

# WHO BANGLADESH COUNTRY COOPERATION STRATEGY: 2020–2024



World Health  
Organization

Bangladesh









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**WHO Bangladesh Country Cooperation Strategy: 2020–2024**

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Printed in Bangladesh

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# Foreword



The World Health Organization has been working with the Government of Bangladesh since 1972. In recent decades Bangladesh has made remarkable socioeconomic progress, and dramatically reduced morbidity and mortality in the country. It has made notable advances in reducing infant and child mortality, increasing immunization coverage, eliminating infectious diseases such as polio, and reducing the incidence of malaria, tuberculosis and diarrhoeal diseases. Bangladesh has achieved several of the health-related Millennium Development Goals, including on under-five mortality.

This Country Cooperation Strategy (CCS) will guide WHO's continued work with the Government of Bangladesh from 2020 to 2024. It is aligned with the Government's Health, Population and Nutrition Sector Programme 2017–2022, which aims to “ensure that all citizens of Bangladesh enjoy health and well-being”. It has been developed through an extensive consultation process involving Government, UN agencies, donors, academia and nongovernmental organizations. It reflects the Region's Flagship Priorities, the ‘Sustain. Accelerate. Innovate’ vision, WHO's Thirteenth General Programme of Work, and the Sustainable Development Goals (SDGs).

WHO appreciates the robust inputs of all stakeholders and looks forward to harnessing this CCS to drive impact at the country level. In line with WHO's strategic shifts, and the health needs of Bangladesh, the CCS emphasizes the critical importance of strong policy advocacy and partnership. The CCS will enable WHO's continued assistance to the Government of Bangladesh to achieve universal health coverage and build a stronger platform for progress towards the SDGs. Together we will make rapid and lasting gains for the health and well-being of all the people across the country.

A handwritten signature in black ink, appearing to read 'Poonam Khetrpal Singh'.

**Dr Poonam Khetrpal Singh**

Regional Director  
World Health Organization  
South-East Asia Region

# Preface



The World Health Organization (WHO) has been working in close partnership with the Government of the People's Republic of Bangladesh to strengthen its health systems since the independence of the country. Over the years Bangladesh has made remarkable progress in the health sector in tandem with its socioeconomic growth. Impressive achievements have been made in improving the health status of the population, including increased life expectancy, reduced infant and child mortality, control of communicable diseases, particularly the eradication of polio. But new challenges such as rising noncommunicable diseases, increased risks associated with disasters, environmental threats and health emergencies during disease outbreaks have emerged along with the existing challenges faced by the health systems and service delivery.

To sustain the achievements and address the critical challenges, the Government of Bangladesh has developed the 4<sup>th</sup> Health, Population and Nutrition Sector Programme (HPNSP) 2017–2022 with the aim “to ensure that all citizens of Bangladesh enjoy health and well-being by expanding access to quality and equitable health care in a healthy and safe living environment”. The Government of Bangladesh is committed to ensure universal health coverage (UHC) in order to achieve the Sustainable Development Goal targets by 2030.

The new Country Cooperation Strategy (CCS) 2020–2024 of WHO is a comprehensive document that has been developed through an extensive consultation process involving different stakeholders including the government, UN agencies, development partners, academia, nongovernmental organizations and civil society. The priorities of the CCS are jointly agreed upon and are focused on i) health systems strengthening; ii) promoting healthy lifestyles,

preventing risk factors and protecting people from emerging and re-emerging diseases; iii) creating an enabling environment for healthy life and well-being; and iv) strengthening health system resilience to mitigate climate change effects and manage health emergencies including disease outbreaks. The CCS is aligned with the HPNSP, WHO's Thirteenth General Programme of Work (GPW13) 2019–2023 and the United Nations Development Assistance Framework (UNDAF 2017–2020) for Bangladesh.

We firmly believe that in the coming days the partnership between the Government of Bangladesh and WHO would be further strengthened and through our united efforts a strong platform would be established during this CCS period for achieving the SDGs. Being a most trusted partner of the government, WHO would continue to contribute towards improving the health and well-being of the people of Bangladesh.

**Lokman Hossain Miah**

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

**Dr Bardan Jung Rana**

WHO Representative  
WHO Bangladesh

# Acronyms

|            |   |
|------------|---|
| AFHS       | adolescent-friendly health service                              |
| ASP        | AIDS STI Programme  |
| ASRH       | adolescent sexual reproductive health                           |
| AusAid     | Australian Agency for International Development                 |
| BCC        | behaviour change communication                                  |
| BNHA       | Bangladesh National Health Accounts                             |
| BSMMU      | Bangabandhu Sheikh Mujib Medical University                     |
| CCS        | Country Cooperation Strategy                                    |
| CC         | community clinic  |
| CSOs       | civil society organizations                                     |
| DP         | development partners  |
| ENBC       | essential newborn care  |
| EPI        | Expanded Programme on Immunization                              |
| EPR        | Emergency Preparedness and Response                             |
| EU         | European Union  |
| FAO        | Food and Agriculture Organization of the United Nations         |
| FENSA      | Framework of Engagement with non-State Actors                   |
| FP         | family planning   |
| Gavi       | Gavi, the Vaccine Alliance                                      |
| GFATM      | Global Fund to fight AIDS, Tuberculosis and Malaria             |
| GNSP       | gender, NGO and stakeholder participation                       |
| GoB        | Government of Bangladesh  |
| GPW        | General Programme of Work                                       |
| HIV/AIDS   | human immunodeficiency virus/acquired immunodeficiency syndrome |
| HMIS       | Health Management Information System                            |
| HR         | human resources   |
| HRH        | human resources for health                                      |
| HPNSP      | Health Population Nutrition Sector Programme                    |
| HSSP       | Health Sector Strategic Plan                                    |
| IEC        | information, education and communication                        |
| IHR (2005) | International Health Regulations (2005)                         |
| IMCI       | Integrated Management of Childhood Illnesses                    |
| KOICA      | Korea International Cooperation Agency                          |
| LCG        | local consultative group  |
| MDGs       | Millennium Development Goals                                    |
| MoE        | Ministry of Education   |
| MoH&FW     | Ministry of Health and Family Welfare                           |



|            |  |
|------------|--|
| MMR        | maternal mortality ratio                                       |
| NCD        | noncommunicable diseases                                       |
| NGOs       | nongovernment organizations                                    |
| NTDs       | neglected tropical diseases                                    |
| RMNCAH     | reproductive, maternal, neonatal and child & adolescent health |
| SAM        | severe acute malnutrition                                      |
| SBASP      | school-based adolescent health programme                       |
| SDGs       | Sustainable Development Goals                                  |
| SEA Region | (WHO) South-East Asia Region                                   |
| SEARO      | (WHO) Regional Office for South-East Asia                      |
| TB         | tuberculosis   |
| TFR        | total fertility rate   |
| UN         | United Nations   |
| UNDAF      | United Nations Development Assistance Framework                |
| UNFPA      | United Nations Population Fund                                 |
| UNICEF     | United Nation Children's Fund                                  |
| WB         | the World Bank   |
| WHO        | World Health Organization                                      |

# Executive summary

In the recent decades Bangladesh has made remarkable socioeconomic progress, including poverty reduction, improvement in women’s education, increasing life expectancy and improvement in population health status and indicators such as reduction in under-five mortality rate (for which Bangladesh has achieved the MDG 4 target).

Notable progress has also been made on other key health indicators such as reducing maternal, infant and child deaths and malnutrition, increasing immunization coverage, eliminating infectious diseases such as polio and reducing the incidence of malaria, tuberculosis and diarrhoeal diseases.

But despite such substantial progress, the country now faces new and emerging new challenges such as the rising burden of noncommunicable diseases, increased risks associated with disasters, environmental threats and health emergencies during disease outbreaks including the COVID-19 pandemic that is a serious public health threat to Bangladesh. To establish a resilience system for future potential pandemics, the national capacity for emergency preparedness and early response to health emergencies needs to be bolstered considerably.

Some of the challenges faced by the health systems remain critical, such as high out-of-pocket payments by households, inequitable access to health services between the rich and the poor, lack of quality of care, shortage of skilled service providers, and widespread increase in unregulated informal providers. All of this has slowed down the progress towards achieving universal health coverage (UHC).

To address the newer challenges as well as sustain the achievements, the Government of Bangladesh has developed the 4<sup>th</sup> Health, Population Nutrition Sector Programme (HPNSP) 2017–2022 to realize the global health targets envisaged by the Sustainable

Development Goals (SDGs) for 2030. The HPNSP has articulated a set of objectives, strategies and activities to advance the country towards achieving UHC. The government has accorded firm priority to people-centred accessible health systems focusing on three key areas: i) governance and stewardship; ii) strengthening health systems, and iii) quality of health services.

This new Country Cooperation Strategy (CCS) for 2020–2024 of the WHO Country Office for Bangladesh has been developed based on partnership experiences with the stakeholders that include the government. An interactive process has been followed with in-depth interviews, group discussions and a series of consultative meetings with the government (the Ministry of Health and Family Welfare), development partners, academic institutions, professional bodies, civil society organizations and nongovernmental organizations being a part.

The strategic agendas of the new CCS are aligned with the 4<sup>th</sup> HPNSP 2017–2022, the Government’s 7<sup>th</sup> Five Year Plan (2016–2020), WHO’s priorities and new roles as outlined in the Thirteenth General Programme of Work (GPW13) 2019–2023, the global and regional priorities of WHO including the Regional Director’s Flagship Priority Programmes, and overall the SDGs. This CCS complements the United Nations Development Assistance Framework (UNDAF: 2017–2020) for Bangladesh.

## Country Cooperation Strategy 2020–2024: Strategic priorities

|  |  |
|--|--|
| <p><b>1. Enhance efforts to ensure more people benefit from UHC</b></p> <ul style="list-style-type: none"> <li>• Governance and stewardship</li> <li>• Human resource for health</li> <li>• Digital health</li> <li>• Quality of care</li> <li>• Financial protection</li> </ul> | <p><b>2. Promote healthy lifestyles, prevent risk factors and protect people from emerging and re-emerging diseases</b></p> <ul style="list-style-type: none"> <li>• Noncommunicable diseases (NCDs)</li> <li>• Communicable diseases</li> </ul>   |
| <p><b>3. Creating an enabling environment for healthy life and well-being</b></p> <ul style="list-style-type: none"> <li>• Health and nutrition status of mothers, newborns, children and adolescents.</li> </ul>  | <p><b>4. Strengthen health system resilience to protect health and mitigate effects of health emergencies, including disease outbreaks, and manage effects of climate change</b></p> <ul style="list-style-type: none"> <li>• Environmental health and climate change</li> <li>• Emergency preparedness and response</li> <li>• Disease and nutrition surveillance, laboratory support and case management</li> <li>• IHR Core Capacity</li> <li>• AMR containment</li> <li>• Nutrition</li> <li>• Food safety.</li> </ul> |

## ▶ Introduction: The renewed commitments

The World Health Organization (WHO) has been providing technical assistance to the Government of the Peoples' Republic of Bangladesh to strengthen the country's health systems since 1972. The support provided by WHO includes the development of policies, evidence-based standard guidelines and protocols, capacity enhancement of the health professionals and service providers, strengthening knowledge base and research, monitoring the country's health situation, improving service delivery and overall strengthening of the health systems.

The Country Cooperation Strategy (CCS) is the basis for WHO's collaborative work. It helps promote national ownership and innovative approaches to achieve national health goals. Strategic directions and specific programming support are provided through the CCS to strengthen health systems. It enhances collaboration between partners and stakeholders.

The new Country Cooperation Strategy for 2020–2024 for Bangladesh has been developed based on the lessons learnt and experiences gained during the tenure of the previous CCS, documentary reviews, extensive consultations and policy dialogues with the national counterparts such as the Ministry of Health and Family Welfare (MoH&FW) and other key stakeholders including development partners (DPs), academic institutions, professional bodies, nongovernmental organizations (NGOs) and civil society organizations (CSOs), and WHO's new transformative role and mandate, as well as country-level engagements of United Nations (UN) agencies.

The new CCS is aligned with the 4<sup>th</sup> Health, Population and Nutrition Sector Programme (1), WHO's priorities outlined in the Thirteenth General Programme of Work (GPW13) 2019–2023 (2), WHO's global and regional priorities including specifically the Regional Director's Flagship Priority Programmes and overall the Sustainable Development Goals (SDGs) (3).

The CCS also complements the United Nations Development Assistance Framework (UNDAF) 2017–2020 (4) for Bangladesh.

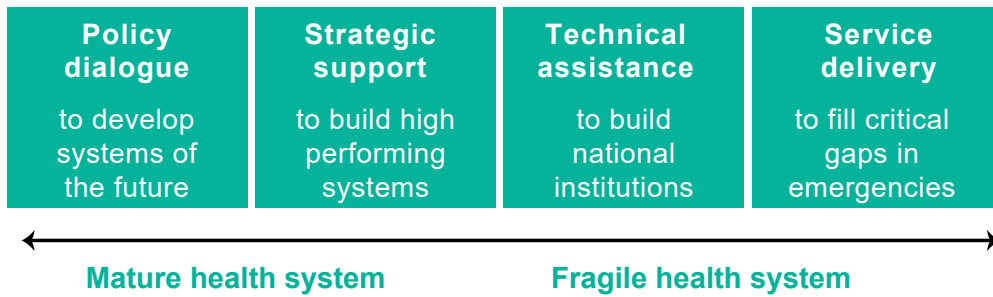
### Country Cooperation Strategy 2020–2024: Guiding principles (5)

- Ownership of the development process by the country including the process of transformation of the health system.
- Result-based and equitable approaches that are in alignment with national priorities, systems and procedures.
- Better partnership building involving multiple health and development stakeholders.
- Harmonization of processes among various UN organizations.

Considering the transitional phase of Bangladesh in terms of its socioeconomic situation as well as WHO's strategic shifts towards result oriented approaches, as adopted in the new WHO Thirteenth General Programme of Work (Fig. 1), emphasis will be given on: policy advocacy, strengthening partnership and networking, knowledge management, quality technical assistance and resource mobilization, throughout the CCS implementation process.

Fig. 1. WHO's Strategic shifts and Core Functions

**DRIVING PUBLIC HEALTH IMPACT IN EVERY COUNTRY**  
differentiated approach based on capacity and vulnerability



Source: Thirteenth General Programme of Work, WHO, 2019–2023 (2)

For implementing the CCS, continuous technical support would be provided by the Regional Office and WHO headquarters to the Bangladesh Country Office, for which a highly competent country office team will be in place. A structured monitoring mechanism will be developed to track the performance in the light of the CCS Results Framework. A mid-term review and a final evaluation towards the end of the CCS cycle will also be conducted.





## 2.1 Political, economic, demographic and social context

### 2.1.1 Political

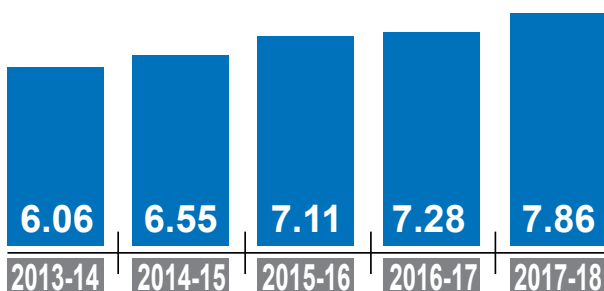


Bangladesh is a parliamentary representative democratic republic with a multiparty system with the Prime Minister of Bangladesh as the head of the government. Executive power is exercised by the government while legislative authority is vested in both the government and Parliament. The current (2021) ruling party has been elected for three consecutive terms. As one of the top performing countries in terms of the Millennium Development Goals, the current government is committed to achieve the Sustainable Development Goal targets (3) by 2030. There are more than 60 ministries and divisions, including Ministry of Health and Family Welfare (MoH&FW), in the government, which is a multi-tier centralized system.

### 2.1.2 Economic

The growth of the gross domestic product was 7.86% during 2017–2018 from 6.06% in 2013–2014. The poverty rate declined to 21.8% in 2018 from 31.5% in 2009. In 1975 Bangladesh was accorded the “least developed country” status in economic terms. On the other hand, in 2015 Bangladesh was recognized by the World Bank as a low-middle-income country. In 2018, Bangladesh fulfilled all the three eligibility criteria to graduate from the

Fig. 2 GDP GROWTH (in %) 2013-2018



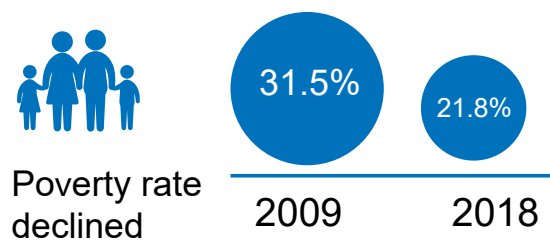
Source: Bangladesh Bureau of Statistics, 2018 (6)

UN’s list of least developed countries for the first time and is on track to graduate from in 2026 [Fig. 2 & 3].

### 2.1.3 Demographic profile

In 2019 Bangladesh had an estimated population

Fig. 3 Poverty rate 2009-2018



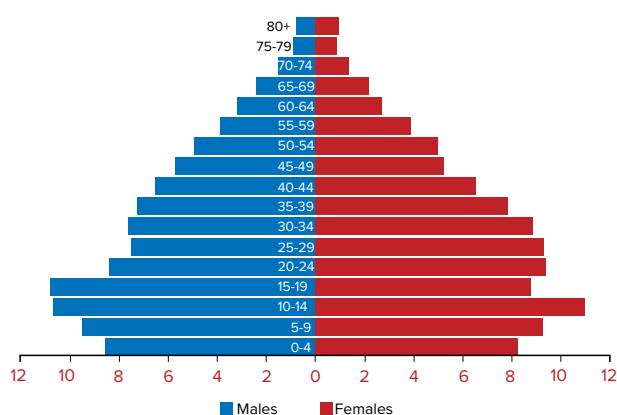
Source: Bangladesh Bureau of Statistics, 2018 (6)

of 166.5 million,<sup>1</sup> up from the 2014 estimate of 156.8 million. The country has a population density of 1116 people per square kilometer. The population of Bangladesh is very young, and the population pyramid has a wider base at the bottom than at the top and

<sup>1</sup>Estimated population, 1 July 2019, Bangladesh Sample Vital Statistics, 2019

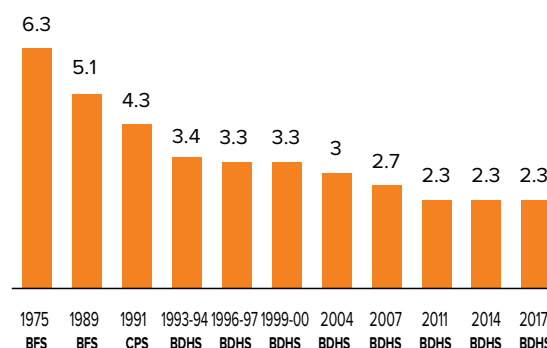
narrows towards the older age groups. Since the 2011 BDHS (7), the total fertility rate (TFR) has remained at 2.3. Due to high adolescent fertility rate (108 per 1000 women aged 15–19 years) and a large childbearing population of 28% (BDHS 2017–2018),(8) a large cohort of the young population will enter the reproductive age in the coming decades. The fertility rate is unlikely to decrease significantly for decades [Fig. 4 & 5].

Fig. 4. Population pyramid of Bangladesh 2019



Source: Bangladesh Sample Vital Registration System (SVRS) 2019 (9)

Fig. 5. Trends in total fertility rate in Bangladesh 1975–2017



Source: Bangladesh Demographic Health Survey (BDHS) 2017 (7)

### 2.1.4. Social

Bangladesh was ranked 135th among 189 countries in the Global Human Development Index (HDI) in 2018.<sup>2</sup> According to UNESCO, in 2017 Bangladesh had an adult literacy rate of 72.89%, with male literacy rate at 75.7% and female at 70.09%. Various women’s empowerment efforts have helped the country make steady progress in gender equality. Bangladesh secured the 47th position among 144 countries in 2017 as per the Global Gender Gap Report.



