

Cooperation for Health Development

The World Health
Organisation's support to
programmes at country level

Country Case Studies:
The South East Asian Region

September 1997

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September 1997

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Country Case Study Reports: The South East Asian Region

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**THE WORLD HEALTH ORGANISATION
AT COUNTRY LEVEL**

**COUNTRY CASE STUDY REPORT
BANGLADESH**

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January 1997

Study Team Activities

The Study Team visited Bangladesh from December 9th to 17th, 1996 and consisted of three members. The national consultant was Dr Syed Jahangeer Haider, Executive Director of Research Evaluation Associates For Development (READ), a private consultancy firm based in Dhaka, Bangladesh. Dr Jahangeer Haider collected the data on the National Health System Capacity and liaised with the Bangladesh WHO Office and the Ministry of Health and Family Welfare (MoHFW) which provided additional information on the WHO Country activities. The Core Team Member was Dr Adetokunbo Lucas from Nigeria and the International Consultant was Professor Patrick Vaughan, on secondment from the London School of Hygiene and Tropical Medicine to the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B).

Following briefing sessions by the WHO Country Representative, Dr Wit Hardjotanojo, and the National Consultant, the Study Team undertook a schedule of interviews and visits with senior staff in the MoHFW, UN Agencies and World Bank, research organisations, and non-government organisations involved in health. Additional information was also available on the support provided by WHO Headquarters to Bangladesh WHO Country Programmes and by the WHO South-East Asia Regional Office in Delhi.

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The Study Team wishes to acknowledge the exceptional cooperation and support that it received during its short stay in Bangladesh, particularly from the WR and his staff in the WHO Country Office, the Ministry of Health and Family Welfare and the NGOs. Many people made time in their busy schedules at short notice, when we were only one of several missions in Dhaka at that time. We would also like to thank those interviewed for their candid responses. In compiling this report we are very grateful for all the information and opinions that we received, but we accept sole responsibility for interpreting the information and for the conclusions we arrived at. This country case study proved to be a very valuable experience, that has added enormously to our understanding of the complex and very valuable role that WHO has in Bangladesh.

Executive Summary

Bangladesh is one of the least developed countries. It is densely populated with about 12 million people and a GNP of US\$240 per capita. Most people live from subsistence agriculture but about 20% are now living in urban areas. It is considered to be a priority country for economic assistance and there are many multilateral and bilateral agencies supporting the health sector.

Although some health indicators have improved, such as falls in total fertility (to 3.9 births) and infant mortality (to 90/1,000 births), both health and population remain very important development issues. Contraceptive acceptance is estimated to be 45%, safe water is available to 90% of people and 75% of young children are enrolled in primary schools. Diarrhoeal diseases, acute respiratory infections, malnutrition, neonatal conditions, and accidents and injuries are important causes of mortality in children and cardiovascular diseases, hypertension and diabetes are important causes of adult morbidity. Vector-borne diseases, such as malaria, are largely under control although visceral leishmaniasis has been increasing. With increasing urbanisation and industrialisation HIV/AIDS, sexually transmitted diseases, environmental pollution and occupational health have all become much more important issues.

The Ministry of Health and Family Welfare (MoHFW) is responsible for health sector policy and planning and two separate directorates, one each for health services and family planning, have responsibility for implementing the government health services. The directorates are vertically organised and programme management is highly centralised in Dhaka. Despite a large investment in rural health infrastructure and health personnel, government services are characteristically seen as under utilised and inefficient. Many primary health care services, particularly for family planning, are also provided by NGOs and numerous private practitioners of various kinds. The MoHFW expenditure has reached 6.9% of the government total, which is equivalent to just over US\$3 per person or about a quarter of the combined public and private expenditure on health. About 73% of the total ministry budget is for recurrent costs, a half of which is for staff. About one half of the total is spent on primary health care at the thana level and below. One third of the total budget is from donor organisations, with a major role played by the consortium of the World Bank and ten bilateral donors in the Fourth Family Planning and health Project (FPH4).

Since Bangladesh has no accepted national health policy or plan, and neither is there an agreed list of health sector priorities, the Ministry undertakes health planning by developing individual projects and seeking support from donor agencies. These projects then have to be vetted and approved by the Government's Planning Commission and External Relations Division. The Ministry now has a total of 110 separate projects, 66 of which are within FPH4 and there 21 are being executed by the WHO Country Office. WHO is also directly involved in more than another 30 projects with the MoHFW. The relationship between WHO and the MoHFW is thus dominated by this large number of technical cooperation projects. By comparison WHO's advocacy role has remained weak, partly because the Organisation has adopted a low profile and also because it has been marginalised in this role amongst the donor agencies.

In Bangladesh WHO is generally seen to be a successful UN agency which is strong in technical cooperation programmes, particularly for disease control and, to a lesser extent for human resources development. It has also shown that it can be a successful executing agency for ministry projects. It is a large WHO Office, with 64 professional staff and over 50 individual projects. However, the Office also suffers from some constraints. For instance, the Organisation is seen to be too closely controlled by the MoHFW, its activities are planned without the benefits of a national health policy or plan, and until recently the health sector was dominated by the needs of family planning. In addition, WHO is only one of many UN and donor agencies working in health, including the Consortium led by the World Bank. The capacity of the WHO Office is also seen to be constrained by the bureaucratic controls exerted by the WHO Regional Office and by the variable quality of some WHO staff, particularly the consultants.

The main 'missed opportunities' for the WHO Country Office are its weak advocacy and health planning role at the national level, lack of expertise in health systems development, need for more collaborations beyond the MoHFW, and a greater involvement in projects aimed at improving the basic and in-service training of the human resources in health.

With regard to the future role of the WHO Country Office in Bangladesh, there appear to be four main options for priority development. Firstly, WHO could remain largely as it is now but focus on a smaller range of priority programmes; Secondly, it could concentrate on being a technical agency and substantially reduce its executive agency role; Thirdly, it could strengthen its advocacy role by developing its capacity for in health sector reforms and health systems development; Or fourthly, due to the size of its technical cooperation and executing agency role, the Office could be given much greater autonomy from the Regional Office for managerial decision making.

Country Case Study Report : Bangladesh

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List of Acronyms

EBFs	Extra Budgetary Funds
ENHR	Essential National Health Research
EPI	Expanded Programme of Immunisation
GoB	Government of Bangladesh
GPA	Global Programme on AIDS
HRP	Human Reproduction Programme
MoHFW	Ministry of Health and Family Welfare
ODA	Overseas Development Assistance
PHC	Primary Health Care
RBFs	Regular Budgetary Funds
RD	Regional Director
SEARO	South East Asian Regional Office
SEAMEO	South East Asian Medical Education Organisation
TCDC	Technical Cooperation for Developing Countries
TDR	Tropical Diseases Research
WB	World Bank
WHOCO	WHO Country Office
WHOHQ	WHO Headquarters, Geneva
WHORO	WHO Regional Office
WR	WHO Representative

1. Bangladesh: An Introduction.

1.1 General Background.

Prior to the partition of India most of present day Bangladesh was within the province of East Bengal, but from 1947 until 1971 the country was known as East Pakistan. Bangladesh became an independent country in 1971 following the war of liberation and it recently celebrated its 25th anniversary. The present day Bangladesh occupies large parts of the Ganges riverine delta area and although it is surrounded on most sides by India, it also shares a border with Myanmar. The country is subject to natural disasters due to river flooding, which on occasions can be very severe, and to cyclones from the Bay of Bengal to the south.

Although there have been periods of military rule from 1975 to 1990, democratic parliamentary elections were held in early 1991 and despite episodes of considerable political unrest, civilian governments have been ruling the country since then. The last general election was held in June 1996. Islam is the faith of about 85% of the population, with Hindus making up most of the remaining 15%.

Bangladesh is one of the most densely populated and poorest of developing countries. The population, which is estimated to be about 120 million, is projected to grow to around 250 million before growth stabilises in about a hundred years time. The present GNP per capita is US\$ 240. The capital city of Dhaka has grown very rapidly in recent years and about 20% of the total population lives in urban areas. Nearly 40% of the GDP comes from agriculture, with rice, jute, tea and fish being important commodities. The manufacturing sector has recently grown substantially, particularly the garment industry, which has resulted in a large rise in the urban-rural migration for employment, especially by young women.

Although there have been notable improvements in some health indicators since the 1970s, health status remains very poor, thus making health and population among the most important development issues. For instance, the incidence of low birth weight (2500 grams or less) is about 50%, maternal mortality remains one of the highest in Asia, infant mortality is about 90/1000, and life expectancy at birth is 55 years and, unlike most countries, it is lower for females than males. In addition, average nutritional calorie intake is estimated to be at 88% of requirements, only 34% of the population have access to sanitation and adult literacy is 35%. However, Bangladesh has also achieved some notable successes. The average total fertility rate has fallen to 3.9, the rate of natural population increase is close to replacement level and the national contraceptive prevalence is estimated to be 45%. Immunisation coverage with DPT, measles and maternal tetanus toxoid has improved rapidly in the last few years, safe water is available to about 90% of the population and about three quarters of young children are enrolled in primary schools.

The main causes of death, particularly in children, remain diarrhoeal diseases, acute respiratory infections, malnutrition, neonatal conditions, and accidents and injuries. Cardiovascular diseases, hypertension and diabetes have emerged as important causes of adult morbidity. HIV/AIDS transmission in Bangladesh is believed to be at a much lower level than in other surrounding Asian countries, but there is no reliable surveillance data on which to assess the situation. Malaria transmission is largely under control but there has been a large rise in the incidence of visceral leishmaniasis. With increasing urbanisation and industrialisation, HIV/AIDS, sexually transmitted diseases, environmental pollution and occupational health are all issues that are becoming much more important.

1.2 Health Systems Capacity.

Ministry of Health and Family Welfare:

Although the Ministry of Health and Family Welfare (MoHFW) has overall responsibility for health sector policy and planning, there are two separate Directorates (also called the two wings), one for health services (DGHS) and another for family planning (DGFP), that have responsibility for organising and implementing the Government of Bangladesh (GoB) health programmes and services. This division of responsibilities between the two directorates was originally established in the early 1970s, since when there has been considerable independence and competition between them. They are both largely organised in a vertical manner and each has developed many of their own services and infrastructure, particularly for primary health care at Thana, Union and village levels. These separate structures have also led to the development of specialised cadres of health personnel and training institutions, together with separate health facilities, supporting services and information systems. However, in recent years considerable efforts have been made to achieve greater integration by organising more joint services at the Thana level and below, which started with EPI and family planning clinics.

Health Services:

The control of the GoB health services is highly centralised in the MoHFW and the two directorates in Dhaka, including for finances and personnel. Since there is no strong administrative capacity at Thana level and neither is there an elected or appointed local government, the two directorates are directly responsible for the implementation of all services, programmes and projects. However, there are proposals for more decentralisation based on strengthening the role of the Thana Health Complexes. Decentralisation and increasing the efficiency of the bureaucratic structure are common themes in planning discussions.

There are also a large number of NGOs working in health, that operate separately from the MoHFW. However, there is an increasing tendency for the GoB to co-opt these NGOs to work in specific under-served areas and to carry out service programmes, particular those for MCH-FP and disease control. Many of the NGOs working in family planning have been directly supported by USAid funds or by the UK ODA supported Bangladesh Population and Health Consortium, an intermediary organisation for funding and capacity strengthening in the area of MCH and family planning. A number of large NGOs have primary health care and disease control programmes which are funded directly by external donor agencies.

There has been a massive GoB investment in the rural health infrastructure, with the construction of almost 400 Thana Health Complexes since the 1970s, together with a network of family planning services, mainly in the form of fixed facilities such as the Union Health and Family Welfare Centres. Human resources, including primary health care personnel, are relatively well developed in the public sector but there is a notable lack of suitable nursing cadres at all levels. However, salaries are low and many positions remain unfilled. Although geographical access is reasonable, these facilities are characteristically under-utilised, suffer from shortages of drug supplies and are inefficiently managed. Although GoB health facilities are supposed to provide most services free of charge, informal and unofficial charging is widely practised. Private practitioners of all kinds, including many medical graduates, are numerous in rural areas and drugs are widely available through the large number of private pharmacies and shop outlets. By contrast, the investment in urban facilities

and services has largely been neglected until recently, even by non-governmental agencies. However, the number of private medical practices and hospitals in urban areas, together with numerous unqualified practitioners, means that the private sector is growing rapidly. These practitioners are poorly regulated and there is no system for registering or licensing them by the GoB.

GoB Health Expenditure:

The MoHFW total expenditure for health and population has been growing as a proportion of total public expenditure, particularly in the last five years, and for 1994-95 it reached 6.9% of the national budget. Although the 1994-95 total health expenditure per capita by the GoB is estimated at over US\$ 3 per person, this is thought to be about one quarter of the total public and private expenditure. The MoHFW allocates 73% of its total budget to recurrent costs, of which about three quarters is for staff costs. About a half of the total expenditure is for primary level care, which includes the Thana complexes.

Of the MoHFW 1994-95 total budget of US\$ 374.2 million, the GoB provided 67% and the remaining 33% came from donor organisations. The main bilateral donors to the health sector in Bangladesh are the governments of Australia, Belgium, Canada, Germany, Japan, Netherlands, Norway, Sweden, United Kingdom and the USA. The European Union and the World Bank are also large donors. The majority of donor funding is channelled through the large Fourth Family Planning and Health Project (FPH4), which is supported by the a Consortium of the World Bank and ten bilateral donors. The Bank has the responsibility for coordinating this Consortium. The FPH4 lasts for five years and consists of 66 different projects, of which 21 are being implemented by the Bangladesh WHO Office in its capacity as an executing agency. To allow more time for the completion of FPH4 the end date has been postponed from December 1996 until mid-1998. This also allows more time for the design of the new and much larger 5th Health and Population Project (HAPP5).

Table 1. Summary Division of Funding and Activities in the Annual Development Provision

Financial Year	GoB	Donor	Capital*	Revenue*
Health Projects				
1990/91	45.9%	54.1%	81.2%	18.8%
1991/92	63.4%	36.6%	85.8%	14.2%
1992/93	52.0%	48.0%	83.4%	16.6%
1993/94	48.0%	52.0%	74.7%	25.3%
1994/95	61.4%	38.6%	83.5%	18.3%
Population Projects				
1990/91	29.7%	70.3%	50.3%	49.7%
1991/92	31.5%	68.5%	49.0%	51.0%
1992/93	38.3%	61.7%	51.6%	48.4%
1993/94	31.3%	68.7%	58.6%	41.4%
1994/95	33.5%	66.5%	59.6%	40.4%

Source: GOB, WB

* Derived from ADP Publications

Health Economics Unit, MoHFW, Dhaka. 1995. Public Expenditure Review of the Health and Population Sectors.

