

WHO

Country Cooperation Strategy

Bangladesh 2014–2017



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Preface



It is our pleasure to endorse the new World Health Organization (WHO) Country Cooperation Strategy (CCS) 2014–2017, which was developed in close consultation with the Bangladesh Government and other stakeholders. Since 1972, WHO has been providing technical assistance to Bangladesh to strengthen its health system and ensure delivery of equitable and quality health services for all. Over the last two decades, Bangladesh has made remarkable progress in improving the health status of the population. Overall life expectancy has increased while the infant/child mortality rates, maternal mortality ratio, and fertility rates have decreased. Support provided by WHO has served a catalytic role in attaining these mammoth gains.

This comprehensive document should be an effective guide for taking on the challenge of further improving health-care delivery and making universal health coverage a reality in Bangladesh.

To sustain the achievements and address the myriad of health challenges – such as the prevalence of emerging and re-emerging communicable diseases, rising trend of noncommunicable diseases, and the further reduction in maternal and neonatal mortality and morbidity – the Bangladesh Ministry of Health and Family Welfare (MoHFW) has gone through a reform process using a sector-wide approach. Many new structural changes and innovative interventions have been introduced. The Health, Population and Nutrition Sector Development Programme (HPNSDP) 2011–2016

of the Government of Bangladesh has been developed with the aim to make health care accessible to all and improve health services at the grass-roots level, through the community clinics and rural health centres.

WHO has been working very closely with the Government to help achieve its health objectives and targets. The WHO CCS for 2014–2017 is well aligned and harmonized with the targets of the current sector development programme. It takes into consideration the new direction of WHO provided through its reform agenda, and WHO's comparative advantage in getting effectively and efficiently engaged with the Government, national organizations, partners, and United Nations agencies to address critical public health challenges in Bangladesh. We firmly believe that during the period covered by the new CCS, the level of cooperation, trust and partnership between WHO and the Government of Bangladesh will be further strengthened.



M.M. Neazuddin

Secretary
Ministry of Health and Family Welfare
Government of the People's
Republic of Bangladesh



Dr Thushara E.I. Fernando

WHO Representative to Bangladesh

Foreword



The World Health Organization has been working very closely with Member States from the South-East Asia Region to improve the health status of their populations. The Country Cooperation Strategy (CCS) is the major medium-term instrument that guides this collaboration towards achieving the priorities of the Organization and supporting the national health development agenda.

WHO has been assisting the Government of Bangladesh and its partners since 1972. During the previous CCS periods, Bangladesh has made remarkable achievements in improving the health status of people, with increased life expectancy, as well as reduced rates in mortality, morbidity, and fertility. Allow me to congratulate Bangladesh for achieving or being on track in achieving most of the health-related Millennium Development Goals.

The CCS for 2014–2017 was built on the country's achievements and capitalized on the lessons learned from implementing previous CCSs. It benefited from an internal assessment and dialogues with colleagues from the WHO Country Office, Regional Office, and Headquarters. I commend the CCS Team for steering a highly consultative process in developing the CCS. I appreciate the participation of the Government, UN agencies, donors, academia, and nongovernmental organizations.

I am confident that the partnerships responsible for the fruitful formulation of this CCS will even grow stronger during the implementation of the strategic priorities. I firmly believe the CCS for 2014–2017 will help the Government of Bangladesh achieve the vision of making health care accessible to all and improve health services at the grass-roots level. It has the full support of the WHO Regional Office for South-East Asia.

A handwritten signature in black ink, reading 'Poonam Khetrpal Singh'.

Dr Poonam Khetrpal Singh
Regional Director
WHO South-East Asia Region

Acronyms

AIDS	acquired immune deficiency syndrome
ANC	antenatal care
BCG	Bacillus Calmette-Guérin
BDHS	Bangladesh Demographic and Health Survey
BMMS	Bangladesh Maternal Mortality Survey
CCS	Country Cooperation Strategy
COIA	Commission on Information and Accountability
CSBA	community-based skilled birth attendant
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
EPI	Expanded Programme on Immunization
FCTC	Framework Convention on Tobacco Control
GDP	gross domestic product
GEHR	gender, equity and human rights
GNSP	Gender, NGO and Stakeholder Participation
GOB	Government of Bangladesh
GPW	General Programme of Work
HIS	health information system
HIV	human immunodeficiency virus

HPN	health, population and nutrition
HPNSDP	Health, Population and Nutrition Sector Development Programme
IHD	ischemic heart disease
JMP	Joint Monitoring Programme
LCC	Local Consultative Group
MDA	mass drug administration
MDC	Millennium Development Goals
MoHFW	Ministry of Health and Family Welfare
MMR	maternal mortality ratio
NCD	noncommunicable disease
NGO	nongovernmental organization
NLEP	National Leprosy Elimination Programme
ORS	oral rehydration salts
PNC	postnatal care
STD	sexually transmitted disease
TB	tuberculosis
UNDAF	United Nations Development Assistance Framework
UNICEF	United Nations Children's Fund
VPD	vaccine-preventable disease
WCO	WHO Country Office
WHO	World Health Organization
WASH	water, sanitation and hygiene
WPV	wild poliovirus

Executive summary

The Country Cooperation Strategy (CCS) provides the strategic priorities and specific programmatic approaches for the collaborative work of the World Health Organization (WHO) with countries. To develop the Bangladesh CCS 2014–2017, a comprehensive process was undertaken that included a series of systematic information collection activities. These comprised in-depth interviews and group discussions, as well as consultative meetings and workshops with the government, United Nations and bilateral/multilateral agencies, academic institutions, professional bodies, civil society organizations and nongovernmental organizations (NGOs). The consultation process underlined the contributions of WHO and lessons learnt in strengthening the health system and improving people's health. Key elements considered in defining the strategic priorities were the nation's development and health priorities vis-à-vis the WHO leadership priorities; achievements, challenges, opportunities of the health system; experience gained from previous CCSs; and the comparative advantage of WHO in the context of its ongoing reform.

Bangladesh has made remarkable progress in recent decades to improve the health status of its people. The infant and under-five mortality rates and maternal mortality ratio have decreased, the population growth rate has declined, and life expectancy at birth has increased. In addition, the country is on track to achieve the majority of the Millennium Development Goals (MDGs). To sustain these achievements and address challenges like high levels of neonatal mortality, emerging and re-emerging communicable diseases and a rising trend in noncommunicable diseases, the Government is guided by the Health, Population and Nutrition Sector Development Programme (HPNSDP) 2011–2016. The HPNSDP has two major components: providing equitable quality health services and strengthening the health system.

The Strategic Agenda of the CCS 2014–2017 is very much aligned with the HPNSDP and the Bangladesh United Nations Development Assistance Framework (UNDAF) Action Plan 2012–2016. The five strategic priorities of the current CCS are described in the following boxes.



Strategic priority 1: Reduce the burden of **communicable diseases**, including vaccine-preventable diseases, tuberculosis, malaria, HIV/AIDS, and neglected tropical diseases.

Selected major approaches: sustain high immunization coverage and introduce new vaccines; achieve “universal access” to quality diagnosis and treatment for all tuberculosis patients; strengthen diagnosis and treatment of malaria, addressing cross-border transmission; build capacity of the National AIDS/STD (sexually transmitted disease) Programme for effective treatment, care and support to HIV-positive people; strengthen diagnosis and treatment of kala-azar, filariasis, leprosy and dengue.



Strategic priority 2: Reduce the burden of **noncommunicable diseases** through health promotion, risk reduction and cost-effective management

Selected major approaches: support effective implementation of the Noncommunicable Disease (NCD) Prevention Strategic Plan 2011–2015, and pilot and scale-up the Package for Essential NCD Interventions in the upazila health system; support the generation of evidence for policy and programmes on mental health, including early detection and prevention of mental/neurological disorders; ensure effective planning on visual and hearing disabilities, and implement comprehensive community-based rehabilitation programmes in light of the National Disability Act and global guidelines; promote the United Nations Decade of Action for Road Safety.



Strategic priority 3: Reduce health, nutrition, environmental and occupational **risk factors** throughout the **life course**

Selected major approaches: support the development, adaptation and use of national policies, guidelines, standards, and tools to enhance health services for mothers and children from birth to adolescence; build the capacity of health providers to ensure quality services; contribute to the development of a functioning result-based programme, monitoring and evaluation system on reproductive, maternal and child health at the national level; support the national strategy to mainstream nutrition through the development of policy, protocols and guidelines involving different sectors; build capacity of the local government on safe water by integrating the Water and Sanitation Programme into water supply management and building climate-resilient water, sanitation and hygiene (WASH).



Strategic priority 4: Promote universal health coverage with **strengthened health systems** based on primary health care

Selected major approaches: support the formulation of legal and regulatory frameworks to move towards universal health coverage, including the Health Care Financing Strategy; strengthen the national regulatory authority to ensure quality medical products; support the formulation of the National eHealth Strategy, developing health data standards and norms for an integrated health information system; strengthen the civil registration and vital statistics system, and encourage the use of International Classification of Diseases version 10 in morbidity and mortality reporting; support the development of a national human resources for health plan; strengthen capacity for evidence-based nursing and midwifery services and practices, and build the capacity of primary health-care providers for quality service delivery; provide policy and planning support at district and upazila levels; contribute to reducing health inequality through monitoring and mainstreaming gender, equity and human rights in national health strategies, programmes and activities.



Strategic priority 5: Reduce mortality, morbidity and societal disruption resulting from **epidemics, natural disasters, conflicts, environmental, and food-related emergencies**, through prevention, preparedness, response and recovery activities that build resilience and use a multisectoral approach

Selected major approaches: support the national plan of action for the International Health Regulations 2005; work to improve laboratory facilities for the diagnosis of emerging and re-emerging infectious diseases; support the effective implementation of the Emergency Response Framework and form a core group of emergency responders at national and sub-national levels; assist in strengthening routine immunization, withdrawing type 2 component of oral polio vaccine, introducing inactivated polio vaccine and sustaining polio-free status.

Chapter-1

Introduction

The World Health Organization (WHO) has been working closely with the Government of Bangladesh (GOB) to strengthen the health sector and improve the health status of the population since 1972. The support provided by WHO includes the development of technical guidelines and protocols, norms and standards, the strengthening of institutions and human resources, the generation of evidence for informed decision-making, the improvement of service delivery and overall strengthening of the health system.

The Country Cooperation Strategy (CCS) is the basis for WHO's collaborative work. It provides strategic directions and specific programmatic approaches. The CCS is WHO's major instrument over the medium-term period to guide the provision of support to national health development initiatives according to the challenges, strengths, strategic objectives and priorities of the country.

The formulation of the CCS for 2014-2017 was guided by the following principles:

- ownership of the development process by the country;
- alignment with national priorities, systems and procedures;
- harmonization with the work of sister United Nations agencies and other partners in the country for better aid effectiveness; and
- cooperation as a two-way process that fosters Member States' contributions to the global health agenda.

In this CCS 2014–2017 the strategic directions, priority areas and strategic approaches (Chapter 5) were designed for WHO's engagement to complement the efforts in Bangladesh aimed at improving the nation's health development. They are aligned with the Health, Population and Nutrition Sector Development Programme (HPNSDP 2011–2016) of the Ministry of Health and Family Welfare (MoHFW). They are also very much linked with the current Bangladesh United Nations Development Assistance Framework Action Plan 2012–2016. In addition, they complement the following six WHO leadership priorities as expressed in its Twelfth General Programme of Work 2014–2019 (*Annex 1*):

- advancing universal health coverage (*Annex 2*);
- addressing unfinished and future challenges to achieve health-related Millennium Development Goals;
- addressing the challenge of noncommunicable diseases, mental health, violence and injuries, and disabilities;
- implementing the provisions of the International Health Regulations;
- increasing access to essential, high-quality and affordable medical products; and
- addressing the social, economic and environmental determinants of health.

In order to respond to the needs of Member States for effective and better coordination of global health issues, WHO is undergoing a reform process. The reform focuses specifically on the main priorities in global health, the ability to address emerging needs, adapt to new ways of working, and use resources efficiently and effectively. The reform process includes a programmatic review on how best to improve people's health, governance reform to increase coherence in global health and managerial reform in pursuit of organizational excellence.

The CCS 2014–2017 was developed through documentary reviews, situation analyses and extensive consultations (*Annex 3*). The valuable recommendations from one-on-one consultations with national programme officers and stakeholder workshops, as well as the lessons learnt and experience gained from the previous CCSs, provided solid groundwork and input to enable WHO to further improve this CCS document.

Chapter-2

Country health and development challenges

2.1 Demographic, political, macroeconomic and social context

2.1.1 Demographic profile

Bangladesh, with a population of 1.55 million in 2012, is one of the most densely populated countries in the world, having a population density of 1050 per km² (Global Health Observatory 2012). The male/female ratio is 104.9/100.0 and the annual population growth rate is 1.37% (Sample Vital Registration System 2011).

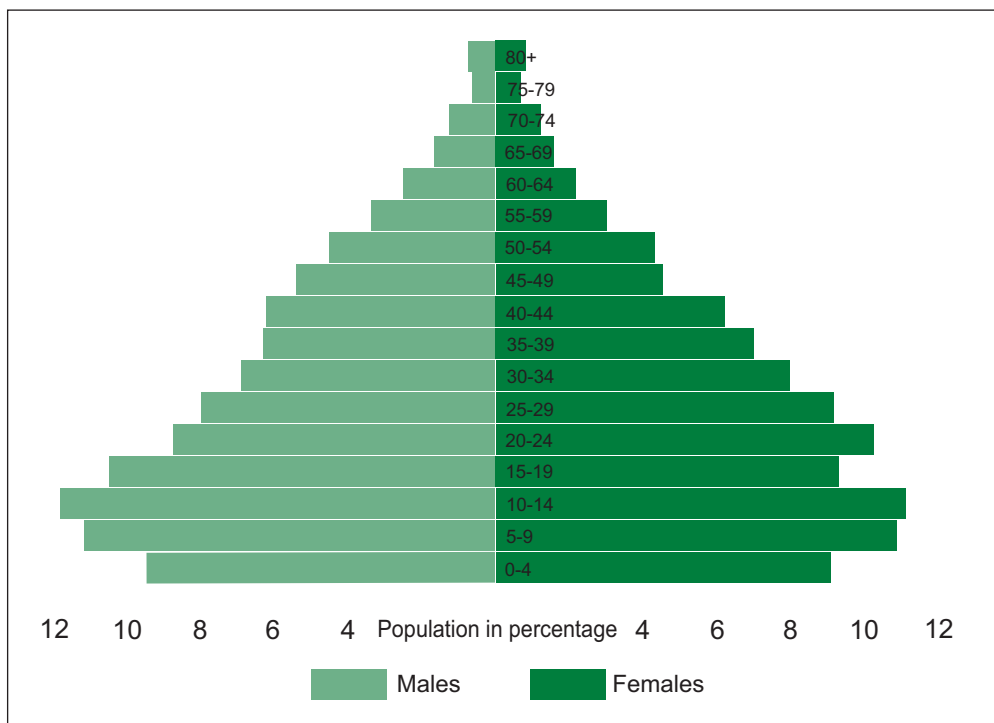
The population of Bangladesh is very young as depicted by its wide-based population pyramid (Figure 1). A large cohort of the young population will enter reproductive age in the coming decades, a phenomenon partly explaining why the adolescent (15–19) years fertility rate in Bangladesh of 118 per 1000 women (Bangladesh Demographic and Health Survey (BDHS) 2011) is not expected to decrease significantly for decades.

