health requires closer attention, particularly in the context of reproductive health.

Bangladesh is at risk of an HIV/AIDS epidemic. This is due to the high prevalence of the disease in neighbouring countries and the limited access to counselling and testing services on account of social stigma. There are also concerns of HIV-tuberculosis coinfection, with Bangladesh being among the countries with the highest burden of

tuberculosis. Malaria is endemic in the east and north-east parts of the country with nearly 11 million people at risk of the most dangerous type of infection, *P. falciparum*, which has the highest rate of complications and mortality.

Neglected diseases such as kala-azar and filariasis demand more attention if they are to be eliminated as planned. Dengue outbreaks occur on an annual basis in urban areas and more effort is needed to control mosquito breeding. There are also threats from emerging diseases including SARS and avian influenza.

It is estimated that by 2010 noncommunicable diseases (NCDs) will be responsible for 59% of deaths compared to 40% in 1990. Underlying factors that contribute to the increasing burden of NCDs include unplanned urbanization, changing dietary habits, unregulated tobacco consumption, air pollution, road traffic injury and lack of awareness about healthy behaviour. Tobacco in particular is a major risk factor, having caused 57000 deaths and 382000 disabilities in 2004 alone.

Environmental determinants of health contribute to communicable and noncommunicable diseases. The extensive levels of arsenic contamination of the shallow groundwater puts an estimated 20 million people at risk of arsenicosis. More efforts to ensure safe drinking water together with improved sanitation will help reduce the burden of diarrhoeal disease. Other important environmental health issues include indoor air pollution, food safety and climate change.

Bangladesh is prone to natural disasters such as floods and cyclones that lead to outbreaks of communicable diseases. During the floods of 2004, more than 400000 people suffered from different diseases in the aftermath and required treatment. The health system must be further strengthened, both in terms of its preparedness and response capability, to cope with this scale of emergency.

In spite of palpable improvement in various sectors, the country's health system still requires further development to meet the basic health needs of the population. The centralized management system of state health services contributes to the inequitable access to quality health services, particularly in rural areas. Although the health workforce has been steadily growing, Bangladesh continues to face a chronic shortage of and imbalance in their skill mix and deployment. The supporting roles of community-based health workers and volunteers need to be better integrated into the system. Effective regulation is required to ensure the quality of health professionals' education and practice, blood safety, and compliance of local pharmaceutical companies with the international good manufacturing practice (GMP) requirements.

At about US\$ 12.16 per capita per annum, the total health expenditure is well below the level needed to scale up essential health interventions. Historically, supply-side financing of healthcare services has been used to increase access to essential health services for the poor. Based on a recent review, a consensus has been reached

over the piloting of some alternative financing mechanisms. The government is now piloting a “demand side financing” option in the form of maternal health voucher schemes to provide support to poor pregnant women.

In 1998 a sector-wide approach (SWAp) was introduced to increase the efficiency of planning, monitoring and management of national health plans and strategies. The Health, Nutrition and Population Sector Programme (HNPS) 2003-2010 is based on the sector-wide approach and emphasises focus on vulnerable groups. In line with the Paris Declaration on Aid Effectiveness 2005, efforts are being made to harmonise donor support and bring them in closer alignment with national plans and strategies. Coordination mechanisms include the Health, Nutrition and Population (HNP) Consortium, the Local Consultative Group (LCG) and the United Nations Development Assistance Framework (UNDAF).

The essential focus of the World Health Organization’s work is to provide technical assistance to the government. This includes the development of health-related policies, evidence-based guidelines, norms and standards, capacity building and institutional strengthening, and research. Currently WHO collaboration is grouped into six clusters: Communicable Diseases and Surveillance (CDS); Emergency and Humanitarian Action (EHA); Family and Community Health (FCH); Health Systems Development (HSD); Noncommunicable Diseases and Mental Health (NMH); and Sustainable Development and Healthy Environments (SDE).

Over the last decade, funding for WHO’s biennial budget has increased from US\$ 7.6 million in 1998-1999 to a projected US\$ 53.7 million in 2008-2009. The increase has mostly come from a substantial flow of voluntary contributions from bilateral agencies and international funds and foundations. WHO constantly seeks to enhance its contribution to the health sector and will identify opportunities for closer alignment with the HNPS.

The WHO Global and Regional Policy Framework has provided vital direction for the CCS 2008-2013. The Eleventh General Programme of Work (GPW) is currently the highest policy document for WHO. It provides a global health agenda that is aimed at all health agencies internationally. WHO will contribute to this agenda by concentrating on its core functions which are based on its comparative advantages.

The overarching principles of the Country Cooperation Strategy for 2008-2013 are a commitment to primary health care, the human right to health, and gender equality and equity. The CCS Strategic Agenda has been aligned with key national and international development priorities including the Millennium Development Goals, the Health, Nutrition and Population Sector Programme (HNPS) (2003-2010), and the National Strategy for Accelerated Poverty Reduction (NSAPR). Seven strategic directions have been identified for the CCS 2008-2013. These are:

- (1) Promote access of vulnerable groups to health services ensuring a continuum of care throughout the life course.
- (2) Enhance capacity for the prevention and control of major communicable diseases and diseases targeted for elimination/eradication, and strengthen integrated disease surveillance.
- (3) Promote healthy lifestyles and cost-effective interventions for the prevention and control of major NCDs and injuries, and for mental health promotion.
- (4) Enhance equitable and sustainable access to safe water and sanitation, reduce environmental and occupational health risks and promote food safety.
- (5) Strengthen multisectoral approaches for emergency preparedness, response and recovery.
- (6) Strengthen the health system with a focus on health workforce development and equitable access to quality health care.
- (7) Foster partnership and coordination for national health development.

The CCS Strategic Agenda will be implemented through three consecutive biennial, results-based workplans and with strong emphasis on research and knowledge management. In order to ensure its effective and timely implementation, WHO will seek to further enhance its cooperation with the government and strengthen cooperation with key stakeholders. WHO will be proactive in identifying new opportunities for synergy and harmonization of our work with that of other UN agencies and development partners. Above all, WHO commits to providing high-quality technical support to the government to attain the goal of “Health for All” in Bangladesh.

Since 1972 WHO has been a key partner of the Government of Bangladesh and provided technical advice and support for the development and improvement of the health of the country's population. The organization has been supporting the government, and working in collaboration with other partners, for the attainment of the highest possible level of health by all. Since the beginning of this collaboration WHO has been providing evidence-based guidelines, norms and standards, supporting capacity building and institutional strengthening, generating evidence for informed decision-making, shaping appropriate health policies and improving the overall delivery of health services.

WHO initiated the formulation of Country Cooperation Strategies (CCS) in 1999 to further strengthen the performance of WHO at the country level. The CCS is a medium-term framework for WHO's cooperation in the country, and highlights what the Organization will do, how it will do the same and with whom. It represents a balance between organizational priorities and national health and development priorities. It acts as a country-specific guidance document for planning, budgeting and resource allocation for the Member States. It will also be used as a tool for advocacy and resource mobilization to address priority needs.

The first WHO CCS for Bangladesh was formulated in 2003 for the period 2004-2007. The strategic direction for WHO's collaborative work in Bangladesh beyond 2007, therefore, needs to be defined. The CCS for 2008-2013 has taken into account demographic and epidemiological transitions, emerging health issues and changing health priorities in the country. Additionally, the WHO Eleventh GPW 2006-2015 and the Medium-term Strategic Plan (MTSP) 2008-2013, have provided new directions for the Organization's engagement in and with Bangladesh.

The WHO CCS 2008-2013 lays down the rationale for the Organization's technical support to Bangladesh's health sector. It was developed through an iterative consultation and planning process involving government officials, development partners and other stakeholders. The process of developing the CCS is summarised in Annex 1. The consultation process also involved the WHO Regional Office for South-East Asia (SEARO), New Delhi, and WHO Headquarters (HQ), Geneva, to ensure that country-specific needs and potentials are in line with regional and global priorities. All efforts were made to ensure that the CCS Strategic Agenda is aligned with key national and international development priorities including the Millennium Development Goals

(MDGs), the revised Health, Nutrition and Population Sector Programme (HNPSPP) 2003-2010, and the National Strategy for Accelerated Poverty Reduction.

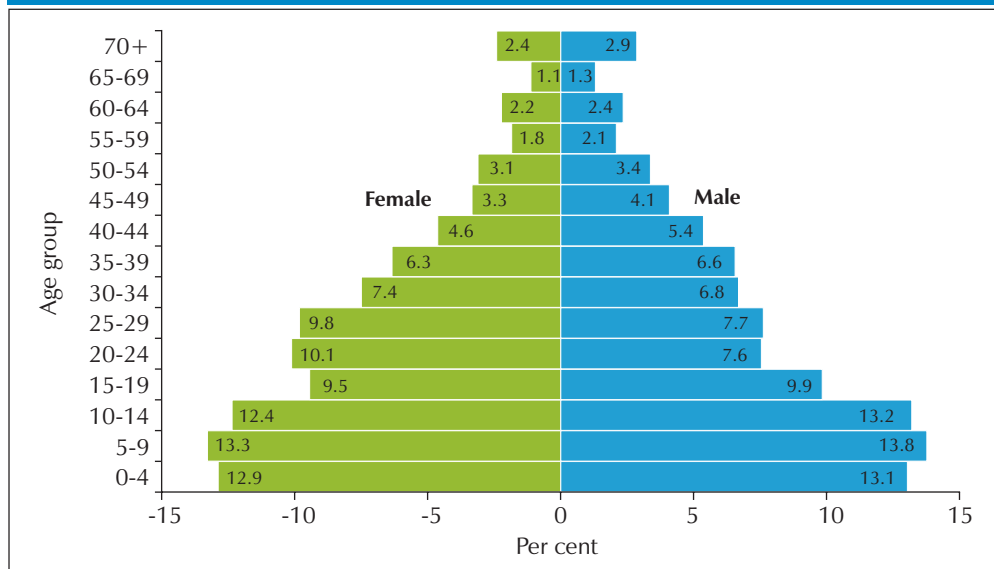
The CCS for 2008-2013 will be resourced and operationalized through three consecutive WHO biennial budgets and workplans. The main principles of the CCS encompass the primary health care (PHC) approach, the inalienable human right to health, and gender equality and equity, and are combined with a strong emphasis on research and knowledge management.

The remainder of this CCS document presents an analysis of information on country health and development challenges, development assistance, aid flow and partnerships for health development, current levels of WHO cooperation and support, and the WHO policy framework including global and regional directions. It also outlines WHO's strategic directions and actions during 2008-2013, and identifies their implications for the work of the WHO Secretariat at the country, regional and HQ level.

## Country health and development challenges

Bangladesh has made considerable progress in recent decades in improving the health of its people. The population growth rate has declined, life expectancy at birth has increased, and infant and under-five mortality rates have been brought down (Country Health Profile is provided in Annex 2). The early stages of a demographic transition have become apparent in the emerging age structure of the population (Figure 1).

**Figure 1:** Bangladesh population pyramid (Census population 2001)



Source: National Population Census 2001.

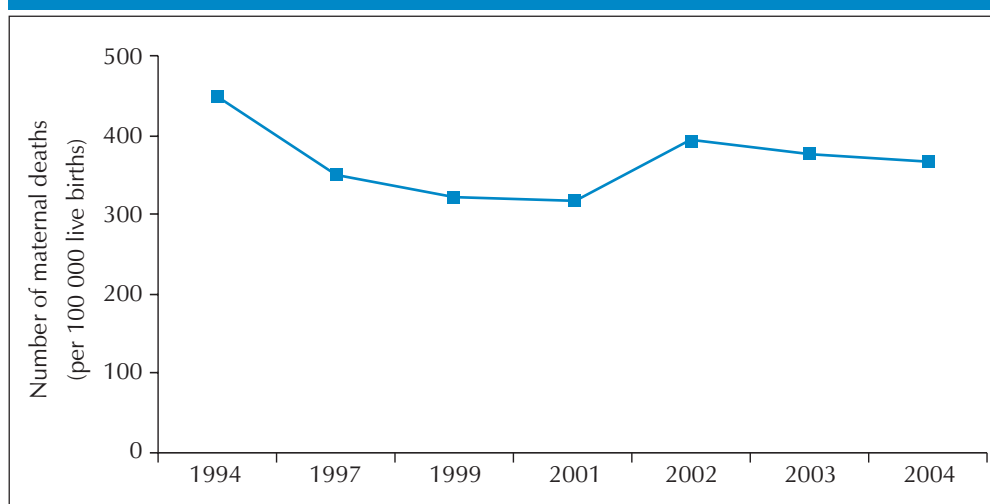
In spite of these improvements there are many areas of concern for health development. Maternal and neonatal mortality remain unacceptably high. Prevention and control of communicable diseases continues to be of concern. Moreover, globalization, unplanned urbanization, environmental and lifestyle factors and an ageing population have contributed to an increased burden of noncommunicable diseases (NCDs). It is estimated that by 2010, NCDs will be responsible for 59% of deaths, compared to 40% in 1990. New and re-emerging communicable diseases such as HIV/AIDS and tuberculosis also have to be factored in. To effectively manage the double burden of disease, health systems need to realign its service-mix, workforce skills, and resource allocation.



## Health of vulnerable groups: Women, children, adolescents and the elderly

Although there has been during the last decade a steady decline in maternal mortality, the figures still remain unacceptably high (Figure 2). Lack of available maternal health services at and around birth is one of the contributing factors to high maternal mortality. The proportion of deliveries assisted by skilled personnel (skilled birth attendants) was found to be only 13.4%, with 9.4% in rural and 29.6% in urban areas, according to the Bangladesh Demographic and Health Survey (BDHS) 2004. Leading causes of maternal mortality are haemorrhage, abortion, injuries, eclampsia, sepsis and obstructed labour. In spite of continuing efforts by the government's micronutrient programme, maternal malnutrition is an underlying cause of many deaths. Nearly half of all pregnant women suffer from malnutrition and anaemia that contributes to low-birth-weight babies and neonatal mortality. Innovative, but nevertheless sporadic, household-level nutrition security initiatives such as kitchen gardens and backyard poultry have not resulted in a significant improvement of the nutritional status of mothers. Micronutrient supplementation has still not been successfully addressed.

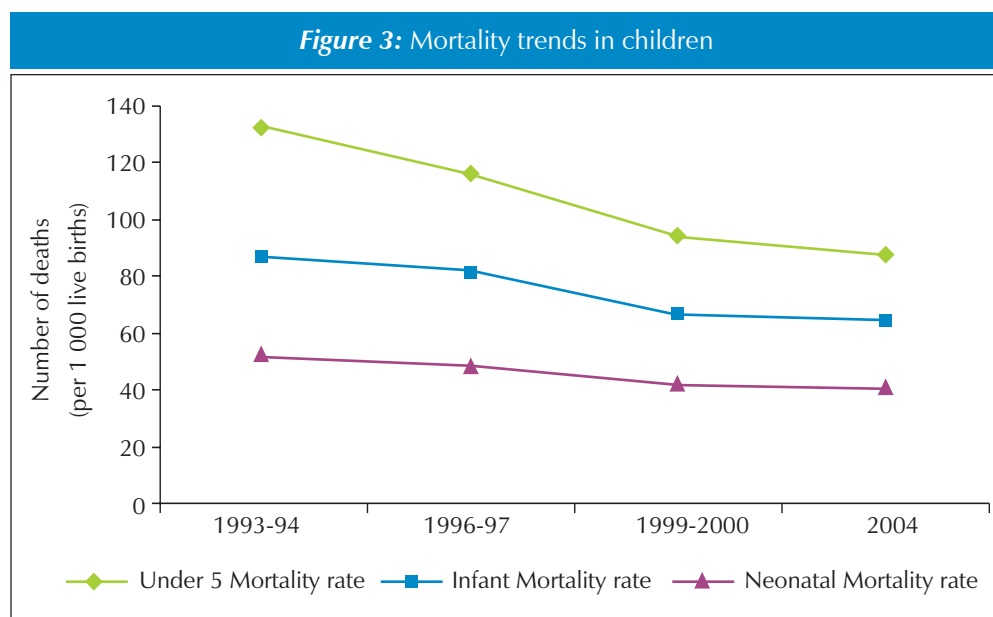
**Figure 2:** Trend of maternal mortality ratio



Source: Sample Vital Registration System (SVRS), Bangladesh Bureau of Statistics (BBS).  
(Note that Maternal deaths include deaths due to abortions starting from 2002)

Violence against women is a widespread social problem that causes mental stress, physical suffering and death. One-fifth of all women are reported to experience physical abuse at home and in the workplace. All the above causes of morbidity and mortality affecting women are largely preventable and amenable by simple interventions. However, improving women's access to quality health services and addressing the underlying socio-cultural factors are major challenges.