Health Projects and the Planning Process:

In the absence of a definite GoB health policy or national plan, the importance of developing an agreed National Health and Population Sector Strategy (NHPSS) has been recognised in the MoHFW and by many donors. This initiative, which has been jointly led by the GoB and World Bank, is seen as a prerequisite to the formulation of HAPP5. However, in addition to NHPSS the newly installed government has recently appointed its own committee with a mandate to formulate a new national health policy, to be presented by mid-1997 at the latest. It is significant that the WHO Country Office has not been closely involved in preparing either the NHPSS or the initiatives for the new national health policy. By way of contrast, the World Bank has been consulted.

Health planning is dominated by the need to have all on-going initiatives defined in terms of an individual project plan. The MoHFW has a strong planning unit, which was led until recently by a health planner who had been head of the unit for the past 18 years. This unit considers all project concept papers and profiles that are submitted to it for review at its monthly meetings. If they are approved the unit is then responsible for preparing the full project documentation. There is a strong GoB Planning Commission that has overall responsibility for approving all new externally funded projects and the GoB Economic Relations Bureau (ERD) is responsible for liaison with the donors. The Commission passes all project proposals through a lengthy review and approval process, that usually takes between one and two years, called TAPP.

The whole project planning process emphasises the design and approval of each individual project, including their renewal, which actually leads to a fragmented approach to health planning. The absence of a national health policy makes this situation even worse. The formulation and approval process is a lengthy and cumbersome one and even when the project is finally approved, implementation relies heavily on the ability and leadership of each individual Bangladeshi project director. For instance, the MoHFW and the two directorates currently have responsibility for a total of 110 separate projects, of which 66 fall within the FHP4 and 21 of these are executed individually by the Bangladesh WHO Office. Even new initiatives for health sector reform are being handled by this project approach! It is obvious that this situation puts some urgency on establishing the new National Health and Population Sector Strategy.

Coordination of Health Research:

Coordination of research is formally undertaken by the Bangladesh Medical Research Council (BMRC) and outside of government by the Essential National Health Research (ENHR) network which is coordinated by BRAC. Although the MoHFW itself has limited research capacity, there are a number of GoB institutes with specific research mandates, particularly for operational studies, such as NIPORT (National Institute for Population Research and Training), NIPSOM (National Institute of Preventive and Social Medicine), NIPH (National Institute for Public Health), IEDCR (Institute for Epidemiology, Disease Control and Research), and BIRDEM (Bangladesh Institute for Research into Diabetes, Endocrine and Metabolic Disorders). The ICDDR,B (International Centre for Diarrhoeal Disease Research, Bangladesh) is an international research organisation affiliated to the UN system that carries out applied and operational research, particularly in reproductive and child health.

WHO has also supported research training, institutional strengthening and capacity building within Bangladesh over many years. However, despite such support and the variety of institutes, it is widely accepted that research capacity in Bangladesh remains weak and poorly funded. For instance, the total WHO TDR funding since 1978 has only been US\$ 307,603 for 13 projects. In addition, since the priority for WHO training fellowships is largely determined by the MoHFW and the clinical specialities, few have been allocated for research training.

1.3 Bangladesh and WHO: Some Critical Issues.

Even though Bangladesh has achieved a marked reduction in total fertility and improvement in some health status indicators, without any marked changes in the overall socio-economic situation, the total population is predicted to double before it stabilises at about 250 million people. Thus the country still faces enormous development challenges if the health status is to continue to improve. Although the country is still in the early stages of both the demographic and epidemiological transitions, the GoB faces major issues concerning its capacity to both plan and implement a broad range of health services. Thus there is some urgency to start on a long-term process for health systems development, including the more immediate priorities within health sector reform. However, it is not clear where Bangladesh will obtain professional expertise needed to tackle such issues.

Bangladesh is already receiving large scale aid from a wide range of organisations, including the UN agencies, bilateral donor governments and international NGOs. Even so, for the next decade Bangladesh will remain a developing country in greatest need. However, since such large scale external funding is unlikely continue indefinitely, questions are already being raised on the long-term sustainability of many of the present MoHFW projects and programmes.

With regard to the planning process, there is no national health plan and no clear health sector priorities; planning is based almost entirely on designing a large number of individual projects, each of which has to go through a lengthy approval process; control over these projects is highly centralised and their implementation is largely dependent on the national managers; the health sector is fragmented by both government and non-government vertical programmes, with little integration even at Thana level; and Bangladesh is crowded with UN and other donor agencies. In such a situation, what are the comparative advantages of WHO? How can these advantages be strengthened and exploited?

The three main future challenges for WHO in relation to its support for Bangladesh are:

- How can the Organisation exert its broad leadership role in the health sector when there are so many other influential actors involved, including the World Bank, UNICEF, EU, bilateral donor agencies and large NGOs?
- How can the Organisation respond to the needs of Bangladesh for strengthening its capacity for health policy analysis and national health planning, including health sector reforms?
- How can the Organisation retain its special role in advising and supporting the MoHFW, while at the same time broadening its role and influence to a wider range of health sector institutions, including the non-governmental organisations?

2. The WHO Country Office: Structure and Processes.

2.1 Professional, Administrative And Institutional Capacity.

The Bangladesh WHO Office is responsible for coordinating and implementing a wide range of health sector activities in a country where there are already many large and influential multilateral and bilateral agencies. It has a close working relationship with the GoB, in particularly with the MoHFW, which clearly sees the Organisation's technical cooperation capacity as its main strength.

The present Bangladesh WHO Representative, Dr Hardjotanojo, has a background in smallpox eradication and EPI, and has been in this post since 1992. The Office pays from RBFs for 26 established posts for professional staff (of which 22 are filled), another 6 national consultants and a further 35 GS staff are also on the regular budget. In addition, there are another 42 professional staff paid for from EBFs. Thus there is a total of 64 such professional staff in all the WHO projects, paid for by either RBFs or EBFs. Of the 22 professional international staff paid for from RBFs, 8 (36%) are from countries in SEARO, 6 from PAHO, 5 from EURO, and one each from AFRO, EMRO and WPRO. There are also three posts for Associate Professional Officers (APOs) but they all are vacant. In terms of gender, only four (8%) of the professional staff and five (14%) of the general service staff are women.

The main WHO Office is located quite separately from the MoHFW and Directorates and the rental and running costs are all paid for from the regular budget. At present the computers are not linked in LANS and neither are internet or e-mail facilities readily available. In addition, many WHO staff have offices assigned to them wherever the project director is located. In this respect it is important to consider the role of WHO in deciding on the allocation and use of the project RBFs. Since all projects are seen as belonging to the MoHFW and their budgets are all designated for particular activities, the national project directors can play a major role in deciding on the hiring of consultants, the purchase of vehicles and equipment, and on the allocation fellowships. They may also have considerable influence over the renewal of contracts and the international travel of professional staff, including such aspects as the renewal of visas.

2.2 Planning And Monitoring Capacity.

The GoB has a strong Planning Commission which is the formal body that approves all externally funded projects whereas the External Relations Division (ERD) oversees all negotiations with the UN agencies, World Bank and bilateral donors. Although the Planning Unit in the MoHFW maintains close working links with these two organisations, it has worked by receiving proposals from sections within the Ministry and then by formulating individual projects. In such a planning system, what should be the role of the WHO Office?

Most of WHO's work in Bangladesh is with the MoHFW and so it too has had to follow the project-by-project approach. In addition, due to the strong control exerted by the MoHFW over the WHO plan of work and the influence of national project directors, once projects have been agreed it is very difficult to stop or even modify them. For instance, in 1995 about a half of the 32 projects supported by WHO RBFs had an expenditure of US\$50,000 or less.

The WHO Bangladesh Office is a large one by most country standards. Besides the WR's Office there are two main groups of activities that cover a total of 53 separate projects, each of which has been through the GoB TAPP process. The first are the agreed WHO Country projects that are mainly supported by the regular budget funds (RBFs) and which are the direct responsibility of the WR. These projects are primarily located within different sections in the MoHFW or one of the two directorates or in an institute that falls under the Ministry. If the management of the WR's Office and FPH4 offices are excluded, there are 15 projects that have professional staff assigned to them and another 13 for which responsibility has to be shared amongst the existing staff. Each of these 28 WHO projects has a Bangladeshi counterpart project director, an agreed plan of activities, budget, offices, staff and equipment.

Thus over time this process has led to a large number of relatively small projects, each of which falls under the control of a national project director. The professional and administrative capacity of these directors has a direct influence on whether the projects are successful or not, including the use of the project funds for consultancies, equipment and fellowships, and even the contracts and travel of international staff.

The second group of activities are those concerned with WHO's executing agency role, in which it has agreed to manage 21 of the 66 projects in FPH4. Although managing these projects is the formal responsibility of WHO, in practice it has established a separate office that has an intermediary role between the Organisation and the World Bank, which is the agency that has the task of coordinating the FHP4 Consortium of donors. Since all these projects were formulated prior to WHO becoming fully involved, the Organisation's technical input in Bangladesh has been most successful when the strong WHO Global programmes, usually those that also have well developed scientific and managerial guidelines, supported the WHO Office and both were involved in the original planning.

In many of these FHP4 projects WHO's implementing role has been large compared to its technical inputs. The executive role mainly involves implementation, using the WHO administrative and financial procedures for technical cooperation. These procedures were designed for small projects and are not necessary suitable for large scale ones, particularly as many of the procedures are basically controlled from SEARO. This means that implementation is frequently delayed due to the bureaucratic procedures involved.

Since there is no agreed health policy document, no clearly stated health sector priorities and no widely accepted sectoral strategies, the GoB planning approach relies almost entirely on approving one project at a time. The emphasis on the project approach makes sector-wide planning very difficult and it leads to narrow, vertical programmatic approaches, together with poor coordination between different projects. However, until recently this project planning approach has also suited the donor agencies, particularly the bilaterals, which have liked their inputs to be clearly demarcated for accountability purposes. The urgent need for a NHPSS, currently being pursued by the World Bank and Donor Consortium with the GoB, is widely accepted both by both groups of actors. This acceptance is gaining momentum as the limitations of project planning are becoming clear, the urgency for health sector reforms becomes more apparent and the need for wider health systems development gains support.

In terms of WHO's national role in advocacy for health policy and planning, there is no open consultation process whereby WHO can make clear what it considers to be the national priorities. In addition, the Organisation suffers from four major constraints to its freedom to advocate policies and make decisions. Firstly, virtually all decisions concerning its projects

and programmes require clearance from the MoHFW; Secondly, WHO has no direct access to the health minister and infrequent access to the health secretary; Thirdly, the Organisation has to operate in the shadow of the World Bank and other donors where, as an executive agency, it is accountable to the Bank rather than the GoB; and Fourthly, for many administrative matters it has to work under the authority of SEARO and its bureaucracy which manages, for instance, most aspects of the recruitment of staff and consultants and the procurement of supplies.

2.3 Interactions With WHO Headquarters and SEARO.

There are many and varied interactions between the Bangladesh WHO Office and programme staff in Headquarters and the Regional Office. In general terms, this support is seen to be very variable, largely depending on the strength of the WHO Headquarters programme. For instance, support is perceived to have been strong from the larger programmes, such as those for diarrhoeal diseases, ARI, EPI, essential drugs, malaria and vector-borne diseases. However, it has been more variable and problematic in the difficult areas of human resources development, for such topics as medical and nursing education, and the organisation of primary health care. The value of WHO's global 'normative' functions to the country level should not be under estimated. For instance, it is clear that those global programmes that have well documented scientific policies and guidelines have a distinctly higher credibility at the country level and they also lend authority and prestige to the WHO country programme and its staff. Global policies and documents can be persuasive in the MoHFW and also influence the donors to support certain programmes rather than others. The former WHO Headquarters ICO programme has been very supportive to Bangladesh in these ways.

3. WHO Country Programmes and Activities.

3.1 WHO Collaborative Programme of Work.

In terms of the balance of its work, the Bangladesh WHO Office clearly sees its main function as providing technical cooperation and professional support to designated programmes and sections within the MoHFW. The WHO staff tend to adopt a low-key role in advocacy for WHO policies and in providing high level policy advice on international norms and standards. The Office is reactive rather than proactive in these areas with the GoB, as well as with the many other development agencies. For high level advocacy work, such as may be necessary for the forthcoming HAPPS or NHPSS, the World Bank and donor organisations have tended to rely on programme staff from WHO Headquarters or, more occasionally, from the Regional Office.

WHO in Bangladesh has a large but low profile programme of work. It is well respected by other UN and bilateral agencies, but is seen as having too little independence from the MoHFW which can compromise the Organisation's advocacy role. In general, its global scientific policy advice, guidelines and norms are highly appreciated and widely referred to. However, despite this situation few agencies apart from UNICEF appeared to have direct collaborative activities with the Organisation. WHO's staff and consultants are also widely seen as being of variable professional ability and, in general, being programme oriented and lacking in higher level policy and planning expertise.

In total there are 32 different projects for which the WHO Office has direct responsibility. Most of these are with the MoHFW. These projects/programmes cover many different areas and activities and can be linked to different institutions. Some projects are centred on Dhaka whereas others may be primarily located in other parts of the country. For instance, the programme called 'Organisation of health systems based on PHC' is based on demonstrating the role of the Thana complex in integrating health services, whereas 'Maternal and child health, including family planning' is concerned with demonstrating how these services can be integrated and their quality improved in designated districts.

The development of research capacity in Bangladesh has been rather slow and problematic. Although WHO has supported the development of the Bangladesh Medical Research Council and research capacity in NIPSOM and NIPORT, as well as collaborated with the ENHR network over many years and developed operational research within its own projects, it is widely believed that the national research capacity has not yet reached a level at which it can take off. Research in universities also needs to be stronger, but clearly the issues are much wider than ones that can be tackled by WHO alone.

Dissemination of information and documentation is another major issue within Bangladesh and one where WHO does not appear to have taken a leading role. Apart from a small library at the WHO Offices, the Country Programme has relied on projects to strengthen national libraries for reference materials. The Organisation does not have a central documentation centre, nor does it produce a newsletter of recent WHO documentation. However, as far as using modern information technology, Internet services have only recently arrived in Bangladesh.

3.2 Study Tracer Programmes.

It is clear that WHO technical cooperation to the MoHFW, particularly since the beginning of the 1980s, in the form of expertise, advice, financial support and fellowships, has played a key role in establishing the success of the present essential drugs, EPI and malaria control programmes. The national situation for these three tracer programmes owes a great deal to this earlier investment. The country also clearly benefited from substantial coincidental support to the health sector over a number of years from the World Bank and USAID and other bilateral aid donors. Many national NGOs have also been important, particularly for EPI and essential drugs. Although these programmes are well developed and now largely self-sufficient, it is also clear that they will continue to need further support in the form of high level technical inputs and policy analysis, as well as advice on programme implementation and the conduct of research.