As in other countries, the population is ageing over time due to decreasing fertility rates (6.3 births per woman in 1975 to 2.3 in 2011) and increasing life expectancy at birth of 69 years in 2011 (BDHS 2011).

2.1.2 Political and governance structure

Bangladesh is a parliamentary representative democratic republic, where the Prime Minister is the head of government. Executive power is exercised by the government, while legislative power is vested in both the government and parliament. The Constitution of Bangladesh was written in 1972. There are over 60 ministries and divisions of the federal government, including the MoHFW. In addition, the Ministry of Local Government, Rural Development and Cooperatives (MoLGRDC) is responsible for primary health care activities in urban areas. Some health programmes are also operated by the district councils, which are under the Ministry of Chittagong Hill Tracts Affairs.

Figure 1: Bangladesh population pyramid, 2011



Source: BDHS 2011

2.1.3 Macroeconomic situation

In fiscal year (FY) 2008–2009, the Bangladesh economy slightly slowed down in the backdrop of negative growth in world trade at the beginning of the global financial crisis. Between FY 2010 and 2011, gross domestic product (GDP) grew by 6.71%, the highest growth rate achieved during recent times (BER 2012). In FY 2011–2012, the GDP growth rate was 6.23%. In 2013, GDP and gross national income per capita stood at US\$ 923 and US\$ 838 respectively, compared to US\$ 840 and US\$ 766 in the previous year (BER 2013).

2.1.4 Other major determinants of health

Unsafe food remains a major threat to public health. Each year, citizens suffer from the acute effects of food contaminated by microbial pathogens, chemical substances and toxins. There is a need to minimize the consumer's exposure to unhygienic, contaminated and adulterated food and drinks through strict laws to control marketing of such products.

Improving women's access to quality health services and addressing the underlying sociocultural factors that prevent it are major challenges. One such factor is **violence against women**. This is a widespread social problem that causes mental stress, physical suffering and even death, and is believed to be grossly underreported. One study (UNFPA 2011) reveals that in Bangladesh about 52% of men in both urban and rural sites reported ever physically assaulting female intimate partners.

According to the Joint Monitoring Programme (JMP) of WHO and the United Nations Children's Fund (UNICEF) (JMP 2013 update), 83% of the population have access to **safe water for drinking**. While the population at risk of consuming arsenic-contaminated drinking water is estimated at 20 million, the number of exposed persons may well be lower because of ongoing awareness-raising activities. The challenge is to ensure access to safe water for 100% of the population.

Basic **sanitation coverage** is 55% against the target of 70% by 2015 (JMP 2013 update). Although more than 90 million people in Bangladesh shifted to fixed-point defecation in the last five years, diarrhoeal diseases remain a leading cause of child and infant morbidity. A research study shows that only 1% of the population wash their hands with soap and water before having a meal, 0.7% before feeding children, and 30% after defecation (Johnston 2009). Behaviour change through hygiene promotion is a priority to achieve the health benefit of sanitation coverage.

The issue of total sanitation coverage also demands a concept that goes beyond excreta disposal to include the environmental sanitation issues associated with the safe management of solid waste, household wastewater and storm water.

Waste management, including clinical waste, solid waste, domestic and industrial wastewater, is putting substantial burden on the environment and creating public health risks. Management of clinical waste including sharps in facilities and elsewhere is a challenge that has to be immediately addressed.

Environmental pressures, exacerbated by **climate change**, remain significant and could easily worsen if remedial actions at the local and global levels are not taken. While the population is expected to stabilize at around 200 million, growing wealth and **mass population movements** will place further enormous strains on ecosystems and the living environment. Concrete and concerted multisector programmes on adapting to climate change need to be in place.

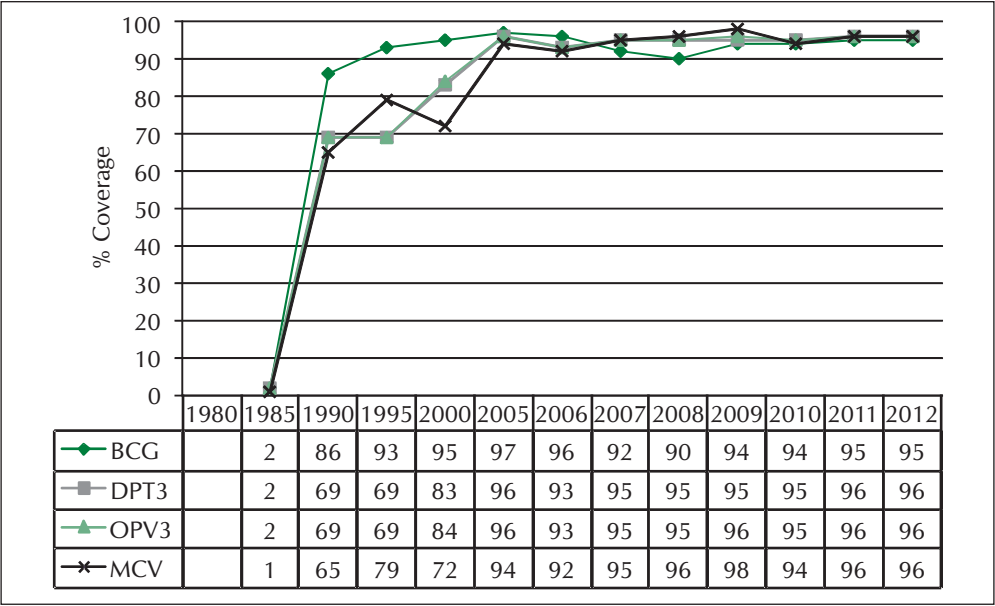
2.2 Communicable diseases

2.2.1 Vaccine-preventable diseases (VPD)

Immunization coverage in Bangladesh has been recognized worldwide for its sustained high levels and its contribution to the reduction in childhood morbidity and mortality. The trend in immunization coverage shows that the national Expanded Programme

on Immunization (EPI) has a strong capacity to reach children with Bacillus Calmette-Guérin (BCG) (99%). Although Bangladesh has reached near-universal coverage with BCG, it is still behind the target coverage of 90% with adequate doses for all other antigens. Only about 81% of infants are **fully vaccinated** (EPI 2013). Trends in national immunization coverage from 1980 to 2012 are shown in Figure 2.

Figure 2: National immunization coverage in Bangladesh, 1980–2012



Notes: BCG, Bacillus Calmette-Guérin; DPT, diphtheria–pertussis–tetanus; OPV, oral polio vaccine; MCV, measles-containing vaccine.
Source: EPI 2013.

Hepatitis B, Haemophilus influenzae type b (Hib) and rubella were introduced in 2003, 2009 and 2012 respectively. Pneumococcal vaccine is planned for introduction in 2014 with support from the GAVI Alliance. EPI has also applied for GAVI Alliance support for the human papillomavirus (HPV) vaccine demonstration programme in Gazipur district. While introducing the **new vaccines**, sustaining high coverage for existing vaccines will be another challenge.

Bangladesh achieved maternal and neonatal tetanus elimination status in 2008. **Neonatal tetanus surveillance** needs to be strengthened to identify pockets of low coverage to sustain this elimination status.

The country also made significant progress towards measles control by conducting a measles catch-up campaign in 2006; introducing measles case-based surveillance in 2008; organizing a measles follow-up campaign in 2010; and incorporating the second dose of measles in routine immunization in 2012. All these have contributed to a reduction in the incidence of measles.

Measles outbreak investigations and laboratory confirmation of specimens unmasked the high incidence of rubella infection and led to an assumption that **congenital rubella syndrome** is a public health problem in Bangladesh. The country plans to conduct a measles-rubella immunization campaign targeting 52 million children aged 9 months to 15 years in 2014. This campaign may further reinforce the national goals of **measles elimination** and rubella control by 2016.

Bangladesh was awarded **polio-free** status on 22 August 2000 when the last indigenous wild poliovirus (WPV) case was reported. WPV was imported from a neighbouring country in 2006 but was successfully contained with the last case reported on 22 November 2006. All countries in the WHO South-East Asia Region maintain polio-free status, but population movement to and from nearby polio-endemic countries (Afghanistan, Nigeria and Pakistan,) continue to constitute a potential threat.

The main **programmatic challenges of EPI** as identified during the “Joint national and international EPI and VPD surveillance review” conducted in March 2012 were to: a) increase and sustain immunization coverage in urban areas; b) determine correct denominators; c) fill up vacant positions of field workers and supervisors; and d) provide appropriate in-service training for all EPI staff including mid-level managers.

2.2.2 Tuberculosis

Bangladesh is one of the 22 high tuberculosis-burden countries. The incidence, prevalence and mortality estimates for tuberculosis (TB) are shown in Box 1, along with statistics on multi-drug resistant cases. TB services are integrated in the primary health care system. The treatment success rate is 92% for the cohort of patients registered in 2011 (NTP 2010).

Box 1: Tuberculosis at a glance, 2012

Estimated new cases of TB (all forms) per year	225/100 000 population
TB mortality (all cases per year)	45/100 000 population
TB prevalence	434 per 100 000 (all cases)
New TB multi-drug resistant cases	1.4%
Previously treated multi-drug resistant TB cases	29%

Source: Global Tuberculosis Report 2013.

The National TB Control Programme has adopted the WHO Global and Regional Stop TB Strategy. This led to the establishment of a National TB Reference Laboratory in 2007 to address drug-resistant TB, and organization of the National Forum for TB/ HIV. Bangladesh is an outstanding example of implementing TB control in partnership with public and private sectors, especially with nongovernmental organizations (NGOs).

The National Strategic Plan for TB, the National Guidelines and Operational Manual for TB Control, and the Management Guidelines for Drug-Resistant TB have been revised. The report on the first Drug Resistance Survey has been published and the Operational Guidelines for Advocacy, Communication and Social Mobilization is being revised. The system for electronic registration of TB data using e-TB manager software, piloted in 2010 and scaled up to 110 centres to date, will need to be expanded to all TB treatment centres. Other needs are to strengthen capacity for diagnosis of smear-negative, extra-pulmonary and childhood TB as well as to expand treatment coverage.

2.2.3 Malaria

Malaria is a major public health problem in Bangladesh with 13.2 million people at risk. Malaria is highly endemic in 13 of the country's 64 districts, from where more than 95% of the total malaria cases are reported (Annual Report Book, United States Centers for Disease Control and Prevention 2013). The three Hill Tract Districts (Bandarban, Khagrachari and Rangamati) and Cox's Bazar district report more than 80% of the malaria cases and deaths every year. These areas experience a perennial transmission of malaria with seasonal peaks in the pre- and post-monsoon periods. Both *Plasmodium falciparum* and *P. vivax* malaria are prevalent in the country. Over the last few years, case incidence and the number of deaths have significantly declined. The major challenge is to be able to sustain these programmatic gains and transit to a pre-elimination stage.

2.2.4 HIV/AIDS

Bangladesh still has a low prevalence of <1% among population groups most at risk. According to the latest serological surveillance, HIV prevalence among specific risk groups (people who use drugs, female and male sex workers, men who have sex with men, and Hijras) was reported to be 0.7% (National HIV sero-surveillance 2011).

2.2.5 Neglected tropical diseases

(i) Leprosy

The Bangladesh National Leprosy Elimination Programme (NLEP) achieved its elimination target at national level in 1998 and has been sustaining that with a gradually declining prevalence rate, which was 0.24/10 000 population in 2012 (NLEP 2013). Although the Government and a few NGOs are maintaining a model partnership to implement leprosy control activities, the stagnancy in case detection rate, variability in multi-bacillary and child cases, and disability rates among new cases indicate the need to strengthen the NLEP strategies and services. The challenge in leprosy control is to sustain infrastructure support in specific geographic areas where elimination targets have not been achieved.

(ii) Kala-azar

Kala-azar has been reported in 104 upazilas of 34 districts of the country. In recent years, the disease burden seems to have been reduced from 3806 cases in 2010 to 1902 cases in 2012 (KEP 2013). Bangladesh, along with India and Nepal, has made remarkable progress in implementing the Kala-azar Elimination Programme, the target of which is to reduce annual incidence to <1/10 000 population in all endemic areas by 2015.

(iii) Lymphatic filariasis

A total of 34 districts with an estimated 70 million population are endemic for lymphatic filariasis. The target of the Elimination of Lymphatic Filariasis programme is 2015. Its main strategies are:

- (a) mass drug administration (MDA) with diethylcarbamazine and albendazole once a year;
- (b) community-based morbidity control; and
- (c) mass awareness programmes. The MDA was scaled up in 19 districts, of which 15 have already achieved elimination status.