Gender has been incorporated through cross-cutting issues in the current health sector plan of the Ministry of Health and Family Welfare (4<sup>th</sup> HPNSP: 2017–2022) (1). The Gender Equity Action Plan 2014–2024 has been developed and the Women-Friendly Hospital Initiative (WFHI) has been launched.

However, the incidence of gender-based violence (GVB) is alarmingly high in Bangladesh. The Violence Against Women (VAW) Survey conducted by the Bangladesh Bureau of Statistics in 2015 revealed that approximately 73% of ever-married women in Bangladesh have experienced some form of partner violence in their lifetime.

## 2.2. Overall health status

### 2.2.1 Life expectancy at birth and healthy life expectancy at birth (HALE)

#### Life expectancy at birth

The life expectancy at birth has increased from 65.2 years to 71.1 years for males and from 65.7 years to 74.4 years for females from the year 2000 to 2016.

Averaged for both sexes it was 72.7 years in 2016, which is more than the average life expectancy at birth of the global population (72 years).

[WHO Global Health Observatory update 2018-04-06] (10)

#### Healthy Life expectancy (HALE) at birth

Healthy life expectancy (HALE) at birth has also increased during this period from 56.8 years to 62.6 years for males and 56.2 to 64.1 years for females.

For both sexes, it was 63.3 years, which is the same as the HALE for the global population.

[WHO Global Health Observatory update 2018-04-06] (11)

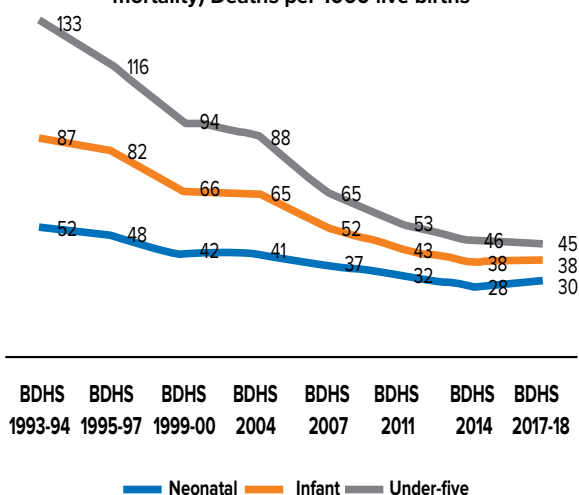
<sup>2</sup>United Nations Development Programme. Human Development Report 2019. New York (USA): UNDP; 2019. 366p. eISSN: 2412-3129

## 2.3. Health, nutrition, and wellbeing

### 2.3.1 Child health and nutrition

Bangladesh has made remarkable progress in reducing infant and under-five deaths during the last 10 years (from 52 to 38 per 1000 live births and 65 to 45 per 1000 live births respectively) (BDHS 2017) (12). But the reduction in neonatal mortality has been slower (37 to 30 per 1000 live births) [Fig. 6]. The majority of the neonatal deaths are due to preventable causes such as birth asphyxia, prematurity and low birth weight and possible serious bacterial infection. Strengthening of social behaviour change communication with proper care-seeking and scale-up of evidence-based quality newborn interventions such as the Bangladesh Every Newborn Action Plan (BENAP) are necessary for better results.

**Fig. 6. Childhood mortality (neonatal, infant & under-five mortality) Deaths per 1000 live births**

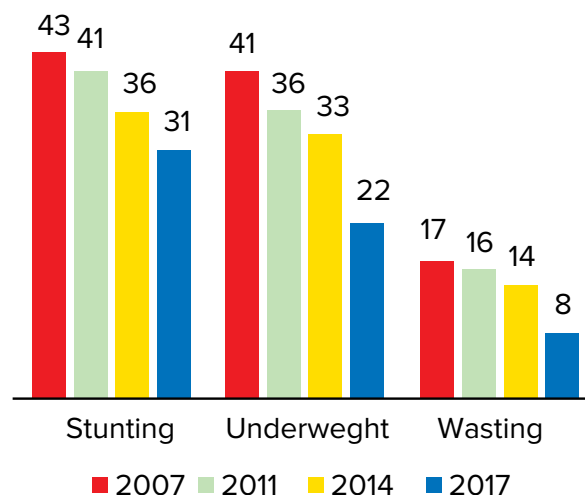


Source: BDHS 2017–2018 (12)

According to BDHS 2017, 86% of children have received the full range of vaccinations by their first birthday. But challenges remain for the urban vaccination programme. Diarrhoea prevalence has decreased remarkably, as only 5% of under-five children had diarrhoea. The use of oral rehydration solution (ORS) for the treatment of diarrhoea has also increased to 83%. However, the causes of under-five deaths currently are mainly pneumonia and neonatal causes, with drowning with pneumonia being the single-most important cause (21%). It is encouraging that, the level of stunting, underweight and wasting among children under five years of age have declined during 2007–2017 (Fig.7).

**Fig. 7: Trends in nutritional status of children 2007–2017**

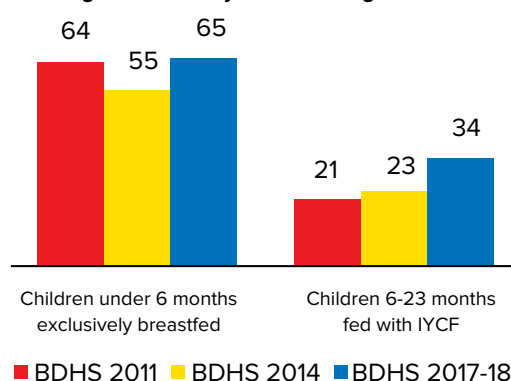
**Percentage of children under 5 based on WHO growth standard 2006**



Source: BDHS 2017–2018 (12)

Exclusive breastfeeding in children aged less than 6 months has also increased from 55% (BDHS2014) (8) to 65% (BDHS 2017) (8). Infant and Young Child Feeding (IYFC) practices among children aged 5 to 23 months have increased from 23% (BDHS 2014) (8) to 34% (BDHS 2017) (12) (Fig. 8). To combat malnutrition in all its forms the Second National Plan of Action for Nutrition (NPAN 2) 2016–2025 has been developed with the involvement of more than 17 ministries and numerous stakeholders and partners. The aim of NPAN2 is to improve the nutritional status of all citizens and reduce all forms of malnutrition, with a focus on children, adolescent girls, pregnant women and lactating mothers.

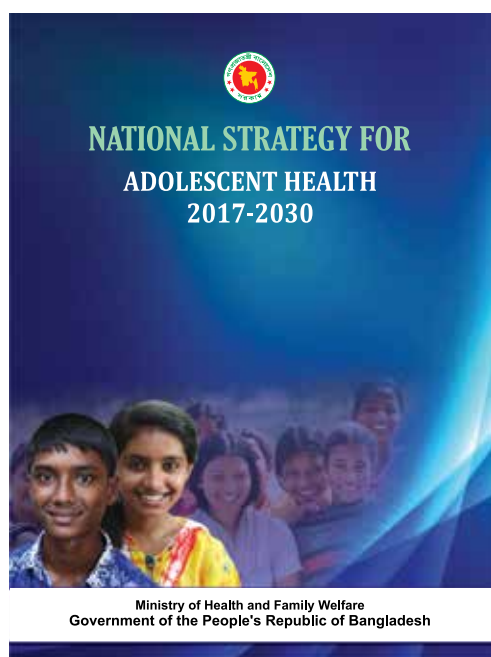
**Fig. 8. Exclusively breastfeeding and IYFC**



Source: BDHS 2017–2018 (12)

## 2.3.2 Adolescent health and nutrition

- The total number of adolescents is 30 674 000 in 2020. This is 19% of the total population of Bangladesh (National Strategy for Adolescent Health 2017-2030). About 30% of the total population in Bangladesh belongs to the age-group 10–24.<sup>3</sup>
- High rates of child marriage (59% of girls get married before the age of 18 years) and adolescent pregnancies (31% of adolescents aged 15–19 have been pregnant) are contributing to high neonatal and maternal mortality and morbidity.
- A National Strategy for Adolescent Health and Action Plan 2017–2030 (14) has been developed.
- Adolescent-Friendly Health Services (AFHS) have been established on pilot basis in public health facilities.
- School-based adolescent health programmes and nutrition services have also been initiated, including adolescent sexual and reproductive health rights (SRHR), nutrition, preventing violence against adolescents, and addressing their mental health issues. More technical assistance would be required to implement the National Plan of Action, including innovative behaviour change communication interventions.



## 2.3.3 Maternal health and nutrition

The reducing trends in maternal mortality ratio (MMR) are very pronounced: MMR declined from 399 per 100 000 live births in 2000 to 165 per 100 000 live births in 2019 (SVRS 2019) (15). The government is committed to reach the SDG target reduction in MMR to 70 per 100 000 live births by 2030. The three major reasons for maternal mortality in Bangladesh are: postpartum haemorrhage (PPH), eclampsia and obstructed labour during pregnancy, labour and the postpartum period.

The Bangladesh National Strategy for Maternal Health 2015–2030 (revised) has been finalized and the SOPs related to the revised Strategy have also been approved (16). Cervical cancer is the second-most common type of cancer in Bangladesh with approximately 12 000 new cases detected every year and over 6000 deaths annually due to the severity of the disease. The National Strategy for Cervical Cancer Prevention and Control: 2017–2022 (17) has been developed by MoH&FW with technical support from Bangabandhu Sheikh Mujib Medical University (BSMMU), WHO and the United Nations Population Fund (UNFPA).

Antenatal care (ANC) coverage (at least four ANC visits) was at 21% according to BDHS 2007 (18) and increased to 47% in 2017. (12) Proportion of delivery by skilled birth attendants (SBA) has increased from 18% (BDHS 2007) (18) to 53% (BDHS 2017) (12). Half of the mothers received postnatal care (PNC) within two days of delivery [Fig. 9].

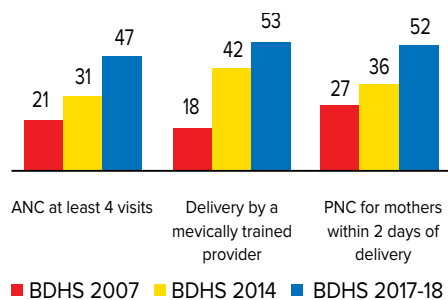
The private sector became a major actor in providing delivery services as about a third of all deliveries are taking place in private facilities compared with only 14% in the public sector. Home delivery remains high at 50% [Fig. 10]. Inequity in use of facility for delivery among women in the highest and lowest wealth quintile is still high. The richest women are now three times more likely to deliver in health facilities compared with the poorest [Fig. 11].

Increase in caesarean section deliveries became alarming as one third of all births taking place were through C-sections and in the private sector this figure was as high as 84% of deliveries (BDHS 2017). (12)

<sup>3</sup>United Nations Population Fund. The State of the World's Population 2014. New York (USA): UNFPA; 2014. 136p. ISBN 978-0-89714-972-3

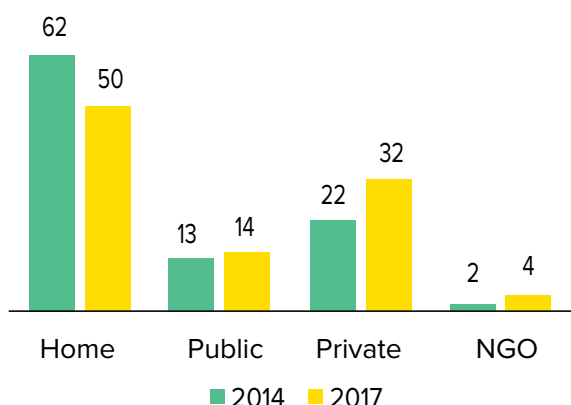


**Fig. 9. ANC visit, delivery by medically trained provider and PNC visits: 2007–2018**



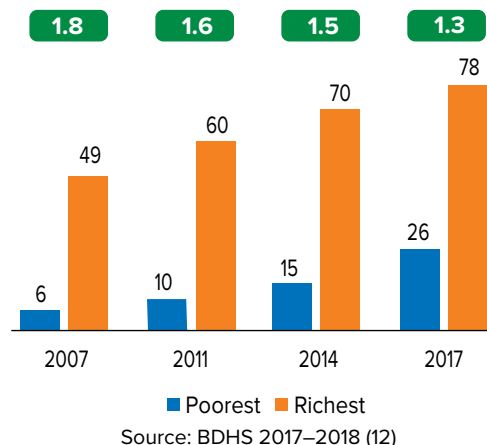
Source: BDHS 2017–2018 (12)

**Fig. 10. Percentage of deliveries in last three years**



Source: BDHS 2017–2018 (12)

**Fig. 11. Inequity in use of facility for delivery: 2007–2017**



Source: BDHS 2017–2018 (12)

## 2.4. Disease burden

### 2.4.1. Communicable diseases

#### 2.4.1.1 Tuberculosis

Bangladesh is one of the world's 30 high-tuberculosis (TB)-burden countries with annual incidence of 361 000 cases [Table 1]. About 38 000 people die annually due to TB.<sup>4</sup> The National Strategic Plan for TB Control 2021–2025 (19) has been developed in line with the Global End TB Strategy. The Strategy focuses on increased treatment coverage, sustaining treatment success rate, increasing case detection of MDR-TB and child TB, TB preventive treatment, and sustained financial support to deliver the quality services needed to achieve the goal of the Global End TB Strategy. WHO has been providing technical support to the National Tuberculosis Control Programme (NTP) (20) and the Ministry of Health and Family Welfare in line with post-2015 Global End Tuberculosis Strategy, Delhi Call for Action, and United Nations High-Level Meeting (UNHLM) on TB to strengthen the TB interventions.

**Table 1. Tuberculosis – Bangladesh scenario, 2019**

|   | Number                       | (Rate per 100 000 population) |
|---|------------------------------|-------------------------------|
| Total TB incidence  | 361 000<br>(262 000–474,000) | 221<br>(161–291)              |
| TB/HIV incidence  | 700<br>(350–1200)            | 0.43<br>(0.21–0.72)           |
| MDR/RR-TB incidence                                       | 3 300<br>(1600–5500)         | 2<br>(0.98–3.4)               |
| Proportion of MDR/RR TB among TB new cases                | 0.7%                         |                               |
| Proportion of MDR/RR TB among previously treated TB cases | 11%                          |                               |
| HIV -ve TB mortality                                      | 38 000<br>(24 000–56 000)    | 24<br>(15–34)                 |
| HIV +ve TB mortality                                      | 150<br>(74–260)              | 0.09<br>(0.05–0.16)           |

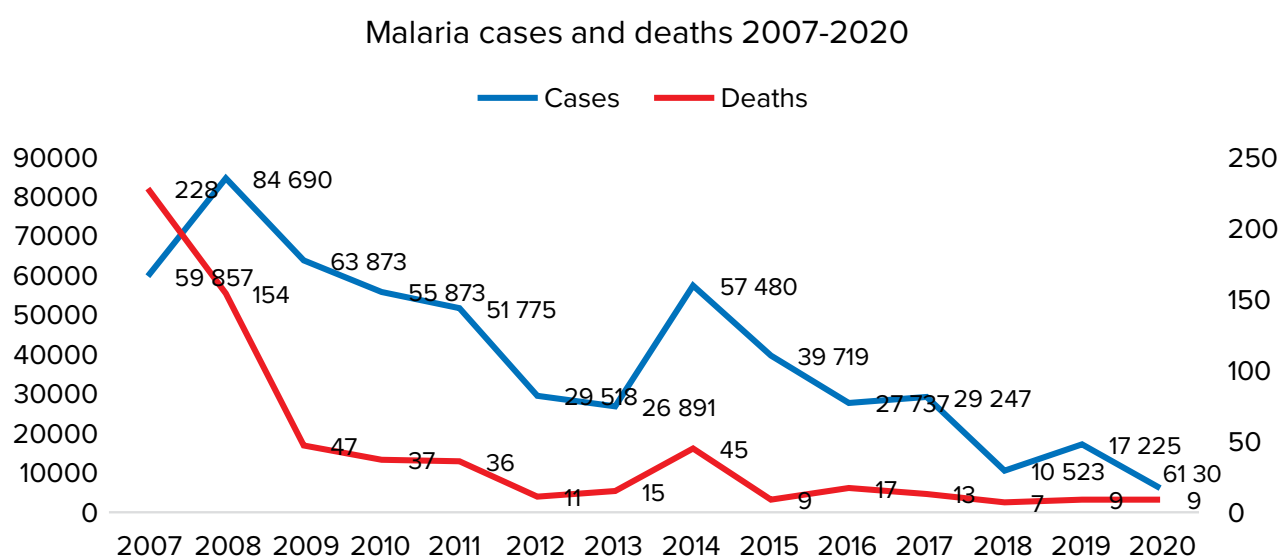
<sup>4</sup>WHO Global Tuberculosis Report 2020

The challenges in controlling TB include : i) detection and management of childhood TB are still largely insufficient; ii) increase in urban TB prevalence among elderly and in workplaces and lack of effective coordination of TB response; iii) low detection of MDR-TB cases and expansion of Gene Xpert; iv) limited engagement of private practitioners and public/private hospitals and mandatory TB case notification not operationalized; v) introduction of TB preventive treatment; and vi) the high dependence of TB response on external funding.

### 2.4.1.2 Malaria

Malaria is endemic in 13 of the 64 districts of Bangladesh and is hyper-endemic in three hilly districts. Successful implementation of early diagnosis and prompt treatment as well as appropriate preventive interventions have drastically reduced the burden in the country over the years (Fig. 12). Only 6130 malaria cases and nine deaths have been reported in 2020. The annual parasite incidence (API) has been reduced to 0.32 per 1000 population. Eight districts targeted for elimination reported only 24 cases in 2020. The National Strategic Plan 2021–2025 has been developed with the aim to eliminate malaria in a phased manner by 2030. WHO is providing technical assistance for strengthening the malaria surveillance system and cross-border collaboration with neighbouring countries.

Fig. 12. Malaria cases and deaths



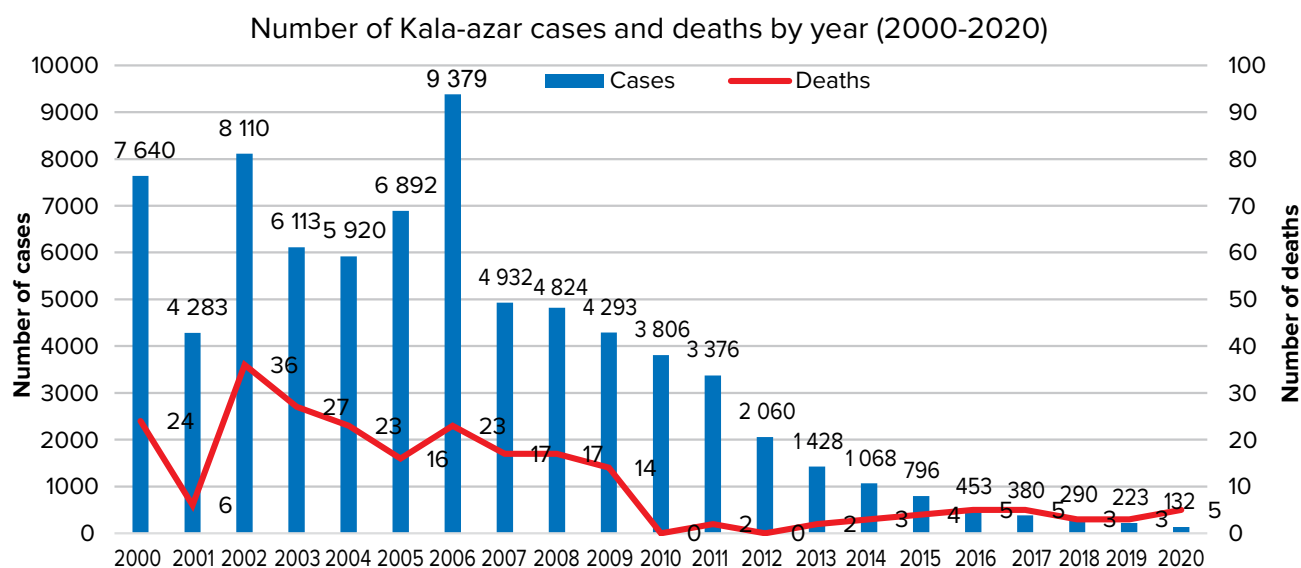
### 2.4.1.3 Neglected tropical diseases

Neglected tropical diseases (NTDs) cause immense human suffering, disability and death. Bangladesh has a high burden of neglected tropical diseases, particularly kala-azar, lymphatic filariasis, soil-transmitted helminthiasis (STH), dengue and chikungunya, leprosy, rabies and snake-bite. Improved programme management of neglected tropical diseases (NTDs) at the national level and coordination among international partners have enabled the attainment of significant results on many programmatic fronts. Bangladesh is on the right track to eliminate neglected tropical diseases such as kala-azar and lymphatic filariasis. WHO Bangladesh is providing supporting for all NTD prevention and control so that the country can achieve the targets related to SDGs and the NTD roadmap.