Child health in general has been improving, with a declining mortality trend having been observed in the last decade. However, the declining trend in infants and neonate mortality over the past few years is not significant enough (Figure 3). The neonatal mortality rate, a major contributor to the burden of infant mortality, is still high at 36 per 1000 live births (SVRS 2004). Acute respiratory infections alone cause 23% of deaths in children aged below five years. Furthermore, nearly half of all children (47%) are moderately underweight and one-third suffers from stunting (BDHS 2004).



Source: Bangladesh Demographic and Health Survey 2004.

Integrated Management of Childhood Illnesses (IMCI), both community-based and facility-based, is in the process of scaling up and an evaluation study is yet to be carried out to assess its impact on child mortality. Measures to address child care in general and neonatal care in particular need to be institutionalized.

Adolescents (10-19 years) constitute 22.5% of the population (2001 Census). They reach adulthood with little knowledge about reproductive health. The majority of youths (aged between 10 and 25 years) have no correct knowledge about sexually transmitted infections, including HIV/AIDS, and risky sexual behaviour is common among them (National AIDS and Sexual Transmitted Disease Programme [NASP] 2006). One out of every three girls aged 15-19 experience teenage pregnancy (BDHS 2004) and face the concomitant risks of childbearing before attaining physical maturity. A large number of adolescents, especially girls, suffer from malnutrition. Many young adolescents get addicted to drugs because of lack of awareness and peer pressure. The National Adolescent Strategy has been finalized and adolescent-friendly health services have been introduced recently to meet the special needs of this group. The failure of formal and informal education in dealing with sensitive health issues and

cultural sensitivities are key factors that prevent adolescents from making full use of the health-care system.

Currently there are about eight million elderly people in Bangladesh. The number has been increasing due to the steady improvement of health services and the consequent longer lifespans of the population. They are yet to receive adequate attention as a vulnerable group, and an adequate strategy and health programme for improving the quality of their lives is yet to be developed. Healthy and active ageing through effective welfare and support systems needs to be promoted.

## **Disease burden: Communicable and noncommunicable diseases**

The first case of Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) was detected in Bangladesh in 1989. Till December 2006 the cumulative number of reported cases of HIV had reached 874. According to the official report, the number of HIV-related deaths is 109 up to December 2006. However, the estimated total number of HIV infections as of December 2006 was 7 500 according to the National AIDS and Sexual Transmitted Disease Programme (NASP) 2006. Considering the high prevalence of the disease in neighbouring countries, the social stigma and also the limited access to HIV counselling and testing services, Bangladesh faces the risk of an HIV/AIDS epidemic. A recent survey indicated that the country is now going through the phase of a “concentrated epidemic” with a nationwide prevalence of 7% among the intravenous drug users (IDUs). There is a need to increase awareness of the disease, improve access of the population to prevention, treatment and care services, and to be better prepared to address the threat of cross-border transmission.

Bangladesh ranks fifth in the global list of 22 countries with the highest burden of tuberculosis (TB). The Directly Observed Treatment Short-course (DOTS) strategy introduced in 1993 has reached a 70% case detection and more than 85% treatment success rate (Directorate-General of Health Services 2006). TB control in Bangladesh faces a threat from HIV-TB coinfection given the rising trends in HIV in the country. Cases of multidrug resistant TB are being increasingly reported (Box 1). The National Strategic Plan for TB covering the period 2006-2010 has been developed. Action plans are developed annually based on the Strategic Plan. The Strategic Plan includes new Stop TB strategies with emphasis on aspects of DOTS strengthening, multidrug resistant TB, TB/HIV and advocacy, communication and social mobilisation, but underplays health systems strengthening and research.

Malaria is highly endemic in 13 bordering districts in the east and north-east with 10.9 million people estimated to be at high risk. The *P. falciparum* infection is over 75%, and there is growing drug resistance. Artemisinin-based Combination Therapy (ACT) for treatment of *P. falciparum* malaria was introduced in 2004. Early diagnosis

### Box 1: Tuberculosis at a glance (2006)

• Estimated new cases of TB (all forms) per year	: 322 197 (229/100 000 population)
• Estimated new smear-positive TB cases per year	: 144 918 (103/100 000 population)
• Estimated new adult cases of TB co-infected with HIV	: 0.1%
• TB mortality (all cases per year)	: 51 per 100 000
• TB prevalence	: 435 per 100 000 (all cases)
• Multi-drug resistance among new TB cases	: 1.6%
• Multi-drug resistance among previously treated TB cases	: 12%

Source: National TB Programme 2006.

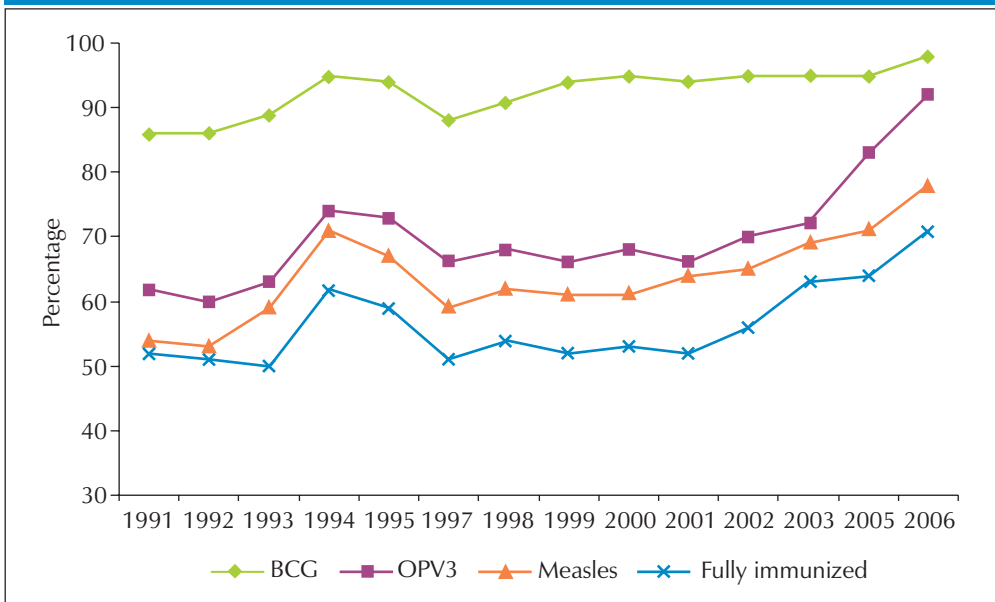
and prompt treatment and use of long-lasting nets/insecticide treated bed nets are the preferred methods for management of the disease. The control programme has defined a goal of 50% reduction of mortality and morbidity by 2012. Partnerships with NGOs and the private sector need to be strengthened to ensure access of patients to quality treatment and to attain sustainable malaria control status.

The immunization programme in Bangladesh has been recognized for its sustained high coverage level, and its contribution to the reduction in childhood morbidity and mortality rates. The trend of immunization coverage shows that the national Expanded Programme of Immunization (EPI) initiative has a strong capacity to reach children with BCG (98%) and OPV3 (92%). Nearly 71% of infants are fully immunized (*Coverage Evaluation Survey 2006*), which indicates an improvement in coverage (Figure 4). The country needs to further intensify efforts for increasing access for safe immunization and to strengthen surveillance against all vaccine preventable diseases. Future decisions for introducing new vaccines require special studies and surveillance activities to ensure that the vaccines are cost-effective in the light of the country's palpable burden of disease.

Bangladesh had been free from poliomyelitis since 2000 until it experienced polio importation from neighbouring country in 2006. This importation led to a recurrence of polio virus transmission in Bangladesh and to date the total case count stands at 18 with the last case detected on 22 November 2006. The immediate challenge for the country is to return to a polio-free status and maintain the same till the South-East Asia Region is certified as polio-free.

Reducing measles mortality and morbidity is another challenge for Bangladesh as an estimated 20 000 children die every year due to measles and related complications. The 'measles catch-up campaign', conducted in 2006, has substantially improved the situation (DGHS 2007). The country needs to sustain this feat by

Figure 4: Trend in immunization coverage



Source: Coverage Evaluation Survey 2006, National Expanded Programme of Immunizations (EPI), DGHS.

increasing routine immunization coverage against measles, provide second opportunities through periodic follow-up campaigns and add a second dose of measles vaccination in routine EPI in the future.

With the expansion of the national immunization programme, deaths due to 'neonatal tetanus' have substantially decreased from 6/1000 live births in 1994 to 2.3/1000 in 2000. Further efforts are required to reach the global neonatal tetanus elimination goal (<1 case per 1000 live births) by increasing routine immunization for TT5 coverage among women of the childbearing age and by conducting periodic neonatal tetanus campaigns in high-risk areas.

Leprosy elimination targets have been achieved at the national level (<1 case per 10 000 population) by 1998. The National Leprosy Elimination Programme needs to consolidate its efforts to achieve sub-national leprosy elimination.

Lymphatic filariasis is endemic in 32 districts. Scaling up of the ongoing mass drug administration and morbidity control in all endemic districts is a major challenge.

Visceral leishmaniasis (kala-azar) is endemic in 34 districts with an estimated 45 000 cases. Bangladesh is committed to eliminating kala-azar and a pilot project is being implemented in select districts. Dengue and dengue haemorrhagic fever (DHF) outbreaks occur every year in the metropolitan cities and a multisectoral approach to its control is essential. Community mobilization for controlling mosquito breeding places is a major challenge for controlling the disease.

In recent years, Bangladesh has been under the global threat of emerging pandemic-prone diseases such as Severe Acute Respiratory Syndrome (SARS) and avian influenza (AI). A systematic and institutionalised approach is required for preventing these diseases. The Government developed and implemented the National Plan of Action for Avian and Human Pandemic Influenza Preparedness and Response in early 2006. Transmission control, enhancing national capacity for laboratory diagnosis, risk communication and improved clinical management of cases are important tasks that need to be achieved.

In the HNPSp the Government has emphasized controlling major noncommunicable diseases (NCDs) in order to halt their increasing occurrence. In 2004, eight major NCDs were among the top 20 causes of deaths (BBS 2006). WHO reported 98 071 deaths and 85 8793 cases of disability in 2004 among those aged 30 years or above due to seven select NCDs in the country. These diseases account for 29% of all admissions in medical college hospitals, as found in a survey conducted by WHO in Bangladesh in 2004 (WHO 2007). The economically productive workforce, especially the poor, bears the brunt of these diseases. Unplanned urbanization, changing dietary habits, unregulated growth of tobacco, processed food and beverage industries, indoor air pollution, road traffic injuries, and widespread lack of awareness about healthy behaviour patterns contribute to the high and increasing incidence of NCDs in the country. Many of these problems are beyond the direct control of the health sector. A strategic plan of action to prevent NCDs was developed recently (DGHS 2007). Shifting the conventional mode of addressing NCDs from the tertiary care level to primary care and with a focus on risk reduction is a necessary but difficult approach for the prevention and control of NCDs.

Tobacco is a major risk factor and costs the country's economy approximately Tk. 26.1 billion (US\$ 380 million) annually according to a recent study conducted by WHO. In 2004, 570 00 deaths and 382 000 disabilities in Bangladesh were attributed to use of tobacco. A strategic plan of action has been developed for 2007-2010. Stringent enforcement of tobacco control laws, incorporating knowledge of the same in formal educational curriculum, media advocacy and stringent tax measures are required to curb tobacco consumption. Overcoming the influence and reach of national and international tobacco industries will be a tremendous challenge.

The current disease surveillance system needs to be strengthened to enable the health system to collect information on mortality and morbidity with an acceptable degree of precision and accuracy for the effective planning, monitoring and evaluation of disease control programmes. Meaningful integration of communicable and noncommunicable disease surveillance is necessary at all levels. Developing an effective mechanism for outbreak investigation with strong laboratory support and immediate intervention is also needed.

## Environmental health

Bangladesh had been making excellent progress towards providing 100% access to safe drinking water but reports of extensive arsenic contamination of the generally shallow groundwater have come as an enormous setback. Currently the overall access to improved drinking water is estimated at 74% (WHO-UNICEF Joint Monitoring Programme 2004). The population “at risk” from consuming arsenic-contaminated drinking water is currently estimated at 20 million, though the net exposed population is almost certainly less than this figure because of the success of recent awareness-building activities. The challenge of ensuring the provision of a regular supply of drinking water to the entire population remains a daunting one.

Although improved drinking water supplies have certainly contributed to reducing diarrhoeal disease, the diarrhoeal disease remains the fifth most important cause of death among the population and causes the death of 20% of all children aged below five (World Health Statistics 2006). This may be partly explained by the more limited progress made in increasing access to sanitation and promoting appropriate hygiene. In 2003 a nationwide baseline survey conducted by the Ministry of Local Government, Rural Development and Cooperatives, indicated that only 33% of households had a hygienic latrine (MoLGRDC, 2005). In response the Government launched a major initiative to improve the sanitation situation and declared an ambitious target of achieving 100% sanitation coverage by 2010, well ahead of the deadline for achieving MDGs. Political commitment at the highest levels and resource mobilization has led to mass awareness of the need for sanitation, but the target of achieving 100% sanitation by 2010 remains challenging.

Management of waste including clinical waste, solid waste and domestic and industrial wastewater is necessary at required and optimal levels to ease the substantial pressure on the environment that has also led to public health risks. Improper management of clinical waste from a rising number of hospitals is also an issue of public health concern. Only a small proportion of wastewater receives any kind of treatment prior to its discharge. Industrial wastewater and agricultural chemicals cause onerous damage to aquatic ecosystems, and also potentially introduce heavy metals and other toxic substances into the food chain. Related to industrial growth there are increasing concerns about occupational health and safety with a large number of workers exposed to dust, heat, noise and harmful chemicals for large period of time everyday. Management of clinical waste including sharp wastes in facilities and other places is also a challenge that needs to be addressed.

Another priority environmental health issue is indoor air pollution. More than 90% of the population burn biomass (wood, tree leaves, crop residues, dung) as fuel for cooking purposes exposing predominantly women and children (BDHS 2004) to the harmful fumes. The health impact of indoor air pollution includes increased risk of acute infections of the lower respiratory tract and chronic obstructive pulmonary

disease. In Bangladesh 18% of all under-five deaths are from pneumonia, and lower respiratory infections form the second largest cause of death among the entire population while chronic obstructive pulmonary disease is the seventh (World Health Statistics 2006).