(iv) Dengue

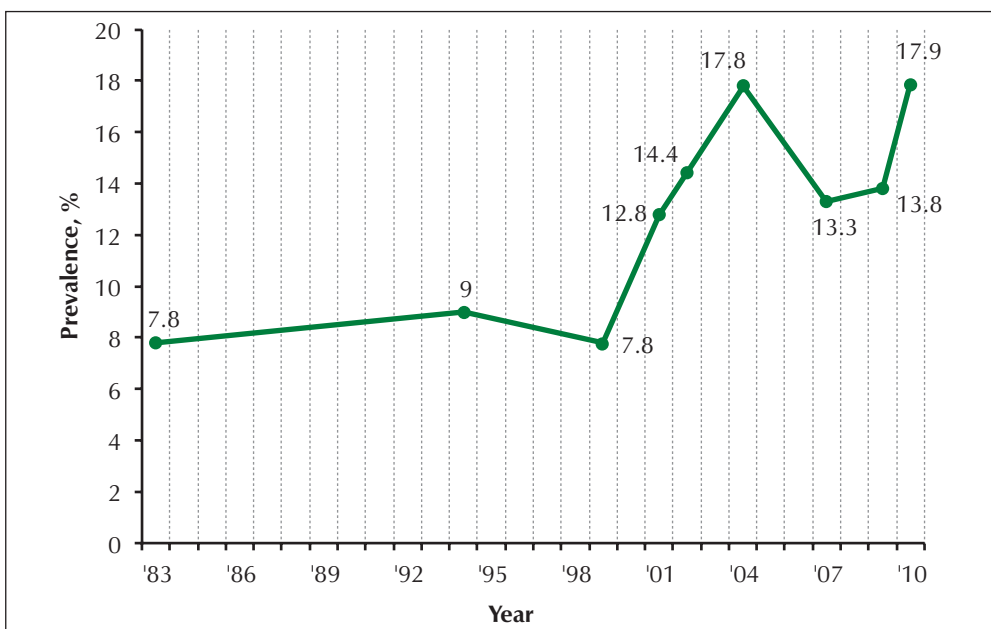
The first outbreak of dengue occurred in 2000 affecting three major cities – Dhaka, Chittagong and Khulna where a total of 5551 cases and 93 deaths were reported. Since then, dengue outbreaks have occurred every year. Although the number of cases is sometimes high, the case–fatality rate remains low due to improved clinical management in hospitals. In 2012, only 474 cases were reported with no deaths. Dengue control strategies include:

- a) improving diagnosis and clinical management of dengue fever/ dengue haemorrhagic fever cases;
- b) disease prevention by the community and through intersectoral collaboration;
- c) strengthening disease and vector surveillance; and
- d) community awareness programmes.

2.3 Noncommunicable diseases

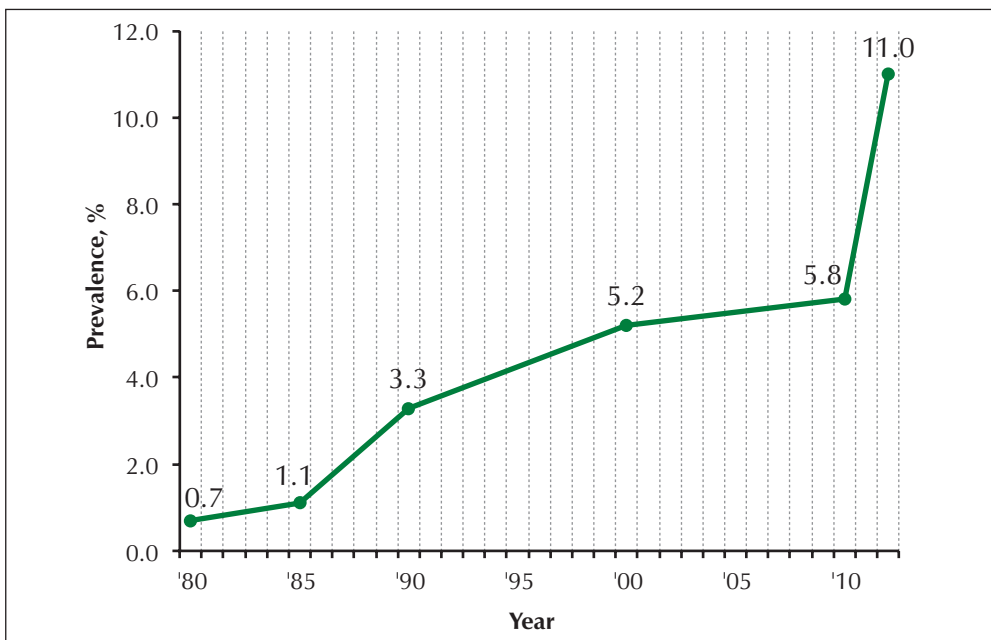
The disease burden in Bangladesh has shifted from communicable to noncommunicable diseases (NCDs) like cardiovascular diseases, diabetes, cancer, and chronic respiratory diseases. More than half of hospital deaths are due to NCDs (MIS 2012). Data from the Matlab demographic survey site showed an increasing trend of NCD deaths from 1986 to 2006 especially due to cardiovascular diseases (Karar 2010). Increasing trends in hypertension and diabetes have also been reported (Figure 3 and Figure 4).

Figure 3: Trend in hypertension prevalence in Bangladesh, 1983-2010



Source: Zaman MM (2013).

Figure 4: Trend in diabetes prevalence in Bangladesh, 1980-2012



Source: Zaman MM (2013).

Tobacco caused 57 000 deaths and 382 000 disabilities in 2004 in Bangladesh, and one in ten persons aged 30 years or above suffers from major tobacco-related chronic illnesses (WHO 2007). Among the chronic illnesses, ischemic heart disease (IHD) (2.5%), stroke (2%) and chronic obstructive pulmonary disease (3.3%) were widely prevalent. More recent data give even a higher prevalence (3.4%) of IHD (Zaman 2007). A strategic plan of action was developed for 2007–2010 incorporating tobacco control in formal education, media advocacy and tax measures. Although legislative measures have been taken for tobacco control, consumption of different forms of tobacco products in Bangladesh remains one of the highest in the world. A substantial proportion of adults (14.2%) use tobacco in dual forms (smoking and smokeless forms) in addition to single use (smoking or smokeless); the users of dual forms are relatively resistant to interventions.

Alcohol consumption is very low (0.9%) but there is evidence of binge drinking (WHO Noncommunicable Diseases Risk Factor Survey, Bangladesh 2010). This acts through intermediary risk factors such as hypertension and glucose intolerance. According to this survey, these risk factors are very common in Bangladesh (Table 1).

Table 1: Number of adults aged 25 years or older with risk factors (in millions)

Risk factor	Men	Women	Both sexes
Smoking	18.5	0.4	18.9
Smokeless tobacco use	9.9	11.3	21.2
Tobacco use in any form	23.6	11.5	35.1
Low fruit/vegetable intake	32.9	31.6	64.5
Low physical activity	3.5	13.9	17.4
Hypertension	6.2	5.8	12.0
Documented diabetes	1.4	1.2	2.7

Source: WHO Noncommunicable Diseases Risk Factor Survey (2010).

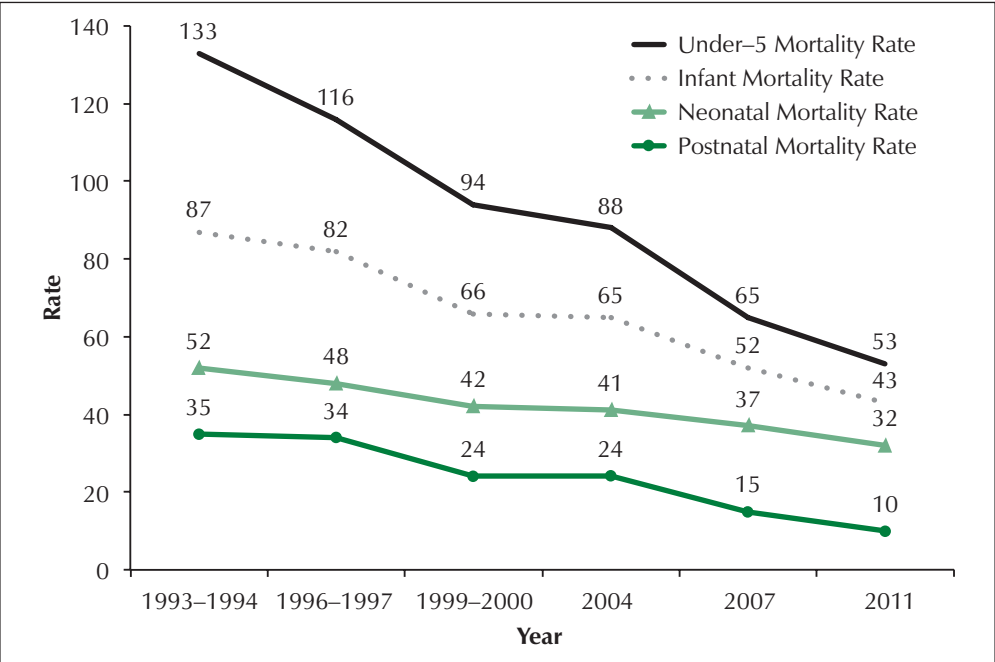
NCDs are now considered to be a major health threat. Many of their root causes are beyond the direct control of the health sector. The Government is currently laying great emphasis on changing lifestyles and on the control of NCDs using a multisectoral approach. The Strategic Plan for Surveillance and Prevention of Non-communicable Diseases in Bangladesh for 2011–2015 has been updated with a stronger focus on preventive measures. The National Cancer Control Strategy and Plan of Action 2009–2015 has also been adopted. As tobacco use is a major risk factor for developing NCDs, Bangladesh has ratified the Framework Convention on Tobacco Control (FCTC) and passed the Smoking and Tobacco Product Usage (Control) Act in 2005. The Act was amended in 2013 to widen its scope to smokeless tobacco and to fulfil better the Government’s obligation as a Party to FCTC.

2.4 Health of children, adolescents and mothers

2.4.1 Child health

Child health, in general, has been improving, as witnessed by a declining mortality trend (Figure 5). Bangladesh is on track to achieve the MDG 4.

Figure 5: Mortality trends in children in Bangladesh, 1993–2011



Source: BDHS (2011).

The reported top causes of death among children under five years of age are shown in Table 2. Pneumonia and other acute lower respiratory infections are the major causes of deaths. Respiratory (mostly pneumonia) and other serious infections are associated with almost two-fifths of all under-5 deaths despite a 37–60% reduction in death rates attributable to these causes. Most deaths due to infections occur in the neonatal period.

Table 2: Main causes of deaths in the under-5 age group, Bangladesh

1993–1994	Acute respiratory infection/pneumonia, diarrhoea, perinatal infections
1996–1997	Acute respiratory infection/pneumonia, diarrhoea, perinatal infections
2004	Acute respiratory infection/pneumonia, diarrhoea, possible serious infection, birth asphyxia
2011	Acute respiratory infection/pneumonia, possible serious infection, birth asphyxia, drowning

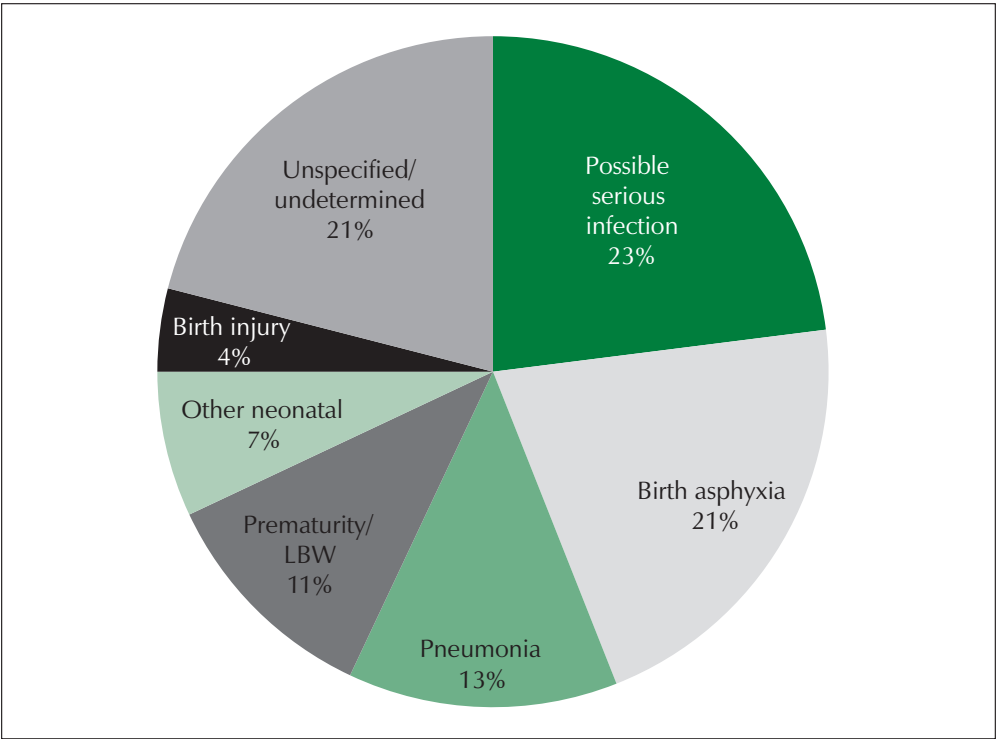
Source: Bangladesh demographic and health surveys.

Diarrhoea is considered a major cause of child morbidity and mortality in Bangladesh, accounting for almost one-fifth of all under-5 deaths in 1988–1993. From 2007 to 2011, however, the proportion was reduced to only 2% of all under-5 deaths, partly owing to the widespread use of oral rehydration salts (ORS). The use of zinc along with oral rehydration therapy has increased from 20% in 2007 to 34% in 2011 (BDHS 2011). Since zinc is considerably more expensive than ORS, further increases in its use may be unlikely unless it becomes available at subsidized retail prices. Its continuous availability to susceptible children is a serious challenge.

Drowning is a cause of death that has not declined over time. It is now responsible for 43% of all deaths of 1–5 year olds; the high percentage is partly due to reductions in other causes of deaths (BDHS 2011).

The neonatal mortality rate is still high at 32 per 1000 live births, which is a major contributor to the burden of infant mortality. The BDHS 2011 survey indicated that the major known causes of neonatal mortality (Figure 6) were serious infection (23%), birth asphyxia (21%), pneumonia (13%) and prematurity (11%). Reducing neonatal mortality will require effective strategies for preventing and managing neonatal infections and effective perinatal interventions to prevent deaths due to asphyxia and preterm birth.

Figure 6: Distribution of neonatal causes of death in Bangladesh, 2006–2011



Source: BDHS (2011).

2.4.2 Child nutrition

While childhood under-nutrition in Bangladesh has declined over the last decade, the rate could have been better. Stunting, which reflects the long-term effects of malnutrition in a population, has not significantly reduced in line with evolving dietary intakes. Its rate of reduction from 2004 to 2011 was only 1.3 compared to a standard of 2–3 percentage points per year.