## A. Kala-azar

Kala-azar is endemic to 100 upazilas (sub-districts) in Bangladesh. The country achieved the target for elimination of kala-azar as a public health problem, which is an incidence rate of <1/10 000 population, in 2016.

Fig. 13 Number of kala-azar and post-kala-azar dermal leishmaniasis cases and deaths in kala-azar endemic upazilas in Bangladesh



Since then, Bangladesh has been maintaining this status with gradual reduction of new cases. Early detection and prompt treatment of cases, indoor residual spray (IRS) and surveillance with response under the National Kala-azar Elimination Programme (NKEP) played an important role in the gradual reduction of cases.

WHO has been supporting NKEP to develop national capacity to detect and manage cases, strengthen surveillance through the Surveillance Medical Officer's (SMO) network, and conduct active case searches within the community. WHO has also been providing technical assistance to develop a kala-azar national strategic plan, various guidelines and a country dossier development for validation of the elimination of kala-azar as a public health problem.

## B. Lymphatic filariasis and soil-transmitted helminthiasis

Lymphatic filariasis is endemic in 34 districts. Of them 19 districts were selected for MDA and 15 were placed under observation as low-endemic. The National Strategic Plan for Lymphatic Filariasis Elimination (2018–2025) has been developed to sustain the gains of LF elimination as a public health problem and progress towards zero incidence level and contribute to the SDG 3 targets. The key challenges include interventions to control morbidity (case management), vector control, surveillance and social mobilization.

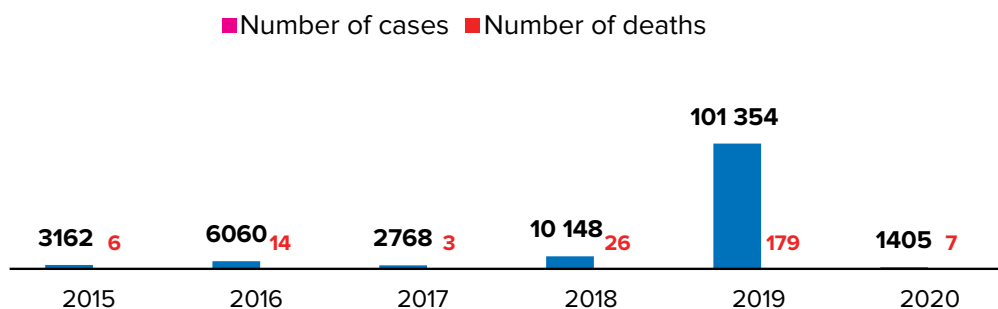
The STH control programme was started nationally in 2008 with the aim to cover 75%–100% school-aged children (6–12 years). Thereafter the programme was scaled up to 5–16 years by the year 2017 covering 40 million children. The programme has demonstrated success by administering >95% school aged children and lowering the worm load to 7.85, according to the survey of 2018–2019.

## C. Dengue

Dengue fever has now become a major public health concern in Bangladesh with trends increasing in recent years. The highest numbers of incidence (101 354 cases) and death (179) were reported (Fig. 14) in 2019. The National Programme revised the Guideline for Dengue Case Management in 2020, which was developed<sup>5</sup> in 2018, with support from WHO. The National Programme conducts periodic Aedes mosquito density survey, capacity-building of the service providers and awareness-raising programmes for prevention and control of the disease. WHO has been providing support in diagnosis (procuring dengue rapid tests kits), updating the integrated vector control guidelines and building local capacity in dengue case management and disease surveillance.

<sup>5</sup>The National Malaria & Aedes-transmitted Diseases' Control Programme, Disease Control Unit, Directorate General of Health Services, "National Guideline for Clinical Management of Dengue Syndrome (4th Edition), 2018.

Fig. 14. Dengue situation in Bangladesh 2015–2020

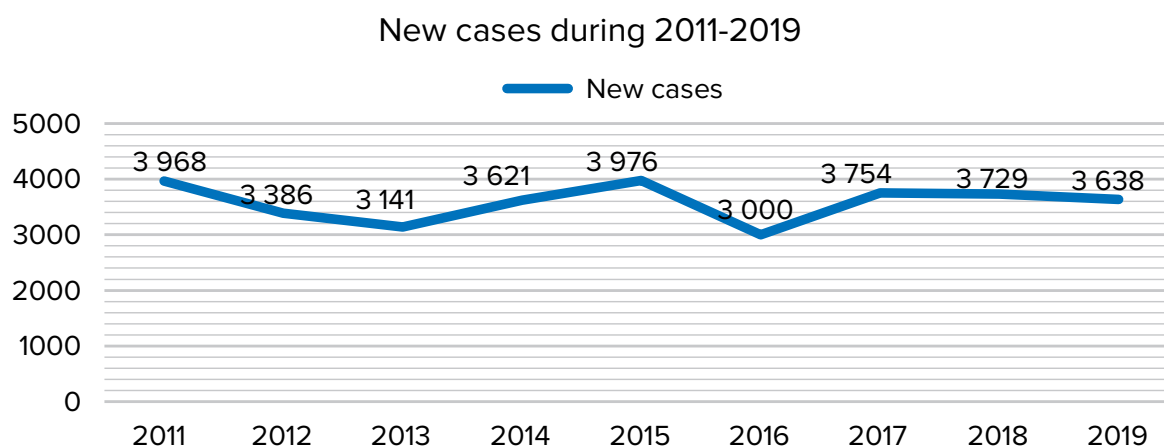


Source: DGHS, 2020

#### D. Leprosy

Although the leprosy elimination target has been achieved at the national level (<1 case/10 000) the subnational targets are yet to be achieved in endemic districts that pose a threat of re-emergence of the disease. In recent years (2011–2019), on an average more than 3500 new cases have been detected (Fig. 15). The National Post-Elimination Leprosy Control Strategy 2016–2020 for Bangladesh has been revised (24) and discussions initiated for the next strategic plan in line with the WHO Global Strategy (2021–2030)

Fig. 15. New Leprosy cases



Source: NLP data 2011–2019

Table 2. Achievement of leprosy activities in Bangladesh

| Parameter                               | 1985  | 1996  | 1998  | 2018  | 2019  |
|---|---|---|---|---|---|
| Introduction of MDT                     | 120 high-endemic subdistricts (120 MDT centres) | 100% nationwide geographical coverage (625 MDT centres) | 100% nationwide geographical coverage (625 MDT centres) | 100% nationwide geographical coverage (581 MDT centres) | 100% nationwide geographical coverage (581 MDT centres) |
| Prevalence rate (per 10 000 population) | 10.79   | 1.19  | 0.869 (elimination achieved)                            | 0.19  | 0.19  |
| New case detection                      | 4834  | 11,226  | 12 371  | 3 729   | 3 638   |
| G2D rate                                | 35.58%  | 11.28   | 8.73%   | 7.96 %  | 6.93 %  |
| Child case rate                         | 7.96%   | 15.85%  | 15.43%  | 5.86%   | 5.77  |
| G2D/1 000 000 population                | 21.5  | 13.32   | 12.52   | 1.78  | 1.44  |

Source: DGHS 2019



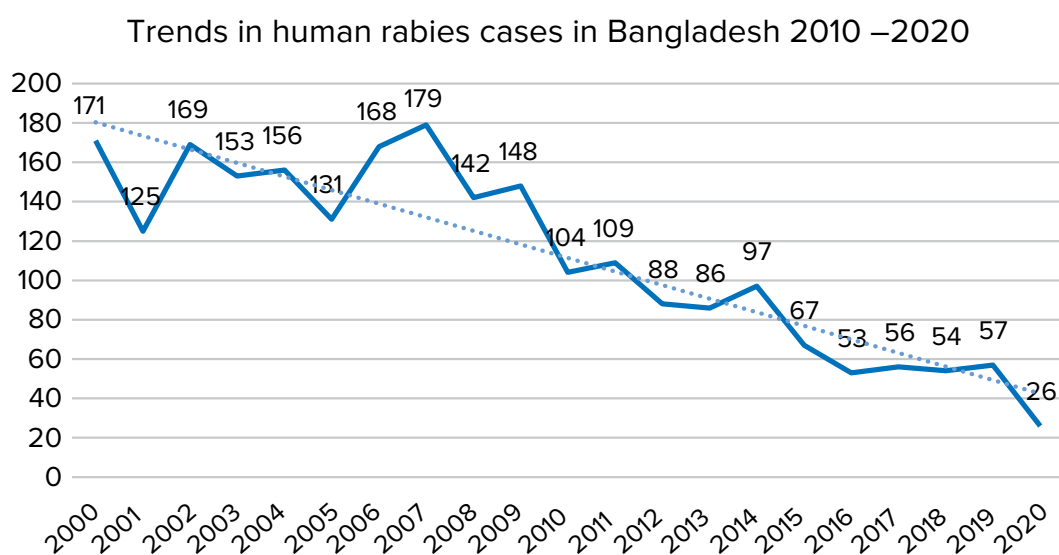
## E. Rabies

Bangladesh is now at a crucial stage of its rabies elimination. The CDC (Communicable Disease Control Unit) of DGHS, Bangladesh, has taken a National Rabies Strategy Plan to facilitate rabies elimination in Bangladesh. There is one NRPPC (National Rabies Prevention Control Centre) and 66 DRPCC (district rabies prevention control centres) in Bangladesh that provide rabies vaccines to people affected by the dog and animal bites.

About 427 583 and 262 742 people have received vaccines for Rabies throughout Bangladesh in 2019 and 2020 respectively. The MDV (mass dog vaccination) campaign conducted in 2011–2012 revealed a paradigm shift from control to elimination of rabies. For the prevention of spread of rabies, herd immunity can be achieved throughout the MDV programme by vaccinating dogs at the micro level.

The combined impact of mass awareness programme, post-exposure prophylaxis and consistent MDV programmes can decrease the annual rabies caseload in Bangladesh. At least one round of MDV has been executed in 62 districts till 2020 and a strong declining trend in rabies cases has been observed in the country over the period 2000 to 2020 (Fig. 16). However, it is necessary to strengthen the existing rabies surveillance system and three rounds of MDV should be completed to achieve the elimination of rabies by 2022.

Fig. 16. Trends in human rabies cases



Source: IDH, BITID and district vaccination centres of Bangladesh, 2020

## F. Snake-bite envenoming

Snake-bite envenoming is a neglected tropical disease that is responsible for enormous suffering, disability and premature death on every continent. WHO has developed a comprehensive strategy to fulfil its mandate to direct and coordinate global action on snake-bites. A national strategy has been planned to be developed in line with the Global Strategy which will require transformational public– private investment with long-term commitment by partners and governments committed to ensuring that the targets and milestones are achieved to halve the numbers of snake-bite deaths and cases of disability by 50% by 2030.

### 2.4.1.4 HIV/AIDS

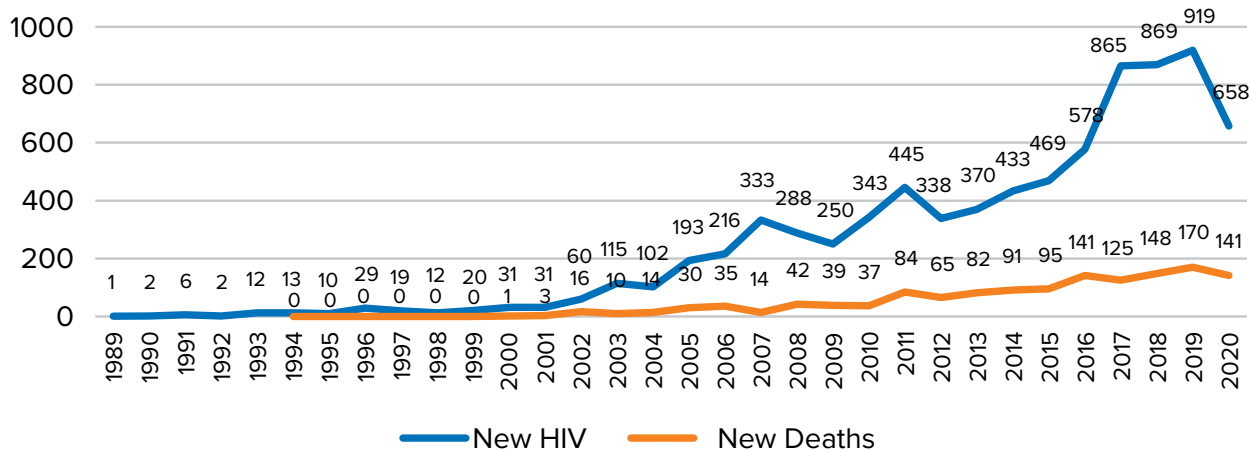
Bangladesh is considered to be a low-prevalence country for HIV, but incidence of new cases has led to diagnosis increasing every year since 2000 with expansion of diagnosis facilities. Over the last few years about 800–950 new HIV infections are diagnosed among key populations and in the general population. As of 2020 a total of 8032 cases have been confirmed in the country of which 1383 have died of the disease as per programme data.

New cases have increased among the general population in the country over the last three years, especially among returning migrants. The country has significantly achieved the global target with 57% of people living with HIV/AIDS (PLHIV) knowing their status, 76% of PLHIVs on antiretroviral therapy (ART) and 88% are virally suppressed, against the programmatic target of 90-90-90.

Still there remains a challenge in achieving the first “90” of the triple target. In recent years the Forcibly Displaced Myanmar Nationals (FDMNs) population has also contributed a significant number of PHIV who have already enrolled in the treatment programme. Considering the current changes and programmatic modality AIDS STI Programme (ASP) updated its 4th National Strategic Plan for HIV and AIDS Response: 2018–2023. The National Strategic Plan (NSP) emphasizes prevention, case detection, universal access to treatment and surveillance. In order to achieve the NSP goals and objectives, ASP revised its operational plan in 2020 with an extension of the target period and has also designed an implementation plan with the support of the Global Fund and other donors.

Fig. 17. Trends in new HIV cases and deaths

### Trends in new HIV cases and deaths 1989-2020



Source: ASP Programme data 2020

#### 2.4.1.5 Hepatitis

Bangladesh along with all Member States of WHO committed to eliminating viral hepatitis as a public health threat by 2030 (defined as a 65% reduction in mortality and a 90% reduction in incidence compared with the 2015 baseline). Viral hepatitis is the seventh leading cause of death globally, accounting for 1.4 million deaths per year. In Bangladesh the prevalence of hepatitis B and C viruses have been estimated at 5.5% and 0.6% respectively.

It has been estimated that in Bangladesh, more than 10 million people are living with viral hepatitis. Liver diseases account for 8%–12% of all admissions in medicine wards. By 2030, globally, 20 million people are expected to die from hepatitis B and the number of people living with hepatitis C is increasing, despite an effective cure being available. A stepped-up national and global response can no longer be delayed.

The establishment of a multisectoral approach for planning, coordination and implementation of viral hepatitis prevention and cure activities by developing the strategy in 2019. Training on viral hepatitis has been provided to health-care providers at different tiers. Hepatitis B and C screening and hepatitis B vaccines have been provided to all health-care providers free of cost in 33 districts as well as in major institutions of the country. Antivirals for hepatitis C were distributed among the patients free of cost since 2017. Much remains to be done in Bangladesh on diagnosis and treatment of hepatitis B and C. Cooperation is needed with GoB fund in the field of diagnosis, management and surveillance of these diseases.

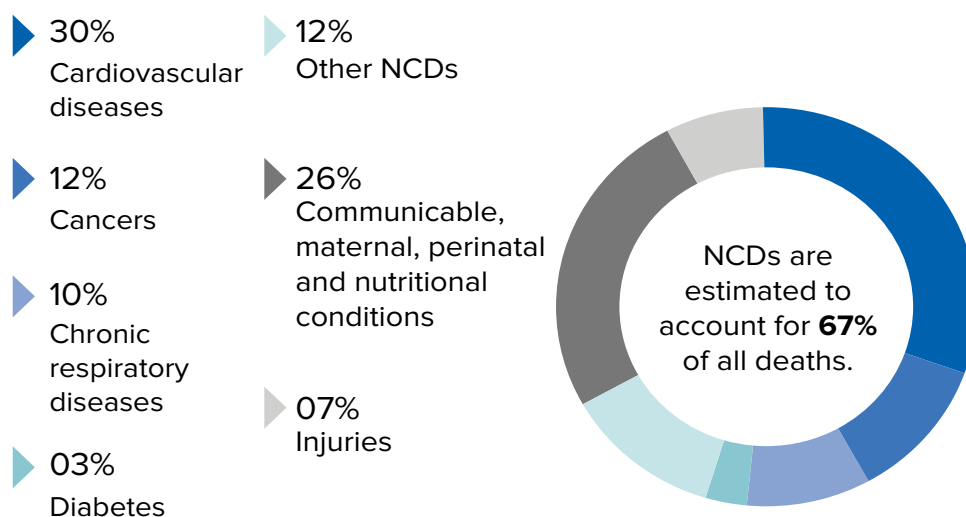
### 2.4.1.6 Vaccine-preventable diseases

|   |   |
|---|---|
| <ul style="list-style-type: none"> <li>• According to the Coverage Evaluation Survey (CES) 2019, valid national pentavalent coverage (Penta3) by 23 months is 93.3% and MR1 is 92.8% and all districts have achieved more than 80% coverage.</li> <li>• Bangladesh has introduced several new vaccines in the past decades – hepatitis B, Hib, PCV, rubella and IPV.</li> <li>• WHO has been providing technical support in vaccine-preventable disease surveillance, new vaccine introduction, immunization and outbreak response and disaster management through the Surveillance and Immunization Medical Officers Network.</li> </ul> | <ul style="list-style-type: none"> <li>• Bangladesh had achieved the maternal and neonatal tetanus elimination goal in 2008 and maintained elimination status since then. Bangladesh achieved the rubella and congenital rubella syndrome (CRS) control goal in 2018, and the hepatitis B control goal in 2019.</li> <li>• Bangladesh has received Gavi awards for best performance in routine immunization in 2009 and 2012. H.E Ms Sheikh Hasina, Prime Minister of Bangladesh, was honoured with the second “Vaccine Hero Award” by Gavi on 23 September 2019 for her contribution to immunization and child health to save the lives of children.</li> <li>• Bangladesh has set a target of measles, rubella and CRS elimination by 2023. Bangladesh continues to sustain its polio-free status and is implementing Global Polio Endgame strategies.</li> </ul> |
|---|---|

### 2.4.2. Noncommunicable diseases

The burden of noncommunicable diseases (NCDs) in Bangladesh is alarming. NCDs, mainly cardiovascular diseases, cancer, chronic respiratory disease and diabetes, are responsible for 580 000 deaths every year in the country. This is 67% of the total number of deaths in the country<sup>6</sup> (Fig. 18 ). Many of these deaths are premature. However, the premature deaths and disabilities can be largely prevented by controlling the behavioural risk factors, including use of tobacco, unhealthy diet and physical inactivity, as well as biological risk factors such as high blood pressure, high blood sugar and increased blood cholesterol levels.