The MoHFW essential drugs programme was first officially established in 1982 when the GoB issued a national ordinance listing more 3000 necessary drugs, with price controls on the 117 drugs that were designated as essential. This policy received a lot of international support and it utilised the policies and guidelines produced from WHO Headquarters. However, the GoB policy was controversial and the bilateral donors and Bangladesh WHO Office were not particularly supportive at that time, although UNICEF did provide support for training and fellowships. Since then the GoB policy has been substantially modified, largely under pressure from the private pharmaceutical industry, but even so today Bangladesh produces nearly all the essential drugs it requires. The MoHFW drug programme now only receives external support from the WHO Office, which includes a small amount of critical funds for equipment, vehicles and training fellowships. The main issues have become those associated with monitoring the quality of the drugs produced in Bangladesh, as well as those imported into the country. The GoB has two testing laboratories but they are poorly funded and have difficulties in maintaining and buying equipment, as well as in retaining and training staff. None of the WHO Headquarters DAP staff have visited Bangladesh in the last six years and neither is there an official WHO DAP project with the country.

EPI in Bangladesh has been very successful over the last decade in going from very low to good levels of coverage for the six vaccines. WHO policies, guidelines and technical support have been essential and these, combined with close collaboration between WHO and UNICEF, enabled the programme to gain credibility and attract support from the donors, particularly USAID, SIDA and Rotary International. In addition, more recently CDC Atlanta has given strong technical backup and training, particularly for surveillance and the implementation of national immunisation days (NIDs). However, apart from tetanus toxoid nearly all vaccines still have to be imported. For the NIDs Bangladesh has been fortunate to gain from the experience of Thailand and to receive considerable support from SEARO. The Bangladesh EPI now feels confident that it is well established and that it has sufficient technical skills. However, for the future it will continue to require policy and technical support from WHO and external funding, particularly for vaccines.

Malaria control is an example of a successful programme that has had its ups and downs over the last two decades, as it competed for priority following the fall in malaria incidence to low levels in the early 1980s. Control used to be the responsibility of an independent Malaria Board but following the setbacks in control caused by the Liberation War, the programme was integrated into the MoHFW in 1977 and was integrated into PHC in 1982. By the late 1980s malaria surveillance had been neglected and by the early 1990s the number of cases

were doubling annually. In addition, despite the high level of known drug resistance, monitoring was stopped in 1992 due to lack of funds. The WHO supported meeting in Amsterdam in 1993 on future malaria control policies was crucial in re-establishing support for malaria control with the GoB and the donor community. Malaria control is now organised as a part of an integrated programme for the control of vector-borne diseases (INCOVED), that also includes filariasis, dengue and kalaazar. There have been over 7,000 cases of Kalaazar diagnosed over the last two years. Malaria control through impregnated bednets is being introduced gradually as funds become available. Although WHO technical support has been critical, the programme is vulnerable to losing its Bangladeshi scientific and technical staff. WHO's future role is still seen as capacity building, particularly for senior and mid level training.

3.3 WHO's Budget And Expenditure: RBFs And EBFs.

The WHO Office budget is an example of where the funds for the 'regular' programmes are small compared to the funds handled by WHO as an executing agency. However, the regular budget funds are potentially programmable by WHO, whereas the programme activities for which WHO acts as the executive agency are largely outside of the Organisation's direct control. For instance, the WHO regular budget expenditure for the 1994-95 biennium amounted to about US\$8.5 million, with an additional US\$0.9 million in EBFs, over a half of which was for GPA alone. In addition, the total budgets for the 21 FPH4 projects executed by WHO may also be included as extrabudgetary funds, which would have the effect of artificially inflating the total WHO country funds. However, in practice these latter funds, although technically also called EBFs, are under the control of SEARO which manages them on behalf of the World Bank Consortium through the Bangladesh WHO Office, where a special section has responsibility for their day to day management.

The five largest WHO Country programmes, which accounted for about 55% of the regular budget for the 1994-95 biennium, illustrates the broad range of programme commitments that the Office supports. It should also be remembered that most of the remaining programmes are relatively small and spend less than US\$100,000 per biennium. The five largest programmes are as follows:

- \$ 1,477,800 for "Organisation of health systems based on PHC (number 3.1.3)";
- \$ 1,097,700 for "Expanded programme on immunisation (5.2.1)";
- \$ 804,300 for "Undergraduate medical education (3.2.1)";
- \$ 641,600 for "Community water supply and sanitation (4.4.1)"; and
- \$ 623,100 for "Planning and management of health services (2.3.1)".

There are four important WHO global programmes that do not have any budgeted RBFs, which are tuberculosis, leprosy and sexually transmitted diseases control, and accident prevention. This is because the first three are fully funded under the World Bank Consortium and the programmes are being executed by the WHO Office. Another example is control of acute respiratory infections (ARI) where WHO only contributed about US\$45,00 in the 1994-95 biennium but substantial funding was also channelled via the Consortium. Some of the most successful MoHFW programmes are thought to be those where there has been substantial extrabudgetary funding and where WHO has published strong policies and guidelines and where the Organisation has provided high level technical inputs and recruited very capable international staff.

3.4 Resource Mobilisation.

The WHO Office does not play a role directly in resources mobilisation, since this is done by the GoB and MoHFW, together with the donor agencies, but it can be very influential through its advocacy and advisory roles. WHO's influence at the Country and Global levels in supporting resource allocation decisions should not be under estimated, particularly where the Organisation has strong and clear scientific global policies, such as for EPI and tuberculosis control programmes. Not only do these policies raise the priority of the health problem, but scientific consensus for which are the best intervention strategies also gives the programmes a much higher credibility at country level, both within the ministry and with the donors. For instance, in Bangladesh Rotary International and Japan have been very supportive to NIDs, and the ODA UK for sexually transmitted diseases.

4. Linkages between WHO and other partners in health development

4.1 Major actors in health and ODA.

Bangladesh is widely considered to be a developing country in greatest need and it is also one that suffers from extreme population pressures and natural disasters. It is highly aid-worthy, therefore, from both the development and humanitarian points of view. Although the country is crowded with aid agencies, the scene is dominated by the World Bank and the bilaterals, with USAID and Japan being strong, but with most of the UN agencies also fully represented.

The social sectors, including health, are seen as priority areas and about a third of the MoHFW annual expenditure is provided for from foreign assistance. In addition, large NGOs like the Family Planning Association of Bangladesh, BRAC and Gonoshrestha Kendra (GK) are active in health programmes and receive their own funds directly, while some other NGOs are also developing new health programmes, such as PROSHIKA and the Grameen Bank. Relatively new actors in health also include the European Union and the Asian Development Bank.

4.2 Mechanisms of cooperation and coordination.

Cooperation and coordination are maintained in a variety of formal ways. The most powerful means of enforcing the GoB's position is the control exerted by the External Relations Division with all donor agencies and through the Planning Commission for project approval. Until recently health sector aid was dominated by the perceived need to strengthen family planning activities, largely through the Directorate for Family Planning, where the services have been organised in a very vertical manner. The World Bank led Consortium, which was first formed in the mid-1980s as a mechanism to coordinate all the donor inputs to family planning, has largely been driven by the need to present a united plan for different projects. Only recently have wider health sector issues received greater priority. Bilateral donors have also been free to operate some projects outside this framework and although USAID has never formally joined the Consortium, it has participated in most discussions. However, as the agenda of the Consortium broadens to include far more health issues, it is now becoming the most dominant mechanism for sector wide coordination. The World Bank in Dhaka has the advantage that it has direct and regular contacts with the Secretary of the MoHFW and regular missions that visit Bangladesh from the Bank's Headquarters in Washington.

UNDP has the formal responsibility for the UN agencies. Since the GoB has not wanted to produce a Country Strategy Note (CSN) until recently, the UN agencies were free to do their own programme formulation together with the appropriate ministry and the ERD. However, the GoB now wants a CSN and UNDP is in the process of identifying how the agencies can reinforce each others policies. Poverty reduction is a central policy. Now that the UN agencies, including UNDP and UNICEF, are tackling issues more on a decentralised and intersectoral basis at subnational levels, WHO's close ties with the MoHFW are believed to be a hindrance for greater inter-UN collaboration. A new plan of action will soon be released for UNAIDS, which has responsibility for defining clearly the roles of the different UN agencies, with WHO being expected to continue to provide most of the technical inputs.

For NGOs to receive overseas funds they must be registered with the GoB's NGO Bureau, but apart from this they are relatively free to work independently of each other. However, NGOs are now more likely to be seen as a partner with the GoB and are commonly utilised as

alternative service providers, particularly for reproductive health and family planning. A new GoB-NGO Coordinating Committee (GNCC) has recently been established.

4.3 Use of WHO's expertise by other organisations.

In Bangladesh the WHO Country Office appears to be very closely tied into the MoHFW, to such an extent that it seems to have very few direct collaborative activities outside of this framework. Apart from its executing agency role, the Organisation is seen as available and approachable for technical advice, but that it is reluctant to commit itself outside of a ministry project. The Organisation's global policies, guidelines and norms are widely referred to and greatly valued, and so are its attempts to analyse, collate and disseminate the results of international health research. SEARO is rarely approached by other agencies because it is seen as supporting mainly the WHO Office. It is also clear that few of the bilateral agencies or NGOs have collaborative projects with the WHO Country Office.

4.4 WHO as an executing agency.

The MoHFW has approximately 110 separate projects, of which 66 are under the umbrella of the World Bank Consortium in FPH4 and 21 of these are being executed by the WHO Office. Between these projects and those for which WHO has direct responsibility, the WHO Office is closely involved in about one half of all the ministry projects. However, for FPH4 it is not clear why so many projects need to have an executing agency when the appropriate ministry or delegated national organisation could be given the full responsibility for implementing the project. Perhaps too much reliance is being placed on intermediary organisations which could be placed directly with the MoHFW. The WHO Office is not an executing agency for any other projects funded by other UN or bilateral agencies.

5. WHO's Mandate And Role.

5.1 Relative strength and comparative advantages of WHO support.

From the country perspective WHO's undoubted comparative advantages are:

5.1.1 WHO has some strong programmes.

WHO's policies, norms and guidelines are widely respected and used. The Organisation is seen as an agency that has some strong global policies and programmes that are based on the consensus of the international scientific community and backed up by strong technical capacity. In addition, the WHO Office can call upon the support of expert staff and consultants from SEARO and Headquarters. However, the lack of a clear, appealing and overall international policy for the Organisation, such as was the case with Primary Health Care, has meant that WHO's reputation now has to rely largely on the performance of its best programmes. The perceived strengths of the Bangladesh WHO Office are, therefore, largely due to the success of these programmes at country level. And this success is seen to be very variable.

5.1.2 WHO has close working links with the MoHFW.

WHO can work closely with the ministry at the policy advocacy level through the Secretary-WR links and for technical advice through its direct links to projects. These two linkages are widely seen as having both advantages and disadvantages. If they are working well, WHO's advocacy and advisory role has potential to be very influential at the country level, but this relies on the WHO Office maintaining its independence and being widely respected within government and by the other agencies involved in health. In Bangladesh it appears that the policy role is comparatively weak and undeveloped, while experience with the project advisory role has been mixed. The close links that currently exist between WHO and the MoHFW have clearly tended to exclude other links developing with a wider range of agencies and, in addition, the WHO Office is seen to be largely under the control of the ministry. A greater autonomy for the WHO Office, including for financial decision making, could enable its policy and advisory role to be far more influential with a wider range of actors in the health sector.

5.1.3 WHO emphasises institutional strengthening and capacity building.

A high proportion of WHO's country technical cooperation and project funds are allocated for training, fellowships and equipment, with the objective of strengthening national capacity. WHO's long term aim is to withdraw from those country programmes that have been strengthened and thus be able to concentrate on new priorities. This latter emphasis is widely applauded, but it does not fit easily with the needs of many of the other development agencies that often criticise WHO for not giving higher priority to programme implementation. In Bangladesh, as in many other countries, it has proved difficult to withdraw project support and this has led to a high proportion of the WHO Country regular budget funds being divided up amongst many small projects. In addition, the funds are largely being used as a substitute for government funds and for short falls in training or equipment. WHO's policy of supporting capacity strengthening is thus seen as less successful than when it supports some of the higher profile programme activities. For example, WHO has supported the strengthening of EPI capacity in the ministry while UNICEF has concentrated on increasing vaccine coverage. Often UNICEF is seen as more successful.

5.1.4 WHO programme activities are supported by professional staff and consultants.

Through regular and extrabudgetary funds WHO is able to employ professionals in programmes and projects at the country, regional and Headquarters levels. Thus highly valued technical expertise can be made available at the country level and clearly Bangladesh has benefited greatly from the Organisation's professional inputs, such as for NHPSS and for HAPP5. Although the expertise of the best WHO long-term staff is recognised and appreciated, the professional ability of other staff is commonly criticised, particularly if they appear to add little to the collective expertise of national staff. Such criticisms are even more frequently heard about short-term consultants, including some of the political reasons why they are recruited by the Regional Office. Since the reputation and credibility of the Organisation at country level largely rests on the transparency of the recruitment procedures and the quality of the staff, improvements in this area should be an urgent priority.

5.1.5 The WHO Country Office has the backup and support of the Regional Office.

In theory the Regional Office, in this case SEARO, provides technical and administrative support to Country Offices, as well as organising regional inter-country activities. The stronger WHO programmes, such as those for tuberculosis and ARI, also support a dedicated programme specialist at SEARO who coordinates the regional activities and who can provide links to Headquarters staff. However, the success of this technical support depends heavily on the quality of the professional staff involved and how well the individual programmes utilise this regional mechanism. In practice, since the results vary from excellent to poor, the role of the Regional Office in technical cooperation urgently requires a thorough review. In addition, as this office is responsible for overseeing the management of Country Office finances and staff, the autonomy of such a large Country Office, such as the one in Bangladesh, is severely restricted and made inefficient by the many bureaucratic procedures and decisions that are being carried out by SEARO. For instance, although the Bangladesh WHO Office is an executing agent for 21 projects with large budgets, all major financial and staffing decisions have to be referred to SEARO for confirmation and approval. Clearly greater technical and managerial authority should be held within such a Country Office if WHO is to have a greater role in Bangladesh.

5.2 Balance between WHO's functions.

In Bangladesh WHO is seen to be strong mainly in terms of its technical cooperation role in support of projects and programmes, where it is seen to be very closely under the control of the MoHFW. Within this role a large part of its regular budget support is concerned with the project costs of fellowships, training, consultancies, equipment and supplies. By contrast, the WHO Office appears to have given advocacy, research development and information dissemination a lower profile and priority.

There are two areas where the WHO Country Office needs to be far more proactive. Firstly, the Office needs to adopt a much higher profile in advocacy for internationally accepted health priorities, for instance in such areas as HIV/AIDS and sexually transmitted diseases. WHO should be the agency taking the leadership role in advocacy in Bangladesh. Secondly, the Country Office should be taking a major role in advocating and advising on issues to do with health systems development, including health sector reforms. At present the leadership is being taken by the World Bank and some bilaterals, without much reference to WHO's experience in these complicated topics. If these two areas were a larger part of its country role, the Organisation would be fulfilling an important function within the MoHFW and

amongst the donor community in Bangladesh. This would undoubtedly raise the profile and credibility of WHO and thus make it a more influential agency at country level.