The prevalence of wasting or acute malnutrition has remained virtually unchanged over the last decade. About 600 000 children under the age of five suffer from severe acute malnutrition and are at risk of death or severely impaired mental development (BDHS 2011). Also, more than one in three children are born with low birth weight (National Low Birth Weight Survey 2003–2004).

The target of children being exclusively breastfed for the first six months of life is only 64%. Complementary foods are introduced at an early age (BDHS 2011). The number of children aged 6–23 months who are fed appropriately according to recommended infant and young child feeding practices declined from 42% (BDHS 2007) to 37% (BDHS 2011).

Anaemia continues to be a major nutritional problem in children and women. Half (51%) of all infants and young children aged 6–59 months suffer from anaemia. Anaemia prevalence is highest (76–79%) in the age group 9–17 months, a period when complementary feeding practices are poor and diets often lack food rich in vitamin B12. Approximately 16.5 million women of childbearing age in the country suffer from anaemia, and their infants are likely to have low iron stores and become anaemic.

Nutrition is considered by the Government as a top priority. The new Operational Plan of the National Nutritional Services has been integrated into the HPNSDP. The Government plans to implement a mainstreamed and comprehensive package of nutrition services to reduce maternal and child malnutrition and ensure universal access. It will strengthen the human resource capacity to manage, supervise, monitor and deliver nutrition services at the different levels of the health and family planning services.

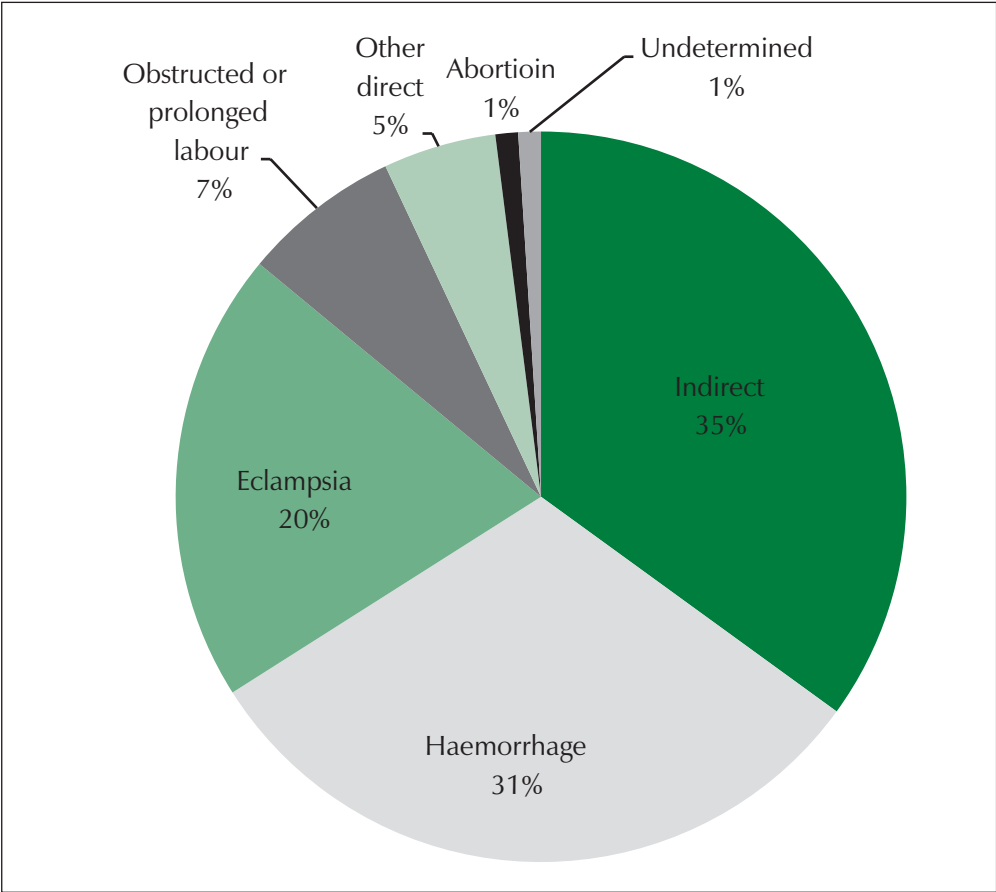
2.4.3 Maternal health and nutrition

The maternal mortality ratio (MMR) declined from 574 per 100 000 live births in 1990 to 194 per 100 000 live births in 2010. This is a 66% decline. Attaining MDG 5 will require a special effort to achieve the remaining 9% reduction in MMR (target is 143 per 100 000 live births) by 2015.

According to the Bangladesh Maternal Mortality Survey (BMMS 2010), haemorrhage (31%) and eclampsia (20%) are dominant direct obstetric causes of deaths and together are responsible for more than half of the MMR. Obstructed and prolonged labour (7%)

and abortions (1%) are the other causes of direct obstetric deaths. Indirect obstetric causes of deaths (like cardiovascular, respiratory diseases aggravated by pregnancy or delivery, anaemia) account for 35% of maternal deaths (Figure 7).

Figure 7: Causes of maternal deaths in Bangladesh, 2010

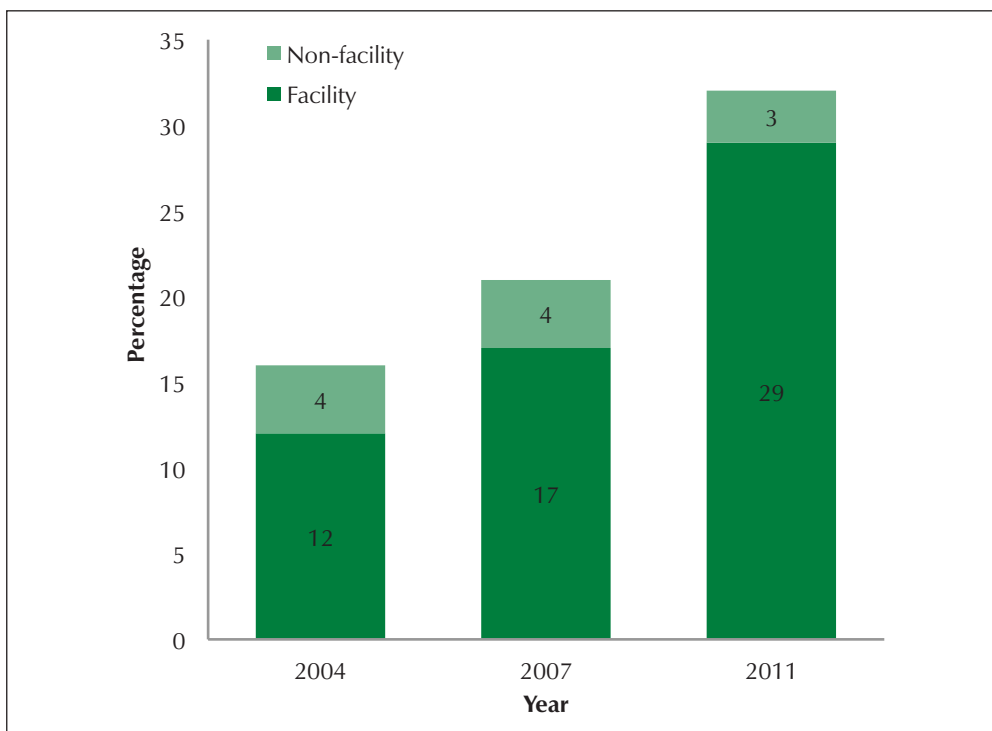


Source: BMMS (2010).

There has been slow progress in antenatal care (ANC) coverage by medically trained providers, with 50.5% of mothers having had only one visit in 2004 and 54.6% in 2011 (BDHS 2011). Mothers having had at least four ANC visits increased from 16.7% in 2004 to 25.5% in 2011. The Government target of four ANC visits is at least 50% by 2015.

Deliveries attended by skilled health personnel doubled from 15.6% in 2004 to 31.7% in 2011. This is due to a significant increase in facility delivery (Figure 8). Of the 68% home deliveries, only 3% were attended by skilled providers. Moreover, there is a large disparity in skilled assistance at delivery between urban (48%) and rural (24%) areas (BDHS 2011).

Figure 8: Trends in skilled attendance at delivery in Bangladesh, 2004-2011



Source: BDHS (2011).

Postnatal care (PNC) also increased significantly from 15.8% in 2004 to 27.1% in 2011. The latest data show PNC coverage of 38.9% in urban area and 16.5% in rural areas (BDHS 2011).

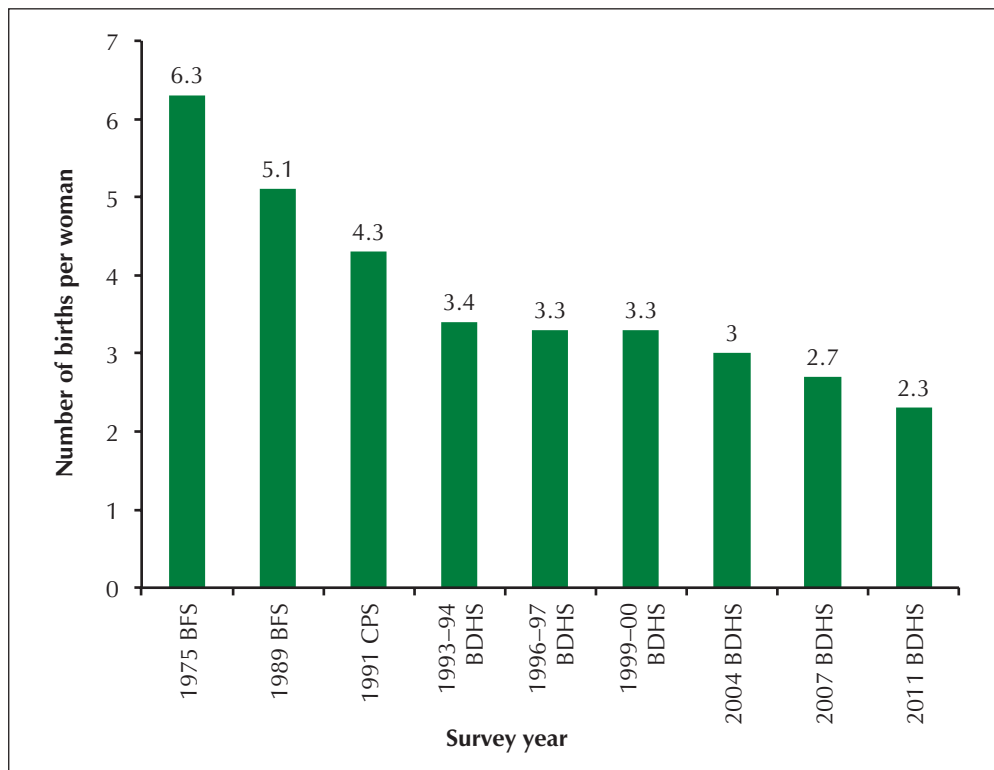
Considering all the above, maternal morbidity will be an issue to be addressed even during the post-MDG scenario.

An often missed but critical underlying factor affecting maternal and infant health is maternal malnutrition. Nearly half of pregnant women suffer from malnutrition and anaemia, which contribute to low birth-weight babies and a higher risk of neonatal mortality.

2.4.4 Fertility

The total fertility rate declined from 6.3 births per woman in 1975 to 2.3 in 2011 (BDHS 2011) as shown in Figure 9.

Figure 9: Trend in total fertility rate in Bangladesh, 1975-2011



Notes: BFS, Bangladesh Fertility Survey; CPS, Contraceptive Prevalence Survey; BDHS, Bangladesh Demographic and Health Survey.

Source: BDHS (2011).

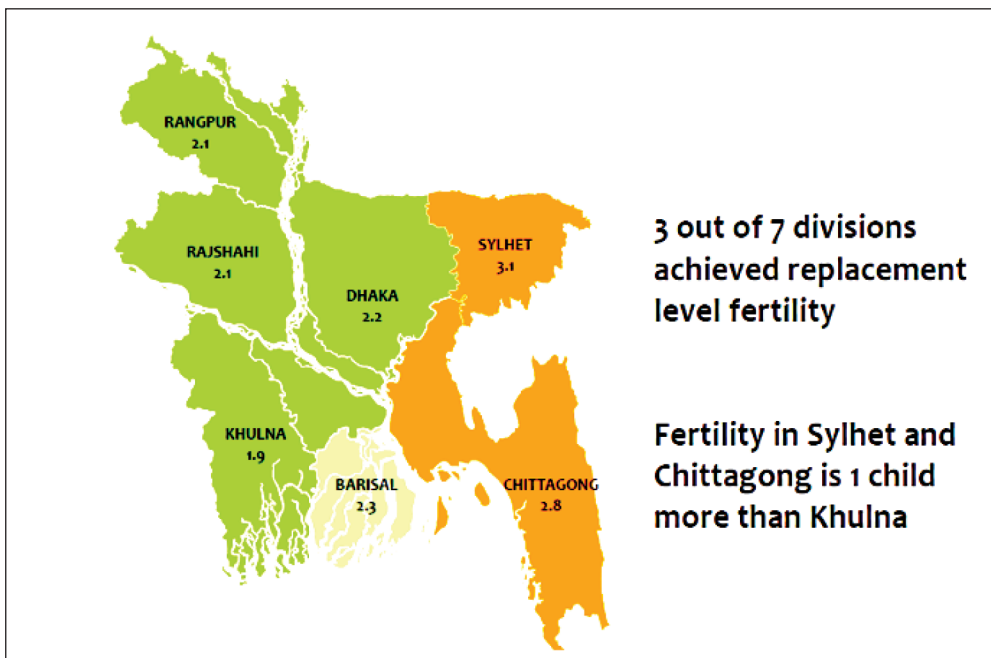
However, regional disparity in fertility exists (Figure 10), which will require a more specific and need-based strategy.

2.4.5 Reproductive and adolescent health

Early marriage and motherhood is very common in Bangladesh. The median age at which women aged 20–24 got married is 16.6 (BDHS 2011), a negligible increase above the median age of 16.4 reported in the 2007 BDHS. The proportion of teenagers who begin child-bearing (pregnant or mother) by age 20 is declining very slowly and remains high at about 30%.

Adolescent fertility is high and a major social and health concern. Through implementation of an adolescent health strategy and national standards, adolescents need to be provided with appropriate life-skills education and increased access to correct information about their physical and psychological changes. Legal sanctions on marriage age for males and females, the deleterious effects of early marriage, early pregnancy and motherhood, and the legal prohibition of dowries, are key messages to convey to this age group and the community.