Food safety is another area where there is an urgent need to raise standards of quality control. The capacity to effectively monitor food manufacturers and suppliers to ensure the bacteriological and chemical safety of food is limited. The importance attributed to food safety remains inadequate and consequently consumer awareness that could be brought to bear on quality of food production and supply is poor. Mass public awareness on food safety covering the gamut from “farm to fork” is required, and this will take considerable effort on the part of the authorities concerned.

## Emergency preparedness and response for disasters

The geographic location and topography of Bangladesh predisposes the country to many natural disasters including cyclones, floods and tornados. Man-made disasters such as building collapses also occur frequently. Bangladesh is an earthquake-prone country because of its location on the Asian Fault Line but earthquake-proof building standards are not enforced. Thus, severe devastation and loss of life will be the likely outcome if a severe earthquake strikes the country. Improving capacity to respond quickly after such natural and man-made disasters should be given a higher priority.

Floods and cyclones are the most frequent and recurring natural disasters in the country. They trigger outbreaks of communicable diseases (mainly waterborne diseases, skin infections and pneumonia) as well as cause malnutrition, injuries and snakebites. The loss of shelter contributes to vulnerability. During the devastating floods of 2004 which inundated nearly two-thirds of the country, more than 400 000 people suffered from various diseases and required treatment. Improving the country’s capacity to respond to the post-disaster situation is another area that requires substantial investment of resources.

Bangladesh endured devastating tidal bores and cyclones mainly in the coastal areas in 1970, 1985 and 1991 that killed altogether more than 500 000 people and inflicted huge financial losses. However, with improved disaster preparedness in recent years including early warning systems and the provision of cyclone shelters in coastal areas, mortality has been substantially reduced. Nevertheless, there is still the conspicuous need for improvement in multisectoral preparedness and response.

## Health system’s response

The health system’s response to the country’s needs has improved over the years but it is still not adequate to meet the entire gamut of health needs and expectations of the people, especially the poor and the disadvantaged. The development of a



countrywide network of health-care facilities has improved physical access to health services, particularly in respect of primary health care. However, the centralized management system of government health services and prevalent managerial practices at the facility level are not sufficiently effective to ensure the availability and adequate utilization of essential supplies and skilled human resources. Moreover, the health information system and health research activities are not able to provide sufficient information and evidence for effective decision-making at different levels. Issues related to ethics, equity and social justice for maximizing health for the entire population and reducing the social and economic barriers to quality health care need to be addressed. The health system's governance and stewardship functions need further strengthening to improve equity and quality of services.

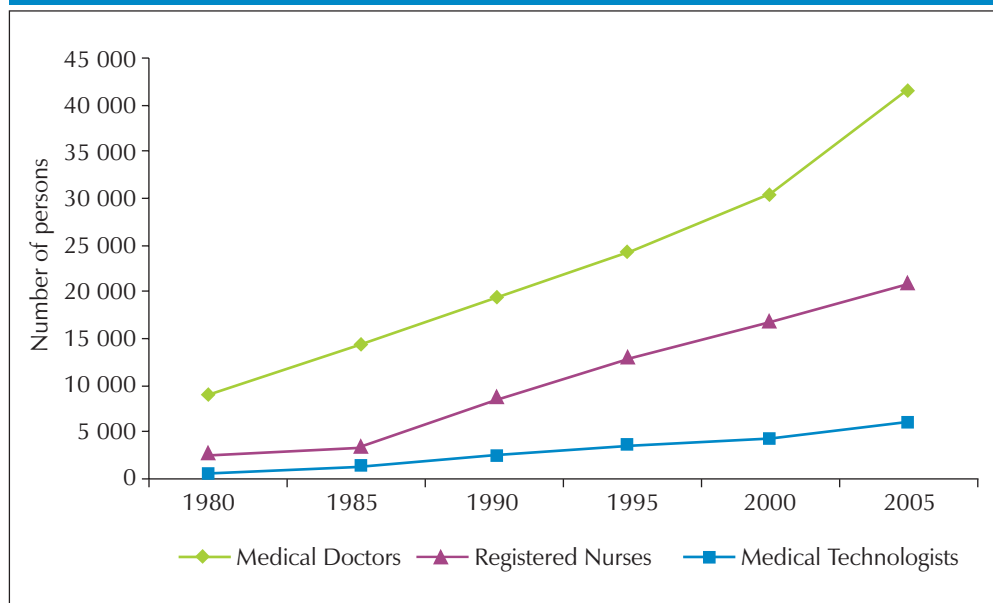
The human resource development function has been central to advancing the health system's response. According to the World Health Report 2006, Bangladesh in 2004 had 38 485 medical doctors, 20 334 registered nurses, 5 658 medical technologists, 5 743 public and environmental health workers, and 46 202 community health workers (CHWs). Additionally, about 720 000 village health volunteers (VHV) have been trained to serve the community. Large numbers of national and international NGOs are also working at the grass-roots for providing necessary services to the population through their community-based health-care providers.

In spite of the progress made, Bangladesh has been identified as one of 57 countries with a critical shortage of the health workforce (doctors, nurses and midwives number below 2.28 per 1000 population). The nurses to population ratio of 0.14 per 1000 and nurses to doctors' ratio of 1:1.85 are among the lowest in the world (Figure 5). There is also an increasing demand for nurses, midwives and medical technologists by the rapidly growing private health sector. Therefore, scaling up and bolstering the development of these categories of the health workforce is a challenging imperative.

The stewardship function for the education, training and practice of health professionals is a shared responsibility between the MoHFW and the professional regulatory bodies such as Bangladesh Medical and Dental Council, Bangladesh Nursing Council, State Medical Faculty and Pharmacy Council. Most of these bodies have limited legal powers and resources to stringently ensure the quality of education and professional practice of health personnel. In the face of the rapidly growing private sector investment in the education and training of health professionals, it is vital to have functional regulatory bodies in place.

Repeated health workforce assessments have revealed an uneven distribution of the health workforce. While the majority of the population lives in rural areas, most health professionals work in urban areas or close to major cities. There is the need to ensure needs-based workforce deployment together with the deployment of measures to attract health workers to rural areas and the "hard-to-reach" locations in particular.

**Figure 5:** Availability of key categories of health professionals



Source: Records of Bangladesh Medical and Dental Council, Bangladesh Nursing Council and State Medical Faculty.

The public health education institutes, in addition to developing a viable public health workforce also have an important role to play in the effective delivery of essential public health functions. To improve services delivery there is a need to build a functioning national network of public health education institutes.

During the last decade there has been rapid growth in the hospital services provided by the private health sector. Between 1991 and 2001 there was a 250% increase in the number of private hospitals from 280 to 712 facilities. Government facilities, on the other hand, increased by only 10%, from 610 to 670, during the corresponding period. This brings with it the challenge of regulating hospital services more effectively in order to ensure quality of services and safety of patients in both government and non-government hospitals. Under the Health Population Sector Programme (HPSP) 1998–2003, several quality assurance initiatives were piloted in select hospitals, including components related to infection control and appropriate disposal of sharps and clinical wastes. It is time to have a holistic and systematic approach for quality improvement in hospital care, with special emphasis on the reduction of health-care associated infection, in accordance with the pledge statement signed by the Minister for Health and Family Welfare during the launch of the Global Patient Safety Challenge in Dhaka, on 17 September 2006.

Blood transfusion safety has improved significantly since the enactment of the Safe Blood Act in 2004. Screening of markers for HIV, hepatitis B virus, hepatitis C virus, syphilis and malaria has been made mandatory and the use of services of

professional blood donors actively discouraged. More effort is needed now to sustain this improvement with effective quality improvement systems, and to upgrade the national blood transfusion services and formulate updated regulations for the private blood transfusion centres guided by the revised National Blood Policy, which is in the process of finalisation.

The National Drug Policy was formulated in 1982, following which the local pharmaceutical industry has witnessed a spurt in growth. According to the Directorate of Drug Administration records, local production met about 95% of the overall demand for drugs and 100% of that of essential drugs in 2005. The National Drug Policy was updated in 2005 to emphasize the need for updating the essential drug list in line with the WHO model and for developing a balanced pricing mechanism. There is a need to build consensus among the stakeholders involved on these two issues.

Monitoring compliance with GMP in the pharmaceutical sector and monitoring the quality and safety of drugs in the market has been mandated to the Directorate of Drug Administration as the regulatory authority. The outcome of repeated inspections organized by UNICEF of the manufacturing facilities of local suppliers who had expressed interest to be recognised as UN pre-qualified suppliers, was that only a limited number of the local manufacturers were able to fulfil the international GMP requirements. Having a functional National Regulatory Authority equipped with essential resources and expertise is vital for meeting the challenge of ensuring compliance with GMP in the pharmaceutical sector.

The total health expenditure constitutes 3.2% of the national Gross Domestic Product (GDP) (National Health Accounts [NHA] 2003). The sectoral share of the GDP of the health sector (at 2000-01 prices) has increased only marginally from 0.71% in 1998-1999 to 0.83% in 2004-2005 (Public Expenditure Review [PER] 2003-2004). Health expenditure in Bangladesh, at US\$ 12.16 per person per year (NHA 2003), is far below the minimum expenditure for scaling up a set of essential health interventions in the country. The government's health expenditure is only around US\$ 4 per capita per annum (NHA 2003) and prospects for its substantial increase, are limited. An effective increase in the public health allocation to meet the minimum needs of the population is a challenging task.

Historically, supply-side financing of health-care services has been the backbone strategy for improving the access of poor households to essential health-care services. But public health subsidies are not always reaching the target groups, and more affluent sections of the population have received a much greater share of public subsidies in health. Moreover, more than two-thirds of the total expenditure on health is privately financed through out-of-pocket payments. Community financing mechanisms and risk-pooling systems are nearly non-existent except on a limited scale from NGO-innovated activities. Recently a review of the health-care financing mechanisms was carried out and consensus built on piloting a few alternative financing options. Demand Side

Financing mechanism in the form of a maternal health voucher scheme for providing support to poor pregnant women is now being piloted by the Government. Its impact is yet to be ascertained. Improving equity-focused public health expenditure, and developing community-based risk pooling mechanisms and innovative financing approaches are also significant challenges for the health sector.

The government has over the past decades periodically attempted to address decentralization, but with the exception of incremental delegation of authority and responsibility to lower levels, no clear vision or roadmap has evolved. Furthermore, strong local government institutions are not functional at sub-national levels to properly manage decentralization. However, the government has decided to increase decentralization, including issuing health sector contracts to NGOs. Local level planning has been prevalent since the last few years but intended outcomes from this decentralized planning initiative will not be realized unless authority is appropriately delegated.

In response to the prevailing issues and challenges for the health system, the MoHFW has been implementing the revised HNPS 2003-10. This programme, with an inherent reform agenda, is built on a sector-wide approach which embodies a holistic focus on health development in order to improve coordination and bring efficiency in resource allocation and utilization throughout the sector. The HNPS has a mandate to deliver essential health services to the entire population with a special focus on vulnerable groups such as women, children, elderly and the poor. The programme emphasizes reducing maternal, neonatal and childhood mortality and improving maternal and childhood nutrition; reducing total fertility to replacement level; bringing down the burden of HIV/AIDS, tuberculosis, malaria and other communicable diseases; prevention and control of major NCDs and reducing injuries and improving emergency services. It is also in harmony with the targets of the country's Poverty Reduction Strategy. The progress in HNPS implementation since its revision in 2005 is far below expected levels. However, efforts are being made to strengthen leadership and management structures of the HNPS for more effective implementation.

## **Towards a better future**

Bangladesh is striving to ensure better health for its people by focusing on controlling a complex mix of health problems through improving the health infrastructure, reducing inequity and urban-rural differences, and fostering partnerships among relevant stakeholders. Moreover, health sector activities must be further aligned with other development programmes in the country.

There are clear evidences of many important achievements in health during recent decades. Bangladesh has been performing well in respect of many of the targets

of health-related MDGs, and is considered to be “on track” in its efforts to reduce child and maternal mortality (MoHFW, 2005). However, there remain principal health development challenges in the health sector (Box 2), and a concerted effort by the Government and development partners will be required to overcome these challenges. This will ensure access to quality primary health-care services for the majority of people and the deprived and vulnerable groups in particular.

### Box 2: Principal health development challenges

- Reducing under-five and maternal deaths by further accelerating quality health services to children and mothers.
- Combating major communicable diseases including multi-drug resistant TB, malaria and the spread of HIV/AIDS.
- Containing the increasing trend of major NCDs and reversing the trend by addressing health risks.
- Ensuring equitable and sustainable access to safe water supply and sanitation, and promoting environmental and occupational health.
- Strengthening epidemic alert, and emergency preparedness and response to effectively tackle public health emergencies.
- Bolstering the health system’s responsiveness for equitable access to quality health care, fairness in health-care financing, and pro-poor and improved governance and stewardship.
- Strengthening human resources for health development by addressing health personnel shortage, and improving quality of their education, deployment and utilization.

## Development assistance and partnerships: Aid flow, instruments and coordination

WHO is supporting the government within an environment of many development partners (DPs) with different types of funding mechanisms for health development. In addition, national and international NGOs are contributing significantly to the development of health in the country.

### Development partners' assistance

Assistance from DPs for health development has been available since 1972, shortly after independence. Before 1998 funding was channelled to different health projects with their defined objectives and activities in specific areas. In order to bring efficiency to the system of planning, monitoring and management, and for harmonization and alignment of donor support to national plans and strategies, a sector-wide approach (SWAp) was introduced in the health and population sector, with the launch of the Health and Population Sector Programme in 1998 (HPSP 1998–2003). Based on the lessons learned from the HPSP implementation and revised Government policy options, the current HNPSP 2003-10 was formulated and later revised in consultation with all DPs in 2005. It continues to be structured on the SWAp concept, and places greater emphasis on serving vulnerable populations through client-focused and better-utilized essential health services. Contributions of DPs in both pool and non-pool funds of the revised HNPSP are depicted in Table 1.

There are pool funding, non-pool funding and parallel funding mechanisms in the HNPSP for development assistance to the Government. Contributions to the pool fund of the HNPSP have been pledged by a consortium of donors led by the World Bank/IDA. Most of the UN agencies are non-pool contributors. Non-pool funding has been pledged by DPs to accomplish their specific objectives within the umbrella of the HNPSP. An amount of US\$ 580 million has been pledged in the HNPSP as non-pool fund. Considering the present trends in resource mobilisation, WHO's estimated contribution of US\$ 46 million for the HNPSP period of 2005-10, made in 2004, was too low and has already been exceeded in 2007.

The HNPSP at present does not support programmes beyond the MoHFW, and has no scope to shape policies and strategies in other related ministries. Urban health

**Table 1: Pledged support for HNPS (for 2005 and beyond) (in million US\$)**

Funding agency	Pool fund	Non-pool fund	Total
World Bank/IDA	300	–	–
DfID	188.7	–	–
EU	130.1	–	–
SIDA	74.6	3.8	78.4
Netherlands	53.1	–	–
GTZ-KfW of Germany	49	15.9	64.9
CIDA	12	64	76
UNFPA	1	35	36
Japan	–	160	160
USAID	–	100	100
GAVI	–	95.6	95.6
UNICEF	–	48.5	48.5
<b>WHO</b>	–	<b>46</b>	<b>46</b>
GFATM	–	11.71	11.71
<b>Grand Total</b>	<b>808.5</b>	<b>580.51</b>	<b>1389.01</b>

Source: Revised HNPS, MoHFW, 2005.