5.3 WHO support to national planning and priorities.

Although WHO works closely with the MoHFW on their joint plans of action for programme budgeting, which involves about a half of all designated ministry projects, it does not appear to play a significant role in the choice of national health priorities. The Country Office is also less involved than it might be in policy level advice, except where this involves technical inputs from specific programmes. Most of the high level policy advice comes from WHO Headquarters staff, particularly from staff in the new Divisions of Analysis, Research and Assessment (ARA) and Child Health and Development (CHD), who have been involved in the new NHPSS formulation process.

5.4 Activities of other UN agencies in health.

UNDP is currently supporting the development of the Country Strategy Note, which is examining in what way each agency can contribute to common policies, such as poverty reduction. The UN theme group for UNAIDS is close to agreeing with each UN agency what each will contribute to HIV/AIDS prevention and control in Bangladesh. WHO's technical role is considered to be crucial. UNICEF is a strong and major contributor to health initiatives which sees its role as rather complementary to WHO. UNICEF maintains a considerable degree of autonomy and works directly with a number of different ministries, including the MoHFW. It sees itself as more action oriented than WHO and it has more direct control over its finances and the hiring of short-term staff. UNFPA is also active in Bangladesh but the agency is in the process of establishing its country priorities and formulating its own reproductive health action plan in the light of the 'Cairo' conference recommendations.

6. Summary of Findings: Country's Needs and WHO's Activities

6.1 Broad achievements.

The broad achievements of WHO at country level can be summarised as follows:

- In general the Organisation it is seen as a successful UN specialised agency, which is widely respected for the scientific and professional basis of many of its global programmes, including the policies, norms and guidelines that underpin its country level operations;
- In its technical cooperation role WHO has supported the MoHFW to establish many strong disease control programmes, including those for malaria, diarrhoeal diseases, EPI and ARI, and the Organisation is currently involved in about a half of the 110 projects that the MoHFW now has;
- It has worked successfully with the MoHFW and a variety of national health training institutes to develop the country's human resources, and WHO continues to support the renewal and modernisation of the curricula and training of medical and nursing graduates;
- It has established that the Organisation can be a successful executing agency for nearly one third of the 66 projects in the FPH4 Project coordinated by the World Bank Consortium, although this new experience in inter-agency collaboration has involved the WHO in attempts to modify the management role and responsibilities of its Country Office in relation to those of SEARO.

6.2 Constraints.

The main constraints facing the Bangladesh WHO Office can be summarised as follows:

- WHO at country level is closely tied into the organisational structure and bureaucracy of the MoHFW, to such an extent that it is not free to decide on its own programme priorities and neither does it have sufficient financial or managerial autonomy;
- The Office and the MoHFW have had to plan their activities without the benefit of a national health policy or even an explicit and agreed list of health sector priorities;
- Until recently the GoB gave the highest priority to family planning and only latterly have wider sectoral issues and the need for a national health policy received more attention;
- WHO has had to operate as only one of many UN and donor agencies working in health, including a very strong consortium of bilateral donors and the World Bank which, until recently, has also largely concentrated on supporting family planning;
- The GoB planning system is heavily oriented towards the development and approval of individual projects, which has resulted in WHO having many small projects supporting vertical programmes that have funded mainly consultancies, fellowships, training and equipment;
- Since WHO's country role is closely tied to supporting technical cooperation projects in the MoHFW, its advocacy role for international health policies has been weakened and neglected;

- In its capacity as an executing agency, the independence, professional role and managerial autonomy of the WHO Office have all been challenged by its relationship to the needs of the World Bank Consortium;
- Despite its size and importance, the managerial efficiency and independence of the WHO Office has been restricted by the constant need to refer to SEARO for decision making, particularly for budgeting purposes and the hiring of consultants and programme staff;
- The WHO Office is crucially dependent on the ability of its professional staff and consultants and yet the GoB, donor agencies and the Organisation have all expressed concern over the variable quality of those appointed to work in Bangladesh.

6.3 Missed Opportunities.

The main 'missed opportunities' for the WHO Country Office are its weak advocacy and health planning role at the national level, lack of expertise in health systems development, need for more collaboration with organisations beyond the MoHFW, and a greater involvement for improvements in human resources in health. These can be summarised as follows:

- Although WHO is seen as the major agency concerned with technical cooperation in health, it has not played a strong advocacy role nor has it been closely involved in giving high level health policy and planning advice. For these functions in the MoHFW the Organisation has been largely displaced by the World Bank and the Consortium of bilateral donors, particularly since the latter have broadened their agenda with the development of HAPP5 from family planning to wider health sector concerns;
- The WHO Office has not strengthened its technical cooperation role to include many of the organisational and structural issues that face the health sector in Bangladesh, which are often grouped under the term of 'health sector reform', including such issues as regulation of the private sector, health financing and decentralisation. In fact, most of the WHO policy advice has come from the involvement of WHO Headquarters staff and not from the Country Office. If WHO wishes to play a significant health policy role in countries like Bangladesh, the whole Organisation needs to strengthen its capacity in the area commonly known as 'health systems development'. Such expertise is urgently required if the Organisation is to play a stronger policy role at country level.
- WHO in Bangladesh works very closely with the MoHFW, particularly through their joint projects and programmes, and this collaboration has tended to exclude the Organisation from having any significant role with UN and other agencies. For example, the WHO Office has virtually no collaborative activities with the large number of NGOs involved in health or even with the ENHR network. This situation has the undesirable effect of significantly reducing WHO's influence over the health policies being pursued by these agencies. WHO's influence could be even more important as the MoHFW introduces health sector reforms that will lead to a greater reliance on a wider range of health care providers. There is an urgent need, therefore, for the Country Office to expand and strengthen its advisory and collaborative role with the UN, non-government and other private health agencies.

- Although Bangladesh has well developed human resources for health, it is generally agreed that this is true in terms of the range and numbers of the different cadres but it is much less true in terms of the quality of their basic and inservice training. There is also an imbalance in the employment of medical and nursing professionals, with many nurses being unemployed. Other issues concern the relatively narrow range of tasks that some paramedical and auxiliary staff are expected to perform, which is a legacy of the way vertical programmes have been organised. Even though WHO has been a major supporter for the development of the country's human resources in health, a lot more needs to be done. The WHO Office needs to give new leadership here, the kind that might be expected from the Organisation.

6.4 Future Possibilities And Directions: What are the options?

6.4.1 Background.

Bangladesh is one of the least developed countries. Since it is densely populated and has major health and disease problems, it is generally considered to be a highly aid-worthy country. Many development agencies, besides the WHO, are already assisting Bangladesh in the health sector, including UNDP, UNICEF, UNFPA, UNAIDS and UNHCR, the World Bank and Asian Development Bank, European Union, and most of the major bilateral organisations, including USAID and Japan. Whereas these agencies can operate individually, attempts to coordinate the UN agencies are carried out by UNDP and another donor group, formed by the World Bank and ten bilaterals, working through a Consortium with the MoHFW for the implementation of the large fourth Family Planning and Health project (FPH4) and the planning of the fifth Health and Population project (HAPP5).

Although it is clear that WHO is considered to be the specialised UN agency for health, its future role remains uncertain and it is unclear what directions it should take. There appear to be four main options: WHO could remain largely as it is now but concentrate on a smaller range of health priority programmes; or it could concentrate on being a technical agency and substantially reduce its executive agency role; or it could add a new dimension to its current work by developing its role in health sector reforms and health systems development; or in addition, in view of the size of its present operations, it could become largely independent of SEARO by being given its own special autonomous status for managerial and financial decision making. These options are not exclusive but are about priorities for future directions.

6.4.2 First option: No substantial or major changes.

In the current Bangladesh WHO Office, the balance of activities, has a broad range of projects with both the MoHFW and the World Bank Consortium. This is a substantial programme of work. Despite many criticisms on the effectiveness and efficiency of the present projects, it can be argued that if greater attention were given to a few priority projects and if more efforts paid were to internal organisational issues, the WHO Office could achieve a lot more at country level. However, fewer priorities and an internal regrouping of responsibilities would not solve many of the difficulties inherent in the WHO-MoHFW relationship and nor would it solve the management issues involved in the WHO Country Office being an executing agency. This option is perfectly feasible and is a 'safe' one to take.

6.4.3 Second option: Strengthen its role as a technical cooperation agency.

It can be argued that the WHO Office was set up to be a mechanism to coordinate the Organisation's technical cooperation function and that by taking on such a large executive agency role, the Organisation has compromised its ability to play an independent advocacy role and to give unbiased support to the MoHFW. It can also be argued that since many of the functions it performs as an executing agency are really those required of an implementing agency, such projects should be managed directly by the MoHFW itself or by other national organisations. The WHO could then have a monitoring role but it would not be involved in such areas as organising programme activities, staff recruitment, finance or procurement. By substantially reducing or relinquishing this executive role the Office could concentrate on a fewer high priority programme areas as well as be involved itself more with a wider range of new partners outside of the present MoHFW.

At present this option is unlikely to be accepted by the World Bank Consortium members, which are relying on the WHO to be the executive agency for the new projects being developed for HAPP5, that is due to start in July 1998. A modification of this option would be for WHO to be an executive agency for only a few high priority and innovative projects, where there is some urgency for implementation to get underway.

6.4.4 Third option: Build new strengths in health systems development.

Arguably the highest priority for the Bangladesh WHO Office is for it to establish new capacity and strengths for advocacy and advisory functions, particularly on the health aspects of health sector reforms. These skills are urgently required by the GoB as it develops its new national health and population sector strategy (NHPSS) and the process for a new national health policy. If the WHO does not join these developments, the MoHFW will have little alternative except to be advised mainly by the World Bank and other bilateral agencies. There is a need for the Ministry and WHO together to take a longer term view of the needs of the whole health sector. This would involve the Organisation at country level in policy analysis and formulation for health systems development, areas where it is currently weak.

To gain credibility in these areas, WHO would have to give priority to developing new capacity in health systems at all levels in the organisation, that is at global, regional and country levels. If this is not done it will be difficult to strengthen capacity at the country level alone. This option has urgency and will require more radical action from the global level.

6.4.5 Fourth option: Establishing autonomy for the WHO Country Office.

As WHO is currently organised, the Country Office has little autonomy for decision making since it is very largely either under the direct control of the MoHFW for priorities and programmes or under the control of the SEARO for most management and administrative matters. The controls exerted by the ministry do not allow this UN organisation to have an independent or autonomous position in technical cooperation and neither does it allow the WHO office to play an adequate role in advocacy or in giving policy advice. In addition, the Regional Office exerts many strong bureaucratic controls over such issues as staff recruitment, consultancies, fellowships and budget expenditures. This control is akin to micro-level management. Given the large scale of the Bangladesh WHO Office, in both its technical cooperation and executing agency roles, there are strong arguments for giving it far greater autonomy for decision making at the local level.

An autonomous Country Office would be expected to act more independently of the ministry of health and to undertake full responsibility for managing its own projects and programmes. This would mean the Office could be an advocate for more appropriate policies and could act quickly to implement local priorities. It would also be able to collaborate with a wider range of health agencies and providers, thus making intersectoral actions for better health much more of a reality. In terms of management it would mean that the Office would need to take direct responsibility for most staff matters, particularly for such aspects as the recruitment and appointment of consultants, and the management of budgets and expenditures. Besides being allocated responsibility for the use of regular budget funds, such an office should be free to enter directly into contracts involving extrabudgetary funds rather than these coming mainly via WHO Headquarters. Clearly such an autonomous Country Office would have higher status and it would need to attract, therefore, high calibre professional and management staff.

As multilateral and bilateral technical cooperation activities become more focused in fewer developing countries, a new classification of WHO Country Offices might be suggested. For instance, countries could be divided on the basis of the scale and functions of the Country Office into five categories. Category One might be those countries with no Office and where there are no technical cooperation activities carried out at local level. This is the situation with most of the richer developed countries. A Category Two Office could be in those richer developing countries where the technical cooperation role is small but where there is still a need to maintain liaison between the government and the Organisation. Category Three might be those countries where the Organisation has a substantial technical cooperation programme and where many aid agencies are active. A Category Four Office might be in the developing countries classified as being in greatest need. Besides having an important programme of technical cooperation activities, the WHO's Office in these countries could also be encouraged to have a strong role as an executing agency. A Category Five Office might be in a country from where the Organisation has a major role in promoting TCDC amongst local countries at the subregional level. In this context, Bangladesh might have a Category Four and Thailand a Category Five WHO Country Office. The autonomy of the Country Office should be greatest for categories four and five. There would also need to be mechanisms for reclassifying the Country Offices as countries change, particularly as they undergo development and become less deserving of aid and technical cooperation programmes.

7. List of Annexes: Bangladesh

1. List of people interviewed and organisations represented
2. Country Programme Expenditure
3. Tracer Programmes Implementation Profiles
4. Profiles of WHOCO use of tools and functions
5. Gaps in National capacity and WHO's role in filling them
6. Note from SEARO regarding EBFs for Bangladesh.