Figure 10: Regional disparity in fertility in Bangladesh, 2011



Source: BDHS (2011).

2.5 Health systems and services

2.5.1 Service delivery

The health system of Bangladesh is hierarchically structured and can be compared to a five-layer pyramid. At the base of the pyramid is the village-level health facility which includes community clinics responsible for the delivery of primary health care services. Each clinic serves approximately 6000 people. The next level is the Union Health and Family Welfare Centre, which is considered to be the first referral centre. This Centre provides maternal and child health care as well as limited curative care. The third level is the Upazila Health Complex, a 30–50 bed hospital, and the fourth level is the district hospital. While the district hospital is conventionally the delivery layer with theatre facilities, some of the Upazila Health Complexes have been upgraded to offer emergency obstetric care. At the top of the health services pyramid, the medical colleges and post-graduate institutes offer a wide range of specialty services.

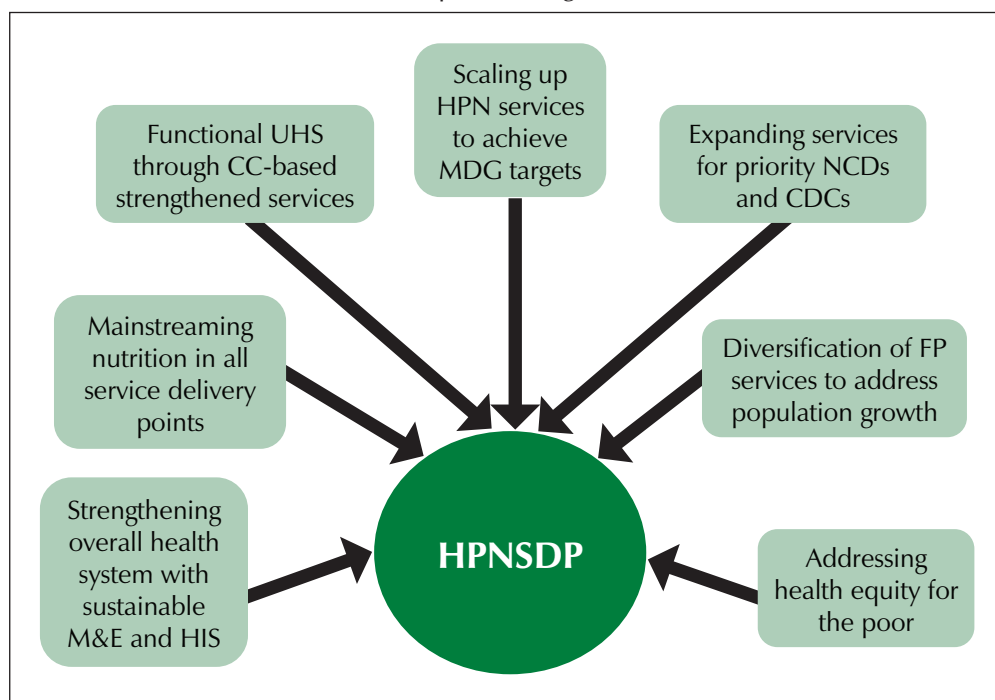
The HPNSDP considers the delivery of primary health care in community clinics to be cost-effective and appropriate for achieving the objectives of the MDGs and the Sixth Five Year Plan. There is a need to scale up and continue to strengthen community-based public health interventions towards achieving the goal of equity and to enhance the quality of health services.

2.5.2 Governance and stewardship

The Government of Bangladesh (GOB) has framed the National Health Policy 2011 and finalized the National Population Policy 2012. It has been implementing its third health sector programme, HPNSDP 2011–2016. Development activities of HPNSDP are being implemented by the MoHFW, Directorate General of Health Services (DGHS), Directorate General of Family Planning (DGFP) and other agencies through 32 operational plans.

The HPNSDP is composed of two main components – improving health services and strengthening health systems. Its seven drivers (Figure 11) are intended to support these two components. The HPNSDP 2011–2016 priority indicators and other development indicators are listed in *Annex 4* and *Annex 5*.

Figure 11: Seven drivers of the Health, Population and Nutrition Sector Development Programme



Notes: CC, community clinic; CD, communicable disease; FP, family planning; HIS, health information system; HPN, health, population and nutrition; HPNSDP, Health, Population and Nutrition Sector Development Programme; M&E, monitoring and evaluation; MDG, Millennium Development Goal; NCD, noncommunicable disease; UHS, universal health care.

Source: Brief version of HPNSDP: 2011–2016 (February 2012, MoHFW).

The GOB has established the following professional regulatory and statutory bodies: the Bangladesh Medical and Dental Council, Bangladesh Nursing Council, State Medical Faculty, Bangladesh Pharmacy Council, and Homeo, Unani and Ayurvedic Board. These bodies play important oversight roles to ensure transparency and accountability in the development of a competent professional workforce who will provide standardized and quality health services.

The GOB has decided to strengthen the stewardship capacity of the public sector through improved monitoring of quality of care and safety of patients in both public and private sectors. It has also put in practice the Citizen Charter for health service delivery in public hospitals and other health facilities. To ensure higher community involvement, the GOB revitalized the community clinics throughout the country. More than 40 000 citizen groups like the Community Clinic Management Groups and Community Clinic Support Groups have been established.

In addition to the Citizen Charter, the GOB has undertaken initiatives like establishing women-friendly hospitals and introducing a decentralized management system through local-level planning. For its part, WHO has been providing support to the development of local-level planning tools for effective planning and monitoring and to building the capacity of local managers and professionals. It has supported the training of frontline service providers of the community clinics and volunteer community support groups. It has involved NGOs in mobilizing community voices in partnership with Government through its Community Clinic Revitalization Initiative.

2.5.3 Health information systems

The major components of the health information system (HIS) are service delivery statistics, human resource information, information on supply of logistics and area-specific programmes. One of the major challenges is the lack of a fully integrated and mainstreamed information system because the DGHS and DGFP have their own mechanisms and structures that function separately. To address this situation, the GOB decided that all the directorates and agencies of the MoHFW can maintain their own health information systems although they will be under a common framework of interoperability and data sharing.

Priority HIS interventions will include:

- designing an integrated HIS to pull together data from a range of sources to strengthen the national capability to plan, monitor and evaluate the progress of health and family planning services; and
- strengthening e-Health initiatives, notably by encouraging participation of the private sector, NGOs and innovative public–private partnerships in the promotion of e-health services.

A pilot initiative with WHO technical support has been undertaken to register and track every pregnant woman and child under five years old, using 11 core indicators suggested by the United Nations Commission on Information and Accountability (COIA), of which WHO is a key partner. Coordination of research work and carrying out limited research and surveys will also be a function of the HIS department.

2.5.4 Human resources

The World Health Report 2006 identified Bangladesh as among 57 countries with a critical shortage of doctors, nurses and midwives (based on the WHO threshold of 2.28 doctors, nurses and midwives per 1000 population). Other major human resource challenges stated in the Bangladesh Health Workforce Strategy 2008, National Health Policy 2011, and HPNSDP 2011–2016 are:

- (a) geographical and skill-mix imbalance;
- (b) unplanned postings and distribution;
- (c) out-migration;
- (d) poor work environment;
- (e) poor set of pecuniary incentives; and
- (f) inadequate managerial competency of service providers.

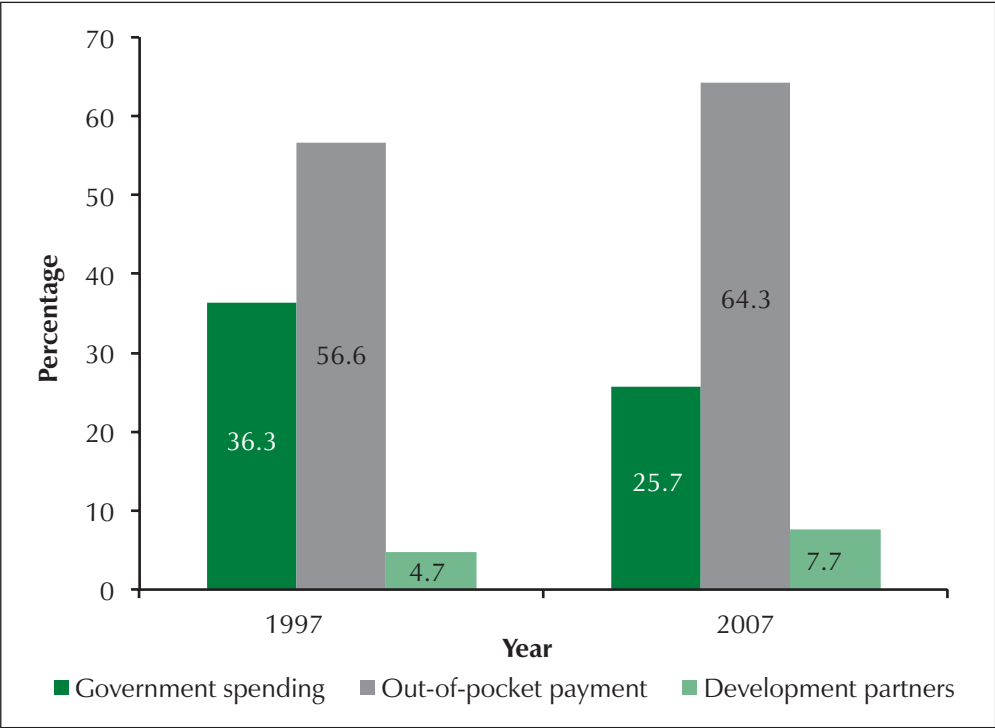
Priority interventions planned to improve the health workforce by the Government include:

- (a) developing and implementing a comprehensive Health Workforce Master Plan which provides for short-, medium- and long-term interventions encompassing public, private and NGO sector perspectives;
- (b) scaling up the production of the critical health workforce to minimize immediate gaps as well as ensure service of such personnel; and
- (c) introducing specific incentive packages to deploy and retain health workers in remote, rural and hard-to-reach areas.

2.5.5 Health financing

Household out-of-pocket expenditure (64%) continues to be the predominant source of financing for health costs, followed by the GOB (26%) and development partners (8%) (Figure 12).

Figure 12: Percentage of total health expenditure in Bangladesh by funding source, 1997 and 2007



Source: Bangladesh National Health Accounts 1997–2007, Health Economics Unit/Data International 2010.

To tackle the disparities and make the health financing system more effective and efficient for the poor, the Government developed the Bangladesh National Health Financing Strategy 2012–2032. Its directions aim to increase the level of funding for health, ensure an equitable distribution of the health financing burden, improve access to essential health services, reduce the incidence of impoverishment due to catastrophic health care expenditures, and improve the quality and efficiency of service delivery.

WHO has supported the development of the plan of action (a costed investment plan, by activity) to implement the Strategy over the short- and medium-term. As part of alternative methods of financing, the Government has piloted a Demand-Side Financing Maternal Health Voucher Scheme, which has shown some impressive gains in its original objectives of improving access to maternal health services and utilization by poor pregnant women. The challenges facing the scheme are sustaining the gains and improving the quality of services, implementation, and facilities.

2.5.6 Medicines and technologies

The key acts and ordinances providing the legal and regulatory framework for medicines and technologies are: the Drug Act of 1940, revised in 1946; the Drug Control

Ordinance 1982; the Safe Blood Transfusion Act 2002; and the Safe Blood Transfusion Rules and Regulations 2008. The National Drug Policy formulated in 1982 launched a rapid growth in the local pharmaceutical industry. The policy was revised in 2009.

For effective implementation of the Safe Blood Transfusion Act (2002), a two-year “cushion period” was given for all to comply. Since then, blood transfusion safety has improved significantly. Screening of markers for HIV, hepatitis viruses, syphilis and malaria has been made mandatory and the use of professional blood donors is now strongly discouraged. It is noteworthy that the GOB has approved the National Blood Policy 2013, which can be considered an important milestone in the area of legal and regulatory framework development for medicines and medical technology in the country. Nevertheless, quick access to all blood groups and rational use of blood products, and proper testing as per prescribed standards for donated blood, remain key challenges for blood transfusion services in Bangladesh.

2.5.7 Gender, equity and human rights

The country’s commitment to and support for women’s development programmes over the past two decades have resulted in positive gains in female life expectancy, reduction of the maternal mortality ratio, infant and child mortality rates, and gender empowerment through education. Gender disparities are evident in some health indicators like low birth weight and nutritional status. Incidents involving violence against women are reported; however, reliable data on violence against women remain scant.

The GOB has prioritized the elimination of discrimination against women and girls. As reflected in the present health sector programme, it remains committed to promoting gender equity. WHO has been closely working with the Gender, NGO and Stakeholder Participation (GNSP) Unit of the MoHFW to develop advocacy programmes geared on mainstreaming gender, including awareness-raising on women’s rights to access quality services from public health service institutions. WHO has provided assistance in conducting research studies developed by the GNSP Unit to carry out situational analyses on gender issues relating to women’s health, through primary-level disaggregated data collection and analyses.

Support has been provided from WHO to conduct a formal training course at hospitals for physicians and nurses on methods to deal with cases of violence against women. WHO is also working closely with UNICEF and other stakeholders to scale up the one-stop crisis centres for female victims of violence.

2.6 Emergency preparedness, surveillance and response

The geographic location and topography of Bangladesh predisposes the country to many natural disasters, notably floods and cyclones. The total land area of 147 570 km² consists mostly of floodplains (almost 80%) leaving a major part of the country (except

the south-eastern highlands) prone to flooding during the rainy season. These natural disasters trigger outbreaks of communicable diseases (mainly water-borne diseases, skin infections and pneumonia), as well as malnutrition, injuries, and snakebites.

Bangladesh is an earthquake-prone country because it is located on a fault line. Considering that earthquake-proof building standards are not always enforced, severe devastation and loss of lives will be the likely outcome if a severe earthquake strikes the country.

Aside from natural disasters, man-made disasters such as the collapse of buildings also occur. Improving capacity to respond quickly after such natural and man-made disasters should be given a higher priority.

Moreover, the adverse effects of climate change – especially high temperatures, sea-level rises, cyclones and storm surges, salinity intrusion, heavy monsoon downpours – have seriously affected peoples' health and overall national economic development.

The establishment of a well-coordinated approach to protect health from climate change and post-disaster health hazards pose uphill tasks for the Government. The MoHFW will strengthen its newly-created Climate Change and Health Promotion Unit to address issues relating to climate change and health protection through a multi-faceted approach.