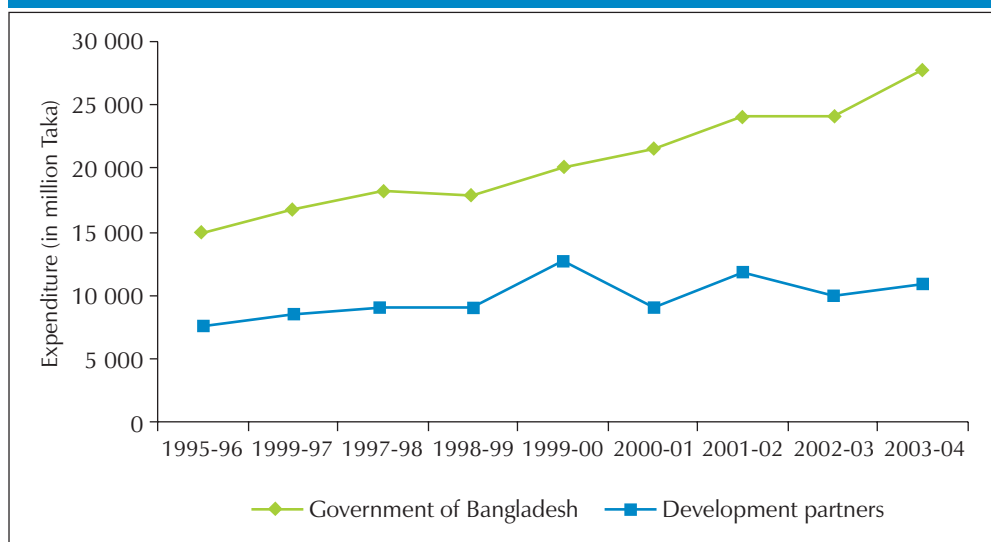
activities in all city corporations and municipalities, which are under the jurisdiction of the Ministry of Local Government, Rural Development and Cooperatives (MoLGRDC), are external to the mandate of the HNP sector programme of the MoHFW but have been supported by many DPs such as ADB, SIDA, USAID, DFID and EU through parallel funding. Apart from support to the MoHFW, WHO is also providing support to other ministries such as the MoLGRDC and the Ministry of Environment and Forest for health development activities.

## Aid flow

The assistance from the development partners over the last decade has consistently been in the range of 30% to 40% of the health, nutrition and population sector expenditure. The figures have been on a gradual rise over the years (Figure 6).

In line with the “Paris Declaration on Aid Effectiveness, 2005” efforts are being made in the country for harmonization of donor support and its alignment with national plans and strategies. Coordination mechanisms such as the HNP Consortium, the HNP Forum and specific Steering Committees in some areas, comprising members from DPs and the government, are in place to improve aid effectiveness. The “pool funding” mechanism within the SWAp is designed to align support from development partners according to the needs of the country, as well as for coordinating the funding for health development. Joint initiatives of the UN agencies, including WHO, are also being

**Figure 6:** Shares of development partners and the Government of Bangladesh in health, nutrition and population sector expenditure



Source: Public Expenditure Review 2003-2004, Health Economics Unit, MoHFW.

implemented. These are addressing issues such as maternal and neo-natal health, malaria control, and the training of community-based skilled birth attendants.

## Other sources of funding

Financial contribution from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the GAVI Alliance constitutes an important component of the HNPSP budget. GFATM funds are channelled through the Government and NGOs, whereas the GAVI Fund is allocated only to the Government. With the approval of the TB component in Round-5, and HIV/AIDS and malaria components in Round-6, the approved support from GFATM will now be well above US\$150 million. Moreover, funds will be available in the country from the Vaccine Fund of the GAVI Alliance, which will enhance the responsiveness of the health system. Recently, the country has received support from the Health Metrics Network for assessment of the existing Health Information System and preparation of an improvement plan for the same. Financial support was made available in specified health areas by international NGOs, foundation and specialized donors such as the Bill and Melinda Gates Foundation, the Bloomberg Initiative, the Sasakawa Foundation, the Spanish Grant for achieving the MDGs, and the Tropical Disease Research Support, among others.

The donor contribution component in the Revised HNPSP 2003-10 stands at US\$ 3.6 billion, which is about 37% of the total. However, it is difficult to assess whether the resources provided are sufficient to meet the country's health needs and to ascertain whether available resources are being efficiently utilized.



## Development partners' priorities

As indicated in Table 2, it is evident that donors with pool funding – such as the World Bank/IDA, the Department for International Development of the United Kingdom, the European Commission, the Netherlands, SIDA, CIDA, and Germany (through KfW and GTZ) – are supporting multiple priority programmes of the Government. Hence these development partners do not support specific projects but support the HNPSP instead.

**Table 2:** *Priority areas of support of non-pool and parallel funding agencies*

Development partner	Priority areas in HNP
<b>Non-pool funds</b>	
CIDA	Life cycle approach, line of commodity, gender and health, health systems reform.
GTZ	HNPSP monitoring and evaluation, demand-side financing schemes, social health insurance, HIV-AIDs, reproductive health.
Japanese Government	For any HNPSP area, as assessed by the Annual Programme Review as a well-performing sector.
JICA	Reproductive health, maternal and child health, measles control, immunisation, filariasis elimination.
KfW	Contraceptive security, quality control of contraceptives, reproductive health and HIV-AIDS, diversification of service-providers, support to the HNP Consortium Secretariat and the Programme Support Office.
SIDA	Reproductive health, women's health and rights, essential service package.
UNFPA	Gender, population development, reproductive health.
UNICEF	Child health, EPI, diarrhoeal diseases, Integrated Management of Childhood Illness (IMCI), acute respiratory infection control, emergency obstetric care, women's health, women-friendly hospitals, nutrition, mineral and nutritional deficiencies, vitamin-A, arsenic and HIV.
WHO	Technical assistance for all health aspects.
<b>Parallel funds</b>	
ADB	Urban Primary Health Care Project.
DfID	Urban Primary Health Care project, maternal health.
EC	Urban Primary Health Care Project.
SIDA	Co-financing of the Urban Primary Health Care Project.
USAID	Social marketing, contraceptive supply, family planning, operations research in HNP, child and maternal health, urban health.

Development partners with non-pool funding are providing support in maternal and child health, HIV-AIDS, women's health, equitable access to health-care finance

and facilities, and micronutrients. Parallel funds have mostly focused on urban health care, family planning and social marketing of contraceptives, though a few are also supporting select areas such as maternal health.

## Partnership and development aid coordination

There is a strong partnership among the development community in Bangladesh which is fully committed to support the MoHFW in its health development programmes that are focussed on achieving goals including the health-related MDGs. The DPs work hand-in-hand with the government through coordinated mechanisms, the key elements of which are described below.

The **Local Consultative Group** is the apex body of DPs tasked with donor-government coordination. It covers all areas of Bangladesh's development priorities, including health, nutrition and the population sector, and has a sub-group to coordinate activities in each area.

The **Health, Nutrition and Population (HNP) Consortium** is a sub-group of the Local Consultative Group and deals with matters relating to the HNP sector. It is primarily a mechanism to coordinate support to the government in improving health outcomes. It is the group of DPs that provides funds to the HNPSF. This consortium maintains a continuous dialogue with the MoHFW on HNP issues.

The **HNP Forum**, a government-led mechanism, facilitates the exchange of information and policy dialogue between the DPs and the government on all matters related to the HNP sector. The Forum is headed by the Secretary of the MoHFW, and includes in its membership senior-level government and DP officials including the chairperson of the HNP consortium and the World Bank representative.

**United Nations Development Assistance Framework (UNDAF)** is an umbrella programming mechanism of the UN Country Team in Bangladesh, which works in close cooperation with and has aligned its priorities to that of the government. The current UNDAF, agreed with the government in 2005, covers the period 2006-2010. The UNDAF is also engaged in monitoring progress made by Bangladesh towards achieving MDG targets by 2015.

In addition, there are **other mechanisms** to coordinate resources from different agencies. The Country Coordination Mechanism is actively involved in policy-making and monitoring of the GFATM activities, and an Inter-agency Coordination Committee is functioning for GAVI-funded activities. The implementation and policy directions for the Health Metrics Network programme in the country are steered by two groups, namely "the Steering Group" and "the Stakeholders' Group" respectively.

While Bangladesh has a good coordination mechanism for harmonizing donor activities and aligning them with country programmes, there seems to be a multiplicity

of consortiums and committees which should be streamlined to minimize time and other costs. The Bangladesh HNP Forum, which is the overarching government-led mechanism, needs to be re-invigorated and given the responsibility for overall coordination of all components of the programme.

## Public-private partnerships

A large part of the health services are financed and provided for privately. Over 70% of the expenditure and nearly 80% of the health-care contacts are in the private sector (World Bank, 2006). Facility utilization rates in the public sector are low, and there has been increasing demand for services provided by the private sector and non-governmental organizations. Bangladesh has a large NGO sector involved increasingly in providing primary health care. The private sector is diverse, ranging from modern facility-based state-of-the-art services to indigenous medical practitioners, village pharmacists and non-qualified practitioners.

Some pilot initiatives have been tried out since the 1990s for collaboration with the private sector, and to outsource select aspects and services related to health care. The Government's partnerships with NGOs is functioning effectively in a number of areas such as the National Tuberculosis Programme. Another example of successful public-private partnership is the Urban Primary Health Care Project, which successfully completed its first phase in 2005 and is now into the second. The theme "private provision of public services" is effectively implemented in the Urban Primary Health Care Project, where PHC services are provided to the urban population of six City Corporations and some select municipalities through NGOs under contractual terms.

## Current status of WHO cooperation

### Background

WHO's collaboration with the Government of Bangladesh began in 1972. The primary functions of the Organization in its collaboration with the Government of Bangladesh are providing technical support for health development, including policy development; developing technical guidelines for service delivery; promoting health research, and building national and institutional capacity. Since 1978 WHO has supported the MoHFW in developing the district health system and implementing public health interventions, based on the PHC approach. The Alma Ata Declaration of 1978 endorsed the emphasis on PHC which was identified as key to attaining the goal of "Health for All". Most importantly, the Declaration re-affirmed that *"...health... is a fundamental human right and... a most important worldwide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector"* (Declaration of Alma Ata, 1978). The implication of a holistic approach to health is reflected in the extent of support provided by WHO to not only the MoHFW but also Government institutions with a mandate to address the environmental and social determinants of health.

In 1998 SWAp was introduced first under the HPSP 1998-2003 and then in the subsequent HNPSp 2003-10. WHO played an active role in supporting the planning and appraisal process of the Strategic Investment Plan and the HNPSp, and continues to support the aims and objectives of both. From 2004 WHO collaboration was guided by the first Country Cooperation Strategy 2004-07.

The WHO programme budget and biennial plan of action is developed in close collaboration with the national Government, aligning organizational priorities identified in the WHO General Programme of Work with national health priorities as reflected in national plans. In its unique institutional position as an inter-governmental agency, WHO has consistently fulfilled its role to provide close support to the Government in the design and management of new public health initiatives, drafting and leading dialogue on policy issues, and engaging in operational research from within the system.

### WHO's contribution

The essential focus of WHO's work is to provide technical assistance. WHO aims in particular to support the development of policy and tools such as guidelines, norms, standards, and protocols that support the effective implementation. The organization builds capacity and evidences through research, innovative pilot projects and training of

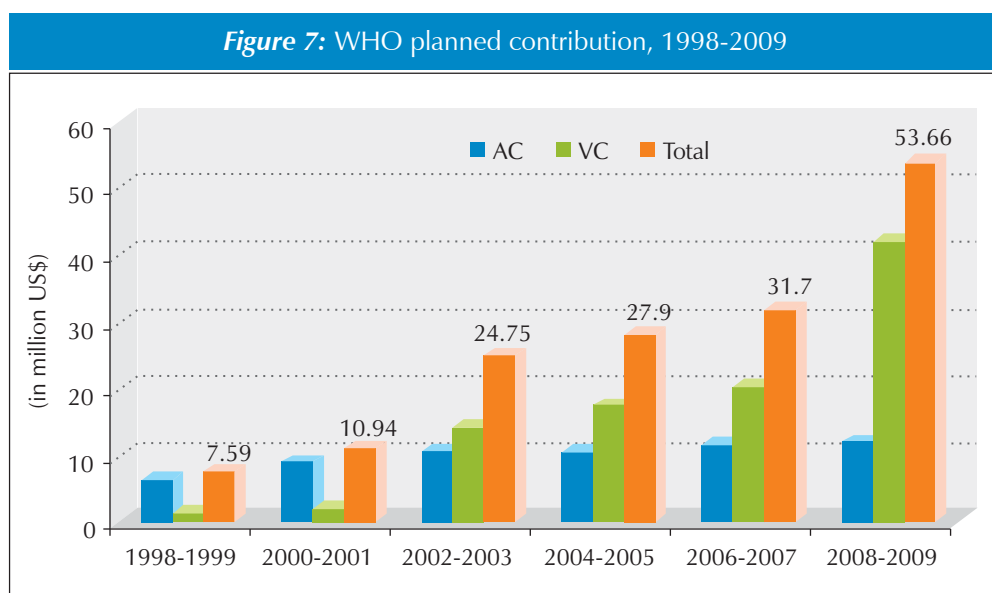
trainers. WHO aims to provide leadership and foster partnerships in order to achieve effective and at-scale impacts. These interventions are elaborated more specifically as “WHO’s Core Functions” (Box 3, Section Five – WHO policy framework: Global and regional directions). In striving to meet the MDG targets, it is evident that these WHO Core Functions have particular relevance. The key concepts of leadership, partnership, information dissemination, ethical and evidence-based policy development, and capacity building all contribute to facilitating the efforts towards achieving the MDGs.

As a technical agency WHO gives particular emphasis to its normative role and in the promotion of skills development. These are considered as keystones to the successful implementation of quality health services that are accessible by all. The approach adopted by WHO is to constantly seek opportunities for partnership which is reflected in the frequent joint programming with Government departments, other UN agencies and NGOs. Such efforts are essential to ensure harmonization of WHO work with partners having a common goal.

Currently WHO collaboration in Bangladesh is grouped in six clusters: Communicable Disease and Surveillance (CDS), Emergency and Humanitarian Action (EHA), Family and Community Health (FCH), Health Systems Development (HSD), Non-communicable Diseases and Mental Health (NMH), and Sustainable Development and Healthy Environments (SDE). Examples of key contributions made by WHO during the first Country Cooperation Strategy can be found in Annex 3.