A Study of Who's Support to Programs at Country Level

BANGLADESH

LIST of INTERVIEWS DURING COUNTRY VISIT

NAME	POSITION/ORGANIZATION
Dr Witjaksono Hardjotanojo	WHO Representative, Bangladesh
Rolf Carriere	UNICEF
Mr Muhammad Ali	Secretary, Ministry of Health and Family Welfare
Professor A.K. M. Nural Amwar	Director General of Health Services
Mr Md. Shirajul Islam	Director-General of Family Planning
Richard Green	USAID
Dr Sharnsul Haque	Project Director - EPI
Dr Abdul Mannan Bangali	Project Director - ICOVED
Dr Uton Muchtar Rafei	Regional Director, WHO South-East Asia Region
Dr Mehtab Currey	Sr. Adviser, Health and Population, DfID, AMOD
Mr Bhanuphol Horayangura	AsDB - Resident Representative
Dr Sudershan K. Sudhakar	Representative - IBRD (World Bank)
Professor Choudhury M. Hassan	Project Director, Drug Administration
Mr F. H. Abed	Executive Director, BRAC

A.1. RESOURCE USE BY PROGRAMME COMPONENT 1992-95

Bangladesh

Information from SEARO

New code	1992 RBF	1992 EBF	1993 RBF	1993 EBF	1994 RBF	1994 EBF	1995 RBF	1995 EBF
1.2.4		15373		246184		440813		55095
subtotal 1	0	15,373	0	246,184	0	440,813	0	55,095
2.3.1	50,828	188,340	22,177	814,024		2,566,013		1,227,503
2.3.2	1,241,302		169,382		1,393,739	16,615	466,153	10,505
2.3.5						57,635		93,199
2.4.0	768,035	156,563	1,097,574	319,911	746,530	216,370	781,497	236,783
2.5.0	1,219,817		814,610	460,746	913,623	1,677,070	856,261	1,407,556
2.6.0	69,215		102,457		58,903		94,635	
subtotal 2	3,349,197	344,903	2,206,200	1,594,681	3,112,795	4,533,703	2,198,546	2,975,546
3.7.0	20,616		102,618	77,603	64,234	54,829	64,465	118,525
3.8.1	50,868		-2,410	58,863		93,823		77,132
3.8.2	44,805		882		44,887		18,969	
3.8.3	7,434		16,192					
3.9.1	25,500	165,809	11,991	741,177	27,560	1,371,004	59,063	1,027,849
3.9.4	7,052		12,333		26,172		53,405	
3.9.5	18,938		-380		35,541		58,222	
3.10.3	41,003		34,578		53,236		41,242	
3.11.5					7,501		7,459	
3.11.4					32,987		-4,410	
3.11.1	524,559		98,176	8,358	444,213	30,435	193,570	5,665
3.12.1	27,522		72,668		40,963		65,423	
3.12.2	81,494	1,417	191,575	-1,310	28,471	1,310	111,459	10,076
3.12.3	102,275		224,419	142,928	85,797	170,468	107,891	4,641
3.12.4	56,893		43,298		9,662		14,943	
3.12.5	12,972		13,793		11,283		29,545	
subtotal 3	1,021,931	167,226	819,733	1,027,619	912,507	1,731,869	821,246	1,243,888
4.13.1	136,797		44,925		853,520		244,191	
4.13.2	214,424		295,266		386,499	639,662	277,291	11,034
4.13.6	40,334	96,896	21,081	304,903	67,258	441,786	51,404	462,812
4.13.7	17,821		20,027	123,270	13,962	395,882	31,643	496,637
4.13.8	12,510		27,516					
4.13.9	5,670	48,114	23,766	11,499		124,425		182,277
4.13.11	15,829		4,051	34,809		45,599		781
4.13.13		313,028		197,216		303,274		197,675
4.13.15	22,159	407	54,918	-240	59,293	1,404	70,593	3,254
4.13.16	71,780		30,676	211,762	184,368	359,175	76,914	-129,612
4.13.17	24,146		49,020		33,000		123,626	
4.13.18	47,835		51,891		102,711		18,550	
subtotal 4	609,305	458,445	623,137	883,219	1,700,611	2,311,207	894,212	1,224,858
5.14.0	62,718		1,460		50,576		17,228	
subtotal 5	62,718	0	1,460	0	50,576	0	17,228	0
total	5,043,151	985,947	3,650,530	3,751,703	5,776,489	9,017,592	3,931,232	5,499,387

Bangladesh

budget		9,913,500	1,866,900		10,694,300	74,937,400
difference		1,219,819	-2,870,750		986,579	60,420,421
% implemented		87.7%	253.8%		90.8%	19.4%

Information from Audited reports: ACT/94.1 29 April 1994 and ACT/96.1 April 1996.

Expenditure as in Audited Report	8,698,668	3,616,082		9,707,700	12,535,132
Expenditure as from SEARO	8,693,681	4,737,650		9,707,721	14,516,979
Difference	4,987	-1,121,568		-21	-1,981,847

Differences in EBFs are apparently mostly unliquidated obligated funds - see fax from SEARO dated 16 June 1997.

Country Report

Annexes, 33

Bangladesh

Annex 3.

National Drug Policy Implementation Profile

Fill in **Y** for Yes and **N** for No representing the indicator(s) which identify(ies) the actual situation in Bangladesh.

	Functional areas	Indicators	Yes No	Comments / Changes
Policy and Management	<u>Policy</u>	- National Policy on drugs updated during the last 10 years - National Policy is in early stage - Low interest/under consideration	No No No	
	<u>Legislation and regulation</u>	- Legislation and regulations exist - Updated during the last 10 years - Licensing of distribution and manufacturing premises and persons is occurring - Inspection of distribution and manufacturing premises is occurring - Product registration is done - Basic In-country QC* is done - Basic ADR** reporting is operational - Full range of in-county QC done - Post-marketing surveillance system operational	Yes No Yes Yes Yes Yes Yes Yes	Recently started/Not yet developed
	<u>Essential Drugs list (EDL)</u>	- EDL by generic name for the public sector exists - EDL updated during the last 5yrs - EDL distributed countrywide - EDL is used for drug management	Yes No Yes Yes	
	<u>Public sector financing policy</u>	- Public drug expenditure is more than 20% of the MoH operating budget per year. - Public drug expenditure represents more than US\$1 per capita per year.	 Yes	Not aware about it.
Supply and logistics	<u>Procurement procedures</u>	- Public sector procurement is by competitive tender - Public sector procurement is between pre-qualified suppliers - Public sector procurement is limited to drugs on EDL	Yes Yes	This is done by the CMSD (Central Medical Store Dept)
Quality Assurance (QA)		- QA system exists - Control laboratory is functioning - Operational research / surveys related to drug management implemented during the last 5yrs	Yes Yes No	
Rational use of drugs	<u>Information</u>	- National publication providing objective information on rational drug use exists. - National publication providing objective information on rational drug use revised during the last 5 years.	No No	
	<u>Manpower development</u>	- National Therapeutic guide with standardised treatment exists - National Therapeutic guide with standardised treatment updated during the last 5 years. - Concept of EDL included in basic training curricula - Systematic continuing education for health workers & QA personnel exists	No No Yes No	

* Quality Control

** Adverse Drug Reaction

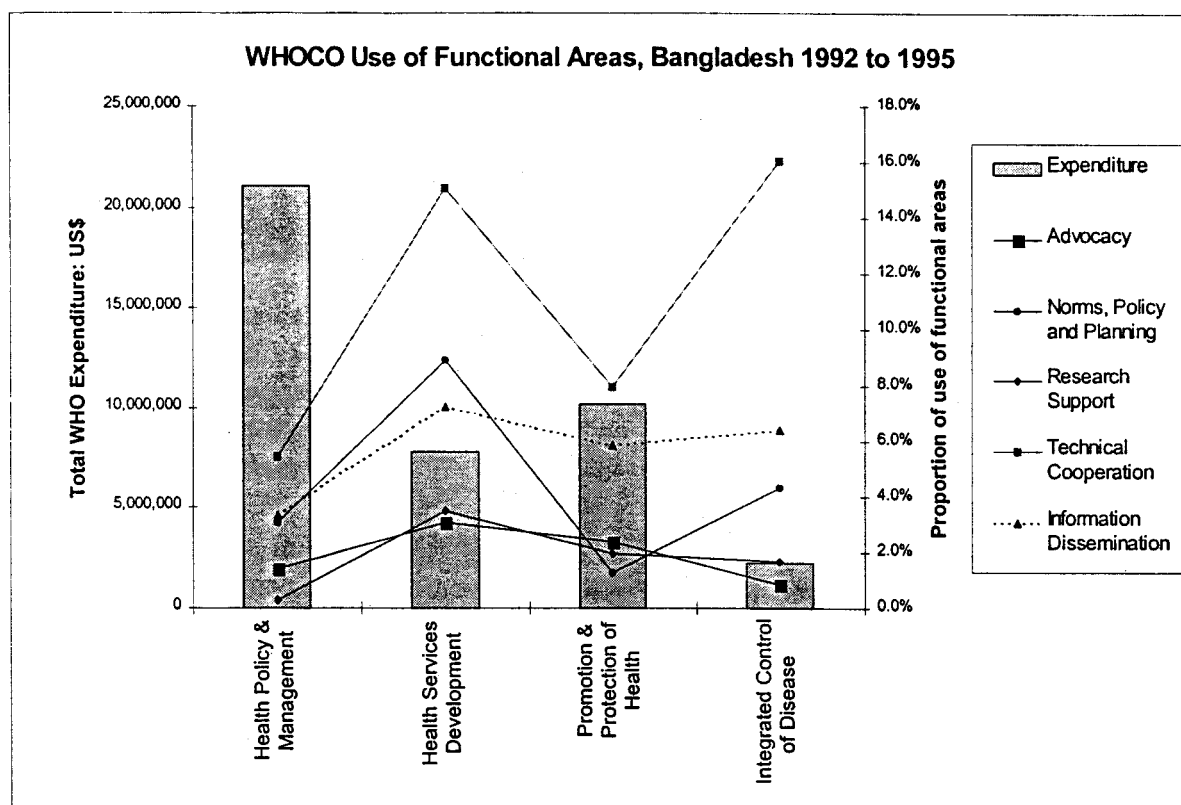
National Immunisation Policy Implementation Profile

Functional areas		Indicators	Yes No	Comments / Changes
Policy and Management	<u>Policy</u>	- National Policy updated during last 5 yrs - National EPI strategic plan exists - Needs assessment done during last 5 yrs - Strategies for linking EPI with the Sick Child initiative initiated	Yes Yes Yes No	During 1996 Copy enclosed (Annex -"A")
	<u>Specific strategies</u>	- Specific targets and strategies for Polio eradication exists - Specific targets and strategies for neonatal tetanus elimination exists - Specific targets and strategies for measles control exists - Specific targets and strategies for the introduction of new vaccines exists - National Immunisation days organised	Yes Yes Yes No Yes	Eradication of polio by the year 2000 AD. To eradicate by the year 2000 AD. To control by the year 2000 AD. Possibility to introduce vaccine against Hepatitis B (HBS-Ag) NID (Nat.Immun.Day) been fixed on 8.12.96 & 8.1.97.
	<u>Public sector financing policy</u>	- A budget line within the national health budget for EPI exists - A proportion of the operational costs of the programme are covered by the national budget (note proportion) - National funds are used towards vaccine purchase - Basic vaccines are provided to public and private or NGO facilities on equal financial terms	Yes Yes Yes Yes	Copy enclosed (Annex - "B") About 43% comes from GOB
			Yes	Only for procurement of TT and DPT. Public an private sectors received vaccine through city corporation & poupa share
Integration		- Policies for integrated management at district level exists - Integration of service delivery at district level and below achieved - Integration of supervision at district level and below achieved - Co-ordination between public and private service delivery at the operational level in place	Yes Yes Yes Yes	Authority did not make any comments.
Supply and logistics		- National vaccine supply plan exists - Guidelines for vaccine procurement exists - Procurement is planned and under-taken by the National Immunisation Programme - Annual distribution plan for EPI prepared - Strategies for reducing vaccine waste exists - Written procedures for receipt, storage, distribution & destruction of vaccines exists	Yes Yes Yes Yes Yes Yes	Copy enclosed (Annex "C") In cooperation with UNICEF This is done on quarterly basis. 15-20% probable wastage
Infra-structure		- Inventories of fridges exist - EPI cold chain monitoring system in place - Information systems that monitor urban / rural coverage are in place	Yes Yes Yes	Authorities did not make any comment
Quality assurance		- Information system that permits regular (monthly or quarterly) monitoring of coverage by district exists - Information system that permits regular (monthly or quarterly) monitoring of disease incidence exists - Strategies for safe injections established - Strategies for monitoring missed opportunities developed - Strategies for targeting high risk groups established and used	Yes Yes Yes Yes Yes	Quarterly reporting. Monthly reporting and weekly reporting system exist. From monthly reporting

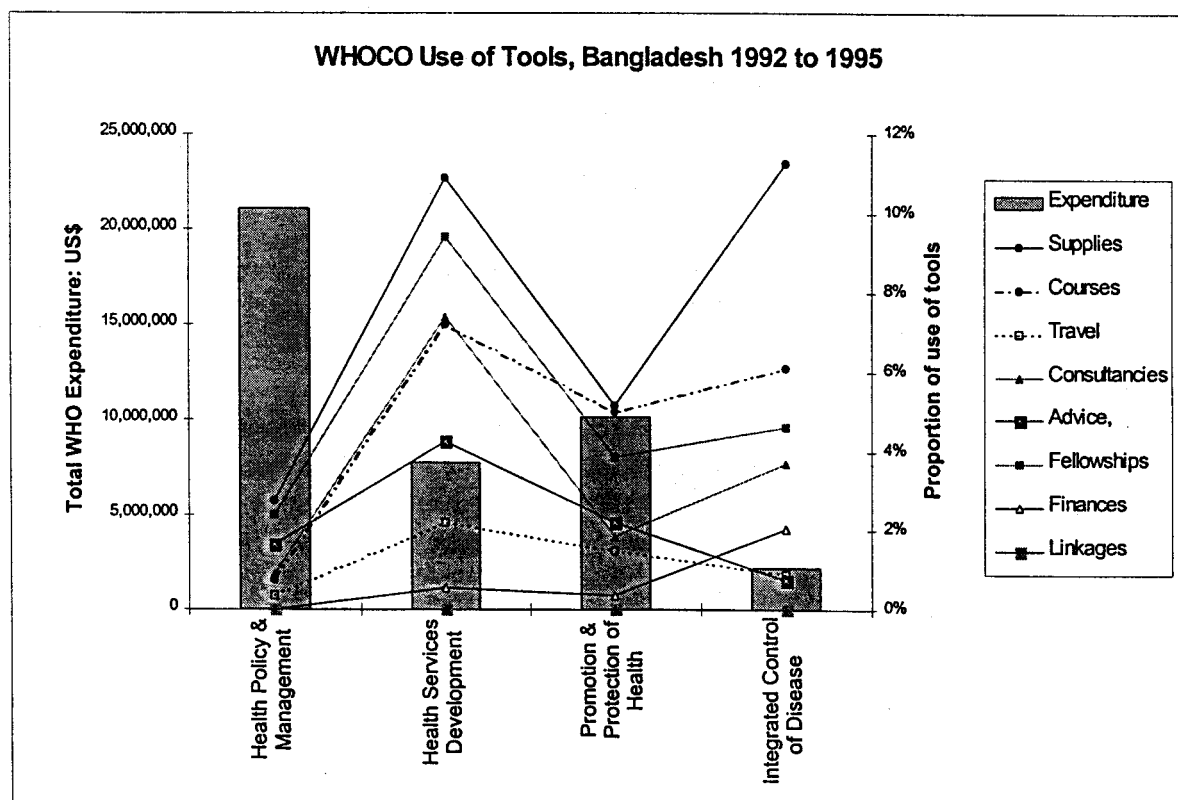
National Malaria Policy Implementation Profile

Functional areas		Indicators	Yes No	Comments / Changes
Policy and Management	<u>Policy</u>	- National Policy updated during last 10 yrs - National Malaria strategy exists - Needs assessment done during last 5 yrs - Strategies for including Malaria in the Sick Child initiative adopted	No Yes Yes No	No national malaria policy exist. Strategy formulated as per..... Revised malaria control strategy (RMCS) & copy enclosed. None.
	<u>Specific strategies</u>	- Malaria control plan exists - National therapeutic protocols exist - Vector control strategy exists - Local research results have influenced the national malaria control programme	Yes No No	Within WHO guideline
	<u>Public sector financing policy</u>	- Operational costs of the programme are fully covered by the national budget - National budget used towards purchase of antimalarial drugs - National budget used towards purchasing insecticides. - National budget is used towards purchasing bed nets - Antimalarial drugs and bed nets are provided to public and private or NGO facilities on equal financial terms.	No Yes Yes No No	Certain changes in definition of malaria, Line of treatment, therapeutic uses of anti-malarial drugs include doses & reporting system. Program is mainly supported by WHO's financial assistance. None No comment ITBN (Insecticide treated bed net) only use in potential epidemic areas.
Supply and logistics		- National Malaria drug supply plan exists - National insecticide plan exists - Procurement is planned and under-taken by the National Malaria Programme - Annual distribution plan for insecticides, bednets and antimalarial drugs prepared - Strategies for reducing waste of insecticides and antimalarial drugs exists - Written procedures for receipt, storage, distribution and destruction of insecticides and antimalarial drugs exists	Yes No Yes No No No	As per indent from district None Only for imported drugs. Locally manufactured drugs are purchased by district health authority. No comment
Infra-structure		- Inventories of spraying equipment exist - National laboratory is in place - Information system that monitors urban and rural coverage is in place	Yes Yes No	Located in DG H5 name of Lab is Malaria Referral Lab. Only disease reporting & surveillance is in existence.
Integration		- Policies for integrated management at district level exist - Integration of service delivery at district level and below achieved - Full integration of supervision in place at district level and below - Co-ordination between public and private service delivery undertaken	Yes Yes Yes No	But not very much effective
Quality assurance		- Recent survey done of the coverage of major interventions outlined in the Malaria Control Programme - Disease incidence data available and updated - Information on prevalence of parasitaemia available and updated - Strategies for safe handling of insecticides exist - Strategies for targeting high risk groups established and used	Yes Yes Yes No Yes	Survey done in the year 1989 last. Copy enclosed. Done depending on available guideline & training. This is in the stage of preparation & is awaiting for implementation

WHOCO profile on use of functional areas



WHOCO profile on use of tools



Evaluative Summary of Country Case Study BANGLADESH

Adetokunbo O. Lucas

1. CONTEXT

1.1 General Development

Bangladesh is a poor developing country (GDP US\$240), densely populated, subject to political instability and natural disasters.