Fig. 18. Proportional mortality



Source: WHO Noncommunicable Diseases (NCD) country profiles, 2018

<sup>6</sup>World Health Organization. Noncommunicable diseases country profiles 2018 [Internet]. Geneva (CH): WHO; 2020[cited 21 January 2020]. Available from: <https://www.who.int/nmh/publications/ncd-progress-monitor-2017/en/>

The Bangladesh NCD Risk Factor Survey 2018 (STEPS) (28) revealed high prevalence of these NCD risk factors with marked differences between urban and rural populations (Table 3)

**Table 3. Prevalence of behavioural, anthropometric and biochemical risk factors among adult populations of rural and urban areas in Bangladesh**

| Key risk factors   | Both | Men  | Women | Urban | Rural |
|--|------|------|-------|-------|-------|
| Inadequate intake of fruits and/or vegetables (<5 servings per day)  | 89.6 | 90.0 | 89.3  | 92.1  | 88.9  |
| Insufficient physical activity   | 12.3 | 9.6  | 14.8  | 14.2  | 11.7  |
| Prevalence (%) of overweight (body mass index 25–29.9 kgm <sup>2</sup> )                                       | 20.5 | 16.0 | 25.1  | 26.0  | 18.9  |
| Prevalence (%) of hypertension (blood pressure: systolic ≥140 mmHg or diastolic ≥90 mmHg or on drug treatment) | 21.0 | 17.9 | 24.1  | 25.2  | 19.8  |
| Prevalence (%) of diabetes (fasting blood glucose ≥126 mg/dl or on drug treatment)                             | 8.3  | 8.9  | 7.9   | 13.2  | 7.1   |

Source: Bangladesh NCD Risk Factor Survey 2018, NIPSOM/WHO

**Tobacco:** Bangladesh has ratified the WHO Framework Convention on Tobacco Control (FCTC) and enacted the Smoking and Tobacco Products Usage (Control) Act. The Government has imposed a 1% health development surcharge on all tobacco products over and above the regular taxes. However, consumption of different forms of tobacco products in Bangladesh remains high. It has been reported that the number of users of smoking and smokeless forms of tobacco respectively among persons aged 15 years and older is as high as 19.2 million (18%) and 22 million (20.6%) (GATS 2017) (29).



Training of Trainers (ToT) on the WHO Package of Essential Noncommunicable Disease Interventions for Primary Care (PEN)

Production of tobacco in Bangladesh is also on the rise along with challenges posed by easily affordable tobacco products and tobacco industry interference. WHO has been supporting the National Tobacco Control Cell of the MoH & FW in improving the enforcement levels of tobacco control laws through building capacity of the authorized officers. To achieve the government’s vision of a “Tobacco-free Bangladesh by 2040”, more robust collaboration would be required among different stakeholders and partners to accelerate implementation of the WHO

FCTC (30). Countering tobacco industry interference and raising the price of tobacco products to deter consumption must be taken up on priority.

**High salt intake:** This is a major risk factor for high blood pressure and can ultimately lead to cardiovascular disease and other organ failure. Dietary salt intake in Bangladesh is much higher than what is recommended by WHO. The mean population salt intake for adults aged 20 and above in the country was estimated to be 9 g/day, which is almost double that which is recommended by WHO (5 g/day).<sup>7</sup> The STEPS 2018 (28) survey revealed that about half the population (48.24%) takes extra salt at meals ((51.5% of women, 44.9% of men). The DGHS has initiated the awareness campaigns to address the issue in 2020.

**Healthy diet and physical activity:** The Noncommunicable Diseases Control unit (NCDC) of the DGHS had initiated dialogues in 2020 with stakeholders to adopt and implement fiscal policies and strengthen regulatory systems to discourage sedentary behaviours and unhealthy food including sugar-sweetened beverages and trans fats, and encourage healthy diet and increased physical activity. The DGHS has started awareness campaigns to address the issue of unhealthy diet and lack of physical activity in late 2021.

**NCD service delivery:** NCD Control programme has adopted the WHO Package of Essential Noncommunicable Diseases (PEN) intervention and HEARTS technical package as the model to strengthen NCD screening and service delivery, specially in primary health care settings. The model, including the supply of essential NCD medicines, has been started in 2018 covering 66 upazilas. The programme will reach 100 upazilas by 2022.

<sup>7</sup>World Health Organization. Noncommunicable diseases country profiles 2018 [Internet]. Geneva (CH): WHO; 2020[cited 21 January 2020]. Available from: <https://www.who.int/nmh/publications/ncd-progress-monitor-2017/en/>

**Mental health:** In Bangladesh, prevalence of mental health conditions among adults is 18.7%, and 12.6% among children.<sup>8</sup> The prevalence of autism spectrum disorders is estimated to be 0.15%. Suicide is also a major public health problem in Bangladesh. Suicide incidence is higher among females than males. Suicides account for 6 deaths out of every 100 000 population.<sup>9</sup>

The government passed the National Mental Health Act in 2018 which replaced the 105-year-old Lunacy Act of 1912. The new law emphasized the provision of caring services to mental health patients, protecting their rights including the right to wealth and inheritance, rehabilitation and overall welfare. The formulation of the National Strategic Plan on Mental Health in line with the National Mental Health Policy (under consideration by the government) (31) is ongoing, and will reflect the action points in the WHO Mental Health Action Plan of 2013–2020 (32). Diagnosis and management of mental health disorders are included in the Essential Services Package. WHO’s mhGAP (33) Intervention Guide 2.0 is being adapted for appropriate assessment and management of common mental health conditions in primary health care.

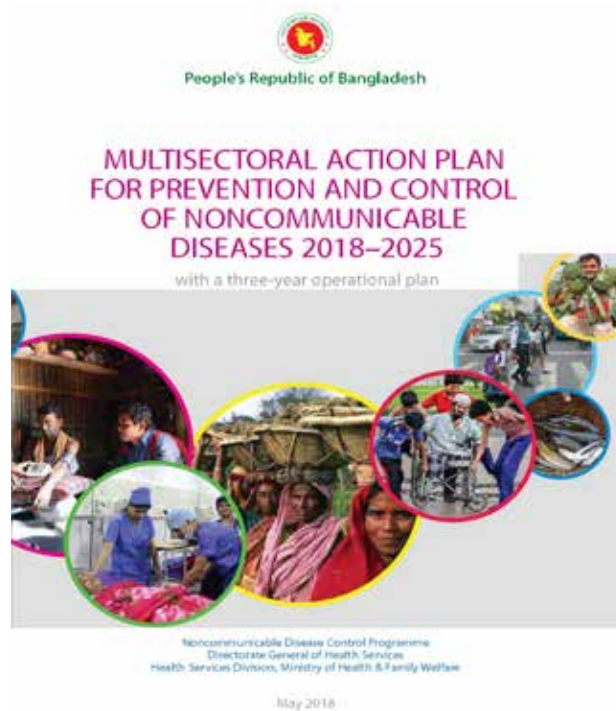
**Road safety:** Globally, the leading cause of death among young people aged 15–29 years is road traffic injury. As per the WHO estimate, there were over 24 954 road traffic fatalities in 2016 in Bangladesh. Many more are injured in road traffic crashes. Two goals have been set out in the SDGs: by 2020, to reduce by half the number of global deaths and injuries from road traffic accidents and by 2030, to provide access to safe, affordable, accessible and sustainable transport systems for all, improving road safety.

**Healthy Cities Initiative:** The NCDC is piloting the “Health Cities Initiative” in a couple of selected cities. A special initiative is undertaken to introduce “good governance for health and well-being” under the Healthy Cities Initiative in Khulna.

**Health promoting schools:** The DGHS has started the health promoting school initiative in some selected schools.

There is strong political commitment from the government to reduce the burden of NCDs, through

coordinated action across ministries. The multisectoral Action Plan for the Prevention and Control of NCDs 2018–2025 (34) has been developed. It contains the National Action Plan for the Prevention and Control of NCDs for the period 2018–2021. At the national level a multisectoral NCD coordination committee has been formed involving 29 ministries and agencies.



“Health in all policies” is the key approach to engage the actors outside the health sector to tackle and influence public policies on shared risk factors, such as tobacco use, unhealthy diet, physical inactivity, harmful use of alcohol, and exposure to poor indoor air quality. Strong emphasis is given under the current 4<sup>th</sup> HPNSP (2017–2022) (1) to address the burden of NCDs including different “lifestyle change” interventions with special focus on behavioural change communications. Under the DGHS, piloting of the community-based NCD management model in selected subdistricts has been initiated in alignment with the WHO PEN (Package of Essential Noncommunicable Disease interventions) protocol.

<sup>8</sup>National Mental Health Survey of Bangladesh 2019

<sup>9</sup>World Health Organization. Suicide rates (per 100 000 population) [Internet]. Geneva (CH): WHO; 2020[cited 21 January 2020]. Available from: [https://www.who.int/mental\\_health/management/depression/prevalence\\_global\\_health\\_estimates/en/](https://www.who.int/mental_health/management/depression/prevalence_global_health_estimates/en/)



## 2.5. Health systems and services

The public health system in Bangladesh is multilayered and hierarchically structured. At the community level, there are domiciliary health providers and health facilities – the community clinics (CCs) responsible to deliver PHC services, with each CC serving approximately 6000 people. The next level is the Union health and family welfare centres, which provide maternal and child health care services and limited curative care. At the upazila and district level there are upazila health complexes (50-bedded hospitals) and district hospitals (250-bedded) functioning. At the tertiary level, medical

colleges and postgraduate institutes are offering a wide range of specialized services.

The current health sector plan of the government (4th HPNSP 2017–2022) (1) has been developed based on the previous experience of implementing three successive sector programmes during 1998–2016. The main objective of the 4th HPNSP is “to ensure that all citizens of Bangladesh enjoy health and well-being by expanding access to quality and equitable health care in a healthy and safe living environment”. There exists high-level commitment from the government to ensure UHC in order to achieve the SDG targets by 2030.

### Components of 4<sup>th</sup> HPNSP: 2017–2022

| Components                   | Focus/Priority areas   |
|------------------------------|--|
| Governance and stewardship   | <ul style="list-style-type: none"> <li>• Setting of the policy framework and overseeing and guiding both public and private sectors.</li> <li>• Regulation of drug administration and quality drug management, legal and regulatory framework, and strengthening roles of different autonomous and semi-autonomous organizations such as the Bangladesh Medical and Dental Council (BMDC), Sate Medical Faculty (SMF), Pharmacy Council of Bangladesh (PCB), Bangladesh Nursing and Midwifery Council (BNMC), Bangladesh Homoeopathic Board (BHB) and the Board of Unani and Ayurveda, Bangladesh (BU&amp;AB).</li> <li>• Ensuring the participation of e citizens.</li> </ul> |
| Strengthening health systems | <ul style="list-style-type: none"> <li>• Bolstering planning and budgeting, monitoring and evaluation, management information systems, research and development.</li> <li>• Strengthening of human resources for health, procurement and supply chain management, and maintenance of physical facilities.</li> <li>• Intersectoral coordination and financial management.</li> </ul>   |
| Quality of health services   | <ul style="list-style-type: none"> <li>• Interventions such as reproductive, maternal, newborn, child and adolescent health; population and family planning services; nutrition and food safety; communicable and noncommunicable diseases; alternative medical care; and behaviour change communication related programmes.</li> </ul>  |

Source: PIP, 4th HPNSP: 2017–2022 (35)

### 2.5.1 Health care financing and universal health coverage (UHC)

In Bangladesh, the Government’s contribution to the total health expenditure is only 23% and out-of-pocket expenditure is very high at 71.82% of current health expenditure.<sup>10</sup> Moreover, per capita current health expenditure (in real terms) is only US\$ 31.84 and Domestic General Government Expenditure (DGGE) as % of GDP is 0.42% (Table 3). The progress monitoring report on UHC and SDGs in the South-East Asia Region

of 2018 revealed that the Bangladesh UHC Service Coverage Index was at 50 out of 100, which is the second lowest in the South-East Asia Region.

Bangladesh has updated its essential services package (ESP), which mostly comprise primary health care services, as a core strategy to achieve UHC by 2030. A recent study by Health Economics Unit of MoH & FW and WHO showed that, in 2016, the government through its public facilities could ensure only 20.4% coverage of essential health care services. A detailed ESP costing study<sup>11</sup> suggested

<sup>10</sup>World Health Organization. Global Health Expenditure Database [Internet]. Geneva: WHO; 2020[accessed on 21 January 2020]. Available from: <https://apps.who.int/nha/database>

<sup>11</sup>The Costs of the Bangladesh Essential Health Service Package: Fourth Health Population and Nutrition Sector Programme. Dhaka: Ministry of Health and Family Welfare, Health Economics Unit and World Health Organization (WHO) Bangladesh; 2018.

that to increase the ESP coverage to the targeted average of 33% in 2022, the government needs to increase its investment by 64% by the next five years.

**Table 4. Key indicators of health-care financing, 1997–2015**

| Indicators  | 1997     | 2007       | 2012       | 2015       |
|---|----------|------------|------------|------------|
| Ratio of current health expenditure (CHE) to GDP  | 2.0%     | 2.39.      | 2.57%      | 2.36%      |
| Out-of-pocket (OOP) expenditure as % of current health expenditure                          | 61.01%   | 65.82%     | 67.47%     | 71.82%     |
| Per capita current health expenditure (real terms)  | US\$ 8.3 | US\$ 13.88 | US\$ 22.75 | US\$ 31.84 |
| Domestic general government expenditure (DGGE) as % of GDP                                  | 0.57%    | 0.55%      | 0.53%      | 0.42%      |
| Domestic general government expenditure (DGGE) as % of general government expenditure (GGE) | 5.21%    | 5.075%     | 3.96%      | 3.34%      |
| Government's contribution to THE  | 36.5%    | 25.8%      | 26%        | 23%        |

Source: World Health Organization, Global Health Expenditure Database. Available at: <http://apps.who.int/nha/database> (36)

### Key actions undertaken by the government include:

- The most important policy document for UHC – “*Health Care Financing Strategy 2012–2032: Expanding social protection for health towards universal coverage*” (37) – has been prepared.
- To reduce the out-of-pocket payments and improve access to quality health services for the people living below the poverty line (around 24% of the total population), the government is also piloting a health protection scheme (Shasthyo Surokhsha Karmasuchi).

### Proposed pathways towards UHC in Bangladesh:<sup>12</sup>

- Channelize more domestic resources to the health and nutrition sector;
- Reduce inefficiency and inequity in budget allocation and utilization;
- Prepare a strategy for a health safety net programme drawing on the lessons from the SSK piloting;
- Initiate social health insurance for civil servants and others in the formal sector (e.g. garments’ workers);
- Introduce pricing caps on OOP on relevant medical services;
- Expand the scope of the ESP, with a focus on NCD-linked chronic conditions and all forms of malnutrition;

- Adopt a co-creative approach to public–private partnerships to meet some of the service delivery gaps;
- Grant greater recognition to the importance of prevention and lifestyle issues in reducing the need for health care and nutrition services.

### 2.5.2 HRH situation

Bangladesh has more number of doctors in service than nurses. With a doctor to nurse ratio of 1:0.6, Bangladesh is well below the international standard of 1:3 for nurse/midwife density. Bangladesh has a threshold density of physician, nurse and midwife of 8.3 per 10 000 populations, which is far below the recommended density 44.5 for SDGs.<sup>13</sup> As per the findings of a study conducted in four districts, the average gap between the number of nurses currently available and the required number of nurses in district hospitals is estimated at 75 for each hospital. For physicians, the gap is 35 for each hospital.<sup>14</sup>

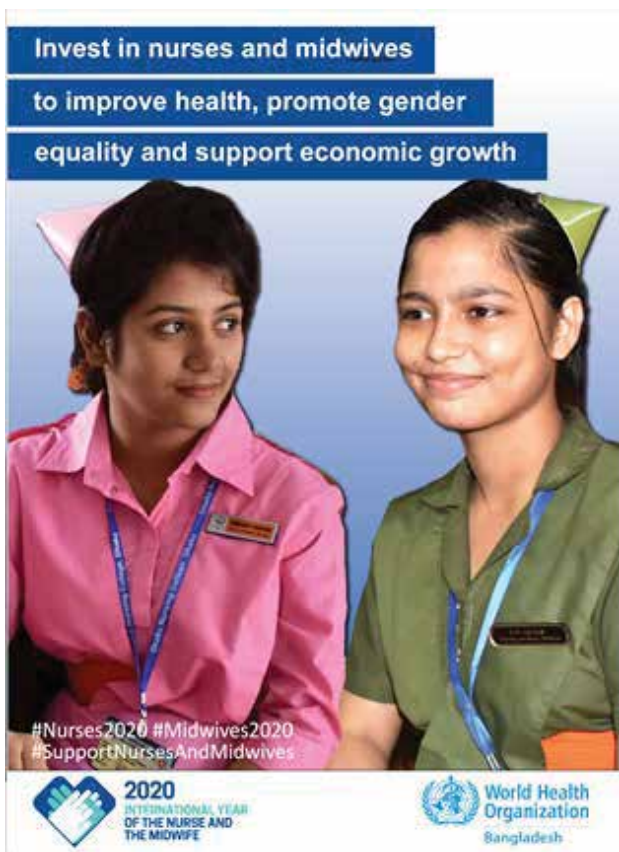
There has been a 69% increase in the total number of medical colleges, 113% increase in the number of nursing colleges and 175% increase in the number of nursing institutes since 2010.<sup>15</sup> To ensure correct academic standards and improve teaching-learning quality, the National Quality Assurance Scheme (NQAS) (38) has been introduced in medical colleges in Bangladesh. The BNMC accreditation scheme for nursing and midwifery institutions was approved in July 2019.

<sup>12</sup>Ministry of Health and Family Welfare Bangladesh. Annual Review of 4th HPNSP (2017-2022). Dhaka; 2019.

<sup>13</sup>World Health Organization. The Decade for Health Workforce Strengthening in the SEA Region 2015–2024: Second review of progress, challenges, capacities and opportunities [Internet]. New Delhi; 2018 [accessed on 21 January 2020]. Available from: <https://apps.who.int/iris/bitstream/handle/10665/273954/sea-rc71-9.pdf?sequence=1&isAllowed=y>

<sup>14</sup>World Health Organization. Workload Indicators of Staffing Need (WISN) Application at Public Sector Health Facilities in Bangladesh. Key Findings Background [Internet]. Dhaka; 2018 [accessed on 21 January 2021]. Available from: <http://www.searo.who.int/bangladesh/wisn-technicalbrief-2018.pdf>

<sup>15</sup>Medical Education & Health Manpower Development, Directorate General of Health Services and World Health Organization. Mapping of Health Professional Education Institutions in Bangladesh Bangladesh. Kurup VT, editor. Dhaka; 2018. 1–183 p.



However, developing quality health professionals in the desired numbers is still challenging. The assessment conducted by the Centre for Medical Education, a WHO collaborating centre, with support from WHO revealed that out of 104 medical colleges (both public and private) only 55 had submitted the NQAS report.<sup>16</sup> The HRH challenges include: shortage, inappropriate skill-mix and retention, inequitable distribution; and weak monitoring and supervision mechanisms to manage providers' performance and productivity and reduce absenteeism. Based on the Health Workforce (HWF) Strategy 2015 (39) of the MoH&FW, an Operation Plan (OP) on Human Resources Development (HRD) has been included in the HPNSP (2017–2022) of the government.<sup>17</sup>

### 2.5.3 Health information

The Government of Bangladesh has accorded high priority to the digitalization process for effective management of public services across the country. “Digital Bangladesh” became an integral part of the government’s Vision 2021. In this connection “the a2i (access to information) Project” (40), a flagship programme, is being implemented with support from the Prime Minister’s Office. It outlines a number

of priorities such as improving quality of services, widening access and decentralizing delivery of public services to ensure greater responsiveness and transparency. District Health Information System version 2 (DHIS2) has been introduced in the health sector and data from the community level (community clinic) to tertiary-level hospitals are captured through this web-based portal system.