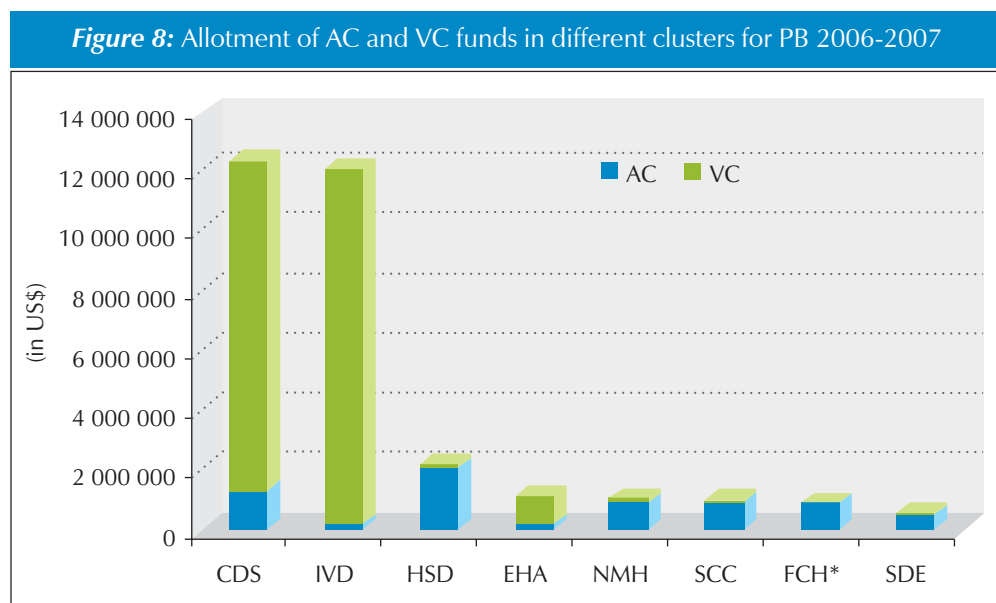
## Resources

A significant factor influencing WHO operations in Bangladesh has been the substantial increase in voluntary contributions (VC) for WHO Collaborative Programme (Figure 7).



The more noteworthy among VC funding agreements are the UN Flash Appeal for flood victims of Bangladesh, the HIV/AIDS Prevention Project, the GFATM and, most recently, the Bloomberg Global Initiative to Reduce Tobacco Use. In addition to these grants, important programme-focused financial support has been channelled through WHO by several bilateral agencies including AusAID, CIDA, DFID and USAID. This support has enabled several large scale programmes to be implemented that address concerns such as polio, tuberculosis and malaria.

The allocation of AC and VC fund for programme activities in different clusters of the current 2006-2007 biennium (Figure 8) indicates that most of the available VC funds is allocated to IVD and CDS clusters, as resources from global funds and other donors are flowing in for communicable disease control. Other important areas like FCH, HSD and NMH clusters, however, remain dependent on AC funds for programme activities in those areas.

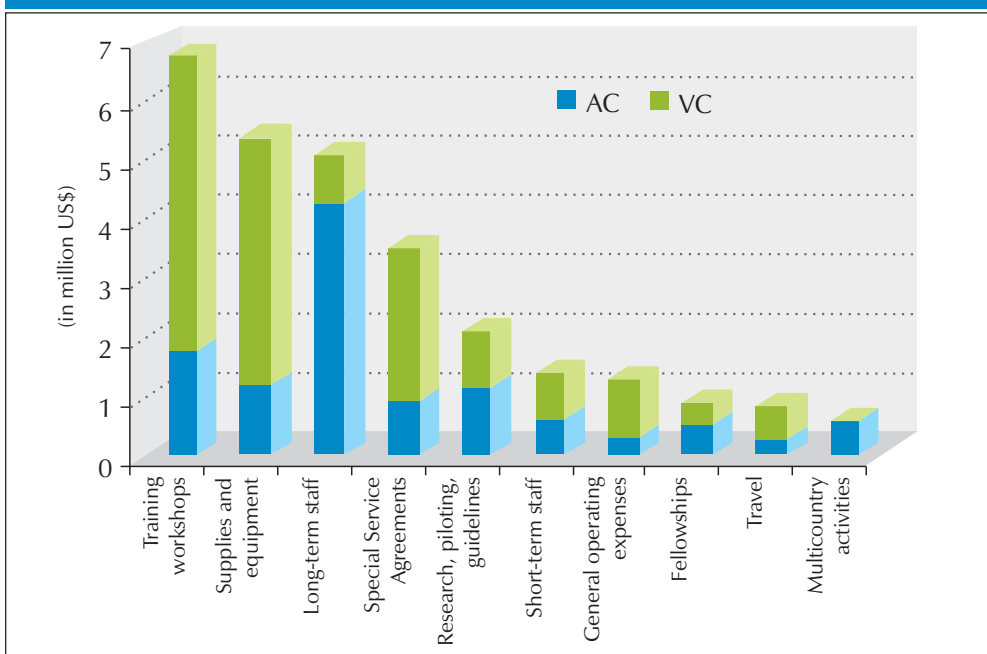


\*FCH excluding IVD.

While VC projects often require the procurement of supplies and equipment, assessed contribution (Regular Budget) of WHO are broadly directed at the provision of technical assistance, administrative and managerial support, and core activities that build national capacity (Figure 9).

WHO Bangladesh employs 11 international staff, including one temporary appointment, 17 national professional staff, including 6 temporary appointments, and 34 general service staff, including 4 temporary appointments. Additional support for programme implementation is provided by 256 Special Service Agreement (SSA) holders (Table 3).

**Figure 9: Planned 2006-2007 budget classified by component and funding source**



**Table 3: Composition of WHO Bangladesh staff and SSA holders classified by work cluster and funding source (as on 1 October 2007)**

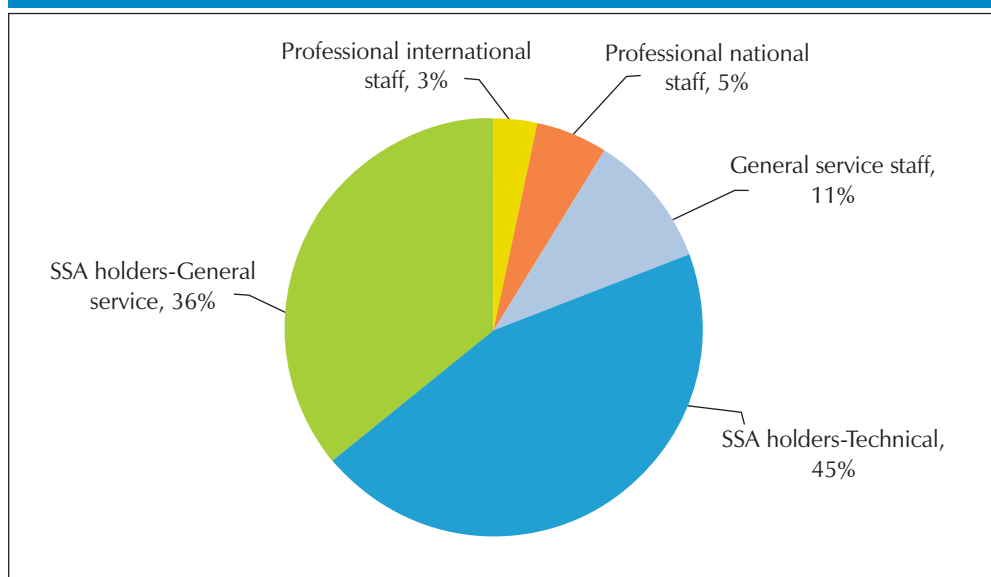
Unit	Professional international		Professional national				General service				Special Services Agreement				Total		Total		
	IPS		TIP		NPO		TNP		GS		TGS		Technical service		Support service				
	AC	VC	AC	VC	AC	VC	AC	VC	AC	VC	AC	VC	AC	VC	AC	VC			
CDS	1	-	1	-	2	2	-	-	2	-	-	-	2	9	4	23	12	34	<b>46</b>
EHA	-	-	-	-	1	-	-	-	-	-	-	-	-	1	3	-	4	1	<b>5</b>
FCH**	1	-	-	-	-	-	1	-	-	-	-	-	11	-	-	-	13	-	<b>13</b>
HSD	3	-	-	-	2	-	-	-	10	-	-	-	12	-	14	-	41	-	<b>41</b>
IVD	-	2	-	-	-	3	-	-	-	4	-	2	-	104	-	56	-	171	<b>171</b>
NMH	-	-	-	-	1	-	-	4	-	-	-	-	-	0	3	-	4	4	<b>8</b>
SDE	1	-	-	-	-	-	1	-	1	-	-	-	3	0	5	-	11	-	<b>11</b>
WRO*	2	-	-	-	-	-	-	-	13	-	2	-	-	-	6	-	23	-	<b>23</b>
<b>Total</b>	8	2	1	-	6	5	2	4	26	4	2	2	28	114	35	79			
	10		1		11		6		30		4		142		114		<b>108</b>	<b>210</b>	<b>318</b>
	<b>11</b>				<b>17</b>				<b>34</b>				<b>142</b>		<b>114</b>				

\*WHO Country Office; \*\*Excluding IVD.

IPS = International professional staff; TIP = Temporary international professional staff; NPO = National professional officer/staff; TNP = Temporary national professional staff; GS = General service staff; TGS = temporary general service staff.

These SSA holders are contracted on annual basis, based on need, to support both technical and general service areas. It is further evident from the table that 10 out of 28 professional staff and 193 out of 256 SSA holders are working under VC funds. A considerable proportion of SSA holders are working in the VC-funded IVD programme that has achieved considerable success in reducing vaccine preventable diseases and eradication of polio through field surveillance networks. Provision of technical staff normally could be made for VC-funded areas, but the provision of administrative staff support through VC funds has been found difficult. It is important to highlight that in addition to the WHO Representative and Administrative Officer the Country Office operates with a core general service staff of 13 and two temporary staff with added support from six SSA holders, and that all of them are from the AC fund. However, the substantial increase in VC budgetary support has presented some difficulties inasmuch that the human resource capacity, particularly with respect to general administrative and support staff, has not kept pace with this rise. The proportion of different categories of staff and SSA holders working in the country is depicted in Figure 10.

**Figure 10:** Composition of WHO Bangladesh staff and SSA holders (as on 1 October 2007)



Expansion of activities through VC funds has also created the need for more office space, and improved communications and logistic capacities. WHO Bangladesh functions from a rented office but a new location that meets the minimum requirements of space and communication facilities should be made operational soon.

Although there is a core group of technical staff located in the WHO Country Office, the majority are based within Government offices to enable collaborative



working arrangements with their counterparts. There are, however, certain disadvantages of having staff functioning in a decentralised fashion. For example, regular staff meetings incur travel time, and instantly-called meetings are not practicable. Furthermore, there are often limited communication facilities in project offices and an unreliable internet connectivity which impedes information sharing among WHO staff and their ministerial counterparts.

In addition to the in-country human resource capacity, WHO Bangladesh counts on the strong support of the Regional Office in New Delhi and Headquarters in Geneva. Both the Regional Office and Headquarters provide technical, administrative and resources support. Regional Advisers for each work area are on hand to provide additional technical support to in-country technical staff. Furthermore, they facilitate regional multi-country activities that provide the opportunity for technology transfer and knowledge management. Support for mobilizing resources, legal advice, formulation of workplans and regional and global strategies is provided on an as-is-needed basis by the Regional Office and Headquarters.

## Enhancing WHO cooperation

WHO seeks to constantly enhance its contribution towards attaining the goal of “Health for All” in Bangladesh. Recognizing that this goal is shared by a wide spectrum of stakeholders, WHO invited comment on the preparatory phases of the CCS 2008-2013. Stakeholders expressed appreciation of and recognized the Organization’s contribution in strengthening health systems and its steadfast commitment to collaborate with both the Government and development partners. Nevertheless, some concerns were voiced such as the need to devote more attention to certain important areas including health promotion and prevention, capacity for quality research, maternal health, and NCDs. Furthermore, stakeholders called for closer alignment between the WHO CCS and the HNPS, and urged WHO to assume a technical leadership role within the HNPS. The demand for WHO assistance coupled with changes in the demographic profile and public health priorities requires that WHO identifies the areas where there is a felt need to strengthen its own human and other resource capacities to ensure that the goals set for the CCS 2008-2013 will be achieved.

## WHO policy framework: Global and regional directions

### Global challenges in health

The General Programme of Work is the highest policy document of WHO. The Eleventh General Programme of Work sets out the direction for international public health for the period 2006 to 2015. The document notes that there has been substantial improvement in health over the last 50 years. However, significant gaps remain, as elucidated in the following paragraphs:

**Gaps in social justice:** Clearly, poverty is a key factor that impedes access to quality health services. In some countries the life expectancy of the poor is 20 years lower than that of other more privileged members of society. Poor health and poverty form a vicious cycle. Other factors that reduce access to services are discrimination on grounds of ethnicity or gender and the fact that women's health concerns are often not adequately addressed.

**Gaps in responsibility:** Health problems today are no longer merely the responsibility of those working on health, but require positive action by those outside the health sector. International conflicts and national crises often lead to the disruption of social services which include health care. Globalization and decisions made regarding international trade have a direct impact on health, especially in terms of pharmaceuticals and the movement of health professionals. In many countries Ministries of Health often do not have the capacity to adequately influence important causes of ill-health outside the health sector.

**Gaps in implementation:** Often the technology to implement cost-effective interventions to improve health is available but these are not implemented because of shortage of funds, lack of human resources or the absence of an effective health system. Available resources may often be allocated to high-cost curative services and are biased in favour of urban areas, without considering many inexpensive and effective interventions in rural and remote areas.

**Gaps in knowledge:** Global advances in science and technology have improved the effectiveness and efficiency of medical services and the prevention and treatment of diseases. However, information about these advances is often not available in many countries. Also, the lack of information about health conditions, and existing rigidities in many countries has in turn made it difficult to formulate and manage effective

health policies and interventions. Even operational research is generally not done for those most in need of health services, thereby reducing the efficiency of key programmes.

## Global health agenda

In order to reduce these gaps over the coming decade, the Eleventh General Programme of Work outlines a global health agenda consisting of seven priority areas:

- (1) Investing in health to reduce poverty.
- (2) Building individual and global health security.
- (3) Promoting universal coverage, gender equality and health-related human rights.
- (4) Tackling the determinants of health.
- (5) Strengthening health systems and equitable access.
- (6) Harnessing knowledge, science and technology.
- (7) Strengthening governance, leadership and accountability.

The global health agenda is meant for everyone working in the field of health development. WHO will contribute to this agenda by concentrating on its core functions (Box 3), which are based on the comparative advantages of the Organization.

### Box 3: WHO's Core Functions

- Providing leadership on matters critical to health and engaging in partnerships where joint action is needed.
- Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge.
- Setting norms and standards and promoting and monitoring their implementation.
- Articulating ethical and evidence-based policy options.
- Providing technical support, catalysing change, and building sustainable institutional capacity.
- Monitoring the health situation and assessing health trends.

## WHO priorities

In accordance with the global health agenda and WHO's Core Functions, the Organization has set the following priorities:

- (1) Providing support to countries in moving to universal coverage with effective public health interventions.

- (2) Strengthening global health security.
- (3) Generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health.
- (4) Increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health.
- (5) Strengthening WHO's leadership at global and regional levels and supporting the work of governments at the country level.

WHO will pursue these priorities through its Medium-term Strategic Plan 2008-2013 and the biennium workplan of the Organization (Annex 4). The Director-General of WHO has clearly placed major emphasis on the work of the Organization at the country level. The Regional Offices and Headquarters have been directed to emphasize support for country work and implement these priorities in Member States, especially where health needs are the greatest.

## Regional Policy Framework

The South-East Asia (SEA) Region has the second highest population among the six WHO regions as well as the highest burden of disease. While there has been considerable economic development in this Region in recent years, the problems of poverty and poor health remain significant. Many countries have faced health emergencies in the last decade and the threat of disease outbreaks is always present. At the same time, non-communicable diseases have become an increasingly important cause of morbidity and mortality in the SEA Region. Therefore, the Global Policy Framework of WHO is appropriate for the countries of the Region, with special attention provided to strengthening the capacity of Member States to support public health interventions.