1.2 The Health Care System

Health indices show the pattern of poor developing countries with relatively high under 5 mortality rate, high frequency of low birth weight, and high but declining birth rate.

The Ministry of Health and Family Welfare is organised into two parallel directorates: one for health services and the other for family planning and maternal and child health. This division goes right down to the most peripheral units at the community level.

The national health budget is of the order of US\$3/head to which is added about US\$9/head from donors.

2. NATIONAL CAPACITY

The health scene is heavily dominated by the involvement of external agencies -- multilateral and bilateral agencies.

2.1 Human & Institutional Resources

Gaps in national capacity are being filled by expatriate experts but some of the apparent gaps relate to managerial problems within the system. For example, nursing staff are apparently in short supply in institutions but at the same time, it is estimated that there are 5,000 unemployed trained nurses.

WHO/SEARO programmes to strengthen human resources development have met with only partial success.

One major gap is the capacity to reform the health care system and make it more efficient. WHO and other agencies are trying to fill this gap.

2.2 RESEARCH CAPACITY

This is a very weak area. Inputs from WHO/SEARO, WHO global programmes and other agencies have produced limited results. One factor may be deficiencies in the basic training of doctors and other health professionals. UK/ODA and other agencies are attempting to rectify this defect by strengthening the academic programmes in medical schools.

3. GOALS

The work of the WHO/CO is heavily dominated by the massive involvement in the implementation of specific projects under the FPH4. WHO staff claim to be working in the background to influence health development but its influence is not clear.

4. LINKAGES

Various mechanisms are in place for attempting to coordinate the programmes of the various donors as well as national NGOs. The most notable example is the consortium of donors involved in the FPH4 programme.

4.1 The Consortium

The consortium of donors, under World Bank's chairmanship, is currently implementing a major population and health programme -- FPH4. The latter consists of over 100 projects; WHO is contracted to implement 21 of these projects.

4.2 Other External Agencies

Some other external agencies, not part of the consortium e.g. USAID, also collaborate with WHO.

5. STRUCTURES

WHO Country Office is large with over 60 professional staff, most of whom are funded by EBFs.

6. WHO'S COUNTRY PROGRAMME

6.1 Traditional technical programmes

WHO has had extensive input into the development of traditional programmes: specific disease control, immunisation, drug action, etc. In spite of the difficulties mentioned above, WHO has achieved some significant successes in strengthening national programmes. The tracer programmes show that national programmes on immunisation, on drugs and on malaria control have been relatively well developed. WHO has been involved in programme planning and in training of key staff.

6.2 Role as executing agency

WHO is closely involved in the implementation of the Fourth Family Planning and Health Project (FPH4) and has the responsibility of implementing 21 of the projects. WHO's function as an executing agency has met with mixed success. One source of complaints was the protracted bureaucratic processes for the procurement of equipment and supplies and the recruitment of personnel. With regard to the latter, there are also complaints about the quality of some of the WHO recruited consultants and project staff. A recent decision to advertise project posts should help to identify competent staff.

WHO needs to make the management of its projects more efficient. Procurement procedures need to be reviewed to make the process faster and more efficient. Some of the delays are beyond the control of WHO staff ; apparently it may take 6 to 12 months to obtain government clearance for selected WHO consultants!

7. COMMENTS ON MAJOR ISSUES

7.1 Health Policy and Advocacy

The health system in Bangladesh is much influenced by external agencies. It does not seem that WHO's voice is heard clearly above the many competing views from UN agencies and bilateral donors. Even on technical matters, WHO's recommendations are not always given adequate hearing. For example, WHO had worked with the national malaria and vector programme to promote the use of insecticide impregnated bed nets and other vector control

measures but the project was frustrated for some 18 months because another arm of the Bangladesh government had banned all imports of insecticides!

The Bangladesh government does not seem to regard WHO as its best source for guidance on health development. Rather, it seems to prefer World Bank's approach which has led to fragmented incoherent programme. WHO has an uphill task to upgrade its status from a mere executing agency to being a credible adviser on health development.

7.2 National Health Policy

The government has not developed a national health policy. The exercise commenced recently. The terms of reference were "cleared by the World Bank" but WHO was not involved at this early stage! The regional director apparently raised the issue during a recent visit to the country. WHO is serving as a technical organisation to implement a set of projects rather than being an important adviser to the national government on health policy matters. It is difficult to find out how WHO became marginalised (WHO is serving at the teller, whilst the World bank is discussing investment policy with the manager!")

Instead of a coherent national health system, the health sector in Bangladesh has been projectised. Will WHO have the opportunity of correcting this error by playing a more active role in the formulation of the health policy. This will depend on the receptivity of the national government and a better understanding of health development by the advisers from the World Bank.

7.3 WHO's Relationship with the Ministry of Health

WHO needs a new image in Bangladesh. It can acquire this new image by improving its own performance. The national government should also change its perspective and make more use of WHO's policy guidelines. The other external agencies, notably the World Bank should refrain from policies that tend to fragment and projectise the health system and they should support WHO in helping the national develop a coherent health policy.

In the interest of a rational development of the health services in Bangladesh, WHO's role needs to be redefined and enhanced. All three parties -- WHO, national government and external donors notably the World Bank: must cooperate in bringing about these changes.

7.4 Sustainability

Is the ready availability of external aid creating a culture of permanent dependency? For example, the government company that manufactures drugs is now making substantial profits and yet the revenue is not used to support the quality control laboratory which still relies on WHO resources for its operation.

Note from SEARO regarding EBFs for Bangladesh.

Regarding the extrabudgetary funds (EBFs) for Bangladesh, the quantum of EBFs shown in the approved column for 1994-95 in the 1996-97 proposed biennium budget is no doubt unusually high compared to those in the previous biennia. You are also correct in your assumption that much of it are due to the World Bank funded projects. In fact, the WHO executed components of the World Bank and its Consortium funded projects account for almost 97% of the total EBFs in 1994-95.

A little background of how these figures were estimated and included in the budget will possibly be useful to explain the situation. The Fourth Population and Health Project of Bangladesh, financed by the World Bank and its consortium was approved for five years (1992-96) to commence from January 1992. But due to delay in completing the procedural formalities by the Bank and the Govt. of Bangladesh, the project could start only in January 1993, that too initially with a few components. WHO got involved in this project towards the end of 1992, at the request of the Govt., the World Bank and its consortium partners. An agreement was signed between WHO and the Govt. of Bangladesh for WHO execution of 21 components of the Fourth Population and Health Project.* The execution was based on the project documents, which were prepared for each component and approved by the Govt. and the funding agencies. The project documents contained yearwise breakdown of budgets. These budgets were the only valid sources available which SEARO could use at that point in time to prepare the 1994-95 EBFs budget projections and estimates. The backlog of funds due to delayed start of the World Bank Fourth Population and Health Projects, were also carried forward to 1994-95, which contributed as well to the high level of EBFs in 1994-95.

Though the projection of EBFs in the WHO budget for Bangladesh was made based on the budget estimates given in the project documents, the actual release of funds, according to the terms of the agreement between WHO and the Govt. of Bangladesh (GoB) was by six monthly instalments, depending on the pace of absorption and implementation.

The WHO/GoB Agreement states that the first tranche of payment will be made to WHO by the World Bank based on the estimated cost of activities to be executed by WHO in the first nine months of its involvement in the project components. Subsequent payments to WHO would be made semi-annually on the basis of bi-annual review and the withdrawal applications submitted by Govt. of Bangladesh to the World Bank to cover the estimated expenditures for the next period.**

Due to varied reasons such as time consuming and complex procedures of the Govt. in clearance of expatriate experts, inordinate delay on the part of the Govt. in appointing national staff, absence of national counterparts in some projects, frequent transfer of national project managers, political unrest, civil disturbances almost through 1995 etc. the progress of implementation was slow and as a result, the amount of funds released were much less than what were budgeted in the project documents. About US\$19.6 million were released up to the end December 1995 against the WHO executed 21 components, of which about 14 million were expenditures for the same period.***

It may also be mentioned that the Nutrition project against which US\$17 million have been shown in 1994-95 WHO budget, though originally intended for WHO execution, was transferred to FAO subsequently. This also reduced the amount of funds released to WHO.

Bangladesh Fourth Population and Health Project was the first ever WHO participation in the execution of a World Bank funded Project and we admit that we had yet to have sufficient understanding of the various ramifications of the Bank's funding procedures and practices, which was to some extent, were also responsible for high projection of EBFs.

Regarding review, monitoring and evaluation of projects' activities, release and utilization of funds, etc. in addition to the routine WHO/Govt. joint monitoring of project activities, the projects are reviewed bi-annually by the World Bank and co-financiers Supervision Missions, in which WHO also participates as the executing agency. A threadbare analysis of the progress of implementation of project activities, delivery of funds, problems encountered, identification of possible solutions, reassessment of priorities, revision of project activities, etc. take place during these missions. A Mid-Term evaluation of the projects was also conducted in May 1995. The findings and the recommendations of these Missions are submitted to the Govt. in the form of Aid-Memoirs. These include detailed report on the current status of implementation of activities and delivery of funds, problems/issues requiring immediate attention, recommendations for follow-up actions etc. It may be mentioned that the project has been extended up to June 1998 to allow time to clear the backlog and complete the unimplemented activities. However, this was done after a thorough assessment by the Supervision Mission which was fielded in May-June 1996. The activities found lagging far behind and were not feasible to be completed within the extended period, as well as those which were considered of relatively lesser priority, were discontinued and the funds were reallocated to the continuing activities of higher priorities.***

Regarding fellowships, Dr Topo Harsono's report was prepared on the basis of contributions received from the nationals and the training institutions. There is a strong likelihood of a mix-up of fellowships and short study tours in these reports. All the fellowships were implemented through SEARO. We would, therefore, suggest that only SEARO data be 'used' in your study. Kindly ignore the data in Dr Harsono's report.

We hope the above will answer your queries.

With kind regards,

S.G. Muktader
ERO/SEARO

- * A list of WHO executed 21 components of the World Bank Fourth Population and Health Project.
- ** WHO/GoB Agreement
- *** Statement of funds received and expenditure up to December 1995
- **** A sample of Aid-Memoir following a six-monthly Supervision Mission.

Sd Dr Than Sein
Director H.P.M., WHO SEARO

**THE WORLD HEALTH ORGANISATION
AT COUNTRY LEVEL**

**COUNTRY CASE STUDY REPORT
THAILAND**

**Prof. Patrick Vaughan
Prof. Thavitong Hongvivatana**

January 1997

STUDY TEAM AND ACTIVITIES.

The Study Team, which consisted of three members, visited Thailand from December 1st to 9th 1996. The national consultant was Professor Thavitong Hongvivatana, of the Faculty of Social Sciences and Humanities of Mahidol University, Bangkok, who collected the data on the National Health System Capacity and liaised with the Thailand WHO Office, which provided the additional data on the WHO Country activities. The Core Team Member was Dr Adetokunbo Lucas from Nigeria and the International Consultant was Professor Patrick Vaughan, on secondment from the London School of Hygiene and Tropical Medicine to the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B).

Following a briefing by the WHO Country Representative, Dr Brian Doberstyn, and other WHO programme staff, the Study Team undertook a schedule of interviews with senior staff in the Ministry of Public Health (MoPH), UN agencies and World Bank, universities and research organisations, and non-government organisations involved in health (See Appendix 3). Additional information was also available on the support provided by WHO Headquarters to Thailand WHO Country Programmes and by the WHO South-East Asia Regional Office in Delhi.

ACKNOWLEDGEMENTS:

The Study Team wish to acknowledge the exceptional cooperation and support that it received during its short stay in Bangkok, particularly from staff in the WHO Country Office, the Ministry of Public Health and the universities. Many people made time in their busy schedules to be interviewed and some even met us during a national holiday to celebrate the King's birthday. We would also like to thank those interviewed for their candid responses. In compiling this report we are very grateful for all the information and opinions that we received, but we accept sole responsibility for interpreting the information and for the conclusions we arrived at. This country case study proved to be a very valuable learning experience for us all!

Executive Summary

Since about 1980 Thailand has sustained strong economic growth and is regarded as a middle-income developing country. Health status has improved rapidly and the country is now experiencing the demographic and epidemiological transitions, with an aging population and the increasing importance of non-communicable diseases, accidents and injuries. Malaria and dengue mortality is largely under control, but social and behavioural factors in health, HIV/AIDS and tuberculosis have become more important. In fact many agencies, such as UNICEF and AusAID, no longer consider Thailand an aid worthy country. Although Thailand has clearly benefited from WHO technical cooperation, the future role of the Organisation now needs to be redefined.

The central government allocation to health has increased by an estimated 10% per year and it now accounts for 6.6% of total expenditure, or about US\$38/person/year. The Ministry of Public Health is the main health care provider, although private-for-profit and NGOs are becoming more important. Despite health improvements, there are marked urban-rural, socio-economic and provincial inequalities in health status. The 8th National Health Development Plan (1997-2001) is being approved and there is strong professional capacity in the MoPH. WHO has supported Thailand in building its research capacity, which is now seen to be strong, and recently a new Thailand Research Fund has been established. Thailand also has its own well developed capacity for health systems research. A Thai-Aid Programme has recently been established, which includes health, that focuses mainly on the Mekong valley group of countries.