Finally, in order to improve preparedness, response and recovery in relation to all types of health emergencies, the national capacity for implementing the Emergency Response Framework would require further strengthening.

2.7 Key achievements, opportunities and challenges

Achievements

- ◉ Polio eliminated
- ◉ Leprosy virtually eliminated
- ◉ National EPI coverage increased
- ◉ TB case detection and cure rates achieved
- ◉ HIV prevalence remains very low
- ◉ Strategic plan for NCD control in place, and tobacco control law amended in 2013
- ◉ Evidence generated on NCD risk factors using the WHO STEPwise approach to Surveillance (STEPS), Global Tobacco Surveillance system, visual and hearing impairment surveys
- ◉ Percentage of children receiving vitamin-A supplements increased
- ◉ Maternal mortality ratio decreased, and infant and under-five mortality rates declined to the point that country is on track to achieve MDG 4 target
- ◉ Life expectancy at birth rising
- ◉ Population growth rate and total fertility rate declined
- ◉ Remarkable countrywide network of health-care infrastructure including at least 12 500 functional community clinics
- ◉ Remarkable progress in Internet-based Health Information System and e-health

Opportunities

- ◉ Strong GOB-NGO collaboration for tobacco control with sufficient fund flow from Bloomberg Philanthropies
- ◉ United Nations High Level Meeting on NCD Prevention and Control
- ◉ Strong administrative and programmatic partnership with the MoHFW
- ◉ Growing recognition of WHO leadership in health development at the country level
- ◉ Donor trust on WHO capability to deliver results
- ◉ Donor consortium to facilitate coordination among donors and the Government
- ◉ Joint programming with numerous active global partnerships and development of new United Nations Development Assistance Framework (UNDAF) 2012-2016 Action Plan
- ◉ Strong civil society including nongovernmental institutions on health issues

Challenges

- ◉ Increasing and sustaining high immunization coverage in urban areas
- ◉ Inadequate capacity for diagnosis of smear-negative, extra-pulmonary and childhood TB
- ◉ Marked rise in NCDs, including injuries
- ◉ Risk factors for prevalence of NCDs are very common, particularly high consumption of tobacco products
- ◉ Low rate of deliveries by skilled birth attendants
- ◉ High rate of early marriage and early pregnancy
- ◉ High rates of neonatal deaths, malnutrition and micronutrient deficiencies
- ◉ Diversification of family planning service and high rate of discontinuation and unmet needs
- ◉ Inadequate gender sensitive and equity-based quality health-care service
- ◉ Inadequacies in human resources: shortage of nurses and midwives, retention of health workforce
- ◉ Sustaining and building on achievement of HIS e-health and monitoring and evaluation system
- ◉ Inadequate governance and stewardship (regulatory) functions to ensure health workforce accountability in both government and non-government sectors
- ◉ Very high component of out-of-pocket private expenditure on health by households
- ◉ Effective implementation of Emergency Response Framework

Chapter-3

Development cooperation and partnerships

3.1 The aid environment in the country and stakeholder analysis

Historically, the aid-financed component of Bangladesh's annual expenditure on the health sector has gradually declined from over 50% in 1991, 41% (including the Global Fund to Fight AIDS, Tuberculosis and Malaria) in 2002, 32% in 2011, to 26% in 2012 (HPNSDP, and Aide Memoire, Annual Programme Review 2013).

The national health budget is composed of two components: the development budget and the non-development budget, which are prepared separately (Table 3). Of the total health budget, development partners provide about a quarter. They have been playing a vital role in streamlining operational procedures as well as providing financial and technical assistance.

Table 3: Health budget estimates of HPNSDP 2011–2016

Budget	Amount (BDT in crore)	Amount (US\$ in billion)
Total estimated cost	56 993.54	7.70
Revenue budget	34 816.88	4.70
Development budget	22 176.66	3.00
GOB contribution	43 420.38	5.90
DP contribution	13 573.16	1.83

Source: Project Implementation Plan, HPNSDP, MoHFW.

The mechanisms for development assistance to the Government include pool funding, non-pool funding and parallel funding. Contributions to the pool fund of the HPNSDP have been pledged by a consortium of donors led by the World Bank/ International Development Association. Most of the United Nations agencies are non-pool contributors. The World Bank and the Japanese International Cooperation Agency

provide credit and grants, whereas other development partners¹ provide direct grants. WHO is a leading non-pool contributor to the HPNSDP.

3.2 Global partnerships

Several donors and international agencies provide technical and financial support to implement innovative partnerships in the country that complement the HPNSDP. Examples of global health partnerships that address the critical needs of the country are:

- (a) the Global Fund to Fight AIDS, Tuberculosis and Malaria;
- (b) the GAVI Alliance;
- (c) Roll Back Malaria;
- (d) Stop TB;
- (e) Health 4 Initiative for Maternal, Newborn and Child Health (H4+);
- (f) Global Newborn Action Plan; and
- (g) Global Measles Control Initiative.

They represent a substantial portion of the external development assistance to the health sector in Bangladesh. WHO actively participates in these partnerships in Bangladesh, and is a member of the United Nations Commission for Commodities and Partnership for World Health.

3.3 Development aid coordination

A strong partnership exists within the development community in Bangladesh that is fully committed to support the Government in its health programmes focused on achieving goals such as the health-related MDGs. In line with the “Paris Declaration on Aid Effectiveness 2005”, efforts are being made in the country to harmonize donor support and align this with national plans and strategies. Various joint task groups and technical committees operate under the sector programme, within which WHO is an active member.

The Local Consultative Group (LCG) is the apex body for coordination between the Government and development partners. It also provides technical support and guidance for policy-making through presentation of data and evidence. It covers all areas of the country’s development priorities, including public health issues.

¹ For example, the Australian Agency for International Development, Canadian International Development Agency, European Commission, GAVI Alliance, German Development Bank, German Society for International Cooperation Ltd., Global Fund to Fight AIDS, Tuberculosis and Malaria, Joint United Nations Programme on HIV/AIDS, Swedish International Development Cooperation Agency, United Kingdom Department for International Development, United Nations Children's Fund, United Nations Population Fund, United States Agency for International Development, and the World Health Organization.

The Health, Population, and Nutrition Consortium (HPN Consortium) is a subgroup of the LCG for Health, Nutrition and Population. It consists of 21 development partners, including bilaterals, multilaterals, and development banks. It is a platform for coordinating support to the Bangladesh health sector.

As a Government-led mechanism, the Health, Nutrition and Population Forum is chaired by the Secretary of the MoHFW and comprises representatives of other relevant ministries, MoHFW officials, civil society organizations, and development partners. It meets quarterly to present its performance over the previous period either based on joint reviews or on an internal review of its work.

3.4 United Nations Development Assistance Framework

UNDAF is an umbrella programming mechanism of the United Nations Country Team. The UNDAF Action Plan 2012–2016 is attuned and aligned to national development priorities and the MDGs. UNDAF is funded by a combination of existing core and non-core resources of the United Nations system. The indicative UNDAF Action Plan budget is nearly US\$ 1.8 billion, out of which an estimated US\$ 1 billion is yet to be mobilized. The coordination structure of the UNDAF Action Plan includes a Steering Committee, the United Nations Country Team, a Programme Management Team and seven Pillar Working Groups. WHO contributes to the realization of the Action Plan indicators through its own workplans and joint programmes with other United Nations agencies. These joint partnership initiatives are harmonized and aligned with UNDAF pillars.

3.5 Challenges and opportunities

Although donor support has been highly appreciated by the Government, the aid harmonization processes remain a challenge. To further improve accountability, transparency and alignment, the HPN Consortium of development partners have initiated the following:

- (a) joint field missions and analytical work;
- (b) a division of labour where lead partners are identified for particular themes;
- (c) coordinated technical assistance in terms of support to task groups; and
- (d) common harmonized procedures for fund release and tracking of fund flows.

Active global partnerships assist in implementing the current health sector programme (HPNSDP). These partnerships are opportunities for harmonization of health development thrusts and optimization of resources.

Chapter-4

Review of WHO cooperation over the previous Country Cooperation Strategy cycle

4.1 The past Country Cooperation Strategy cycle

Although WHO has been collaborating with the Government of Bangladesh since 1972, the first CCS became effective from 2004–2007. The CCS 2008–2013 was based on the strategic directions of the Eleventh General Programme of Work (GPW) 2006–2015 and the Mid-term Strategic Plan 2008–2013, and was developed through a consultative process with the Government and other stakeholders. Its seven strategic directions (Box 2) formed the foundation for the programmatic collaboration of the WHO Country Office. They are aligned to the categories in the Twelfth GPW and the CCS 2014–2017.

Box 2: Strategic directions of the WHO Country Cooperation Strategy 2008–2013

- (1) Promote access of vulnerable groups to health services ensuring a continuum of care throughout the life course (*Category 3 in the 12th GPW and CCS 2014–2017*)
- (2) Enhance capacity for the prevention and control of major communicable diseases and diseases targeted for elimination/eradication, and strengthen integrated disease surveillance (*Categories 1 and 5*)
- (3) Promote healthy lifestyles and cost-effective interventions for the prevention and control of major NCDs and injuries, and for mental health promotion (*Category 2*)
- (4) Enhance equitable and sustainable access to safe water and sanitation, reduce environmental and occupational health risks and promote food safety (*Categories 3 and 5*)
- (5) Strengthen multisectoral approaches for emergency preparedness, response and recovery (*Category 5*)
- (6) Strengthen the health system with a focus on health workforce development and equitable access to quality health care (*Category 4*)
- (7) Foster partnership and coordination for national health development (*Category 6*)

4.2 The review process

A comprehensive qualitative process was carried out by the WHO Country Office from April to July 2013. Its objectives included: (a) to conduct an internal review of the WHO Country Office performance; (b) to solicit feedback on WHO's performance of its core functions, particularly its role and contribution in addressing priority national health needs; and (c) to identify the stakeholders' future expectations from WHO.

The WHO review of performance reports was complemented with a systematic collection of information from key stakeholders through individual in-depth interviews, group discussions, and workshops at national level. More than 200 external stakeholders were invited from government policy-makers and managers involved with the implementation process; United Nations and bilateral/multilateral agencies; academic institutions/professional bodies and WHO Collaborating Centres; and NGOs and other civil society organizations.

4.3 Highlights of feedback from stakeholders

4.3.1 Strengths

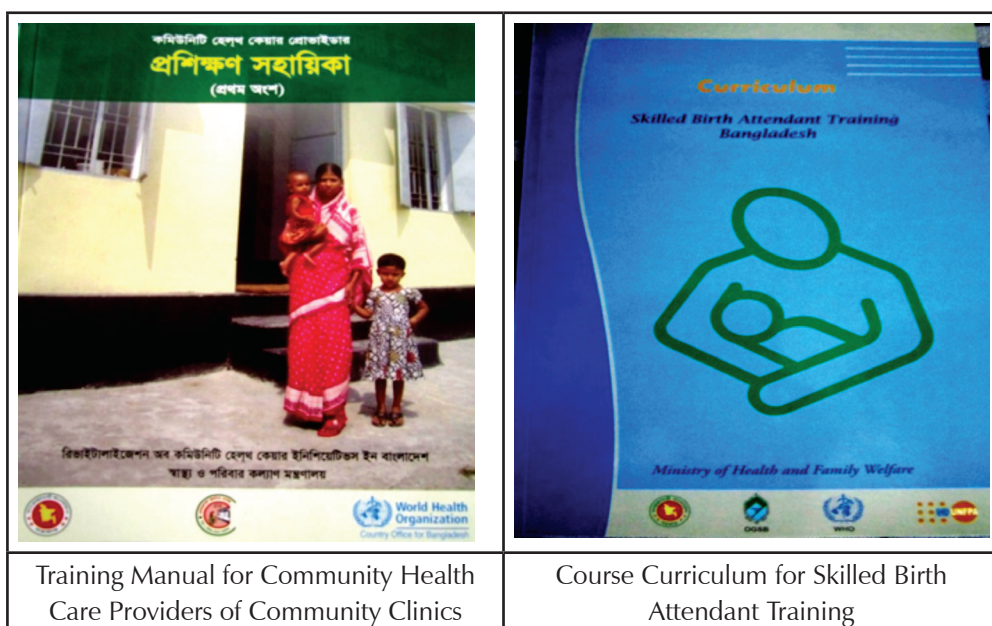
The key informants appeared to have a favourable perception of the WHO Country Office in the performance of its four core functions:

- Setting norms and standards;
- Providing technical support, catalysing change, and building sustainable institutional capacity;
- Stimulating the generation, translation and dissemination of valuable knowledge; and
- Engaging in partnership with other development partners and United Nations agencies.

During the past CCS, WHO's technical support for development, adaptation and use of national policies, guidelines, standards and other tools (Figure 13) was perceived to contribute positively to improving the maternal, infant and child health status of the country.

WHO's continuous focus on building sustainable institutional capacity through skill development of different levels of service providers like doctors, nurses, paramedics and community health workers has helped the Government improve the quality, accessibility, and use of health services. For example, it has worked in close collaboration with the Directorate of Nursing Services and Bangladesh Nursing Council to address the shortage of nursing personnel and improve nursing education quality and the accreditation process. To improve access to services of skilled birth attendants, a community-based skilled birth attendants (CSBA) training programme has been scaled-up with support

Figure 13: Examples of training manual and course curriculum



from WHO and in partnership with the United Nations Population Fund. A total of 5159 CSBAs across the country have been certified by the Bangladesh Nursing Council, which has also accredited 29 CSBA training institutes.

WHO has supported national level public health institutions to develop their faculties through short-term training and fellowship programmes with international educational institutions. Its support in enhancing the competency of MoHFW counterparts in planning, monitoring and evaluation has contributed positively to achieving the objectives of the past and current national health sector plans.

WHO's technical support has been highly effective in preparedness and management of emergency situations such as natural disasters and disease outbreaks.

The Organization has also assisted the enhancement of research capacity both at institutional and individual level through grants and technical activities. It has provided support in conducting research (e.g. Global Adult Tobacco Survey, National Survey on Risk Factors of Noncommunicable Diseases) that was helpful in planning and designing health interventions. WHO has consistently supported the Government diseases surveillance system, which has been commended by some stakeholders.

Being a member of the United Nations Country Team and the HPN Consortium, WHO is actively involved in providing support to technical working groups, task groups or pillars. It has served as a dependable partner for other United Nations agencies in

jointly implementing initiatives to improve maternal and neonatal health in selected districts as well as to facilitate access to safe water and sanitary facilities in some coastal community clinics. Its role as the lead development partner for the Health Finance Resource Task Group has been welcomed by the Government, as well as bilateral and multilateral agencies.