The WHO South-East Asia Regional Office has always placed strong emphasis on its work in Member States. Of the total budget provided to the Region, 75 % is allocated for countries, the highest among all WHO Regions. The Regional Director for the SEA Region has recently increased the delegation of authority to country offices to enable them to plan and implement programmes with a higher degree of independence and to be more accountable. At the same time, he has emphasized that the Regional Office staff should give the highest priority to support the work in these countries.

# 6

## Strategic Agenda

Commitment to the principles of PHC and a rights-based, gender equality and equity approach to health remains the central paradigm for WHO's support to and role in countries. As the United Nations specialized agency for health, WHO will focus its support to the national government on the formulation of policies, service standards, service guidelines and service delivery processes. Concurrent research into critical determinants of health, health services delivery and health systems performance will strengthen the evidence base to do so. In addition the application of research findings and knowledge management will support the Government to improve technical and allocative efficiency of public health expenditure.

### Strategic directions

Based on the analysis of health and development challenges, current WHO collaborative programmes, WHO's comparative advantage, and a review of work of development partners, seven strategic directions have been identified. These are elaborated in Box 4:

#### Box 4: Strategic directions

- (1) Promote access of vulnerable groups to health services ensuring continuum of care throughout the life course.
- (2) Enhance capacity for the prevention and control of major communicable diseases and diseases targeted for elimination/eradication, and strengthen integrated disease surveillance.
- (3) Promote healthy lifestyles and cost-effective interventions for the prevention and control of major NCDs and injuries, and for mental health promotion.
- (4) Enhance equitable and sustainable access to safe water and sanitation, reduce environmental and occupational health risks and promote food safety.
- (5) Strengthen multisectoral approaches for emergency preparedness, response and recovery.
- (6) Strengthen health systems focusing on health workforce development and equitable access to quality health care.
- (7) Foster partnership and coordination for national health development.

## **1. Promote access of vulnerable groups to health services ensuring continuum of care throughout the life-course**

WHO will continue to support capacity building that aims to improve the health of mothers, children, adults and the ageing population through a life-cycle development approach but with special attention to adolescent and neonatal health needs. In line with the rights-based approach to sexual health, reproductive health needs of both genders will be addressed. A community focus and adherence to the principles of PHC remain central to WHO support.

### **Strategic actions:**

#### ***1.1 Support for increased access to maternal, newborn, child and adolescent health services ensuring continuum of care throughout the life course and across different levels of the health system, including the community:***

WHO will support adaptation and use of guidelines, standards and tools for enhancing health services for mothers, newborns, infants, children and adolescents including the institutionalization of the community-based skilled birth attendants (SBA) programmes. Research will be conducted to formulate evidence-based policies and strategies to mobilize the participation of individuals, families and communities, and to improve access to quality services with the aim of ensuring continuum of care for safe motherhood and newborn health.

#### ***1.2 Promote diversification of health services for adolescents, adults and the ageing population including reproductive health services:***

Support will be provided for innovative approaches for equitable access to gender-sensitive health services, including reproductive health services for both women and men, that will also include operationalization and scaling up of adolescent-friendly health services and strengthening of community-based care for healthy and active ageing. WHO will support research to address gender issues, empowerment of women and domestic violence, healthy ageing, sexual and reproductive health care and interventions.

#### ***1.3 Advocate for mainstreaming a rights- and gender equality-based approach to life-cycle development:***

Promotion of rights-based and gender equality leadership, advocacy and strategies in the health sector; and the principle of “women friendly hospitals” at all health service facility levels are to be advocated. Gender-based violence is to be addressed through a multisectoral approach. Gender equality in training, recruitment, deployment and staff development practices are to be promoted.

#### ***1.4 Support the comprehensive integration of nutrition throughout the lifecycle into the health sector framework:***

WHO will support effective and efficient institutionalization of nutrition programmes for enhancing synergies in services delivery as well as programme monitoring and

evaluation. Research and development of technologies and interventions for micronutrient supplementation throughout the lifecycle will be strengthened. Support will also be continued for operationalization of the strategic plan for infant and young child feeding and management of severe malnutrition in health-care facilities.

## **2. Enhance capacity for prevention and control of major communicable diseases and diseases targeted for elimination/ eradication and strengthen integrated disease surveillance**

For Bangladesh, communicable disease control remains pivotal in its fight against poverty. WHO support will target the policy, institutional and operational level, and will focus on capacity development measures, introduction of new and appropriate technologies, operations research on cost-effective and community-based horizontally integrated services delivery models, and improved epidemiological surveillance.

### **Strategic actions:**

#### **2.1 Strengthen national capacity for effective management of major communicable diseases (HIV/AIDS, tuberculosis, malaria) and diseases targeted for elimination/eradication particularly leprosy, filariasis, kala-azar, and dengue):**

Support will be provided to identify and address gaps in programme management capacities at individual and institutional levels, and at the central, district and upazila levels. Necessary support will be provided to increase access to and utilization of the services, particularly for the at-risk population. Access to affordable and effective preventive measures and school-based and other approaches for awareness building will be promoted. Public and private sector collaboration and partnerships will be strengthened. Support will also be provided for the review and updating of policies and strategies with a view to improve the programme management system.

#### **2.2 Enhance capacity of the national immunization programme for effective prevention and control of vaccine preventable diseases:**

WHO will continue to support the implementation of the national immunization programme. Technical support will be provided for the introduction of new cost-effective vaccines as well as the ongoing drive for polio eradication. Support will also be provided for preparatory work towards building capacity at the district and sub-district level so that the functions of the existing “Field Surveillance Network” can be integrated into the national surveillance and other priority public health outreach programmes.

#### **2.3 Support for effective integrated disease surveillance system for communicable and non-communicable diseases:**

WHO will support the strengthening of the integrated disease surveillance system including mainstreaming of existing field surveillance networks along with

implementation of strategies and operational guidelines which facilitate utilization of evidence through infobases and networking.

#### ***2.4 Enhance emergency preparedness and response for emerging and re-emerging diseases and implementation of International Health Regulations 2005:***

National capacity for surveillance will be enhanced with the development of early warning and rapid response to outbreak investigations and interventions of communicable diseases. Support will be provided for health risk assessment and building of core capacity of the government for implementing International Health Regulations (IHR) 2005 with multisectoral involvement to address diseases caused by regional and global threats.

#### ***2.5 Strengthen public health laboratories to combat potential pandemic disease threats:***

WHO will support the institutionalization of standard operating procedures for public health laboratories. Laboratory capacity will be strengthened to support integrated disease surveillance, International Health Regulations 2005 implementation, and establishing a national network of laboratories.

### **3. Promote healthy lifestyles and cost-effective interventions for prevention and control of major NCDs and injuries, and for mental health promotion**

The economic and demographic transition in Bangladesh increasingly causes adverse effects on both health and wealth. High consumption of tobacco, changes in eating habits, increasing substance abuse, widespread lack of physical activity and an unregulated food and beverage industry are increasingly leading to noncommunicable diseases. WHO support will focus on the promotion of healthy living, enforcement of relevant laws and generation of evidence for programmes and policies that aim to reduce lifestyle-based risks for the individual as well as for the community.

#### **Strategic actions:**

##### ***3.1 Strengthen health promotion for healthy lifestyles and mental health using multisectoral approach:***

WHO will support policy development, legislation, regulation, public and professional education, guideline development, media interventions and research that address the determinants of health including mental health at the individual and community level. Support will also be provided for mass awareness through school-based and other approaches. At the macro and micro level, partnerships with public and private sectors, academic institutions and civil society groups will be promoted.



### ***3.2 Enhancing the evidence base for the development of policies, programmes and legislation for NCD prevention:***

Special efforts will be made for the collection of data that will be necessary for NCD prevention. WHO's step-wise surveillance approach will be followed to generate data on risk factors for major NCDs and their disease burden and consequent deaths. Priority NCDs to be addressed include ischaemic heart disease, stroke, diabetes mellitus, Chronic Obstructive Pulmonary Disease, and cancers of the oral cavity, lungs, breast and cervix. Essential data will be disseminated in various forms.

### ***3.3 Capacity building for reducing deaths and disabilities from major chronic NCDs and injuries, and for promoting mental health:***

WHO will focus its support on building institutional capacity for integrated prevention and control of NCDs. This needs development and promotion of the use of tools, guidelines and standard protocols for prevention and management of major NCDs and injuries. Early detection and efficient management of diabetes, hypertension and certain cancers at the primary and secondary care level as well as pre-hospital care for efficient management of injuries will be supported. Successful models for community-based mental health services and primary eye care at the upazila level through participatory mechanisms will also be supported.

## **4. Enhance equitable and sustainable access to safe water and sanitation, reduce environmental and occupational health risks and promote food safety**

Continued population and economic growth exert increasingly adverse impacts on environmental determinants of health which threaten the achievement of sustainable development in Bangladesh. WHO's response to this challenge is to continue its multisectoral policy and programmatic advisory service to address priority environmental health issues including pollution of drinking water, inadequate sanitation, indoor air pollution and food safety. More emphasis will be put on the facilitation of evidence-based strategies for the primary prevention of pollution, and identifying and promoting sustainable technologies and approaches to prevent environmental health risks for both urban and rural communities.

### **Strategic actions:**

#### ***4.1 Enhance equitable and sustainable access to safe water supply and sanitation:***

WHO will promote preventive approaches to water management using the concept of water safety plans to enable utilities, communities and households to maintain supplies of safe drinking water. Support will be provided to identify approaches and

technologies that ensure access to safe water for vulnerable communities; monitor and evaluate arsenic mitigation strategies that address safe supplies and patient management; and facilitate the updating of drinking water quality standards in accordance with health-based targets. Support for sanitation, including ecological sanitation, will focus on helping the government to achieve the goal of total sanitation by 2010 and ensure that this achievement is sustainable in the long term.

#### ***4.2 Strengthen national capacity to reduce environmental health risks:***

WHO will support the government in the promotion of healthy public policies through research, policy advice, capacity building and awareness to address such issues as occupational health, health-care waste and the health impacts of climate change. WHO will give particular attention to sustainable and affordable measures to minimize indoor air pollution. Healthy public policy will be promoted through the healthy settings programme to address environmental determinants of both communicable and noncommunicable diseases.

#### ***4.3 Enhance food safety from production through to consumption:***

WHO will emphasize capacity building of government institutions to develop an appropriate and effective management framework that ensures the safety of food from the production stage to consumption. Support will be provided to strengthen government capacity to monitor food safety with modern approaches and techniques; develop policy and strategies that lead to increased food safety in the public and private domains; identify successful approaches to raising awareness on the importance of food safety among diverse stakeholders; build mass awareness among the population and advise on food safety standards and regulations.

### **5. Strengthen multisectoral approaches for emergency preparedness, response and recovery**

WHO will continue to build capacity and provide logistics support for adequate response during emergencies. More advisory capacity will be directed at preventive preparedness planning. A broad coordinated intersectoral approach towards emergency and humanitarian action, including gender consideration, will be promoted.

#### **Strategic actions:**

##### ***5.1 Strengthening multisectoral coordination, planning, cooperation, communication, and action for disaster mitigation, emergency preparedness, response and recovery:***

WHO will provide support to strengthen crisis management teams and establish multisectoral “core groups” at all levels in collaboration with the Disaster Management

Bureau, the Comprehensive Disaster Management Programme of Ministry of Food and Disaster Management and other related stakeholders, as well as maintain better cooperation and collaboration within the country and abroad. Support will also be provided to enhance community participation and involvement in disaster mitigation and response.

### ***5.2 Enhancing the country's responsiveness to public health emergencies including medical response to natural disasters:***

Support will be provided to strengthen the National Disaster Management System and to enhance capacity to maintain revolving stocks of essential emergency medicines and supplies, laboratory reagents and kits, personal protective equipments (PPE) and other medical equipment at all levels. Special attention will be given to developing the capacity of rapid response teams (RRTs) of the Directorate-General of Health Services (DGHS) by providing technical and logistical support for response and recovery in natural disasters and public health emergencies on the basis of priority need.

## **6. Strengthen the health system with a focus on health workforce development and equitable access to quality health care**

WHO support is directed at maximizing the core values of the Bangladesh health sector which are equity, gender equality and service responsiveness. In addition to the provision of technical assistance to selective and innovative pilot interventions, WHO's aim is to support comprehensive health systems development at central, district and sub-district levels. WHO will strengthen the evidence-base for policy and planning, regulatory and organizational development through research into demand and supply-side factors, workforce skill-mix, biomedical technology, pharmaceuticals, and patient safety issues including clinical waste management. WHO will together with partners support the Government of Bangladesh in the development of effective masterplans that will increase safety and utilization levels and enhance the impact of health services.

### **Strategic actions:**

#### ***6.1 Support health policy-making, planning, implementation and monitoring of health programmes at the national and local level to accelerate the achievement of MDGs and improve health equity:***

WHO will focus its support on reviewing and updating existing policies, planning, implementation and monitoring levels of health programmes to accelerate the achievement of MDGs and improve health equity; develop enhanced capacity in the MoHFW to exercise a stewardship role in the health sector, and bring about the gradual decentralization of responsibility and authority for improving performance, including the effective management of local level planning.

### ***6.2 Support the planning, development and utilization of an effective and responsive health workforce:***

WHO will support the formulation of policies and plans for scaling up the training of nurses, midwives, health technologists and community health workers. It will develop tools for the proper utilization of the workforce, enhancing the capacity of professional regulatory bodies and associations involved in improving the quality of education and practice in partnership with the national network of public health education institutes.

### ***6.3 Enhance national capacity to ensure access to quality essential medicines, vaccines and medical technologies:***

Support will be directed towards strengthening the capacity of the National Regulatory Authority in ensuring quality medicines and vaccines, monitoring the impact of the National Drug Policy 2005 on access to essential medicines, enhancing awareness on the impact of TRIPS on access to the same, and promoting the rational use of drugs. Quality, safety, efficacy and rational use of traditional medicines will also be promoted. Further support will be provided for effective implementation of a policy on blood transfusions and enhancing access to quality public health laboratory services.

### ***6.4 Strengthen country health information systems, knowledge management, health research and evidence for better decision-making:***

Support will be provided for strengthening the Health Management Information System and developing and implementing its improvement plan. Support will also be provided for capacity building for knowledge management and modernization of health libraries, generating sex-disaggregated data and gender analysis, conducting needs-based quality health research, developing and managing effective health research information systems, and generating and disseminating evidence for informed decision-making.

### ***6.5 Support alternative health-care financing for equitable access to health care:***

Support will be provided for the development of alternative health-care financing schemes, including social health insurance, and demand-side financing mechanisms with a view to provide policy options for effective equitable financing, while also assisting the MoHFW in its efforts to introduce and sustain health components in social safety net schemes. Support will also be provided for the generation of evidence for improvement in allocative efficiency and equity.

### ***6.6 Strengthen the organizational and managerial capacity of the national and local health systems for delivering accessible, quality and safe care to the communities, with special focus on vulnerable groups:***

WHO will provide support to enhance the service mix, service quality and service responsiveness of health service delivery institutions, particularly at the district and upazila levels. Support will also be provided to enhance capacity of village health

volunteers and community health workers. Special attention will be given to interventions that focus on eliminating demand-side barriers. Support will also be provided to address health-care associated risks through patient safety measures such as blood safety, hand hygiene, safe injection practices, hospital waste management and other areas of facility-based quality assurance.