WHO is well respected in Thailand for the support it has given the country. In 1981 Dr Mahler gave Thailand special decentralised control over its own regular budget funds so that the Ministry could use them to implement primary health care. However, stricter financial controls have now been re-established by SEARO and the MoPH, with the WHO Country Office now having less direct influence over the use of these funds. The Country regular budget for a biennium, of about US\$6.5 million, is the eighth largest for a member state but extrabudgetary funds are now very small. One half of the regular funds are spent on human resources development, including fellowships and training. The Study "tracer" programmes - essential drugs, EPI and malaria control - have all clearly benefited from WHO technical support in the past but they are now strong and largely self-sufficient. The 1996-97 Plan of Action contains 20 programmes, with the four largest covering policy reforms and restructuring, equity in health and health care, tuberculosis control and technology assessment. The WHO Country Office has a strong local advocacy role, but it is not involved in resources mobilisation and nor does it act as an executive agency for other donor organisations.

WHO's comparative advantages today in Thailand are its international, scientific and 'normative' functions, where the Organisation's expertise is well respected. Given Thailand's wealth, the country is at a stage where it could contribute a great deal to WHO whereas the Organisation's technical cooperation function is widely seen as largely unnecessary. From the country perspective the WHO programmes and the professional staff and consultants are all perceived to be of very variable quality. The Country Office is often seen as being too closely controlled by the MoPH and largely under the bureaucratic control of the SE Asia Regional Office.

Thailand is now actively contributing as a partner with WHO in technical cooperation with neighbouring countries. From the country perspective there appear to be three main future options for the Thailand WHO Office. The first is to continue as now, but this will be increasingly hard to justify. The second is for the Office to be phased out and many of the present functions transferred to the MoPH. The third option is to use the regular funds to support TCDC collaboration at sub-regional levels. The latter appears to be Thailand's preferred choice.

Study Of Who Support To Programmes At Country Level: Country Case Study Report : Thailand

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List of Acronyms

AIDSCAP	AIDS Collaborative Action Plan
DTEC	Department of Technical and Economic Cooperation
EBFs	Extra Budgetary Funds
ENHR	Essential National Health Research
EPI	Expanded Programme of Immunisation
ESCAP	
FDA	Food and Drug Administration
GPA	Global Programme on AIDS
GPO	Government Pharmaceutical Organisation
HRP	Human Reproduction Programme
MoPH	Ministry of Public Health
NESBD	National Economic and Social Development Board
ODA	Overseas Development Assistance
PHC	Primary Health Care
PICTs	Project Implementation Coordination Teams
RBFs	Regular Budgetary Funds
RD	Regional Director
RTG	Royal Thai Government
SEARO	South East Asian Regional Office
SEAMEO	South East Asian Medical Education Organisation
TCDC	Technical Cooperation for Developing Countries
TDR	Tropical Diseases Research
UNCAP	UN Collaborative Action Plan
WB	World Bank
WHOCO	WHO Country Office
WHOHQ	WHO Headquarters, Geneva
WHORO	WHO Regional Office
WR	WHO Representative

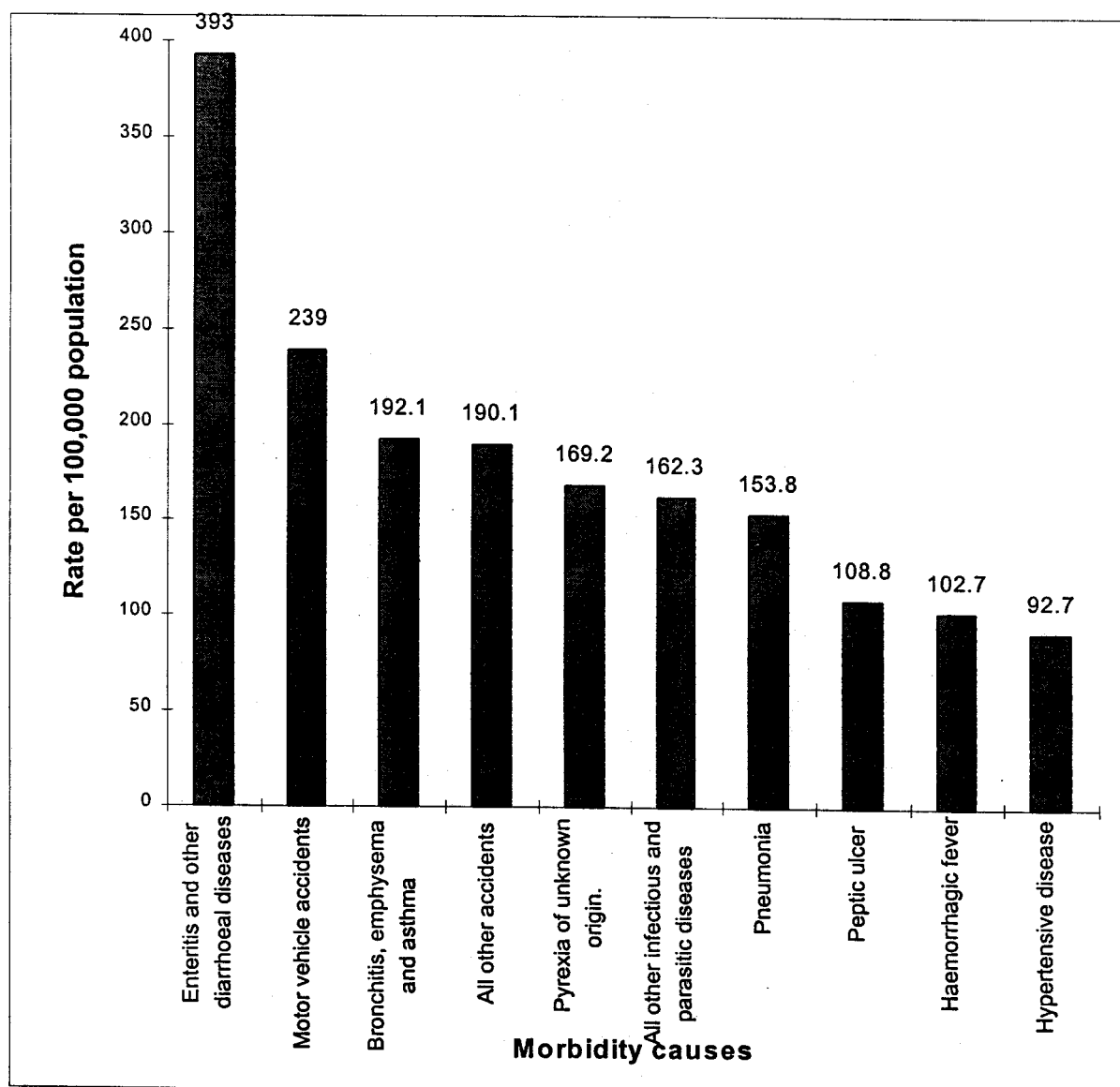
1. Thailand: An Introduction.

1.1 General Background.

Thailand joined the newly formed World Health Organisation in 1947, before its constitution was formally adopted, since when it has been both an active member and benefited greatly from the Organisation's programme activities. Thailand is in the South East Asia Region (SEARO) of WHO and it is currently a nominated member of the WHO Executive Board.

Thailand, officially called the Royal Kingdom of Thailand, shares borders with Myanmar, Malaysia, Cambodia and Laos. However, unlike these countries it retained its independence and never came under direct European colonial rule. It has a population of approximately 60 million people, made up mainly from Thai and Lao ethnic groups. Population annual growth rate from 1980 to 1994 has been 1.6% and contraceptive prevalence was 66%. Approximately one third of the population is under 16 years of age, and 20% of the population lives in urban areas.

Figure 1. Leading Causes of Morbidity of Admissions in Thailand, 1993



Source: Bureau of Health Policy and Planning, MoPH

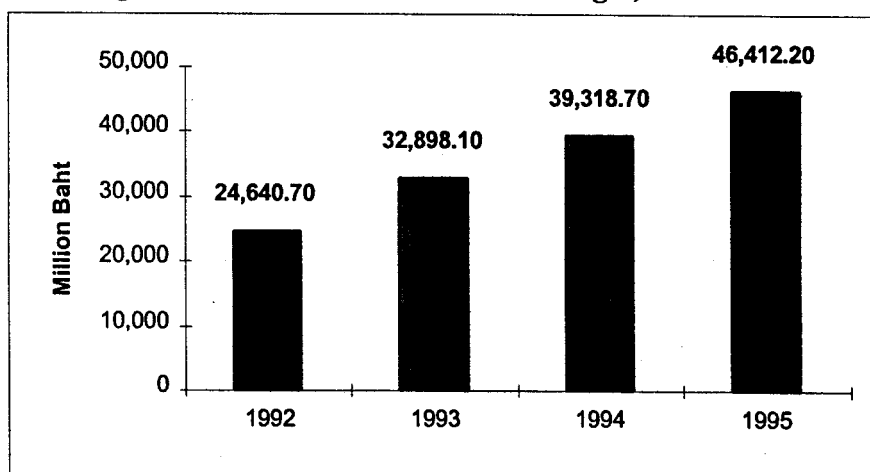
Since around 1980 Thailand has had a period of sustained and high economic growth, originally due largely to foreign investment and industrialisation. The GNP was estimated by the World Bank to have reached US\$1,750 per capita by 1992 and it is now about US\$ 2,400. Thus Thailand is now often categorised as one of the new middle-income developing countries. It is a major exporter of textiles, clothing, electronic components, rice, natural rubber and maize and since the early 1990s tourism has been an important part of the economy.

Health status has been improving rapidly and the country is now clearly experiencing both the demographic and epidemiological transitions, with the emergence of an ageing population structure, as well as the increasing importance of non-communicable diseases, including cardiovascular diseases and accidents and violence (See Figure 1). For instance, in 1993 the crude birth and death rates were 16.5 and 4.9 per 1000, infant mortality was 35/1000 and expectation of life at birth was 63.5 and 68.8 years for males and females respectively. Mortality from the communicable diseases, such as dengue and malaria, has largely been brought under control, although dengue cases have been increasing and malaria cases are imported from neighbouring countries. Tuberculosis and leprosy remain important problems. In addition, social and behavioural factors in health have become much more important, particularly with the recent epidemic of HIV/AIDS and the increased availability of alcohol, tobacco and addictive drugs. With urbanisation and industrialisation, environmental pollution and occupational health issues have also assumed much greater importance.

1.2 Health Systems Capacity.

During the recent period of economic growth, increases in government budgetary allocations to the Ministry of Public Health (MoPH) have been very rapid, commonly estimated at about 10% to 15% per annum (See Figure 2), and for 1996 the estimated Ministry annual allocation amounts to 6.6% of the total Government budget and 1.7% of GDP. This increase has been most marked since the late 1980s. The MoPH is now spending an estimated US\$ 38 per capita, with about 40% being for personnel costs and a total of 65% being on all recurrent costs. Primary health care, which includes basic curative care at health centres and district and higher level facilities, accounts for 29% of the total budget. Human resources are reasonably well developed. For instance, in 1993 on average ratios were: 1 physician to 4,260 population, 1 nurse to 788 and 1 pharmacist to 12,299 people; but with much better ratios for Bangkok.

Figure 2. Growth of Thai Health Budget, 1992 - 1995



Source: Bureau of Health and Planning, MoPH

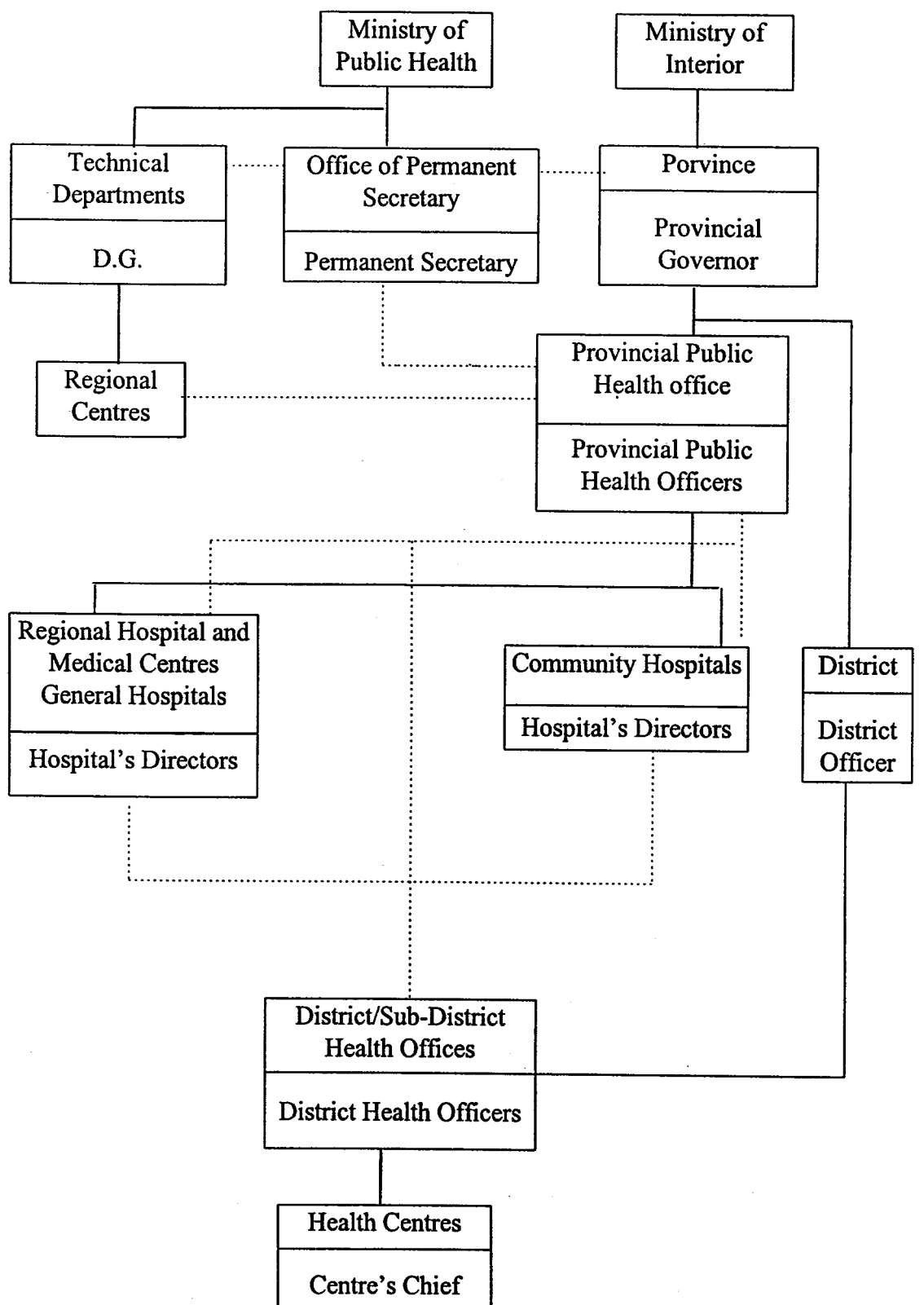
External overseas development assistance (ODA) to the health sector, which is coordinated by the Department of Technical and Economic Cooperation (DTEC), is estimated to be about US\$49.3 million during 1990-98 excluding WHO, with 43% from bilateral agencies, 30% from UNICEF, 26% from other UN agencies (excluding WHO) and only 1% from NGOs. About 54% of this ODA was designated for HIV/AIDS in 25 of the total of 45 projects. The ten main donors to the health sector were WHO, UNICEF, UNDP and UNFPA in the UN agencies; Denmark, Germany, Australia, Japan and Sweden; and Red Barna amongst the NGOs. However, many donor agencies and countries, including UNICEF and Australia, do not now consider Thailand to be an aid worthy country and are withdrawing their financial support. In a complementary move Thailand has also now formed its own Thai-Aid programme that has an annual budget of about US\$ 16.5 million that is coordinated by DTEC. This programme, which includes health, focuses mainly on neighbouring countries.