4.3.2 Areas for enhancement and suggestions

Being a highly credible and reputed global organization with access to a broad base of experts from within and outside the region, the WHO Country Office is expected to be pro-active in the following areas:

- assisting the Government to develop evidence-based protocols and guidelines;
- policy advocacy with the Government;
- assisting the Government in human resource development;
- disseminating cost-effective health innovations to a broader audience that includes local NGOs/institutions; and
- providing leadership, convening, coordinating and engaging in partnership.

The stakeholders highly recommend the strengthening of the WHO Country Office staff knowledge and skills on partnership development for it to work more effectively in a collaborative mode. They also suggest their involvement in the development of this and future CCSs.

4.4 Resources for past Country Cooperation Strategies

The seven strategic directions were implemented over three biennia with their respective workplans: 2008–2009; 2010–2011; and 2012–2013. Between these biennia, the assessed contributions declined constantly by about 2% (Table 4). However, the voluntary contributions for the first biennium dropped by two-thirds. The budget performance assessments during the three biennia helped WHO to develop cost-effective workplans throughout the past CCS.

Table 4: Budget during the Country Cooperation Strategy period: 2008–2013

Biennium, years	Assessed contribu- tions, US\$	Voluntary contribu- tions, US\$	Total, US\$
2008–2009	11 014 000	41 630 000	52 644 000
2010–2011	10 830 000	14 014 000	24 844 000
2012–2013	10 412 700	13 384 700	23 797 400

The human resources that provided the backbone for implementation of the past CCS included international and national technical staff on long- and short-term contracts, general service staff and personnel under Special Services Agreements. Professional staff were assigned to manage the workplans. The cluster approach was introduced to further enhance coordination among technical areas of work.

4.5 Summary of review

The lessons learnt and the experience gained during the previous CCS were thoroughly analysed through an internal process within WHO and a series of external consultations with the Government, donors, academic institutions, professional bodies, civil society organizations, and NGOs. Through these participatory consultations, the contribution of WHO, its strengths in terms of approach and focus, and areas which require enhancement were identified. The performance of the Country Office in implementing the previous CCS, including the availability of financial/ human resources and leadership opportunities, were also thoroughly analysed. Considering WHO's reform process, a more focused CCS 2014–2017 was developed that is aligned with the national priorities.

The Strategic Agenda for WHO cooperation, 2014–2017

5.1 Prioritization process to define the Strategic Agenda

The CCS Strategic Agenda is composed of five “strategic priorities” that are high level medium-term directions for the WHO Country Office for Bangladesh. The “main focus areas” are the expected actions required to achieve each strategic priority. Finally, the “strategic approaches” are the ways and means the whole of WHO will deliver on these main focus areas through its core functions and partnerships.(Figure 14)

Figure 14: Structure of the Strategic Agenda



To define the Strategic Agenda, a CCS team led by the WHO Representative was formed. It followed a very comprehensive process that included a review of the previous CCS described in Section 4.2. It further sought technical input from the WHO Regional Office for South-East Asia and WHO headquarters. The CCS team therefore defined the Strategic Agenda based on lessons from the previous CCS, challenges identified through a situation analysis, concerns of stakeholders, and the comparative advantage of WHO, and inputs from its Secretariat. The Strategic Agenda for 2014–2017 is guided by the priorities outlined in the WHO Twelfth General Programme of Work, and those of the Region, UNDAF and Bangladesh.

5.2 Strategic priority 1: Communicable diseases

Strategic priority 1:

Reduce the burden of communicable diseases, including vaccine-preventable diseases, tuberculosis, malaria, HIV/AIDS, and neglected tropical diseases



1.1 Main focus area

Harmonize vaccine-preventable disease control strategies with overall disease reduction

Strategic approaches

- 1.1.1 Sustain routine immunization coverage in all districts and introduce new vaccines
- 1.1.2 Achieve the measles-rubella elimination status by maintaining high coverage of Measles-Containing Vaccine type 1 and Measles Second Dose, intensifying measles-rubella surveillance, coordinating standardized laboratory tests to support the surveillance, and conducting supplementary immunization campaigns
- 1.1.3 Mainstream polio immunization into public health programmes while ensuring adequate support until certification and containment is completed

1.2 Main focus area


Assess TB, malaria and HIV/AIDS trends and foster cost-effective interventions

Strategic approaches

- 1.2.1 Provide support to achieve universal access to quality diagnosis and treatment for all TB patients in the community through public-private partnerships, and to reach the target of halving TB deaths and prevalence
- 1.2.2 Facilitate revising the National TB Control Plans beyond 2015 in line with the post-2015 global TB strategy
- 1.2.3 Contribute to improving the surveillance and monitoring system for malaria, establishing quality assurance for diagnosis and treatment of the disease, addressing cross-border transmission, and preventing drug and insecticide resistance
- 1.2.4 Support the strengthening of disease and vector surveillance in sentinel sites
- 1.2.5 Build capacity of the National AIDS/STD Programme and provide technical support to enhance treatment, care and support to HIV/AIDS positive people in the country; establish or expand HIV testing and counselling, and voluntary counselling and testing services in government settings; to strengthen the surveillance and monitoring system; and to promote quality assurance for diagnosis and treatment

1.3	Main focus area Reduce the burden of neglected tropical diseases, specifically kala-azar, lymphatic filariasis, leprosy and dengue
Strategic approaches	
1.3.1	Provide support to reduce the annual incidence of kala-azar to <1 per 10 000 population in all endemic areas by 2015 through early diagnosis and complete case management, effective disease and vector surveillance, integrated vector management including indoor residual spraying, and social mobilization
1.3.2	Provide support to eliminate lymphatic filariasis from the country by 2015 through scaling up mass drug administration in all affected districts, community-based morbidity control and mass awareness programmes
1.3.3	Provide support to the Bangladesh National Leprosy Elimination Programme in sustaining the leprosy elimination process through early detection, complete case management and strengthening the existing public–private partnership
1.3.4	Provide support to capacity building for relevant personnel in diagnosis and clinical management of dengue cases, and strengthen disease prevention through intersectoral collaboration

5.3 Strategic priority 2: Noncommunicable diseases

Strategic priority 2: Reduce the burden of noncommunicable diseases through health promotion, risk reduction and cost-effective management		
2.1	Main focus area Increase access to interventions to prevent and manage noncommunicable diseases, including cardiovascular diseases, diabetes, cancers, and chronic lung diseases, and their risk factors using a primary care approach	
Strategic approaches		
2.1.1	Provide support in evidence generation and implementation of the global monitoring framework on noncommunicable diseases, which includes setting national targets for prevention and control of indicators to monitor trends and assess progress made in the implementation of national strategies and plans	
2.1.2	Support the piloting and scaling-up of the Package for Essential NCD Interventions developed by WHO in the upazila health system to improve access of communities to NCD services through a multisectoral approach	

2.1.3	Provide policy advocacy support for effective implementation of the NCD Prevention Strategic Plan 2011–2015 with a special focus on the Tobacco Control Act involving different ministries with a view to implement the WHO FCTC
2.2	Main focus area Increase access to services for mental health and substance use disorders
	Strategic approach
2.2.1	Provide support to generate evidence for policy and programmes on mental health, and scale-up the pilot project using the WHO Mental Health Gap Action Programme
2.2.2	Provide support to develop policies and plans for early detection and prevention of mental/neurological disorders with special focus on autism and epilepsy
2.3	Main focus area Reduce risk factors for road traffic injuries, blindness and deafness, while increasing access to services for people with disabilities
	Strategic approaches
2.3.1	Provide support to promote the Decade of Action for Road Safety launched by the United Nations involving different ministries including the National Road Safety Council which is under the Ministry of Transportation
2.3.2	Support the Government to make effective plans for control of visual and hearing impairments by conducting situation analyses and information collection (like national-level surveys) and building the capacity of academic institutions
2.3.3	Facilitate the development and implementation of a comprehensive community-based rehabilitation plan involving different ministries (Health, Social Welfare, Education) in light of the National Disability Act and the guidelines developed by the International Disability and Development Consortium, International Labour Organization, United Nations Educational, Scientific and Cultural Organization, and World Health Organization

5.4 Strategic priority 3: Health throughout the life course

Strategic priority 3:

Reduce health, nutrition, environmental and occupational risk factors throughout the life course



3.1 Main focus area

Facilitate the accelerated reduction of maternal, newborn and child mortality and morbidity as well as the reduction of vulnerabilities of adolescents and the elderly

Strategic approaches

- 3.1.1 Provide support for the development, adaptation and use of national policies, strategies, plans, standards, guidelines, and other tools to enhance health services for mothers, newborns, infants, children and adolescents (e.g. standard operating procedures for maternal health and newborns, National Maternal Health Strategy and Guideline, National Neonatal Health Strategy and Guidelines, Adolescent Reproductive Health Strategy, Integrated Management of Childhood Illness guidelines)
- 3.1.2 Provide support to actions to achieve universal coverage of skilled care at birth
- 3.1.3 Provide support to develop functioning result-based programming, a monitoring and evaluation system for effective decision-making, and to global monitoring and evaluation approaches such as COIA, Maternal Death Surveillance and Response, implementation and evaluation of innovative approaches for improvement of quality of care for maternal, newborn, child, and adolescent health
- 3.1.4 Facilitate capacity-building of service providers from all service delivery levels to ensure quality services based on evidence generated from an enhanced information system and research

3.2 Main focus area

Support the mainstreaming of nutrition services to reduce the high burden of malnutrition across all age groups

Strategic approaches

- 3.2.1 Support the Government in the development of policy, protocols and guidelines on nutrition as well as in capacity-building for management of nutrition services involving different sectors (health, agriculture, food, education, local government, etc.)
- 3.2.2 Facilitate activation of national-level technical committees and task groups; assist in conducting evidence-based research and knowledge/experience sharing in collaboration with academic institutions including WHO Collaborating Centres
- 3.2.3 Enhance the capacity of public health nutrition workforce, community-based promotional activities on infant and young child feeding, and management of severe malnutrition in health-care facilities through a multisectoral approach

3.3 Main focus area Support the reduction of environmental and climate change, and occupational risk factors

Strategic approaches

- 3.3.1 Provide support to facilitate equitable and real access to safe water and improved sanitation particularly in health facilities at community and referral centres through strengthening health sector monitoring mechanisms
- 3.3.2 Coordinate support between LCGs and the Government in harmonizing their activities related to environmental risk reduction
- 3.3.3 Support the enhanced capacity of the local government towards ensuring safe water supply through integrating the Water and Sanitation Programme into the management of water supply and building climate resilient water and sanitation hygiene (WASH)
- 3.3.4 Provide support for the development of the National Management Information System – a web-enabled Management Information System/Geographic Information System – for the water supply and sanitation sector and its utilization for effective planning and monitoring with targeted financing
- 3.3.5 Support awareness-raising and policy advocacy to manage health risks

5.5 Strategic priority 4: Health systems

Strategic priority 4:
Promote universal health coverage with strengthened health systems based on primary health care



4.1 Main focus area Support the Government of Bangladesh to ensure equity in national health policies, strategies and plans

Strategic approaches

- 4.1.1 Support the formulation of legal and regulatory frameworks to move towards universal health coverage including the implementation of the Health Care Financing Strategy
- 4.1.2 Support the MoHFW to strengthen its capacity to use evidence in policy development as well as to generate national data disaggregated by relevant socioeconomic stratifiers for analysing health financing and equitable effective service coverage across the continuum of care
- 4.1.3 Strengthen the capacity of the national regulatory authority to ensure quality medicines and vaccines including monitoring the impact of the National Drug Policy

4.1.4	Assist the MoHFW to formulate a national eHealth strategy, and to develop health data standards and norms for integrating health information systems and sub-systems using the Health Information Exchange Architecture
4.1.5	Strengthen the Civil Registration and Vital Statistics system and the use of the International Classification of Diseases version 10 in morbidity and mortality reporting
4.2 Main focus area Advocate for a more integrated human resource development	
Strategic approaches	
4.2.1	Support the strengthening of capacity for preparing the costed national human resources for health (HRH) development and retention plan
4.2.2	Support the strengthening of capacity for the delivery of evidence-based nursing and midwifery services and practices
4.2.3	Support the strengthening of capacity of professional regulatory bodies, associations and institutions active in health workforce development
4.2.4	Support the strengthening of networking capacity of public health institutes
4.3 Main focus area Facilitate the delivery of quality and integrated people-centred services	
Strategic approaches	
4.3.1	Support the enhancement of the quality and safety of services at different levels of care including primary health care from community service providers
4.3.2	Provide policy and planning support to improve access and equity in health service delivery with special emphasis on planning processes at district and upazila levels
4.3.3	Provide support to strengthen the gender, equity and human rights (GEHR) focus in programmes and working procedures of WHO, as called for by WHO and the United Nations System-wide Action Plan (UN-SWAP), and to national authorities and partners for health inequality monitoring and mainstreaming GEHR in national health strategies, programmes and activities
4.3.4	Assist in building national capacity to increase access to safe blood and blood products through quality transfusion practices

5.6 Strategic priority 5: Preparedness, surveillance and response

Strategic priority 5:

Reduce mortality, morbidity and societal disruption resulting from epidemics, natural disasters, conflicts, environmental and food-related emergencies, through prevention, preparedness, response and recovery activities



5.1 Main focus area

Support the control of epidemic and pandemic diseases

Strategic approaches

- 5.1.1 Support the implementation process of the national plan of action for the International Health Regulations (IHR 2005)
- 5.1.2 Provide support in the establishment of improved laboratory facilities for the diagnosis of emerging and re-emerging infectious diseases (EIDs)
- 5.1.3 Facilitate a national level dialogue mainly in relation to zoonotic diseases, food, chemical and radio-nuclear safety and points of entry (POEs)
- 5.1.4 Provide support to strengthen the National CODEX Committee to implement food safety standards, guidelines and recommendations

5.2 Main focus area

Improve preparedness, response and recovery in relation to health emergencies

Strategic approaches

- 5.2.1 Support the national capacity building process and implementation of the Emergency Response Framework during emergencies
- 5.2.2 Provide support to build capacity of the Core Group for Emergency Responders at national and sub-national levels and strengthen coordination among the stakeholders through networking, risk assessment and communication
- 5.2.3 Provide medical logistics, including WASH, for mass casualty management and early recovery

5.3	Main focus area Promote the implementation of the Polio Eradication and Endgame Strategic Plan
Strategic approaches	
5.3.1	Strengthen routine immunization, withdrawal of type 2 component of oral polio vaccine, and the introduction of inactivated polio vaccine
5.3.2	Provide technical support for surveillance of acute flaccid paralysis, certification standards and laboratory containment
5.3.3	Advocate best practices and lessons learnt from the polio eradication programme, particularly strategies used for reaching marginalized populations and children

5.7 Validation of the CCS Strategic Agenda with the HPNSDP and UNDAF priorities

The Health, Population and Nutrition Sector Development Programme of the MoHFW was developed to address public health challenges through an extensive consultation process with different stakeholders including WHO. The strategic priorities of this CCS are very much in line with those in the HPNSDP (*Annex 6*). The strategic approaches will support the achievement of the national programme objectives.