## **7. Foster partnership and coordination for national health development**

WHO will provide, within the scope of this strategic agenda, technical assistance to the MoHFW and development partners in support of the implementation of the health sector programme. In addition WHO will continue its liaison function with respect to global funds, foundations and nongovernmental organizations. Technical assistance in support of urban primary health care will be strengthened.

### **Strategic actions:**

#### ***7.1 Assist the MoHFW to coordinate donor support for national health development***

WHO will support the MoHFW to work effectively with donor partners to ensure that national health development goals and strategies are achieved. Special attention will be given to the health sector programmes including HNPS.

#### ***7.2 Work closely with health development partners in Bangladesh to improve communications among partners and with the MoHFW***

WHO will facilitate a positive dialogue among health development partners to identify key implementation and policy issues, promoting the result of the dialogue with the MoHFW and other related ministries.

#### ***7.3 Provide technical support to health development partnerships including the global funds and regional initiatives:***

WHO will provide MoHFW and NGOs technical advice required to develop project proposals to access global funds and global partnerships. Such activities will be supported through resources from HQ, regional and country offices.

## **Linkages of strategic directions with WHO Core Functions and Strategic Objectives**

The six Core functions and 13 Strategic Objectives form the policy, planning and implementation framework for WHO's work at the country level. The CCS Strategic Agenda was developed within this framework. The following two tables (Table 4 and Table 5) illustrate how and where the CCS country-specific strategic directions are

**Table 4: Relationship between WHO Core Functions and CCS strategic directions**

WHO Core Functions	CCS strategic directions						
	1 Promote access of the vulnerable groups to health services ensuring continuum of care across the life course	2 Enhance capacity for the prevention and control of major communicable diseases and diseases targeted for elimination/eradication and strengthen integrated disease surveillance	3 Promote healthy lifestyle and cost-effective interventions for the prevention and control of major NCDs and injuries, and for mental health promotion	4 Enhance equitable and sustainable access to safe water and sanitation, reduce environmental and occupational health risks and promote food safety	5 Strengthen multi-sectoral approaches for emergency preparedness, response and recovery	6 Strengthen health systems focusing on health workforce development and equitable access to quality health care	7 Foster partnership and coordination for national health development
1. Providing leadership on matters critical to health and engaging in partnerships where joint action is needed	++	++	++	++	++	+	+++
2. Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge	+	++	+++	+	+	+++	++
3. Setting norms and standards, and promoting and monitoring their implementation	+++	+++	+++	+++	+++	+++	+
4. Articulating ethical and evidence-based policy options	+	+	++	+	+	+++	++
5. Providing technical support, catalyzing change, and building sustainable institutional capacity	++	+++	+++	++	+++	+++	++
6. Monitoring the health situation and assessing health trends	++	++	+	+	++	+++	+

+++ : Very strong linkage; ++ : Strong linkage; + : Some linkage.

**Table 5: Relationship between WHO Global Strategic Objectives and CCS strategic directions**

WHO Global Strategic Objectives	CCS strategic directions						
	1	2	3	4	5	6	7
1. To reduce the health, social and economic burden of communicable diseases		+++			+	+	+
2. To combat HIV/AIDS, tuberculosis and malaria		+++				+	+
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries			+++		+	++	++
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence; and improve sexual and reproductive health and promote active and healthy ageing for all individuals	+++				+	+	+
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact			+	+	+++	+	+
6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex		+	+++			+	+
7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches			+			+++	++
8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health				+++		+	+
9. To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development	++			+++	+	++	+
10. To improve health services through better governance, financing, staffing and management informed by reliable and accessible evidence and research.	+	+	+	+	+	+++	+
11. To ensure improved access, quality and use of medical products and technologies	++	+				+++	+
12. To provide leadership, strengthen governance and foster partnerships and collaboration with countries in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work							+++
13. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	+	+	+	+	+	+	++

+++ : Very strong linkage; ++ : Strong linkage; + : Some linkage.

interrelated with WHO's global core functions and the strategic objectives planning framework.

As a technical agency WHO will use its comparative advantage to provide the Government with technical assistance required to address priority health challenges. The WHO Country Office will strengthen its own capacity through regular budget and voluntary contributions to effectively manage and monitor the proposed Strategic Agenda. Additional capacity will be made available through increased strategic cooperation with other UN agencies, development partners and NGOs and through the promotion of partnerships with identified centres of excellence.



# 7

## Implementing the Strategic Agenda

The Strategic Agenda in Section Six has elucidated the future directions and priority areas for WHO's collaborative work in Bangladesh for the period 2008-13, which coincides with the timeframe of the WHO Medium-term Strategic Plan. WHO Bangladesh will have to consider these priorities to decide how it will organize its work for the next three bienniums. In addition, these priorities will be the basis for determining the number and type of human resources and the level and allocation of financial resources required as well as the nature of support from the Regional Office and Headquarters. Moreover, issues the Organization encountered in current cooperation in the country, stated in Section Four as well as anticipated challenges will need to be carefully addressed for the effective implementation of the Strategic Agenda.

### Technical support for implementing the Strategic Agenda

Currently, WHO Bangladesh's core technical staff consists of 11 international professional staff and 17 national professional staff. In addition, there are 142 SSA holders providing technical support for programme implementation. The majority of these SSA holders support the MoHFW in implementing key programmes such as EPI, TB and PHC including Demand Side Financing programmes. The Strategic Agenda implies, in line with WHO's Core Functions and mandate, that in the future more emphasis will be placed on provision of technical assistance than on implementation aspects. This will have an impact on the required numbers and competencies of WHO staff as well as required services of SSA holders.

In order to ensure full implementation of those strategic actions described under each strategic direction and to enhance WHO's contribution to national health development, the Organization must intensify its technical support to the government and its development partners. Estimated composition of staff at the Country Office required for successful implementation of WHO collaborative programmes under each strategic direction is provided in Table 6. Nevertheless, this estimate will need to be carefully reviewed to validate the required competencies and determine needs for re-profiling of competencies of existing professionals.

As per the contractual reform, all six existing short-term (temporary appointment) national professionals' positions will be converted to long-term professional posts. In addition, there will be new core national professional posts in areas that WHO devotes

**Table 6:** *Estimated changes in Country Office professional staff\* to fully implement the CCS*

CCS strategic directions (Described in brief key area)	Core international professionals		Core national professionals		Short-term International/national professionals (in person-years)	
	Current	Required	Current	Required	Current	Required
1. Health of vulnerable groups	1	3	–	3	1**	1.00
2. Communicable diseases	3	5	7	7	1	2.00
3. Noncommunicable diseases	–	–	1	6	4**	0.50
4. Environmental health	1	1	–	2	1**	0.40
5. Emergency preparedness	–	–	1	1	–	0.10
6. Health systems development	3	3	2	4	–	2.00
7. Partnership for health	–	1	–	–	–	–
<b>Total</b>	<b>8</b>	<b>12</b>	<b>11</b>	<b>23</b>	<b>1 + 6**</b>	<b>6</b>

\*Excluding WHO Representative and Administrative Officer; \*\*Short-term national professionals.

increased attention to such as nutrition and food safety. Hence, numbers of national professionals are expected to increase significantly from 11 to 23.

Furthermore, intensified support is required to assist the Government in tackling high maternal and newborn deaths and in improving health of the adolescents and the elderly. As such, the number of professional staff, both international and national, under Strategic Direction 1 will increase significantly from two to six with additional short-term international professional support in various assignments for one person-year. Hence, intensified action for resource mobilization is required to bring in additional resources for required staff support.

To complement existing core staff, international professionals are needed with competencies including gender and women's health, child and adolescent health, HIV/AIDS, and partnerships in health development. In addition to core staff, services of international experts will be mobilized for a short duration (temporary appointment) to carry out specific assignments as specialized capacity cannot be deployed cost-effectively in-country on a continuous basis. While additional services of national experts in various areas will still be continued through contracts. It is likely that there will be a substantial decrease in numbers of contracted national experts in the transitional period when WHO is phasing out its existing implementation role.

On the other hand, both WHO HQ and the Regional Office will continue providing technical support to the Country Office for implementing the Strategic Agenda in the area where expertise is not available in the country. As a matter of urgency, technical support is required from the Regional Office and HQ for the forthcoming competency review along with the implementation of the required capacity re-profiling plan. In

addition, technical support is also required to equip professional staff at WHO Bangladesh with knowledge and competencies to advocate and mainstream rights to health and gender equity and equality, which are the underlying principles of the strategic directions. Support is also needed in the area of knowledge management for generating, managing and utilizing information and knowledge for health development.

WHO Headquarters, in keeping with its mandate, will continue to provide the regional and country offices with global policy advice, directives on health development, and guidance on global norms and standards. In addition, it will advocate the cause of the country and take action for resource mobilization for the country at the global level. Similarly, the Regional Office will provide regional policy advice and guidance on regional norms and standards as well as resource mobilization for the Country Office.

Furthermore, with their broad-based networks the Regional Office and HQ are also required to facilitate inter-country collaboration and multi-country activities for transfer of technology, sharing of experience, expertise and resources between countries within and outside the Region. This will enable WHO Bangladesh to address common issues of interest as well as learn of best practices, effective strategies and approaches for health development in other countries. Moreover, regional assistance will usually be required to address emergency, humanitarian and other emerging issues such as avian influenza, in order to provide timely support in emergency situations.

In addition to technical staff support, there are several challenges that the Country Office needs to carefully address for effective implementation of the strategic agenda. The need to strike a balance between the technical functions of WHO and its role in supporting the MoHFW in implementing health programmes warrants special attention. Another challenge is related to expanding partnerships for health development. In addition to the existing collaboration the Country Office will reach out to other key government offices, professional organizations/bodies and civil societies that can contribute significantly to health development in Bangladesh. Moreover, the Country Office will strive for increased engagement of NGOs and the private sector in WHO collaborative work. Partnerships with other UN agencies and development partners will also be intensified.

The ability of the Country Office to be selective and to focus its efforts on priority health problems and actions in which WHO has a comparative advantage remains a challenge. There are competing demands which may result in diluted WHO support. The Country Office will intensify its action to advocate and obtain broad-based support for focusing WHO support in select priority areas.

## **Mobilizing financial resources to implement the Strategic Agenda**

The Strategic Agenda identifies a number of new technical areas for WHO Bangladesh that will determine resource allocation. Increased actions are proposed for the

protection of vulnerable groups, NCD control, health systems development and support for partnerships for health development. In addition, the Strategic Agenda identifies priority intervention areas such as kala-azar elimination, occupational and environmental health, and promotion of healthy lifestyles, for which the resource allocation in the past was insufficient. For most of these identified priority actions, WHO's assessed contributions (regular budget) is not sufficient and the Country Office will have to be proactive to mobilize these resources. It is also foreseen that past support for key areas in communicable disease control and immunization programmes will continue through the period of this CCS. Therefore, the current estimate of VC funding of US\$54 million for the biennium 2008-2009 is likely to increase during the coming years of the CCS. It is evident that if the expected volume of voluntary contributions materializes, it will be important that sufficient funds for professional and administrative staff support are allocated.

As the Country Office has to be proactive for mobilising resources to secure the funds required for effective implementation of the Strategic Agenda, support is especially required for capacity building of the office and staff for better mobilization of resources and meaningful partnerships.

Finally, in mobilizing additional resources, it is essential to ensure the adequate funding of management and the administration at the Country Office (refer to section below). As much as possible, these should be included in donor-supported projects with WHO.

## **Ensuring effective and efficient management and administration of the Country Office to implement the Strategic Agenda**

The WHO Bangladesh Office management and administrative capacity was designed to meet the administrative demand for WHO collaboration under the regular budget in the 1980s. Since then, WHO's work has substantially increased commensurate with the increase in both regular budget and voluntary contributions but with no increase in administrative support staff in the Country Office. As explained in Section Four, the voluntary contributions now account for the majority share of the WHO Country Budget. Thus it has imposed an additional strain on the administrative support services. Simultaneously internal delegation of authority from the Regional Office to Country Offices has increased the workload of the WHO Bangladesh Office.

The effective and efficient management of WHO collaboration depends largely on competency, commitment and productivity of staff. The introduction of the new GSM system in 2008 will streamline and speed-up management and administrative functions of the WHO Country Office. However, the challenge is to equip the staff with skills to effectively manage the GSM. It is, therefore, crucial that special attention

be given to staff development and learning. The Country Office will intensify its efforts to organize and provide learning opportunities, through both formal and non-formal programmes, for its professional and administrative support staff to improve performance and develop competencies.

The Country Office will, therefore, organize a review of current competencies and identify gaps and required capacity to provide adequate administrative and management support, in conjunction with the review of competencies for the professionals, to ensure the effective implementation of the Strategic Agenda. It is expected that the Regional Office and HQ will assist with this review.

The location and infrastructure of the current WHO Bangladesh Office is inadequate with respect to space, security and modern management support systems. The introduction of the GSM system requires uninterrupted access to high-speed Internet; the increasing use of video conferencing for consultation and information sharing requires reliable and accessible communication systems; and increasing use of “just-in-time” management requires ready access to the Global Private Network connection or international facsimile networks. It is critical that effective communication systems are put in place between the Country Office and Project Offices and with the Regional Office and Headquarters. Hence, the Country Office will require support for improving information and communication systems.

In addition, a number of security requirements for the Country Office to achieve minimum office security standard compliance need to be addressed. The Country Office is taking action to remedy the situation and to find a suitable premises for its location. Such a venue would be complementary to the existing facility rather than in lieu of current arrangements that have professional staff based within government offices or in separate project offices in proximity to them.

## Results-based management

The Strategic Agenda will be implemented through three consecutive biannual programme budgets and workplans. These workplans are results-based and complete with a monitoring framework of intervention-specific indicators. WHO’s regular six-monthly monitoring of workplan implementation progress is complemented by periodic in-depth evaluations of select programmes to determine their outcomes and impact on national health development.

Collaborative efforts in support of the national health sector programme implementation and supervision will be further strengthened. The function of the Government and the WHO Coordination Committee and joint quarterly monitoring meetings by WHO, the MoHFW and the Directorate-General of Health Services will be strengthened. This will enable the Country Office to be able to identify issues

hindering programme implementation and the remedial action to be taken to achieve expected results.

Although the overall principles of WHO, guided by the Eleventh General Programme of Work and the Medium-term Strategic Plan will remain valid throughout the period of this CCS, the priorities in the strategy, may need to be reviewed and modified according to the evolving health sector environment and the possibility of changed priorities.

The Country Office will ensure timely and effective implementation of the Strategic Agenda through a number of measures. As mentioned in earlier sections, cooperation with the MOHFW, MoLGRDC and other relevant ministries, stakeholders such as professional associations, NGOs and the private sector will be strengthened. Local and regional partnerships and twinning arrangements will be promoted for appropriate and sustained capacity development. Finally, an effective knowledge management system for generating, managing, sharing and utilizing results and evidences for informed decisions and evidence-based practice will be institutionalized.

WHO will be proactive in identifying new opportunities for synergy and harmonization of its work with that of other UN agencies and development partners. And above all, WHO Bangladesh commits to provide high-quality technical support to the government to attain “Health for All” in Bangladesh.