A number of innovative initiatives have been undertaken such as: i) establishing health call centres (“*Shaystho Batayan*”) that help citizens get health consultation free of cost and critical health information in emergency situations and provide feedback about service quality including lodging complaints against service providers; ii) introduction of a videoconferencing system to monitor service quality; iii) establishment of telemedicine centres at different health facilities; and iv) setting up a human resource information system (HRIS) for government health professionals.

There is need to improve the quality of routine data to strengthen evidence-informed decision-making. Support would be required in the areas of integration of different information systems, the interoperability of existing platforms and transfer of knowledge and skills to better monitor and track the country’s progress towards meeting the SDG goals and UHC targets. The civil registration and vital statistics (CRVS) system must be strengthened to improve the quality of cause-of-death data. Further, capacity-building on the use of the International Classification of Diseases-11 (ICD-11) (41) across all the private and public health facilities is urgently needed.

There is critical need to strengthen the in-house human resource capacity to manage, maintain, and further advance and sustain the existing digital health initiatives. A nutrition information system (NIS) based on service records and reports at the community level would enable the monitoring of the progress of activities undertaken according to the targets. The National Nutrition Services (NNS) has undertaken activities leading to mainstreaming of the nutrition system within management information system (MIS) of both DGHS & DGFP, capacity development of personnel, networking, and linkage with MIS of other relevant stakeholders. NNS has already integrated DNI indicators with the routine information system of DGHS & DGFP rather than develop a parallel system,

<sup>16</sup>Centre for Medical Education and World Health Organization. Technical Brief Assessing Implementation of National Quality Assurance Scheme in Different Medical Colleges in Bangladesh [Internet]. 2017. Available from: <http://origin.searo.who.int/bangladesh/finaltechnicalbriefnqas070118.pdf>

<sup>17</sup>Government of the People’s Republic of Bangladesh, Ministry of Health and Family Welfare, 4th Health, Population and Nutrition Sector Programme (January 2017–June 2022), Programme Implementation Plan (PIP), 2017



and is encouraging other stakeholders working in urban areas such as urban primary health care services delivery project and nongovernmental organization health service delivery project (UPHCSDP & NHSDP) to use a similar platform.



Ministry of Health and Family Welfare (MOHFW) supported by WHO Bangladesh initiates the development of a national digital health strategy, an essential step for using technology to improve the accessibility, quality and affordability of health services.

## 2.5.4 Essential drugs and medicines

In Bangladesh, the local pharmaceutical industries supply 98% of all essential drugs for the country. The Directorate General of Drug Administration (DGDA) is the country's sole regulatory authority for medical products. DGDA has been making serious efforts to raise drug regulation to international standards. Due to limitations in regulatory capacity, access to quality medical products with affordable prices has been a challenge, especially for vulnerable groups. The Bangladesh National Health Accounts (BNHA 2015) revealed that out-of-pocket expenditure on pharmaceuticals and other medical non-durable goods is alarmingly high (69.3%).

### Key actions undertaken included:

- The National Drug Policy 2016 (42) was gazetted in 2017. The National Control Laboratory (NCL) has achieved ISO 17025 certification and is seeking WHO prequalification. The “National Guideline on the Pharmacovigilance System” has been developed. An Adverse Drug Reaction Monitoring (ADRM) cell has been formed and is functional.
- WHO has been providing technical support to build DGDA capacity in strengthening its main

regulatory functions according to the Institutional Development Plan (IDP). Key aspects of the support include standardization of processes and development of standard operating procedures, capacity-building of DGDA staff, enhancing organizational capacity for post-marketing surveillance and improving collaboration with other regulatory agencies in the Region and beyond.

- An external benchmarking mission from WHO was conducted to monitor DGDA's progress towards achieving maturity level 3, according to the WHO Global Benchmarking Tool for medicines regulatory authorities. Accordingly, a comprehensive IDP was developed.
- A Coalition of Interested Partners (CIP) is active in Bangladesh to coordinate the development partners' efforts to support the country's initiatives to ensure access to quality, safe and efficacious medicines for all. Model pharmacies (a total of 237) and model medicine shops (233) have been established on a pilot basis in 24 districts.



World Patient Safety Day: raising awareness to minimize risk and harm in health care

## 2.5.5 Quality of care

Overall performance of the public health facilities is not satisfactory. An in-depth analysis<sup>18</sup> of different tiers of health facilities (520) in Bangladesh, i.e. upazila health complex (UHCs), district hospitals (DHs), medical college hospitals (MCHs) and specialized hospitals (SpHs), revealed that the overall level of good performance is less than 4% (Table 5).

<sup>18</sup>Ministry of Health and Family Welfare Bangladesh, Directorate General of Health Services, Management Information System and World Health Organization. Performance of Public Sector Health Facilities in Bangladesh 2017: An in-depth Analysis [Internet]. Dhaka; [cited 21 January 2020]. Available from: <http://www.searo.who.int/bangladesh/analysis-report-hss-10042019.pdf>

**Table 5. Overall performance of all health facilities (N = 520)**

| Level of performance          | Overall, N = 520 (%) |
|-------------------------------|----------------------|
| Good (≥75%)                   | 19 (3.73%)           |
| Moderately good (50% to <75%) | 269 (52.75%)         |
| Moderately poor (25% to <50%) | 205 (40.20%)         |
| Poor (≤25%)                   | 17 (3.33%)           |

Source: Performance of public sector health facilities in Bangladesh, 2017: An in-depth analysis jointly conducted by DGHS and WHO

The majority (90%) of the district hospitals lack good observation of infection prevention & control (IPC) practices through documentary evidence. About 30% of the district hospital ambulance services were found to be non-functional for maintaining an effective referral system. About 27% of the posts are vacant in district hospitals. Most service providers (50%) in district health hospitals are not satisfied with their jobs because they are overburdened with a large number of patients.<sup>19</sup>

### Key actions undertaken include:

- A Quality of Care Secretariat has been established at the national level and Strategic Plan on Quality of Care for Health Service Delivery (2015) developed.
- A Technical Advisory Group has been formed for reviewing standards, guidelines, etc.
- The Total Quality Management (TQM) approach including clinical supervision has been piloted in selected health facilities.
- Accreditation process for women-friendly hospitals and perinatal and newborn death reviews were also introduced on a limited scale.
- For quality improvement a robust partnership has been achieved among the development partners such as UNICEF, UNFPPA, USAID, Save the Children and other professional bodies including Obstetrics and Gynecology Society of Bangladesh (OGSB) and the Paediatric Association that focus on maternal and child health.

## 2.5.6 Community clinics: Essential health and nutrition services at people's doorsteps

To provide access to an integrated essential health services package (ESP) at the doorsteps of the people, the government has established community clinics (CCs) nationwide. Each CC serves a population cohort of approximately 6000 people and currently

<sup>19</sup>Baseline assessment of quality of care and clinical risks in selected district health systems, Bangladesh, May 2017,WHO (Unpublished)

there are more than 13 500 CCs functioning across the country. WHO has been providing support to the community clinics since the late 1990s and later since 2009 under the Revitalization of Family Health Care Initiatives in Bangladesh (RCHCIB) programme. Technical support included building capacity of different types of services providers, creating a pool of master trainers, developing educational material, community group formations, an essential services package, performance monitoring, and the like.

It is estimated that an average of 40 clients receive services, including free medicines, every day at a community clinic, and 95% of them are women and children. This is a flagship programme of the government and is recognized as the "Community-centred Model". A number of positive lessons have been learnt from this model in terms of community involvement in managing the operation of community clinics, resource mobilization, raising health awareness and developing referral systems through community groups.

This is a unique example of multisectoral involvement as local elected representatives are involved in the management of these CCs. The utilization of community clinic services and client satisfaction has increased and the elected members of the local government institutions such as the Union Councils are now more involved to improve services from these community-based health centres. However, there is the scope to improve service quality as well as assess rational use of drugs. A comprehensive strategy is also required to include the provision of NCD services systematically at the CC level and to ensure that a quality nutrition counselling and reporting mechanism is in place.





## 2.6 Emergency preparedness and response

Bangladesh has been experiencing the adverse effects of climate change such as a slow but steady rise in the sea level, increasing severity and frequency of tropical cyclones, and extreme rainfall events. Climate change affects the social and environmental determinants of health such as clean air, safe drinking water, sufficient food and secure shelter. The health risks from climate change include: i) diarrhoeal diseases from temperature change and disasters; ii) spread of vector-borne diseases such as malaria, dengue and kala-azar; iii) mortality from excess floods, cyclones, storm surges, droughts and heat waves; and iv) injuries, snake-bites, psychosocial stress and respiratory diseases.

For an integrated management of overall public health risks, preparedness as well as emergency response are the key elements for building climate-resilient health systems. The Government of Bangladesh has started a process to formulate a National Adaptation Plan for the Health sector (H-NAP) (43) against the impact of climate change, which will guide the health sector to take up appropriate adaptation measures.

The health adaptation elements will be the health component of the National Adaptation Plan (NAP). Climate-related health data are yet to be integrated into the National Disaster Risk Reduction Strategy. Climate-informed health early warning systems should be developed to better manage outbreak of climate-sensitive diseases. Capacity of the existing Climate Change Health Promotion Unit (CCHPU) (44) of the MoH&FW needs to be further strengthened with adequate human and financial resources. As climate change poses a big threat to the health system, enhancing capacities of the health workforce and institutions, and building climate-resilient “green hospitals” can contribute to reduce system vulnerability to climate change. More policy advocacy would also be required to build climate-resilient health systems in alignment with the six building blocks of health systems.

Climate resilient water safety plans (CR-WSPs) (45) have been piloted successfully by different NGOs and international agencies including WHO in climate vulnerable districts. Improvement of water, sanitation and hygiene services in community clinics (40) in coastal areas has been successfully tried out by WHO in partnership with UNICEF and the Department of Public Health Engineering (DPHE). A National WASH Strategy for the health care facilities and national WASH Standards have

been adopted with active collaboration of the water sector and civil society organizations. But for effective results and long-term sustainability, closer collaboration between health and WASH interventions are required.

When the COVID-19 pandemic raged across the country from 2020, the WHO Country Office has supported the MoH&FW to design nutrient-dense food packages for disaster affected populations for the Ministry of Disaster Management and Rehabilitation. WHO is also an active member of the Nutrition Cluster and assisted with the development of the infant and young child feeding in emergencies (IYCF-E) manual, and coordinated nutrition messages for emergency response and a rapid nutrition and food security assessment during the pandemic.

### 2.6.1 Responding to health emergencies including disease outbreaks

#### Disease surveillances and outbreak investigations

The Institute of Epidemiology, Disease Control and Research (IEDCR) (46) is the focal institute under the DGHS for disease surveillance and outbreak investigation. As the National Rapid Response Team (NRRT) the IEDCR responds to any unusual health events or diseases on an emergency basis. The IEDCR has been providing surveillance and outbreak investigation support for disease outbreaks such as chikungunya, diphtheria, cholera, dengue, measles, avian influenza and others.

It has five laboratories, one each for virology, parasitology, microbiology, entomology and for “One Health”. In 2017 the public health emergency operations centre (PHEOC) has been established at IEDCR. The IEDCR has also established five sentinel sites for the surveillance of antimicrobial resistance in Bangladesh. WHO has been providing technical support to build capacity of the IEDCR in diseases surveillance, response to outbreaks and laboratory investigation.

#### IHR (2005) capacity

According to the Joint External Evaluation (JEE) conducted in May 2016, the average core value of the 13 IHR Core Indicators for Bangladesh was found to be 76%. Bangladesh was placed at IHR Level 3 and had developed some capacities in emergency preparedness. However, it borders countries with limited (Level 2) emergency preparedness capacity

that makes cross-border health emergencies a more enhanced threat. Bangladesh has been regularly reporting the IHR requirements such as the “State Party Annual Reporting questionnaire” and “Yellow fever vaccination for international travellers”. Immigration officials at the different points of entries (PoEs) were provided with a number of trainings on IHR issues under the current health sector programme (HPNSP) of MoH&FW.

### Health sector response to COVID-19 pandemic

The first three known cases of COVID-19 were reported on 8 March 2020 by the country’s epidemiological institute, the Institute of Epidemiology, Disease Control and Research (IEDCR), and Bangladesh registered its first death due to COVID-19 on 18 March. Although infections remained low until the end of March 2020, there was a steep increase in cases and the number of deaths became alarming within a few months. According to IEDCR, between 9 March and 27 December 2020, a total of 509 148 confirmed COVID-19-positive cases and 7452 deaths had been reported.<sup>20</sup>

Although the Government of Bangladesh undertook several initiatives such as imposing lockdowns, enforcing physical distancing, testing and contact-tracing, surveillance and case management, these measures were found inadequate in containing the spread of disease. Limited national capacity in emergency preparedness and early response to global pandemics, including monitoring of IHR interventions; inadequate multisectoral coordination and awareness; and lack of supplies, logistics and human resources were the main causes behind such rapid spread of the infection.

WHO extended its support to develop the first National Preparedness and Response Plan (NPRP) on COVID-19. This was developed after referring to WHO global guidance. Furthermore, being the lead for the Health Emergency Cluster, WHO has been coordinating with the Development Partners to provide emergency technical support to MoH&FW. This support included: i) developing different national training guidelines/modules and SOPs to prevent and treat COVID-19 infection; ii) providing training for different levels of caregivers on IPC, PPE, isolation,

etc. and PoE authorities on the screening process during entry; iii) strengthening capacity in disease surveillance, response to outbreaks and laboratory investigations; and iv) developing different risk communication materials for mass awareness on infection prevention through social media.

Under the leadership of MoH&FW, WHO in collaboration with health development partners and the National Technical Committee on COVID-19 has supported the development of the “Bangladesh Preparedness and Response Plan” (BPRP) for COVID-19. The main purpose of the plan is to prevent and control the spread of COVID-19 in Bangladesh in order to reduce its impact on the health, well-being and economy of the country, as well as to set out the framework for the treatment of the population that has been infected.

The plan outlines a multisector coordination structure, which includes as its principal response mechanism Ten Technical Pillars. Seven of these are for epidemiological response and health service delivery, and they are:

- surveillance and laboratory support;
- contact-tracing and mitigating community transmission;
- points of entry and quarantine;
- infection prevention and control;
- COVID-19 case management;
- ensuring essential health, population and nutrition services delivery;
- research.

There are also three cross-cutting pillars:

- planning, coordination and response strategy;
- logistics and procurement; and
- risk communication and community engagement, and research. To strengthen national capacity on emergency preparedness and early response for health emergencies including disease outbreaks, more technical support including allocation of resources are needed to better respond to the ongoing pandemic and establish a resilience system for potential pandemic outbreaks in the future.

WHO has extended technical support to deliver the

<sup>20</sup>Covid-19 Situation Report #28, 7 September 2020): [https://www.who.int/bangladesh/emergencies/coronavirus-disease-\(covid-19\)-update/coronavirus-disease-\(covid-2019\)-bangladesh-situation-reports](https://www.who.int/bangladesh/emergencies/coronavirus-disease-(covid-19)-update/coronavirus-disease-(covid-2019)-bangladesh-situation-reports)

following nutrition services to the population during the COVID-19 pandemic:

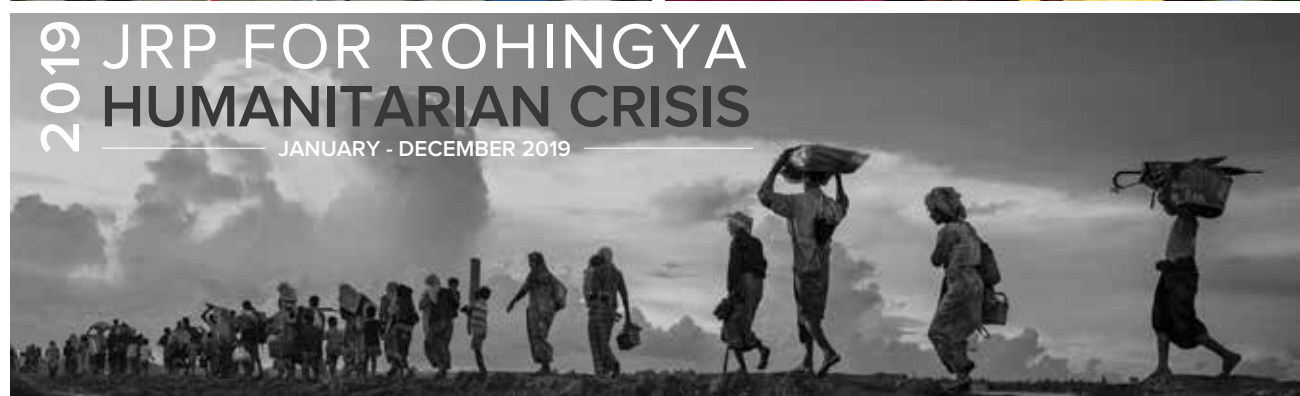
- Report on the projections of the possible malnutrition burden during and post-COVID-19 in Bangladesh.
- IEC materials on adult nutrition, breastfeeding and complementary feeding, health workers, breast-milk substitutes and maternal nutrition, and a video on breastfeeding during COVID-19.
- Guidelines to continue and strengthen implementation of essential package of nutrition interventions in health system in the COVID-19 context.
- Nutritional management guidelines for COVID-19 patients, at-risk people and COVID-19-affected who are admitted in the ICU (adapted from the WHO European Region).
- Operational Guidelines for National Vitamin A Plus Campaign (NVAC) in COVID-19 situation
- Joint UN report for Scaling Up Nutrition (SUN) movement, including responses to COVID-19.

## 2. 6. 2 Food safety

There are multiple agencies involved in food safety from different ministries including food, agriculture health, commerce and law. The country faces serious public health risks due to increased prevalence of foodborne diseases. The MoH&FW has set up a Food Safety Unit within the Institute of Public Health (IPH) of DGHS. For foodborne disease surveillance the Institute of Epidemiology, Disease Control and Research (IEDCR) (46), of the DGHS, has set up a sentinel site-based surveillance system across the country. A national Food Safety Emergency Response Plan has also been drafted.

To adopt the Codex standards, the Bangladesh Standard and Testing Institution (BSTI) (47) is the institution designated as the Codex contact point and it has adopted 40 Codex standards as national standards. Bangladesh Food Safety Authority (BFSA) (48), a facilitating agency, has been established by the government in 2015. It is responsible for coordinating all food safety activities such as food production, processing, storage, sales and import of food products by the relevant agencies of different ministries. As food safety activities in Bangladesh are fragmented and multiple ministries and agencies are involved, more coordination and harmonization would be necessary.

### The Rohingya crisis<sup>21</sup>



<sup>21</sup>World Health Organization, Bangladesh - Rohingya Crisis Timeline: A chronological overview of the events and WHO's response. <http://www.searo.who.int/mediacentre/sear-in-the-field/bangladesh-myanmar-event-timeline/en/>

Bangladesh is experiencing a man-made crisis over the influx of forcibly displaced Myanmar nationals (FDMNs) into Cox’s Bazar district. WHO has classified this humanitarian crisis with the Rohingya refugees as a Grade 3 emergency. An estimated 706 364 Rohingya refugees crossed over to Bangladesh from Myanmar’s Rakhine State between August 2017 and December 2018, joining another 201 636 refugees that had fled in earlier waves of displacement. They now live in Kutupalong and Balukhali mega camps in Cox’s Bazar district as well as 11 other conglomerations of settlements, some of which include host communities. The health interventions of the Government of Bangladesh in partnership with WHO and other partners targeted 1.3 million people in Cox’s Bazar, including the Rohingyas and more than 336 000 members of the host community.<sup>22</sup>

The Ministry of Health and Family Welfare along with more than 100 health partner organizations (including UN agencies, development partners and NGOs) including WHO as the Co-Lead of the Health Cluster (49), are involved in this rehabilitation effort.