Furthermore, the CCS Strategic Agenda is very much linked with the current Bangladesh UNDAF Action Plan 2012–2016 (*Annex 7*), which has seven pillars. As a member of United Nations Country Team, WHO was actively involved in developing – and will continue to be a strong partner in implementing – the current UNDAF Action Plan.

Chapter-6

Implementing the Strategic Agenda – implications for the WHO Secretariat

6.1 WHO Country Office – the key undertakings

To implement the Strategic Agenda described in the previous chapter, the WHO Country Office will continue to provide need-based technical assistance. This will mainly cover areas like national level policy formulation, setting norms and standards, improving knowledge dissemination and management, monitoring country health situation and building sustainable institutional capacity. It will play a greater leadership role in different national level policy and technical forums like the HPN Consortium and its technical task groups. It will be more proactive in developing mutually beneficial partnerships with the government and other stakeholders.



To ensure the most effective implementation of the CCS during 2014–2017, the Country Office team will place emphasis on four aspects.

First, the structure of the Country Office team will be revisited in light of the CCS strategic priorities. The organizational needs will be assessed to equip the Country Office with adequate staff. Long-term personnel commitments will be scrutinized and only those that are sustainable will be approved. Special Services Agreements will be discouraged, and each position will be reviewed from time to time. “Doing more with fewer, quality staff” will be the guiding principle.

Second, a highly competent country team will be essential to an effective and efficient management of the Country Office. Technical capacity enhancement and leadership development will be cornerstones of staff development and learning. Horizontal collaboration among technical units will be promoted. The services of high level international experts will be mobilized for shorter periods through temporary appointments to carry out specific assignments. To support efficiency and effectiveness, information and communications technology will be updated as and when required.

Third, while effectively and efficiently using available resources, the WHO Country Office will mobilize additional financial resources to fill the gaps, particularly those required to deliver the outputs essential to the attainment of the CCS strategic priorities. It will be more proactive in responsibly managing its traditional donors. It will work in unison with the Regional Office and headquarters to explore with potential non-traditional partners common interests and development objectives.

Fourth, successful implementation of the CCS will be partly anchored on constructive and synergistic collaboration with several stakeholders within the health sector and across multiple others. For this reason, the WHO Country Office will continue to work closely with the MoHFW and will further reach out to other ministries like those for social welfare, education, local government, and the environment. It will enhance its collaboration with WHO collaborating centres, professional organizations/bodies, academic institutions and civil societies that have been contributing significantly to health development. It will be favourable to joint advocacy, planning, or programming with other United Nations agencies.

6.2 Collaborating with the WHO Regional Office and headquarters

The WHO Regional Office for South-East Asia will continue to provide policy advice and guidance on regional norms and standards. It will coordinate intercountry collaboration and multicountry activities to foster exchange of technology, experience, expertise and resources among countries within the Region. The participation of national-level counterparts will be facilitated in intercountry meetings, workshops and seminars organized by the Regional Office or other Member States. It will provide assistance as requested by the Country Office during emergency situations like disease outbreaks and natural disasters.

As per its mandate, WHO headquarters will continue to provide the regional and country offices with global policy advice, directives on health development and guidance on global norms and standards.

6.3 Using the Country Cooperation Strategy

The CCS document will be widely disseminated to the Government, development partners, United Nations bodies, collaborating centres, and other key stakeholders. A CCS brief is available in English and Bangla versions. Both the CCS main document and the CCS brief will be posted on the WCO website and links will be shared with relevant stakeholders. Additional communication materials will be developed highlighting the contribution of the Strategic Agenda to the attainment of national health and development objectives. These will be utilized to orient policy-makers, line directors and programme managers.

The CCS 2014–2017 will be implemented through two consecutive biennial programme budgets and workplans. It already served as the overarching framework for the 2014–2015 Workplan as its formulation ran in parallel, and will be used to define the significant expected results for 2016–2017.

As the CCS 2014–2017 is aligned to the Bangladesh UNDAF 2012–2016 and the national HPNSDP 2011–2016, it will be utilized by the WHO Country Office as a platform for collaboration, partnership, resource mobilization and joint advocacy with other United Nations agencies and development partners.

The CCS will also be utilized by the Regional Office and headquarters to ensure that technical interactions between the Country Office and the Government are consistent with and based on the CCS priorities.

6.4 Monitoring and evaluation of the Country Cooperation Strategy

A result-based monitoring framework with specific indicators will be developed to track the progress of each expected output. The existing monitoring mechanisms will be enhanced: a) policy-level monitoring jointly conducted between the GOB and WHO, chaired by the Additional Secretary for WHO; b) programmatic-level joint monitoring coordinated by the Director General of Health Services; and c) internal review of programmatic and financial performance by the WCO monthly, annually and at the end of a biennium.

To assess the overall impact in addressing the health challenges, a review of the CCS at mid-point and/or towards the end of the CCS will be organized in consultation with the WHO Regional Office and headquarters. The CCS midterm assessment will coincide with the preparation period for the next national health sector programme. The lessons learnt and best practices from this assessment will be shared with the Government and other stakeholders.

Furthermore, the WCO will further develop its knowledge management system in order to generate, share and use high quality technical information that will be useful not only for monitoring the collaborative programmes under the current CCS but also for planning subsequent CCSs.

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- **Advancing universal health coverage:** enabling countries to sustain or expand access to essential health services and financial protection and promoting universal health coverage as a unifying concept in global health.
- **Health-related Millennium Development Goals** – addressing unfinished and future challenges: accelerating the achievement of the current health-related Goals up to and beyond 2015. This priority includes completing the eradication of polio and selected neglected tropical diseases.
- **Addressing the challenge of noncommunicable diseases** and mental health, violence and injuries and disabilities.
- Implementing the provisions of the **International Health Regulations:** ensuring that all countries can meet the capacity requirements specified in the International Health Regulations (2005).
- Increasing access to essential, high-quality and affordable **medical products** (medicines, vaccines, diagnostics and other health technologies).
- Addressing the **social, economic and environmental determinants** of health as a means of reducing health inequities within and between countries.

Source: Sixty-sixth World Health Assembly, WHO Geneva (A66/6).

Annex 2:

Universal health coverage

Universal coverage is firmly based on the WHO Constitution of 1948 declaring health a fundamental human right and on the health-for-all agenda set by the Alma-Ata Declaration in 1978. Equity is paramount. This means that countries need to track progress not just across national populations but within different groups (e.g. by income level, sex, age, place of residence, migrant status and ethnic origin).

The goal of universal health coverage is to ensure that all people obtain the health services they need without suffering financial hardship when paying for them. To achieve universal health coverage, key factors must be in place.

- **A strong, efficient, well-run** health system that meets priority health needs through people-centred integrated care (including services for HIV, tuberculosis, malaria, noncommunicable diseases, maternal and child health) by:
 - informing and encouraging people to stay healthy and prevent illness;
 - detecting health conditions early;
 - having the capacity to treat disease; and
 - helping patients with rehabilitation.
- **Affordability** – a system for financing health services so people do not suffer financial hardship when using them; this can be achieved in a variety of ways.
- **Access** to essential medicines and technologies to diagnose and treat medical problems.
- **A sufficient cohort of well-trained, motivated** health workers to provide services to meet the needs of patients, clients or communities based on the best available evidence.

Source: http://www.who.int/features/qa/universal_health_coverage/en/ accessed 29 April 2014.

Annex 3: Process of developing the WHO Country Cooperation Strategy 2014–2017

- Meeting with WHO Country Office professionals to discuss the need to review the CCS 2008–2013 and developing the CCS 2014–2017.
- Formation of a country team, headed by the WHO Country Representative, to coordinate all actions for formulating the CCS.
- Review of strategic documents and collection of information from different stakeholders.
- Assessment of selected WHO collaborative programmes over the previous three biennia.
- Conduct of a qualitative study to assess the external stakeholders' views about WHO's contributions and their expectations.
- In-house meetings to consolidate the information and develop a draft Working Paper on CCS 2014–2017.
- Consultation workshops organized at national level with Government, United Nations and bilateral/multilateral agencies, academic institutions, professional bodies, civil society organizations and NGOs.
- In-house meetings to consolidate the findings and develop draft of the CCS 2014–2017.
- Sharing of the draft with and requesting feedback from major stakeholders, including WHO staff at the Regional Office and headquarters.
- Finalization of the CCS document taking into account comments and suggestions from stakeholders and WHO officials.

Annex 4: Health, Population and Nutrition Sector Development Programme 2011–2016: priority indicators

Indicator	Baseline	Updated as of June 2013	Target by 2016
Infant mortality rate	52 (BDHS 2007)	43 (BDHS 2011)	31
Under-5 mortality rate	65 (BDHS 2007)	53 (BDHS 2011)	48
Neonatal mortality rate	37 (BDHS 2007)	32 (BDHS 2011)	21
Maternal mortality rate	194 (BMMS 2010)	194 (BMMS 2010)	<143
Total fertility rate	2.7 (BDHS 2007)	2.3 (BDHS 2011)	2.0
Prevalence of stunting among children under 5 years old	43.2% (BDHS 2011)	38.7% (UESD 2013)	38%
Prevalence of underweight among children under 5 years old	41.0% (BDHS 2007)	35.1% (UESD 2013)	33%
Prevalence of HIV in most at-risk populations	<1% (SS 2007)	0.7% (SS 2011)	<1%

Notes: BDHS, Bangladesh Demographic and Health Survey; BMMS, Bangladesh Maternal Mortality Survey; SS, Sero-Surveillance; UESD, Utilization of Essential Service Delivery.

Source: Annual Programme Implementation Review September 2013, MoHFW.

Annex 5: Other development indicators

% population under 15 (2012)	30.57
% population over 60 (2012)	6.89
Density of physicians (per 1000 population) (2011)	0.356
Density of nurses and midwives (per 1000 population) (2011)	0.218
Total expenditure on health as % of GDP (2012)	3.6
General government expenditure on health as % of total government expenditure (2012)	7.7
Private expenditure on health as % of total expenditure on health (2012)	65.6
Adult (15+) literacy rate (2011)	57.7
Population using improved drinking-water sources (%) (2012)	85 (Total), 86 (Urban), 84 (Rural)
Population using improved sanitation facilities (%) (2012)	57 (Total), 55 (Urban), 58 (Rural)
Poverty headcount ratio at US\$ 1.25 a day (purchasing power parity) (% of population) (2010)	43.3
Gender inequality index rank (2012)	111
Human development index rank (2012)	146

Sources of data: Global Health Observatory, <http://apps.who.int/gho/data/node.cco>, 08 May 2014.

Annex 6: Relationship between national health priorities and Country Cooperation Strategy Agenda

National health priorities [HPNSDP: 2011–2016]	CCS Strategic priorities				
	Reduce burden of vaccine-preventable diseases, malaria, tuberculosis, HIV / AIDS, and neglected tropical diseases	Reduce the burden of noncommunicable diseases through health promotion, risk reduction and cost-effective management	Reduce health, nutrition, and environmental occupational risk factors throughout the life course	Promote universal health coverage with strengthened health systems based on primary health care	Reduce mortality, morbidity, societal disruption due to epidemics, natural disasters, conflicts, environmental, and food-related emergencies by prevention, preparedness, response and recovery activities that build resilience and use a multisectoral approach
Expand access to and quality of MNCH services	+	+	+++	++	+
Revitalize family planning interventions to attain replacement level fertility			++		
Mainstream nutrition within regular DGHS and DGFP		+	++	++	
Strengthen preventive/control programmes for communicable and noncommunicable diseases	+++	+++	+	+	++
Strengthen support systems and increase health workforce at all levels	+	+	+	+++	+
Strengthen drug management and improve quality drug provision	+	+	+	++	+
Increase service coverage: public, NGO and private sector	++	+	+	++	++
Prioritize institutional and policy reform coordination		+		+++	

+++ : Very strong linkage; ++ : Strong linkage; + : Some linkage
DGFP, DGHS, MNCH, NGO

Annex 7: Relationship between UNDAF pillars and CCS Strategic Agenda

UNDAF pillars [2012–2016]	CCS Strategic Priorities				
	1	2	3	4	5
Pillar 1: Democratic governance and human rights	+	+	++	+	+
Pillar 2: Pro-poor economic growth with equity	+	+	++	++	+
Pillar 3: Social services for human development	++		+++	+	
Pillar 4: Food security and nutrition	++	+	+++	+	++
Pillar 5: Climate change, environment, and disaster risk reduction & response			+++	+	+++
UNDAF Pillar 6: Pro-poor urban development	+		+	+	
Pillar 7: Gender equality and women's advancement			+	+	

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

The World Health Organization (WHO) has been working closely with the Government of Bangladesh (GOB) to strengthen the health sector and improve the health status of the population since 1972. The Country Cooperation Strategy (CCS) is the basis for WHO's collaborative work. In this CCS 2014–2017, the strategic directions, priority areas and strategic approaches were designed for WHO's engagement to complement and strengthen Bangladesh's health development efforts. They are aligned with WHO's 12th Global Programme of Work, national health developmental priorities and the current UNDAF Action Plan.

The strategic priorities of the CCS are directed at: i) reducing the burden of communicable and noncommunicable diseases; ii) reducing health, nutrition, environmental, and occupational risk factors throughout the life course; iii) promoting universal health coverage; and iv) reducing mortality, morbidity, and societal disruptions caused by epidemics, natural disasters, conflicts, and environmental and food-related emergencies.

The CCS 2014–2017 was developed through documentary reviews, situation analyses, review of previous CCS, and extensive stakeholder consultations. Through this CCS, the partnership between WHO and the Government of Bangladesh will be further strengthened.