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## Annex 1

### Process of developing WHO CCS 2008-2013

- Sensitization meeting of WHO professionals.
- Formation of a country team comprising of selected WHO professionals and MoHFW officials for formulation of WHO CCS.
- Review of the strategic documents for formulation of the CCS.
- Evaluation of select WHO Collaborative Programmes of the 2002-2003 and 2004 2005 bienniums.
- Stakeholders' consultation to obtain their views on WHO work in Bangladesh and recommendations for enhancing WHO collaboration.
- Presenting outcomes of an evaluation of WHO Collaborative Programmes and Stakeholders' Consultation in the GoB – WHO Coordination Committee Meeting for comments.
- Preparation of the draft CCS 2008-2013 by the CCS country team.
- In-house meetings of WHO professionals to review the draft document
- In-country mission established with participation of SEARO and HQ staff and the CCS country team to further develop the draft CCS document.
- Stakeholders' Consultation on CCS 2008-2013 to critically review the preliminary draft CCS document and recommend improvement.
- In-house meetings of WHO professionals to prepare the final draft CCS document.
- Forwarding the final draft CCS document to major stakeholders and WHO staff at SEARO and HQ for comments.
- Finalizing the CCS document taking into account comments and suggestions from stakeholders and WHO officials.



## Annex 2

### Country health profile

	Indicator	Value	Source and year	
<b>A. Geography</b>				
1	Location	Between 20°34 and 26°38 north latitude and 80°01 and 92°41 east longitude.	Statistical Pocket Book Bangladesh 2006, BBS	
2	Area (sq.km.)	147 570 sq.km. (56 977 sq. miles)		
3	Rainfall (annual variation in cm.)	119-147		
<b>B. Administration</b>				
4	Divisions	6	Statistical Pocket Book Bangladesh 2006, BBS	
5	Districts	64		
6	Upazila/thana	507		
7	Union	4 484		
8	Mouza	59 990		
9	Villages (approximately)	87 310		
10	Households (in million)	25.49		
11	Average size of households (members)	4.8	SVRS, 2004, BBS	
<b>C. Demography</b>				
12	Population (2001 census)	Total	124.355 million	Statistical Pocket Book Bangladesh 2006, BBS
		Male	64.091 million	
		Female	60.264 million	
13	Population (2005 estimated)	Total	138.60 million	SVRS, 2004, BBS
		Male	71.00 million	
		Female	67.60 million	
14	Sex ratio (M:F)	105.2 : 100	SVRS, 2004, BBS	
15	Under-5 population (in %)	11.7	SVRS, 2004, BBS	
16	Under-15 population (in %)	37.8	SVRS, 2004, BBS	
17	Female population (15-49 yrs in %)	51.7	SVRS, 2004, BBS	
18	Population (60 yrs + in %)	6.2	SVRS, 2004, BBS	
19	Population density per sq.km.	926	SVRS, 2004, BBS	
20	Crude birth rate (per 1000 pop.)	20.8	SVRS, 2004, BBS	

	Indicator	Value	Source and year
21	Crude death rate (per 1000 pop.)	5.8	SVRS, 2004, BBS
22	Population growth rate (%)	1.50	SVRS, 2004, BBS
23	Total fertility rate (birth per women)	2.51	SVRS, 2004, BBS
24	Gross reproduction rate	1.21	SVRS, 2004, BBS
25	Net reproduction rate	1.18	SVRS, 2004, BBS
26	Urban population (in million)	32.4	SVRS, 2004, BBS
27	Life expectancy at birth	Total	65.1 years
		Male	64.4 years
		Female	65.7 years
28	Mean age at first marriage	Total	21.95 years
		Male	25.31 years
		Female	19.03 years
<b>D. Health status</b>			
29	Infant mortality rate (per 1000 live birth)	52	SVRS, 2004, BBS
		65	BDHS, 2004
30	Maternal mortality ratio (per 1000 live births)	3.65	SVRS, 2004, BBS
31	Neonatal mortality rate (per 1000 live births)	36	SVRS, 2004, BBS
		41	BDHS, 2004
32	Under-5 mortality rate (per 1,000 live births)	74	SVRS, 2004, BBS
		88	BDHS, 2004
33	Per cent of population using safe drinking water	Total	97.4
		Rural	96.9
		Urban	99.9
34	Per cent of population using water seal latrines	46.2	SVRS, 2004, BBS
35	Per cent of urban population with access to improved sanitation	78.6	SVRS, 2004, BBS
36	Per cent of prevalence of night blindness among pre-school children	0.04	IPHN, DGHS, 2006
37	Per cent of pregnant women with anaemia	46	IPHN, DGHS, 2006
38	Malaria incidence rate per 1000 population	0.34	DGHS, 2005
39	TB incidence rate per 100 000 population	99	DGHS, 2005
40	Per cent of smear-positive pulmonary TB cases detected under DOTS	62%	TB Annual Report 2005, NTP, DGHS.
41	Per cent of smear-positive pulmonary TB cases cured under DOTS	92%	
42	Per cent of <5 children with diarrhoea treated with ORT (ORS or home-made solution)	74.6	BDHS, 2004
43	Per cent of <5 children with symptoms of ARI seeking care from trained provider	20.3	BDHS, 2004

	Indicator	Value	Source and year
<b>E. Health-related macro-economics</b>			
44	Per capita GDP (in US\$)	445	Bangladesh Economic Review 2005, Ministry of Finance
45	Per capita GNI (in US\$)	470	
46	Total health expenditure as % of GDP	3.2	NHA, 2003
47	Per capita total health expenditure (in US\$)	12.16	NHA, 2003
48	Per capita public health expenditure in US\$	4	NHA, 2003
<b>F. Education</b>			
49	Adult literacy rate (Pop. 15+), 2004	51.6	SVRS, 2004, BBS
<b>G. Health services provision</b>			
50	No. of hospital beds	51 684	MIS, 2005
51	No. of beds in public sector	35 579	MIS, 2005
52	No. of beds in health sector	32 941	MIS, 2005
53	No. of beds in private sector	16 105	MIS, 2005
54	No. of hospitals in public sector	671	MIS, 2005
55	No. of hospitals in health sector	537	MIS, 2005
56	No. of clinics/hospitals in private sector	1 005	MIS, 2005
57	No. of registered physicians (as of June 2007)	45 723	BMDC, 2007
58	No. of registered dental surgeon (as of June 2007)	2 945	BMDC, 2007
59	No. of government medical colleges	14	DGHS, 2005
60	No. of private medical & dental colleges	34	DGHS, 2005
61	No. of private institute of health technology (IHT)	18	DGHS, 2005
62	No. of health personnel under DGHS	103 210	DGHS, 2005
63	No. of physicians under BCS health cadre	7 833	DGHS, 2005
64	No. of doctors under health services	10 338	DGHS, 2005
65	No. of registered nurses (as on June'2007)	21 715	BNC, 2007
66	No. of nurses in public sector	14 971	DGHS, 2005
67	No. registered midwives	19 354	BNC, 2005
68	No. of dentists under BCS health cadre	536	DGHS, 2005
69	No. of medical assistants under dghs	4 699	DGHS, 2005
70	No. medical technologist (Lab)	1 311	DGHS, 2005
71	No. of medical technologist (radiography)	674	DGHS, 2005
72	No. of technicians	1 849	DGHS, 2005
73	No. of sanitary inspectors	491	DGHS, 2005
74	No. of health inspectors	1 400	DGHS, 2005
75	No. of assistant health inspectors	4 200	DGHS, 2005
76	No. of health assistants	21 000	DGHS, 2005

	Indicator	Value	Source and Year
<b>G. Health services</b>			
77	DPT3	84%	Coverage Evaluation Survey 2006, EPI, DGHS
	BCG	98%	
	Measles	78%	
	TT2	94%	
	TT3	19%	
	VIT-A	93%	
	OPV3	92%	
	Fully Immunized	71%	
78	ARI: U5 seeking care from trained providers	20.3%	BDHS, 2004
79	Diarrhoea: U5 treated with ORT	74.6%	BDHS, 2004
80	Antenatal care coverage (at least one visit)	48.7%	BDHS, 2004
81	Postnatal care of mother from trained provider	17.8%	BDHS, 2004
82	Postnatal care for infant from trained provider	17.5%	BDHS, 2004
83	Population per physician	3 012	DGHS, 2005
84	Physicians per 10 000 population	3.3	DGHS, 2005
85	Population per bed	2 665	DGHS, 2005
86	Hospital beds per 10 000 population	3.75	DGHS, 2005
87	Physician to nurse ratio	2:1	DGHS, 2005
88	Population per nurse	6 342	DGHS, 2005
<b>H. Place and assistance in delivery</b>			
89	At home	87.4	SVRS, 2002
90	Hospital/clinics	11.2	SVRS, 2002
91	Others	1.4	SVRS, 2002
92	Per cent of delivery attended by trained personnel	13.4	BDHS, 2004
93	Per cent of delivery attended by untrained birth attendants	64	
94	Per cent delivery attended by relatives/friends/others	8.8	

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## Annex 3

# Key WHO contributions during 2004-2007

Examples of key WHO contributions classified by cluster during the first CCS period of 2004-2007 are provided below:

### Communicable Disease and Surveillance

WHO supported the strengthening of malaria control programme through training of doctors and nurses for improved management of malaria. In lymphatic filariasis, WHO supported the scaling up of Mass Drug Administration and promotion of community-based morbidity control and prevention of disability. WHO is also working for the elimination of visceral leishmaniasis (kala-azar) and supported the formulation of a National Strategic Plan in line with the Regional Strategic Framework. WHO supported the study of Miltefosine (a new oral drug treatment) to determine its efficacy and effectiveness in the treatment of kala-azar.

For effective control of communicable diseases, WHO supported the establishment of a National Disease Surveillance Centre and Rapid Response Teams for outbreak investigation have been formed and trained at different tiers of Government, right down to the lowest rural level. Strategies and operational guidelines for integrated disease surveillance were developed and implemented nationwide for improved surveillance and reporting.

WHO's technical support to the TB control programme, together with concerted efforts by other partners, has resulted in 70% case detection and an over 85% treatment success rate for DOTS.

Support was provided for conducting a needs assessment of supply and equipment for 97 blood centres and a reference laboratory. A review on the capacity of regulated and unregulated blood banks to provide safe blood was completed, and a dissemination workshop organized for policy-makers to bolster the Safe Blood Transfusion Programme.

### Emergency and Humanitarian Action

During the first Country Cooperation Strategy the WHO Emergency Humanitarian Action programme provided training and public education on health emergency management to those working on the "frontlines" of the health sector. This has improved the coping mechanisms of the local community in the mitigation and reduction of adverse health effects following emergencies and disasters. A National Policy on Health Emergency Management and standard operating procedures for health emergency management were prepared in collaboration with the health sector.

The National Avian Influenza and Pandemic Influenza Preparedness and Response Plan was prepared by the multisectoral planning team with joint technical support from WHO and Food and Agriculture Organization of the United Nations. Currently WHO is providing technical and logistical support for implementing the plan by strengthening the surveillance system, training, laboratory infrastructure and capacity building.

## Family and Community Health

Through its field-based Surveillance Medical Officer network, WHO has strengthened immunization system capacity by supporting the implementation of vaccine-preventable disease control activities, including eight rounds of the National Immunization Day in response to polio importation in 2006, and conducting the world's largest measles campaign that targeted 35 million children.

WHO contributed to the increased access of rural women to basic midwifery care through the designing and piloting of the community-based skilled birth attendants (SBA) training programme. This programme is designed to equip Family Welfare Assistants and Female Health Assistants with skills to provide antenatal care, conduct normal deliveries, ensure postnatal and newborn care, and early detection and referral of complications. Support was also given for the development of an accreditation system to regulate the quality of the training and a supervisory mechanism to enhance the contribution of community-based SBAs.

WHO is providing technical assistance for the development of a major Demand-Side Financing initiative, which is a maternal health voucher scheme. The goal is to increase utilisation of quality maternal health services through creating equity of access irrespective of the patient's ability to pay for the same. Under this scheme an estimated 100 000 poor pregnant women will receive free maternal health services annually. Private, public and NGO providers can participate in the scheme after a normative quality certification process. The voucher scheme covers antenatal and postnatal care, safe delivery and treatment of pregnancy complications. The scheme aims to avert 50% of Maternal mortality and 33% of Infant mortality each year.

## Health Systems Development

WHO has provided support to the Government to develop the Strategic Investment Plan (SIP) 2003-2010 for modernization of the health sector, and for preparation of the Health Nutrition and Population Sector Programme (HNPS) 2003-2010, which has been approved and is in the process of implementation. Monitoring of activities related to achieve MDG and PRSP targets have also been supported by WHO.

In line with the Regional Public Health Initiative, WHO supported NIPSOM to conduct an assessment of the public health workforce and public health functions,

organize short training courses for service-providers, conduct studies on prevailing public health problems and develop the Bangladesh Public Health Education Institutes Network. WHO is also supporting a faculty exchange programme between NIPSOM and the Faculty of Public Health, Mahidol University, Thailand, to improve local capacity.

WHO has also provided support to improve the quality of nursing education by upgrading the curriculum and strengthening the capacity of teachers to implement the new policy of admitting high school graduates to nursing schools. WHO has also supported the development of model wards for provision of exemplary professional nursing care and strengthened nursing regulations to ensure quality education. Assistance was provided for improving the quality of medical and paramedical education by piloting quality assurance guidelines and tools, developing training modules on effective teaching and assessment methods, and for the integration of teaching health ethics in medical education.

### **Noncommunicable Diseases and Mental Health**

WHO supported the development of the National Strategic Plan of Action for Surveillance and Prevention of NCDs, and advocated the promotion of healthy lifestyles as central to NCD prevention. A principal component of WHO support has been tobacco control with support provided for policy development, plans of action and legislation. A WHO study on the economic impact of tobacco use in Bangladesh was instrumental in the enactment of the Tobacco Control Act 2005 by Parliament. WHO mobilized resources from the “Bloomberg Global Initiative to Reduce Tobacco Use” to create an intensive tobacco control movement in the country. A landmark achievement towards this end has been the establishment of the National Tobacco Control Cell.

### **Sustainable Development and Healthy Environments**

WHO has developed capacity in water quality management through the modernization of four regional laboratories, and by conducting several rounds of water quality surveillance in around 200 municipalities. National water quality seminars have been organised since 2004 on an almost annual basis to promote the third edition of the WHO Drinking Water Quality Guidelines and introduce the concept of water safety plans. Support was provided for the preparation of the national “Water Quality Monitoring and Surveillance Protocol for Rural Water Supplies”, and also for the development of a National Arsenic Mitigation Policy.

## Annex 4

# Strategic Objectives under Medium-term Strategic Plan 2008-2013

Strategic Objectives for the Medium-term Strategic Plan 2008-2013 are as follows:

- (1) To reduce the health, social and economic burden of communicable diseases.
- (2) To combat HIV/AIDS, tuberculosis and malaria.
- (3) Prevent and reduce disease, disability and premature deaths from chronic noncommunicable conditions, mental disorders, violence and injuries.
- (4) To reduce morbidity and mortality and improve health during the key stages of life, including pregnancy, childbirth, the neonatal period, and childhood and adolescence; and improve sexual and reproductive health and promote active and healthy ageing for all individuals.
- (5) To reduce the health consequence of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.
- (6) To promote health and development, prevent and reduce risk factors for health conditions associated with the use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex.
- (7) To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive and human right-based approaches.
- (8) To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root cause of environmental threats to health.
- (9) To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development.
- (10) To improve health services through better governance, financing, staffing and management informed by reliable and accessible evidence and research.
- (11) To ensure improved access, quality and use of medical products and technologies.
- (12) To provide leadership; strengthen governance and foster partnership and collaboration with countries, the United Nations system and other stakeholders in order to fulfil the mandate of WHO in advancing global health agenda as set out in the Eleventh General Programme of Work.
- (13) To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively.





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