The key health interventions include: i) providing centre-based primary health care services with referrals; ii) developing a health sector emergency preparedness & contingency plan and conducting special vaccination programmes for cholera, measles and diphtheria; iii) building capacity of the health professionals and other service providers on health emergency preparedness and response; iv) formation of rapid response teams (RRT) at district and subdistrict levels; and v) coordination with other clusters such as WASH, Nutrition, Food Security and Logistics.

The “Joint Response Plan 2019 for the Rohingya Humanitarian Crisis”<sup>23</sup> has been developed with 12 essential components: i) protection services (gender-based violence and child protection); ii) food security; iii) education; iv) site management and site development; v) health; vi) nutrition; vii) water, sanitation and hygiene (WASH); viii) shelter and non-food items; ix) communication with communities; x) logistics; xi) emergency telecommunications; and xii) coordination.

### Challenges and priorities<sup>24</sup>

| Challenges  | Key priorities  |
|---|---|
| <ul style="list-style-type: none"> <li>• Overcrowding and poor water and sanitation services pose high risks of water- and vector-borne diseases and other communicable diseases.</li> <li>• The number of primary-care facilities functional 24x7 is below the recommended national standards and referral services are not fully functional. Temporary structures that house the health-care facilities are at risk of being damaged or destroyed by monsoonal rain or cyclones.</li> <li>• Less than 50% of deliveries among Rohingyas and the host population take place in health facilities and family planning needs are unmet. Provision of MHPSS and NCD services remain very limited.</li> <li>• Government health facilities are overwhelmed with patients and face resource constraints, including chronic staffing shortages.</li> </ul> | <ul style="list-style-type: none"> <li>• Improve equitable access to and utilization of quality life-saving and comprehensive primary and secondary health services for crisis-affected populations, with special focus on reproductive, maternal, neonatal, child and adolescent health (RMNCAH) services, mental health and psychosocial support, and NCDs.</li> <li>• Ensure prevention and timely response to outbreaks of diseases with epidemic potential and prepare for other health emergencies including the monsoon and cyclones.</li> <li>• Encourage healthy living, and improve health-seeking behaviour and utilization of the essential service package among refugee and host populations, through community engagement with special attention to gender considerations and vulnerable groups.</li> <li>• Strengthen health sector coordination and information management.</li> </ul> |
| <p>Although the joint efforts by the Government and partners helped save thousands of lives, and deadly disease outbreaks were prevented and rapidly curtailed, the situation continues to be fragile and the Rohingya population remains extremely vulnerable</p>  |   |

<sup>22</sup>Strategic Executive Group. World Health Organization. Weekly Situation Report #19, Rohingya Refugees. WHO Situat Rep [Internet]. 2018 [cited 2020 Jan 21];(March):27–30. Available from: [http://www.searo.who.int/bangladesh/weeklysitrep19cxb\\_ban.pdf](http://www.searo.who.int/bangladesh/weeklysitrep19cxb_ban.pdf)

<sup>23</sup>Strategic Executive Group. 2019 Joint Response Plan For Rohingya Humanitarian Crisis [Internet]. United Nations OCHA; 96p. Available from: [https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/2019\\_irp\\_for\\_rohingya\\_humanitarian\\_crisis\\_compressed.pdf](https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/2019_irp_for_rohingya_humanitarian_crisis_compressed.pdf)

<sup>24</sup>World Health Organization, Cox’s Bazar, Bangladesh, Annual Report 2018



### **3.1 Principal development partners for health and nutrition in Bangladesh**

In 1998 the Government of Bangladesh had introduced a sectorwide approach (SWAp) of management of the health sector for better coordination, harmonization and alignment of multiple donor projects and resources. Based on the lessons learnt on donor coordination and strengthening partnerships for achieving the programme goals, the government has been committed to follow this approach for its subsequent health programmes (50) nutrition and population (HNP. Under the current health sector programme (HPNSP 2017–2021), which is based on the 4th SWAP, there exists a strong partnership between the development partners (DPs) and the government.

To improve aid effectiveness in the health sector, the Development Partners Consortium<sup>25</sup> has been formed, comprising bilateral and multilateral donors, UN agencies and the World Bank. The aim is to promote donor coordination and effective policy dialogues among the partners. A number of task groups (TGs) comprising representatives from the government and DPs are in operation. These provide technical support and guidance on policy and operational issues including setting priorities, developing result frameworks, monitoring and evaluation, etc. These task groups report to the local consultative group (LCG) Health Working Group, which is the apex body for coordination between the government and development partners of all sectors. WHO has co-Chaired the DP Consortium since 2016 and is an active member of different task groups.

In Bangladesh, NGOs, both national and international, are very active in the health and nutrition sector and made have commendable and conspicuous contributions towards achieving national health goals. Under the current 4th HNPSP (1), a large number of donor-funded national and International NGOs such as BRAC (51), Save the Children (52), CARE (53), Plan International (54), Ipas (55), Marie Stopes (56), Engender Health (57), icddr,b (58), Population Council (59), and the like are implementing different innovative projects and working closely with the government, focusing on quality service provision, in particular on

RMNCAH services, strengthening health systems and community mobilization for hard-to-reach and poor people (60). There are a number of veritable examples of government and NGO collaboration and partnership, including the Expanded Programme of Immunization and TB control programmes across the country, both in urban and rural areas.

It is estimated that more than 100 health partners comprising UN agencies, national and international organizations and civil society/religious organizations and others are closely working with the government for the welfare of the Rohingya population in Cox's Bazar where WHO is involved as the Co-lead of the Health Cluster. WHO is also involved as member of the nutrition cluster, Steering Committee for Nutrition Implementation (SCNI) and Nutrition Implementation Coordination Committee (NICC).

In September 2012, the People's Republic of Bangladesh joined the Scaling-up Nutrition (SUN) Movement with high-level commitment from the Prime Minister, H.E. Sheikh Hasina. In SUN multiple stakeholders such as governments, civil societies, donors, UN and institutions come together and commit to common results to tackle malnutrition. WHO is the co-Chair of SUN-UN network for Bangladesh. The Bangladesh National Nutrition Council (BNNC) is the highest body of the government in the field of nutrition management, which is responsible for

<sup>25</sup>DP Consortium members: World Bank, GFF, Gavi-ISS & MR, Gavi-HSS, GFATM, DFID, JICA, USAID, GAC, Swedish Development, WHO, UNFPA, UNICEF, MSF, Netherlands, CDC Atlanta, European Union



the coordination, administrative management and leadership of nutrition policy matters. BNNC is working with 22 relevant ministries to develop 10-year as well as annual workplans in line with the Second National Plan of Action for Nutrition (NPAN2).

### 3.2 Collaboration with the United Nations system at country level

The **United Nations Development Assistance Framework (UNDAF)** (61) is the mechanism of joint programming between the UN System and the Government of Bangladesh on any development agenda. The current UNDAF: 2017–2021 (62) is well aligned with the national development priorities and the SDGs. The UNDAF has three main SDG-aligned outcomes for closer collaboration among the UN agencies (63) (see Table 5).

**Table 6. UNDAF Bangladesh 2017–2021**

| Outcomes  | Strategic Areas  |
|---|--|
| People: All people have equal rights, access and opportunities<br>Education, health, water and sanitation, governance, urban development, social protection |  |
| Planet: Sustainable and resilient environment   | Environment, climate change and disaster management, power energy and mineral resources, agriculture and water resources |
| Prosperity: Inclusive and shared economic growth  | Poverty reduction, employment growth, gender equality, and empowerment of women  |

Source: UNDAF (2017–2021) (64)

As a member of UN Country Team (UNCT), WHO has been contributing towards achieving the UNDAF outcomes through its own health plans as well as through joint interventions that are currently implemented by the Organization and other UN agencies including UNICEF (65) and UNFPA (66). All members of UNCT have unique modes of collaboration and partnership in the area of emergency preparedness and response, particularly in the Cox’s Bazar region for the displaced Rohingya population as well as the host communities.

WHO has been actively involved in monitoring the progress of the UNDAF health indicators through joint reviews and regular meetings held by UNCT. As part of UN reform and keeping in mind the SDGs, the future UNDAF to be renamed United Nations Sustainable Development Cooperation Framework (UNSDCF) would be the most important joint programming tool among the UN agencies. It is expected that all health issues included in the new development framework will reflect stronger political commitment and WHO would contribute in greater measure towards the realization of the action plans.

**Points of entry: A proactive and collaborative effort to keep the COVID-19 outbreak at bay in Cox's Bazar's densely populated refugee camps**

Forced to flee their homes three years ago, the more than 860 000 Rohingya refugees living in the densely populated camps in Cox's Bazar in Bangladesh face restrictions of movement that keep them away from areas greatly affected by COVID-19. Still, it remains pivotal to reduce the risk of coronavirus transmission by screening people for symptoms at the multiple entry/exit points in Ukhiya and Teknaf from where life-saving humanitarian aid reaches the camps.

To mitigate the risk of rapid transmission of COVID-19 in the Rohingya camps, WHO coordinated the establishment of 19 points of entry to proactively identify those who may be sick, refer them to health care, and prevent them from crossing a defined boundary in the camps from where it would be difficult to deter the virus should they be infected.

Each person entering the camps is required to have their temperature checked. When those living in the camps present with fever they are immediately directed to the closest primary health care facility, while febrile visitors are requested to return home and seek medical consultation.

Currently fully operational, the 19 points of entry in the Rohingya refugee camps are the result of a proactive and collaborative effort from the health, education, WASH, shelter and site management sectors to slow the spread of coronavirus in the Cox's Bazar densely populated refugee camps. Since June, more than 350 000 individuals have been screened at the points of entry across the camps.



An IOM Community Mobilizer checks the temperature of passengers on a motorized rickshaw in Teknaf, Cox's Bazar



After having his temperature checked, a visitor is advised to wash his hands with soap



Slowly, populations in Cox's Bazar are adjusting to the strictures at the points of entry to the Rohingya refugee camps

Source: Report dated 10 September 2020 on Cox's Bazar, Bangladesh, in [\[https://www.who.int/bangladesh/news/detail/10-09-2020-points-of-entry-a-proactive-and-collaborative-effort-to-keep-coronavirus-at-bay-in-cox-s-bazar-densely-populated-refugee-camps\]](https://www.who.int/bangladesh/news/detail/10-09-2020-points-of-entry-a-proactive-and-collaborative-effort-to-keep-coronavirus-at-bay-in-cox-s-bazar-densely-populated-refugee-camps)

## 4.1 WHO's work in Bangladesh

The World Health Organization has been providing technical assistance to the Government of the Peoples' Republic of Bangladesh for the development and strengthening of the country's public health systems since 1972, within days after the War for the Liberation of Bangladesh ended. The support provided by WHO to the Ministry of Health and Family Welfare covers a gamut of areas, including: i) development of health-related policies; ii) generation of an evidence base for informed decision-making; iii) developing guidelines, norms and standards; iv) capacity-building and strengthening the knowledge base and research; v) monitoring the country situation; vi) improving service delivery; and vii) overall strengthening of the health system (67).

### Areas of technical focus

- **Communicable diseases:** Reduce the burden of vaccine-preventable diseases, tuberculosis, malaria, HIV/AIDS, and neglected tropical diseases.
- **Noncommunicable diseases and mental health:** Reduce the burden of cardiovascular diseases, diabetes, cancers, chronic lung diseases, and mental health conditions through health promotion, risk reduction and cost-effective management using the primary care approach.
- **Health throughout the life-course:** Reduce maternal, newborn and child mortality and morbidity and vulnerabilities of adolescents and the elderly; mainstreaming of nutrition, food safety and reduction of environmental and climate change and occupational risk factors.
- **Health systems:** Promote universal health coverage with strengthened health systems based on primary health care.
- **Preparedness, surveillance and response:** Reduce mortality, morbidity and societal disruption resulting from epidemics, natural disasters, conflicts, and environmental and food-related emergencies (68).

### Key achievements of Bangladesh on the health front

- Zero polio cases since 2006.
- High vaccination coverage achieved.
- Transmission of hepatitis B among five-year-old children controlled.
- Bangladesh is on the right track to eliminate neglected tropical diseases.
- Elimination of measles, rubella and CRS by 2023 is on track.
- Rubella control goal achieved in 2018.
- Multisectoral Action Plan for Prevention & Control of NCDs 2018–2025 developed, endorsed and is being implemented.
- WHO PEN and mhGAP technical packages for strengthening primary health care for NCDs and mental health adapted and implemented in Bangladesh.
- National Strategy for Cervical Cancer Prevention and Control 2017–2022 developed.
- Second National Plan of Action for Nutrition (NPAN 2) 2016–2025 developed.
- National Health Workforce Action Plan endorsed.
- Access to ESP services increased through 12 500 functional community clinics countrywide.

- Increased national capacity on emergency preparedness and response.
- Partnership among the health and nutrition stakeholders strengthened.
- High political commitment in evidence to achieve the SDGs.

### Lessons Learnt and unfinished tasks

- Sustained focus on ESP contributed to increased access to primary health care services for the poor. Community engagement in delivering primary health care services has increased, but the gap between the rich and poor with respect to health outcomes remains high. A more integrated approach would be required to promote universal health coverage.
- Positive lessons have been learnt in RMNCAH areas. But quality of care remains a major area that demands more attention. Skill development of service providers, including those involved in the supply of drugs and logistics, is essential.
- National capacity on emergency preparedness and response has increased, but more robust preparedness is required to tackle future climate change-related emergencies.
- Adopting the approach of “Health in all policies” is crucial to achieve the SDGs.
- Competency development of service providers on nutrition counselling and ensuring multisectoral, multistakeholder collaboration is essential for nutrition service delivery.

## 4.2 Bangladesh’s contribution to the regional and global health and nutrition agenda

- **Bangladesh has developed a polio transition plan:** Bangladesh is the first country to have a government-endorsed polio transition plan. Bangladesh developed its polio transition plan in line with the Seventy-first World Health Assembly resolution, which was endorsed by the Interagency Coordination Committee on Immunization (ICC) on May 2018. In recent global high-level stakeholder polio transition meetings, Bangladesh was showcased for its success story and lessons learnt on polio eradication and early integration/transition with routine immunization and VPD surveillance (69).



Health Minister’s National Award 2019 : WHO supports the Ministry of Health and Family Welfare (MoHFW) to assess and award the best performing health facilities in the country.

- **International Conference on Autism and Neurodevelopmental Disorders:** The conference concluded in 2017 in Thimphu, Bhutan. Jointly organized by the WHO country offices for Bangladesh and Bhutan, it was the first conference of its kind in the Region. The conference brought together policy-makers, advocates, experts and persons living with autism spectrum disorder (ASD) and other neurodevelopmental disorders (NDDs) from all over the world to discuss effective and sustainable programmes for individuals and families affected by these disorders (70).
- **Regional meeting on PEN implementation, Dhaka, 2018:** Over 70 government health officials, representatives of medical schools and clinical experts from 11 countries of the WHO South-East Asia Region shared best practices and lessons on strengthening essential NCD services and modalities on scaling up the package of essential noncommunicable diseases (PEN) interventions at the primary health care level in the South-East Asia Region.
- **Multisectoral Regional Meeting on Suicide Prevention:** This was organized by the WHO Country Office for Bangladesh on 11 September 2019 with the aim of strengthening suicide prevention actions. It also developed an adaptation of the Regional Strategy on Suicide Prevention to the country context (71).
- **Bangladesh Health Minister’s award (72)** for best performing health facilities: In the context of moving towards universal health coverage in Bangladesh, recognition by the health minister of the performance of public health facilities has contributed to motivating health leaders and improving national capacity, and thereby setting a robust model that can be adapted by other countries in the Region and globally (73).
- **Quality low-cost generic medicines:** Bangladesh



is a source of quality low-cost generic medicines for many countries in the Region and globally, contributing towards improved access to essential medicines, which is a central component of UHC.<sup>26</sup> Two medicines from Bangladeshi manufacturers have achieved WHO prequalification.

- **Endorsement and launching of NAPN2:** Along with the government WHO organized the Bangladesh National Nutrition Council Meeting to share the developed Bengali and English version of NAPN2 that is endorsed by the honourable Prime Minister of the Peoples Republic of Bangladesh in 2017.



### **Prime Minister of Bangladesh receives 2019 Vaccine Hero Award**

‘Sheikh Hasina is a true champion of immunization’

– Dr Seth Berkley, CEO of Gavi

**New York, 23 September 2019:** Her Excellency Sheikh Hasina Wazed, Prime Minister of the Republic of Bangladesh, has been honoured with the second-ever Vaccine Hero Award by Gavi, the Vaccine Alliance.

The Vaccine Hero Award celebrates global figures whose dedication to the Vaccine Alliance’s mission has played a key role in helping Gavi and its partners protect hundreds of millions of children across the world.

The award was presented at a dedicated Side-event of the United Nations General Assembly High-Level Meeting on Universal Health Coverage held in New York City.

Source: Gavi news media room : [https://www.gavi.org/news/media-room/prime-minister-bangladesh-receives-2019-vaccine-hero-award#:~:text=New%20York%2C%2023%20September%202019.by%20Gavi%2C%20the%20Vaccine%](https://www.gavi.org/news/media-room/prime-minister-bangladesh-receives-2019-vaccine-hero-award#:~:text=New%20York%2C%2023%20September%202019.by%20Gavi%2C%20the%20Vaccine%20Alliance)

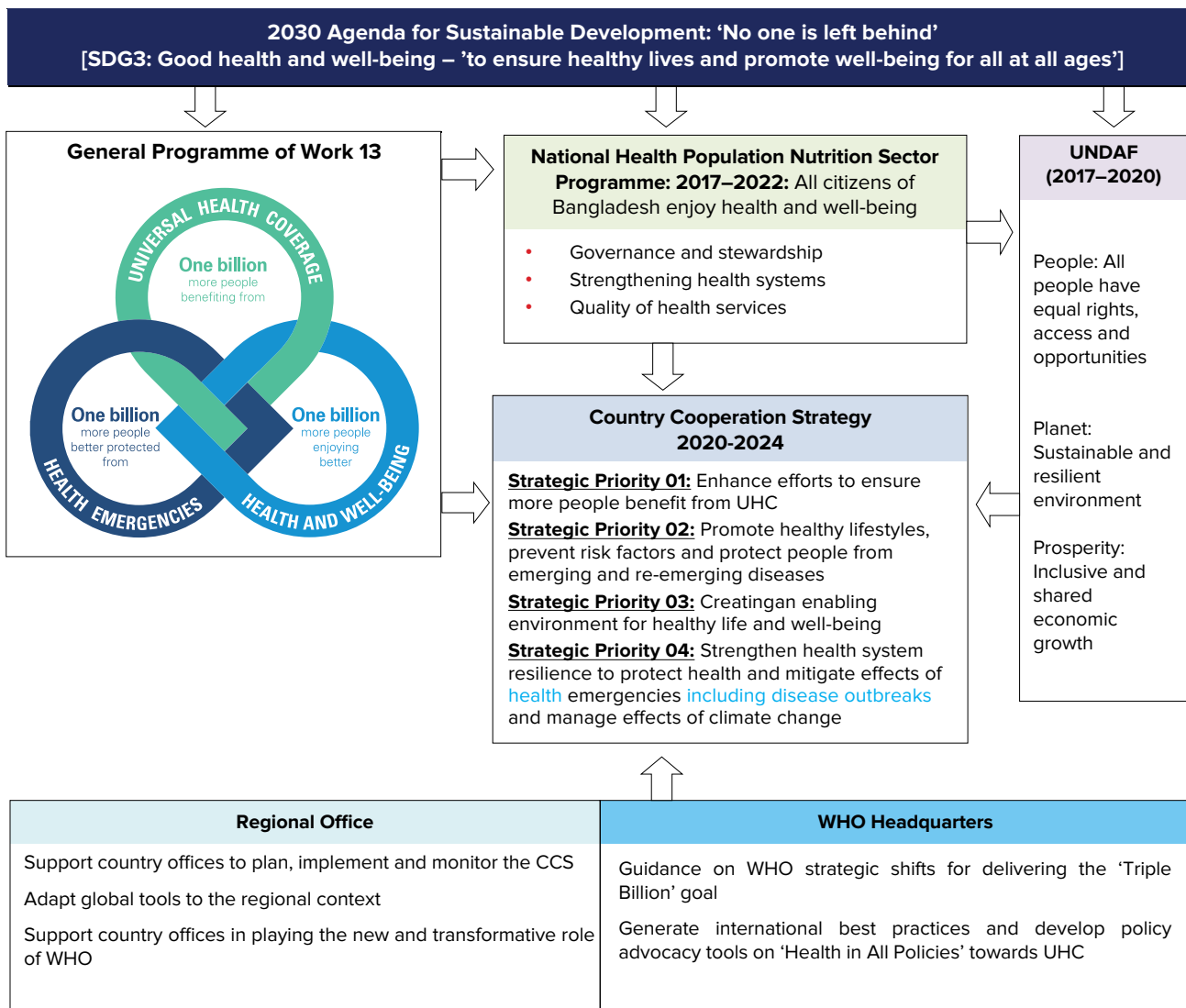
<sup>26</sup>Wirtz VJ, Hogerzeil HV, Gray AL et al. Essential medicines for universal health coverage. Lancet 2017; 389: 403–76. Available from: [http://dx.doi.org/10.1016/S0140-6736\(16\)31599-9](http://dx.doi.org/10.1016/S0140-6736(16)31599-9)



The Strategic Priorities for the new Country Cooperation Strategy 2020–2024 have been developed based on: i) lessons learnt and experiences gained during the previous CCS, including achievements during the bienniums; ii) country health situation analysis through consultative meetings with different stakeholders; iii) national health plans of Bangladesh; iv) WHO’s role and mandate; and v) UNDAF.

A strong policy dialogue has been in place with the national stakeholders to finalize the results-based Strategic Priorities, which are guided by the 4th HPNSP (2017–2022), WHO’s priorities outlined in the GPW13 2019–2023 (2); WHO’s Global and Regional Priorities including the Regional Director’s Flagship Programmes; the UNDAF priorities and the overall targets of the SDGs (Fig. 19).

**Fig. 19. Interconnected process to develop the priorities of WHO Bangladesh Country Cooperation Strategy**



## Strategic Priorities<sup>27</sup>

|   |
|---|
| <p><b>Strategic Priority 01: Enhance efforts to ensure more people benefit from UHC</b></p>   |
| <p><b>Focus areas:</b> Governance and stewardship; human resources for health, primary health care, digital health, quality of care, nutrition and financial protection</p>   |
| <p><b>Key deliverables:</b></p> <ul style="list-style-type: none"> <li>• Evidence- based equitable health financing model developed and implemented for ensuring UHC</li> <li>• Capacity strengthened to implement quality Essential Services Package (ESP) focusing on primary health care</li> <li>• National HRH plan implemented and health workforce shortage and uneven distribution reduced</li> <li>• Institutional capacity strengthened to improve medical education, knowledge sharing and research</li> <li>• National capacity strengthened on quality, safety and efficacy of the medical products (including alternative medicines)</li> <li>• National capacity strengthened on elderly and geriatric health</li> <li>• National capacity strengthened on quality, safety and efficacy of medical products</li> <li>• Digital health system strengthened for evidence-based information generation, performance tracking including health related SDG indicators, and ensuring stronger voice and accountability.</li> </ul>  |
| <p><b>Strategic Priority 02: Promote healthy lifestyles, prevent risk factors and protect people from emerging and re-emerging diseases</b></p>   |
| <p><b>Focus areas:</b> Noncommunicable diseases and communicable diseases</p>   |
| <p><b>Key deliverables:</b></p> <ul style="list-style-type: none"> <li>• Multisectoral Action Plan for Prevention &amp; Control of NCDs implemented and monitored</li> <li>• Behavioural risk factors for NCDs addressed through implementing the WHO Framework Convention on Tobacco Control, developing and implementing national dietary salt intake reduction plan based on WHO SHAKE technical package, and policies to discourage unhealthy food and encourage healthy food and physical activity</li> <li>• WHO PEN-HEARTS package addressing cardiovascular diseases, diabetes, chronic respiratory diseases, cancer and palliative care; services for oral, eye and ear care strengthened as part of essential health service delivery; and surveillance system for NCDs and digitalization of NCD service delivery strengthened</li> <li>• Implementation of WHO Mental Health Gap Action Programme (mhGAP), including service for persons with autism and neurodevelopmental disorders scaled up. Strategic action plan for mental health finalized, costed and implemented</li> <li>• Steps taken to prevent injuries and disabilities, including strengthening road safety and post-crash response, prevention of drowning, prevention of blindness</li> <li>• Community-based rehabilitation of physically and mentally disabled persons, including availability of assistive devices strengthened</li> <li>• Healthy Cities Initiative and initiative to reduce air pollution strengthened</li> <li>• High vaccination coverage sustained and polio eradication status maintained</li> <li>• Capacity to implement National TB Strategic Plan 2021–2025 strengthened in line with the Global END TB Strategy</li> <li>• Elimination process of communicable diseases (NTDs, leprosy, malaria, measles, rubella and CRS, JE, HepB) strengthened</li> <li>• National capacity strengthened to diagnose, treat and control transmission of infectious, vector-borne and zoonotic diseases (HIV/AIDs, dengue, chikungunya, Zika, hepatitis, rabies and snake-bite).</li> </ul> |

<sup>27</sup>To implement the CCS priority interventions emphasis would be on the “Sustain. Accelerate. Innovate”(SAI matrix) vision in the context of the WHO SEAR Region Flagship Priority Programmes (Annex 2).

**Strategic Priority 03: Creating an enabling environment for healthy life and well-being****Focus areas:** Health and nutrition status of mothers, newborns, children and adolescents**Key deliverables:**

- Facility readiness and capacity strengthened to reduce maternal, neonatal, adolescent and childhood mortality and morbidity
- Capacity strengthened to implement national actions plans [Bangladesh National Strategy for Maternal Health 2015–2030; National Strategy for Cervical Cancer Prevention and Control 2017–2022; Bangladesh Every Newborn Action Plan (BENAP); Second National Plan of Action for Nutrition (NPAN 2) 2016–2025; and National Strategy for Adolescent Health and Action Plan 2017–2030]
- Capacity strengthened to implement school-based adolescent health programmes including adolescent sexual and reproductive health rights (SRHR), nutrition, preventing violence against adolescents, and addressing the mental health of adolescents
- Capacity strengthened to generate demand and provide quality SRH services including family planning
- Institutional capacity on midwifery and nursing strengthened
- Capacity of national nutrition service providers, e.g. MoH&FW, NNS and BNNC, strengthened through policy analysis and coordination, to implement essential package of nutrition interventions
- Capacity of national nutrition service providers such as MoH&FW, NNS and BNNC strengthened on food safety and health diet.

**Strategic Priority 04:** Strengthen health system resilience to protect health and mitigate effects of health emergencies including disease outbreaks and manage effects of climate change**Focus areas:** Environmental health and climate change; emergency preparedness and response; disease surveillance, laboratory support and case management; IHR Core Capacity; AMR containment and food safety**Key deliverables:**

- Capacity of the Climate Change Health Promotion Unit (CCHPU) of MoH&FW strengthened and National Adaptation Plan for the Health Sector (H-NAP) implemented
- National capacity strengthened on emergency preparedness and control of disease outbreaks, including surveillance, laboratory support and case management
- IHR Core Capacity strengthened including at points of entry and quarantine zones
- National capacity strengthened on early warning systems (EWARS), operating health emergency operations centres (HEOCs) and emergency medical teams
- Capacity to implement the national WASH strategy for health facilities bolstered
- Institutional capacity on AMR containment and food safety interventions strengthened.

## Results Framework

The CCS priorities and focus areas are well linked with the outcomes and targets of GPW13, 4th HPNSP (2017–2022); the SDGs and UNDAF (2017–2020). To monitor the contribution and progress of the CCS in achieving national health indicators, including the targets, a Result Framework for CCS has been drafted. This will be finalized upon developing the new UNDAF (UNSDCF: 2022–2026) as well as the Mid-term Review of the 4th HPNSP in 2020 (Table 7).

Table 7. Results Framework

| Key Indicators   | Baseline (year and source)   | Target of 4th HPNSP: (2022)                            | Indicator alignment  |
|--|--|--|--|
| <b>Strategic Priority 01: Enhance efforts to ensure more people benefit from UHC</b>   |  |  |  |
| % of total health expenditure (THE) financed by the public sector  | 23.1%<br>BNHA, 2012 (74)   | 26.2% (1)  | 4th HPNSP, GPW, SEA Region Flagships, SDGs                                 |
| % of public facilities with key service readiness [quality of care] as per approved Essential Services Package (ESP)                     | FP: 51.6%;<br>ANC: 9.3 %;<br>CH: 2.4% (BHFS 2017)                      | FP 70%<br>ANC 50%<br>CH 50%                            | 4thHPNSP, GPW, SEA Region Flagships, UNDAF, SDGs                           |
| % of service provider positions functionally vacant in public facilities, by category (physician, nurse/midwife, paramedics)             | Physician: 30.5%,<br>Nurse: 7.8%,<br>Paramedic: 7.1%,<br>BHFS 2014 (1) | Physician: 15%,<br>Nurse/midwife: 4%,<br>Paramedic: 4% | 4th HPNSP, GPW, SEA Region Flagships, SDGs                                 |
| % of public health facilities/public service delivery points without stock-outs of essential medicines/ FP supplies                      | Drugs: 66%<br>FP methods: >98%<br>BHFS 2014 (1)                        | Drugs: 75%<br>FP methods: >98%                         | 4th HPNSP, GPW, SEA Region Flagships, SDGs                                 |
| <b>Strategic Priority 02: Promote healthy lifestyles, prevent risk factors and protect people from emerging and re-emerging diseases</b> |  |  |  |
| Tuberculosis case-detection rate   | 53%<br>Global TB Report 2014   | 90%  | 4th HPNSP, GPW, SEA Region Flagships, SDGs                                 |
| Prevalence of hypertension among adult population  | Female :32%,<br>Male:19%,<br>BDHS, 2011 (7)                            | Female: 32%,<br>Male: 19% (1)                          | 4th HPNSP, GPW, SEA Region Flagships, SDGs                                 |
| Tobacco use in persons aged 15 years and above   | 35.3% (GATS 2017)  | 35%  | 4th HPNSP, GPW, SEA Region Flagships, SDGs                                 |
| Proportion of children fully vaccinated by the age of 23 months  | 88%<br>(CES 2019) (77)   | 95% (1)  | 4th HPNSP, GPW, SEA Region Flagships, UNDAF, SDGs                          |
| Measles-rubella (MR) immunization coverage among children aged under 12 months   | 92.8%<br>(CES 2019) (77)   | 90% (1)  | 4th HPNSP, SEA Region Flagships, SDGs                                      |
| <b>Strategic Priority 03: Creating an enabling environment for healthy life and well-being</b>   |  |  |  |
| Under-5 mortality rate (U5MR)  | 45% (BDHS 2017–2018)   | 34% (1)  | 4th HPNSP, GPW, SEA Region Flagships, UNDAF, SDGs                          |
| Neonatal mortality rate (NNMR)   | 30% (BDHS 2017–2018)   | 18% (1)  | 4th HPNSP, GPW, SEA Region Flagships, UNDAF, SDGs                          |
| Maternal mortality ratio (MMR)   | 173 (WHO 2017)<br>165 (SVRS 2019)                                      | 121 (1)  | 4th HPNSP, GPW, SEA Region Flagships, UNDAF, SDGs                          |
| Prevalence of stunting in under-5 children   | 30.8% (BDHS 2017–2018)   | 25% (1)  | 4th HPNSP, GPW, SEA Region Flagships, UNDAF, SDGs, WHO Global Targets 2025 |



|  |  |   |   |
|--|--|---|---|
| Prevalence of wasting in under-5 children  | 8.4% (BDHS 2017–2018)  | 8%  | 4th HPNSP, UNDAF, WHO Global Targets 2025         |
| Total fertility rate   | 2.3 (BDHS 2017–2018) (79)  | 2.0 (1)                                   | 4th HPNSP, GPW, SEA Region Flagships, UNDAF, SDGs |
| Percentage of delivery by skilled birth attendants (SBA)   | 53% (BDHS 2017–2018)   | 65% (1)                                   | 4th HPNSP, GPW, SEA Region Flagships, UNDAF, SDGs |
| School-based adolescent health & nutrition services developed in Sylhet and Chattogram divisions, Number of selected schools for implementation of SBAHP among 12 selected districts of Sylhet and Chattogram divisions        | 0% (2016–2017)<br>4th HPNSP  | 421 secondary schools                     | 4th HPNSP   |
| <b>Strategic Priority 04: Strengthen health system resilience to protect health and mitigate effects of emergencies and manage effects of climate change</b>   |  |   |   |
| Proportion of local government institutions (Union level) that adopt and implement local disaster risk reduction strategies in line with the internationally agreed instruments (Sendai Framework) for disaster risk reduction | 16% (2005)<br>Local assessment reports, annual reports, mid-term and final evaluation reports        | 60%<br>[UNDAF target by 2020]             | UNDAF, SDGs                                       |
| Average (%) implementation status of IHR Core Capacities   | 67% (GHO, WHO, 2019)   |   | 4th HPNSP, SDGs, SEA Region Flagships             |
| % population having access to a) basic sanitation, b) improved sanitation facilities   | a) 80%; b) 61%<br>WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation (UNJMP) 2014 | a) 100%; b) 80%<br>[UNDAF target by 2020] | UNDAF, SDGs                                       |

To implement the Strategic Priorities, result-oriented and differentiated approaches as adopted in the WHO GPW13 would be followed throughout the CCS period. The key approaches would include: i) leadership development; ii) advocacy and policy dialogue; iii) strategic support for coordination and building partnerships; iv) technical assistance to strengthen national institutions; and v) service delivery to fill the critical gaps.

## 6.1 WHO Country Office: Key undertakings

To address the national health priorities and emerging health-related challenges as mentioned in the Strategic Agendas, the WHO Country Office will continue to provide need-based technical assistance to the government and its partners. This technical assistance will mainly cover areas such as formulating policy, developing evidence-based guidelines, norms and standards; capacity-building and strengthening knowledge base and research; monitoring country health and development situation, and building institutional capacities.

For effective implementation of the Strategic Agendas, emphasis will be placed on WHO's leadership role, quality of technical assistance including innovations in knowledge management, advocacy and partnership development. Specifically, the WHO Country Office will give emphasis on the following aspects:

### **Developing a more competent country office team:**

The current country office structure will be revisited in the light of the Strategic Agendas. Internal needs assessment will be conducted to equip the Country Office with adequate staff. Serious efforts would be made to fill the vacant positions. Continuous leadership development and technical capacity enhancement would be the key focus of the Staff Development and Learning (SDL) initiatives in the Country Office. Services of national/international experts will be mobilized for knowledge sharing including through the E-learning process. Internal communication among different technical units would be bolstered.

**Strengthening multisectoral collaboration:** For greater understanding among the policy-makers about the impact of different social and environmental factors on health as well as to promote “health in all policies”, policy advocacy would be the key strategy. Evidence-based policy dialogues will be held regularly with other ministries such as education, social welfare, women and youth, local government, planning, emergency preparedness, food, industry, fisheries and livestock, and the environment. WHO will play a proactive role to support the implementation process of different multisectoral health and nutrition interventions such as on NCDs, climate change, food safety, environmental health, IHR (2005), AMR containment, and so on. Emphasis will be placed on establishing a resilience system that will involve multiple stakeholders to combat future potential pandemics.

### **Strengthening partnerships and networking:**

Collaboration with professional organizations/ bodies, academic institutions including WHO collaborating centres, NGOs and civil society organizations will be enhanced. Considering WHO's leadership role and current partnership environment in the health and nutrition sector, it is advantageous to conduct more joint advocacy and programming. WHO will explore opportunities for joint UN interventions beyond health, particularly on environment and climate change issues, under UNDAF. WHO would take the lead to develop a platform for policy advocacy and sharing of best practices involving different stakeholders. The WHO FENSA (Framework of Engagement with non-State Actors) guideline and Scaling Up Nutrition (SUN) platform will be extensively used to build up partnerships with potential NGOs/ CSOs in the areas

such as RAMNCH-FP, NCDs including tobacco control, environmental health and climate change including WASH, nutrition and food safety, and others (80).

**Knowledge dissemination:** There will be emphasis on research and knowledge dissemination. The country office research unit will be equipped with competent staff. A “knowledge hub” on innovative research and knowledge-sharing will be created. To build research capacity as well as increase knowledge sharing, stronger networks will be developed with the academic institutions and WHO collaborating centres (80).

**Increasing visibility:** WHO will play a proactive role to increase its visibility using both traditional and new innovative approaches such as advocacy, communication through mass media, etc. The Communication Unit at the Country Office will be equipped with newer technology, including innovative digital communication systems. The new CCS will be widely disseminated to all stakeholders. A CCS brief will be available in English and Bangla. The key elements of the CCS will be shared at high-

level forums such as the GWCC (Government, WHO Coordination Committee) meetings, UNCT and DP Consortium meetings, and at all policy-level forums of WHO and MoH&FW. The CCS document will be posted on the Country Office website and links will be extensively shared with relevant stakeholders.

**Resource mobilization:** Strong emphasis will be placed on financial resource mobilization. Coordination with the current donors – such as DFID (FCDO), Global Affairs Canada, USAID, the Global Fund, Gavi, USDOS, ECHO, NORAD as well as the donors for and supporters of the humanitarian interventions in Cox’s Bazar – will be bolstered. A comprehensive resource mobilization plan will be developed specific to the four Strategic Priorities of the CCS with estimated financial targets. Exploring new funding opportunities, both nationally and internationally, would be one of the prime tasks of the WHO Country Office for Bangladesh during this CCS period (80).

## 6.2 Support from the Regional Office and headquarters: Working as one WHO

| Regional Office  | WHO headquarters   |
|--|--|
| <ul style="list-style-type: none"> <li>Adapt global tools to the regional context and continue to provide policy advice and guidance.</li> <li>Support multicountry collaboration to share experience, exchange of technology and expertise within the Region.</li> <li>Support to strengthen research capacity and generation of evidence in different priority areas including RAMNCH, NCDs, nutrition, food safety, climate change and strengthening health systems.</li> <li>Provide technical support to implement the Flagship Programmes including diseases elimination interventions.</li> <li>Support strengthening Country Office capacity on emergency preparedness and response systems to control disease outbreaks.</li> </ul> | <ul style="list-style-type: none"> <li>Support the Regional and Country Offices with global policy advice and directives including WHO’s strategic shifts and transformative role.</li> <li>Generate international best practices on ‘going beyond health’ and ‘Health in All Policies’ approaches to strengthen multisectoral involvement to achieve UHC.</li> <li>Generate evidences and support developing strategies and tools to prevent and manage environmental and climate change-related diseases and risks.</li> <li>Support regional and country offices with global strategies and protocols in case of a public health emergency of international concern (PHEIC).</li> </ul> |

## Bangladesh achieves international recognition in quality testing for medicines



The Bangladesh National Control Laboratory (NCL) for Medicinal Products has recently been recognized as being compliant with WHO recommended standards of good practices for pharmaceutical quality control laboratories (GPPQCL). As such, the laboratory is added to the WHO list of prequalified medicines quality control laboratories.

- Quality assurance of pharmaceuticals is a major public health challenge, particularly in the light of growing cross-border health issues and the international dimensions of trade. The quality of pharmaceuticals has been a concern for WHO since its inception. Quality assurance is a wide-ranging concept covering all matters that individually or collectively influence the quality of a product.

Regarding pharmaceuticals, quality assurance can be divided into major areas: development, quality control, production, distribution and inspections.

- Bangladesh has now one of the 55 laboratories, globally, on the WHO list of prequalified medicines quality control laboratories. This is a great achievement for the country and a major step towards ensuring access to quality essential medicines at national, regional and global levels.
- The NCL is in the jurisdiction of the Directorate General of Drug Administration (DGDA). Under the leadership of DGDA, a Coalition of Interested Partners (CIP) for medicines regulatory affairs was established in 2016 with technical guidance from WHO. Within this CIP, development partners mainstream their support to DGDA and coordinate regulatory system strengthening activities. Partners supporting the National Control Laboratory included: United States Pharmacopoeial Convention's Promoting Quality of Medicines Programme (USP-PQM), USAID, the World Bank; DFID (FCDO) and WHO.

'WHO remains committed to supporting the Government of Bangladesh in strengthening capacity for medicines quality control mechanisms and capacities, a key step in achieving universal health coverage'

Source : <https://www.who.int/bangladesh/news/detail/13-04-2020-bangladesh-achieves-international-recognition-in-quality-testing-for-medicines>



## 7.1 Purpose, process and activities

The main purpose of the monitoring and evaluation exercise is to : i) improve programme performance; ii) improve organizational learning; and iii) increase accountability. This CCS 2020–2024 will be implemented through two consecutive biennial Programme Budgets and workplans. Performance of the CCS will be monitored regularly through a process involving stakeholders including MoH&FW. The existing coordinating mechanisms of WHO with MoH&FW such as quarterly review of the Biennium Workplan and six–monthly performance reviews during the GWCC meeting will be bolstered further.

In the light of the CCS Results Framework, a CCS performance tracking “checklist” would be developed jointly. The progress of the CCS deliverables would be assessed annually using colour codes similar to a “traffic light system” (Fig. 20). An annual report would be circulated among all stakeholders.

The current CCS Results Framework would be re-aligned with the new UN Sustainable Development

Cooperation Framework (UNSDCF) and the National Health Plan, as required. Reviews of the CCS at mid-point and towards the end of the term will be organized in consultation with key stakeholders including the WHO Regional Office and headquarters. Documentation of key achievements and lessons learnt including case studies would be conducted at the end of the first biennium

**Fig. 20: Annual performance tracking sheet for CCS Strategic Priorities [sample]**

| Deliverables                 | Progress         |           |           |           | Code      |         |
|------------------------------|------------------|-----------|-----------|-----------|-----------|---------|
| <b>Strategic Priority 1:</b> | Good progress    |           |           |           | Green     |         |
|                              | Some progress    |           |           |           | Yellow    |         |
|                              | Limited progress |           |           |           | Red       |         |
| <u>Key deliverables</u>      | Year 2020        | Year 2021 | Year 2022 | Year 2023 | Year 2024 | Remarks |
| 1.                           |                  |           |           |           |           |         |
| 2.                           | S A M P L E      |           |           |           |           |         |
| 3.                           |                  |           |           |           |           |         |
| 4.                           |                  |           |           |           |           |         |
| <b>Strategic Priority 2:</b> |                  |           |           |           |           |         |
| <u>Key deliverables</u>      |                  |           |           |           |           |         |
| 1.                           |                  |           |           |           |           |         |
| 2.                           |                  |           |           |           |           |         |

## 7.2 Mid-term review

The main objective of the mid-term review would be to: i) assess the progress with accomplishing the deliverables for specific indicators of the CCS Results Framework; ii) identify constraints and potential risks that may require revisiting and changing of

approaches; and iii) identify specifications required to accelerate progress to achieve the set targets during the second half of the CCS cycle. A participatory review would be conducted involving the stakeholders and, based on the findings and recommendations, a joint action plan will be developed.

## 7.3 Final evaluation

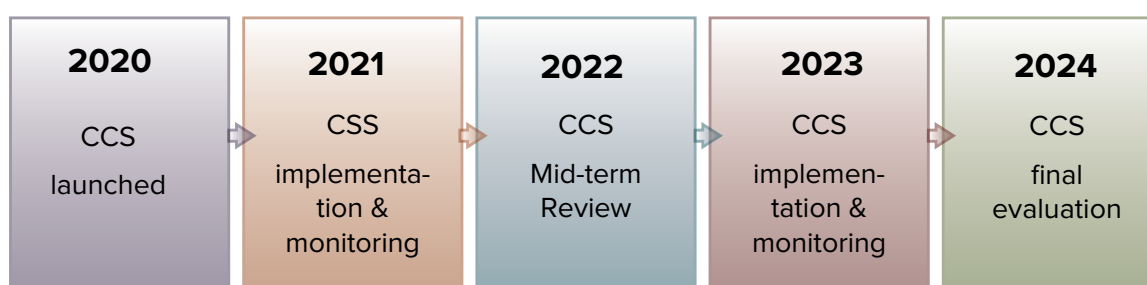
The purpose of the final evaluation would be to assess the contributions of WHO in achieving national goals and targets of the CCS Results Framework. Specific objectives would be to i) assess progress and document achievements and challenges with respect to the priority areas of the CCS; ii) determine WHO's contribution to improving national health outcomes through the implementation of the CCS priorities, in collaboration across the three levels of the Organization and with the government and partners; and iii) identify lessons learned and make recommendations on priorities and ways of working to strengthen collaboration under the next-generation CCS. The key evaluation aspects would cover the i) relevance; ii) effectiveness; iii) efficiency; iv) impact/results; and iv) sustainability of the strategic priorities.

The evaluation would be carried out using quantitative and qualitative analysis of available official data and information gathered from review of documents

and interviews with key stakeholders involved in the development and implementation of the CCS. To ensure independence and objectivity of the evaluation, an Evaluation Management Group (EMG) would be formed comprising representations from the three levels of the WHO (Country Office, Regional Office and headquarters) and would be chaired by the WHO Representative to Bangladesh and co-Chaired by a senior representative from the Regional Office or headquarters.

The findings of the evaluation, including lessons learned, impediments and success factors and recommendations, will be shared with stakeholders and partners and used to develop the next CCS. The CCS Final Evaluation Report will be published and circulated to all relevant stakeholders. The milestones are outlined in Fig. 21 below.

Fig. 21. Key milestones



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# Annexes

## Annex 1: Key health, nutrition and development indicators for Bangladesh

| Key indicators: Bangladesh   |                         |
|--|-------------------------|
| WHO Region   | South-East Asia         |
| Child health   |                         |
| Infants exclusively breastfed for the first six months of life (%) (2014)                          | 55.3                    |
| Diphtheria, tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%) (2018) | 98                      |
| Demographic and socioeconomic statistics   |                         |
| Poverty headcount ratio at US\$1.25 a day (PPP) (% of population) (2010)                           | 43.3                    |
| Gender inequality index rank (2014)  | 111                     |
| Human development index rank (2014)  | 142                     |
| Health financing   |                         |
| Total expenditure on health as a percentage of gross domestic product (2014)                       | 2.82 (Bangladesh note)  |
| Private expenditure on health as a percentage of total expenditure on health (2014)                | 72.10 (Bangladesh note) |
| General government expenditure on health as a percentage of total government expenditure (2014)    | 5.66 (Bangladesh note)  |
| Health systems   |                         |
| Physicians per 1000 population (2015)  | 0.472                   |
| Nursing and midwifery personnel per 1000 population (2015)   | 0.267                   |
| Mortality and global health estimates  |                         |
| Neonatal mortality rate (per 1000 live births) (2018)  | 17.1 (Both sexes)       |
| Under-five mortality rate (probability of dying by age 5 per 1000 live births) (2018)              | 30.2 (Both sexes)       |
|  | 28 (Female)             |
|  | 32.2 (Male)             |
| Maternal mortality ratio (per 100 000 live births) (2017)  | 173 [ 131–234]          |
| Sustainable development goals  |                         |
| Life expectancy at birth (years) (2016)  | 71.1 (Male)             |
|  | 74.4 (Female)           |
|  | 72.7 (Both sexes)       |
| Births attended by skilled health personnel (%) (2017)   | 67.8                    |
| World Health Statistics  |                         |
| Total population (in thousands) (2016)   | 162 952                 |
| Population proportion under 15 years (%) (2016)  | 28.9                    |
| Population proportion over 60 years (%) (2016)   | 7.5*                    |
| Literacy rate among adults aged >=15 years (%) (2007–2012)   | 58                      |

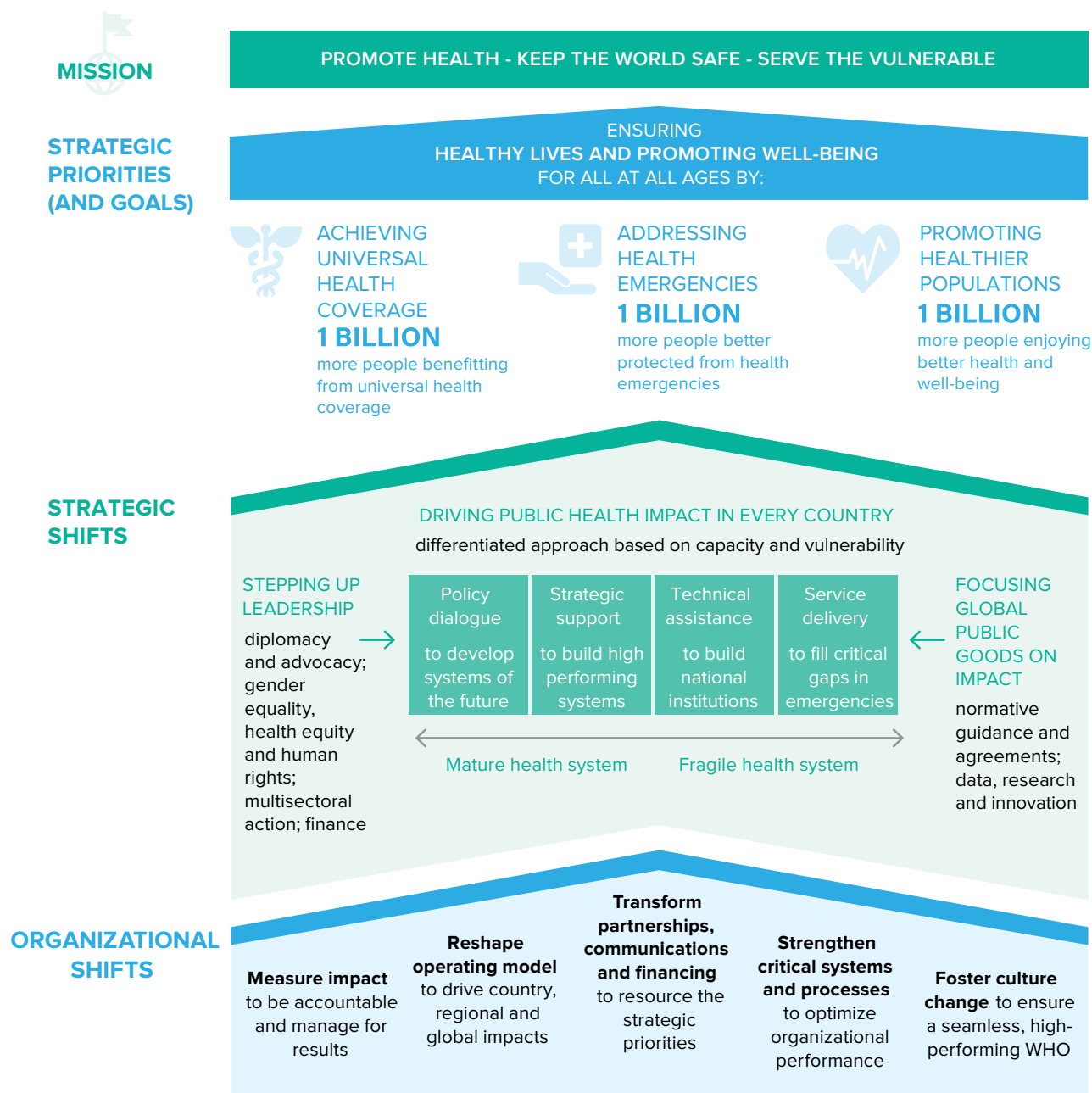
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## Annex 2: WHO sustain, accelerate and innovate (SAI) matrix for key priority areas

| CCS Priority Areas   | WHO SEA Region Flagship Priority Programmes   | Sustain. Accelerate. Innovate  |   |  |
|--|---|--|---|--|
|  |   | Sustain  | Accelerate  | Innovate   |
| <b>Universal health coverage</b>   | Continue progressing towards universal health coverage with a focus on human resources for health and essential medicines.  | National commitment and leadership.<br>PHC approach with community involvement.  | Quality of care.<br>Institutional capacity to develop skilled health workforce.<br>National capacity to access quality medical products.<br>Use of digital health systems for evidenced- based information generation and performance tracking.   | Evidence-based equitable health financing model.<br>Knowledge sharing and research interventions.  |
| <b>Noncommunicable diseases (NCDs) and communicable diseases</b>   | Prevent and control noncommunicable diseases through multisectoral policies and plans, with a focus on 'best buys'<br>Eliminate measles and rubella by 2023.<br>Finish the task of eliminating neglected tropical diseases and other diseases on the verge of elimination.<br>Accelerate efforts to end TB by 2030. | National commitment to implement multisectoral action plans on NCDs.<br>Measles-rubella (MR) immunization coverage among children under 12 months.<br>Efforts to eliminate kala-azar, malaria and lymphatic filariasis and STH (active case detection, treatment and prevention measures).<br>Public-private partnerships for early TB case detection and treatment. | Implementation of WHO FCTC, SHAKE technical package, PEN package and mhGAP interventions.<br>Vaccination coverage in low-performing districts.<br>Interventions in the endemic districts including surveillance system.<br>National capacity to implement the National Strategic Plan for TB Control 2018–2022 in line with the Global END TB Strategy. | 'Life-style change' interventions.<br>Follow-up campaigns.<br>Community involvement.<br>Public-private partnership including resource mobilization.                    |
| <b>Health of mothers, newborns, children and adolescents</b>   | Accelerate reduction of maternal, neonatal and under-five mortality.  | Reduced infant and under-five child mortality.<br>Current coverage of vaccination, ANC and PNC.  | National capacity to implement the action plans on RMNACH including quality service delivery.<br>Institutional capacity-building on nursing and midwifery.  | Interventions to reach the unreached.<br>Social behaviour change communication.  |
| <b>Strengthen health system resilience to protect health and mitigate effects of emergencies and manage climate change effects</b> | Further strengthen national capacity for preventing and combating antimicrobial resistance.<br>Scale up capacity development in emergency risk management in countries.   | Current coverage of access to safe drinking water and improved sanitation.<br>Current interventions on emergency preparedness and response.  | Emergency preparedness and control of disease outbreaks, including surveillance, laboratory support and case management.<br>IHR Core Capacity.<br>Early warning system (EWARS), operating health emergency operations centres (HEOCs) and emergency medical teams (EMT).<br>Implementation of National Action Plan on AMR.                              | Multisectoral approach for prevention and control of pandemics.<br>Multisectoral approach for AMR containment.<br>Climate resilient health infrastructure and systems. |

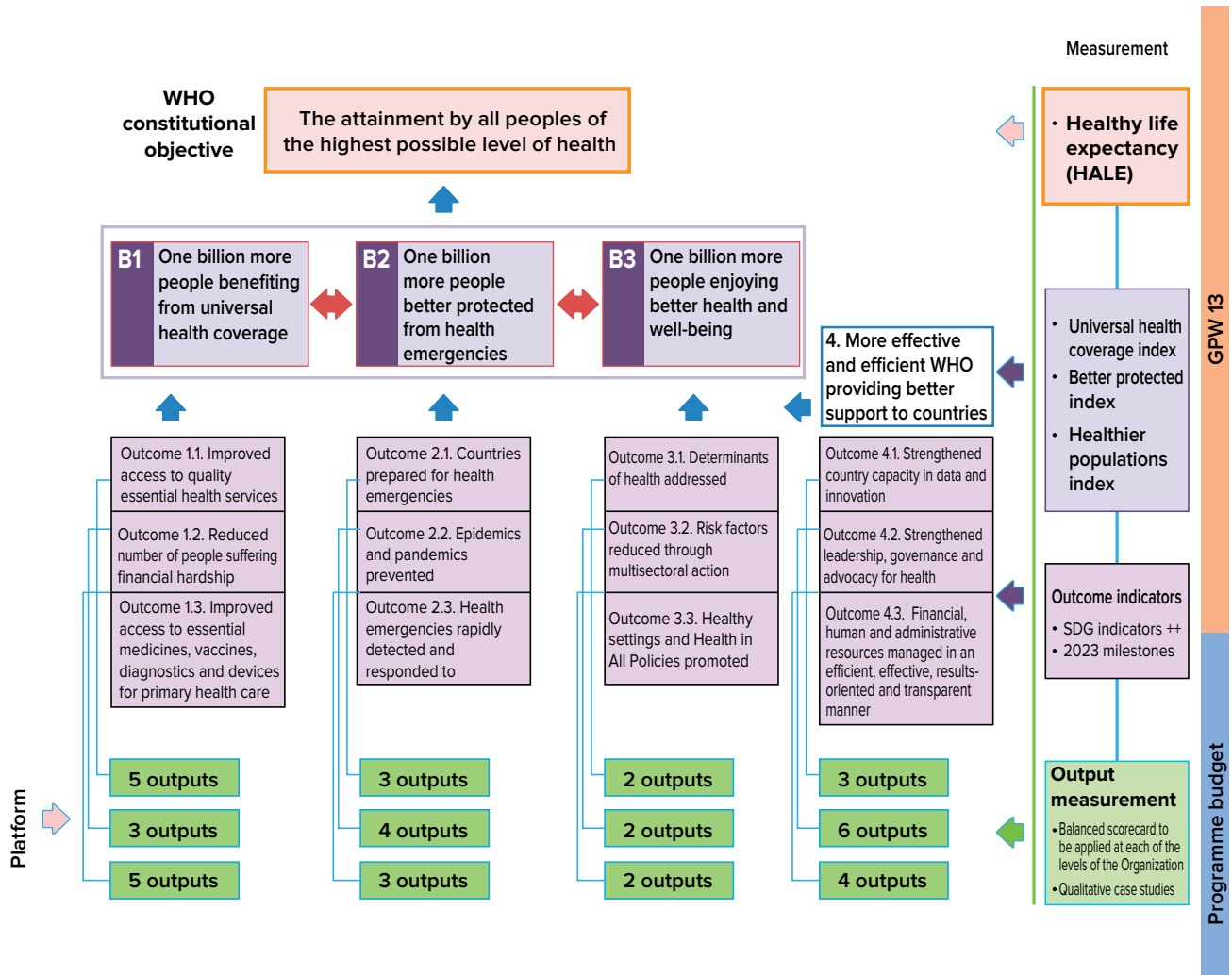


## Annex 3: GPW 13 Strategic Priorities and Shifts (81)



Source: World Health Organization, Thirteenth General Programme of Work 2019–2023  
<https://apps.who.int/iris/bitstream/handle/10665/324775/WHO-PRP-18.1-eng.pdf>

## Annex 4: GPW 13 Results Framework



Source: World Health Organization, Thirteenth General Programme of Work 2019–2023

[\[https://apps.who.int/iris/bitstream/handle/10665/324775/WHO-PRP-18.1-eng.pdf\]](https://apps.who.int/iris/bitstream/handle/10665/324775/WHO-PRP-18.1-eng.pdf)







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