The MoPH is the main provider of health services, particularly in the smaller towns and rural areas. However, the private-for-profit health services have been growing rapidly in recent years, particularly in Bangkok and other large cities, and national NGOs, such as those concerned with HIV/AIDS, have also become very much more important. In 1993 it was estimated that the government was providing 79% of the health facilities and 83% of hospital beds, and handled over 85% of both outpatients and inpatients. Services are largely provided free, particularly for the poorer groups, but charges are made for all prescribed drugs and diagnostic services. These charges are retained by the facility and are used for its own management. About 60% of people have some form of insurance cover, either through the green card system or from government or private employment benefits. Those patients who carry a free medical care card and those judged as being very poor by doctors and social workers can receive free services. In effect, therefore, the government services are heavily subsidised. However, control over these services is centralised in the MoPH in Bangkok, including finances and personnel. The MoPH is represented in each province by a public health authority that reports directly to the provincial governor, who comes under the Ministry of the Interior (See Figure 3).

The MoPH, which has recently moved to a series of new buildings on a new campus in outer Bangkok, is organised around the Office of the Permanent Secretary and six large and influential Departments (See Figure 4). The Thailand WHO Office, which relates directly to the Permanent Secretary, is also located within this new complex.

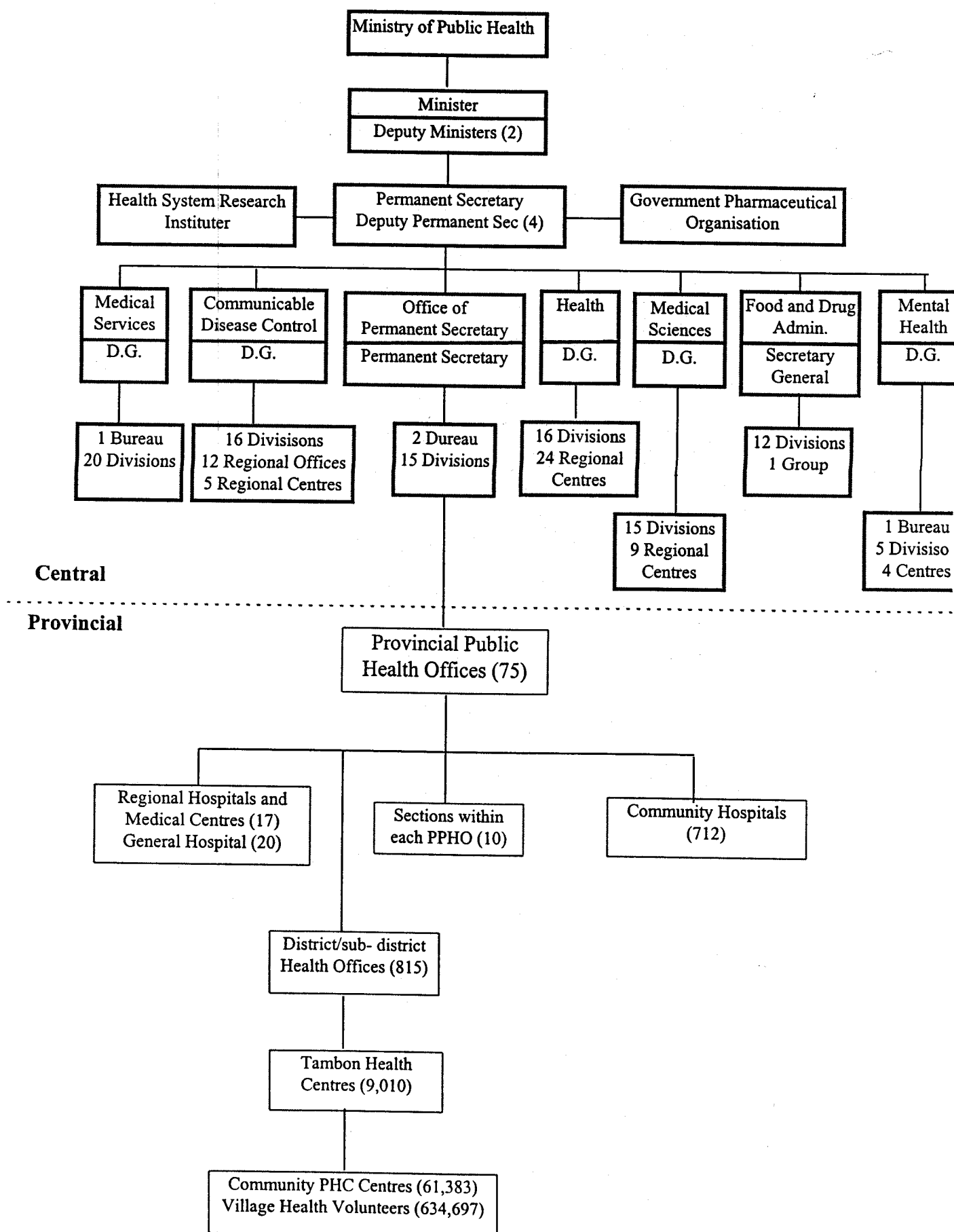
Development planning policies have concentrated on economic growth, but it is now acknowledged that this has resulted in large inequalities. Although health status has improved and services are provided throughout the country, there are well recognised economic disparities and health status inequalities, with health care provision being best in Bangkok, while the NE provinces have a poorer health status and relatively fewer health services and personnel. In addition, programmes such as EPI and family planning have lower coverage in the southern provinces, often attributed to cultural and religious factors since Islam is stronger in these areas.

Figure 3. Organization Structure of the Provincial Health Administration



————— Line of Administration
 Line of Supervision and Cooperation

Figure 4. Organisation Structure of the Ministry of Public Health



There is a well developed and strong capacity for health planning within the MoPH and the 8th National Health Development Plan (1997-2001) is currently being placed before the Cabinet for approval. The Plan incorporates a new emphasis on human rather than purely economic development. Health priorities include an increasing emphasis on non-communicable diseases and health promotion activities, as well as on tackling behavioural, social and environmental health problems. The key national agency is the National Economic and Social Development Board (NESDB) that has responsibility for strategic planning, with the health components being prepared and coordinated mainly by the Ministry's own Bureau for Public Health Policy and Planning. Also important are inputs from the semi-autonomous Health Systems Research Institute, attached to the MoPH. The once strong Planning Bureau has become less influential over time and it now appears that it does not have adequate links with other technical and research units in the MoPH, such as the Office of Health Insurance. The Planning Bureau is no longer seen as strong enough to be effective in its mandate for health policy analysis and development. However, developing new strengths in these areas is widely seen as a high priority for the Ministry.

Health sector reform, although not explicitly identified in the 8th Plan, is to receive increasing importance, including such topics as improving the efficiency and coverage of the national system, further development of human resources, greater decentralisation to Province and Tambon (subdistrict) levels, introduction of health insurance systems, and more reliance on regulation of the non-government and private organisations.

Although Thailand's research capacity is well developed, there is no formal mechanism for setting national research priorities or for coordinating different agencies. Essential National Health Research (ENHR) activities are present but they are not particularly prominent. The newly established Thailand Research Fund includes health as a priority and the National Science and Technology Development Agency offers fellowships for training overseas. The MoPH also offers training fellowships, commissions research and it supports the Health Systems Research Institute. Support for research training, institutional strengthening and capacity building within Thailand has been considerable since the 1970s, particularly by the WHO TDR and HRP Special Programmes and through the Rockefeller Foundation initiative for training in epidemiology. The Thailand MoPH has really benefited from a large number of well trained epidemiologists, some of whom have gone on to specialise in health planning. The SEAMEO Tropmed Network is a regional initiative for human resources development for research and training in tropical medicine and public health. Thailand is an active member, with the secretariat based in the Faculty of Tropical Medicine in Bangkok.

1.3 Thailand and WHO: Some Critical Issues.

Clearly the future of the WHO Office is uncertain a wealthy country like Thailand. Although WHO's previous technical contributions to Thailand appear to have been successful, the future role of the Organisation at the country level remains unclear and will need redefining. Thailand now has its own aid programme and is an active contributor to technical cooperation activities with neighbouring countries. However, it is also clear that if the Organisation wants to remain relevant to Thailand it will have to strengthen its capacity in such areas as health systems development.

The population of Thailand has shown remarkable improvements in health status over the past 20 years and the demographic and epidemiological transitions are well underway. Since many of WHO's traditional capacity and strengths in communicable diseases control have already been transferred and established in Thailand, the Organisation clearly faces new

challenges with such countries. Thailand is now adjusting its health system to the non-communicable diseases, as well as coping with the new and emerging health problems associated with rapid social, behavioural and environmental changes. However, infectious diseases remain a major problem, with tuberculosis in resurgence and HIV/AIDS remaining an overwhelming problem.

Thailand is now a wealthy country that already devotes a considerable proportion of its national resources to health and health services. It has a relatively well developed health care delivery system and many well trained human resources, together with training establishments and research institutes. However, it now faces many new challenges, partly due to its economic success and the associated rapid expansion of its public health services. A widely recognised need is to explicitly tackle equity issues and to plan for a transition in its health systems, including health sector reform.

WHO's present day financial contributions to Thailand, mainly from the regular budget and with only small amounts from extrabudgetary sources, are now so small that they are almost irrelevant when compared to availability of national resources. If the Organisation wishes to remain relevant to such middle income developing countries, it will have to adapt and respond rapidly to such changes. Not only will the Organisation need to show new strengths in areas where it is known to be noticeably weaker, such as health systems development, it will also have to introduce new and more flexible management structures that will enable countries like Thailand to contribute more effectively to regional technical cooperation activities.

2. The WHO Country Office: Structures and Processes.

2.1 Professional, Administrative and Institutional Capacity.

The WHO Thailand Office has been much reduced over the past 10 years and it is now a relatively small one, with a strong team of eight professionals and 14 support staff. There are three international staff (specialists in malaria and in public health, and one administrative officer), one short-term international consultant, one national professional officer (with another one proposed), three senior national consultants, and 14 national support staff. Only one of the professional staff is a woman. The present WR has been in post since January 1992 and had previously worked in Thailand and at WHO Geneva as a malaria specialist and in Cambodia as WR. The Office is well equipped and spacious and located within the new MoPH buildings. Its computers are connected to the MoPH computer network and Internet. The Ministry provides free offices and it also pays for electricity, air conditioning and local telephone calls.

Although the main work of the Office focuses on the Plans of Action for Thailand, in the 1994-95 and 1996-97 biennia it has undertaken considerably more work in support of programme activities in SEARO and WPRO, as well as for other Regional Offices and countries. For instance, during 1995 the Office was involved in 39 meetings in Thailand and 97 outside the country; it recruited 15 Thai STCs; it placed in Thailand 478 fellows from other countries, including 30 on postgraduate courses, from over a thousand requests; and arranged for many purchases and laboratory tests for other countries. In terms of financial transactions alone, it was estimated that the payment of training costs for the training of incoming fellows came to over US\$ 750,000. This substantial work load is relatively new but is one that might largely be under taken by an international section within a ministry of health.

2.2 Planning and Monitoring Capacity.

The strengthening of national health planning capacity in the MoPH was supported by WHO Headquarters and the Regional Office and began with Country Health Programming in 1975, followed by the formation in 1976 of a formal Coordination Committee between the Royal Thai Government (RTG) and WHO. In 1981 the DG Dr Mahler and the RD Dr KoKo agreed in the "Bangkok Declaration" to give Thailand special status and to decentralise from Global and Regional levels to the Country, all decision making for the utilisation of the Thailand country budget for biennia 1982-83 and 1984-85. This was an exceptional move, as an experiment in support of PHC. This initiative was implemented through a coordination committee and a number of programmes and operational groups, later called Project Implementation Coordinating Teams (PICTs). Although there were over twenty programmes in the three biennia between 1990 and 1995, the number of PICTs was gradually reduced and then abolished for the 1996-97 biennium. The biennium budgets were disbursed according to the Detailed Plan of Action which specified the agreed mechanisms for all the programmes. The special status enjoyed by the WHO Thailand Office had gradually changed and the PICTs were finally cancelled with the 1996-97 biennium. Management of the WHO regular budget, though retaining the banner of a decentralised programme budget, has in fact become steadily more centralised, both in the Ministry and in relation to SEARO.

For the 1996-97 biennium informal discussions on collaboration between the RTG and WHO can take place at the MoPH weekly Executive Committee meeting, chaired by the Deputy Permanent Secretary and attended by the Departmental Directors and Heads of Bureaux and the WR if required. Formal agreements are made, however, by the Joint Secretariat

Committee which is co-chaired by the WHO WR and the Permanent Secretary and attended by senior WHO staff and the Head of the Planning Bureau and the International Health Division from the MoPH. This Committee met two times in 1996. The WHO office has one national programme officer who is concerned full-time with WHO-MoPH coordination.

In formulating the 1996-97 Plans of Action, the MoPH Permanent Secretary requested that, after deducting all the fixed costs of running the WHO Country Office, the remaining funds should be split so that 35% would be spent on issues of importance in Thailand, 50% on human resources development (but only for short-term and high level fellowships and training), and 15% on activities that involved Thailand's immediate neighbours. Only minimal funds were to be spent on supplies and equipment. The WHO SE Asia Region (SEARO), and Thailand in particular, have been criticised for the high proportion of funds that have been spent on human resources, including fellowships and consultants. In addition, since there is considerable resentment at the administrative costs of running the WHO Country Office (US\$1.3 million for 1992/93 and almost \$2 million for 1994/95), these were not to exceed a quarter of the total regular budget. The inclusion of these costs within the Thailand biennial budget allocation has been a continuing source of irritation to the RTG.

The 1996-97 Plan of Action contains 22 Programmes, 80 products and 300 quantified outputs in the form of specified activities. Each proposal has to be submitted in a standardised format and undergoes evaluation by WHO staff and peer review, in a process that has been modelled on that followed by TDR/HQ. Each agreed proposal then requires its own technical or a contractual services agreement. The limited power of the WHO Country Office to manage its own funds is illustrated by the fact that agreements totalling more than \$25,000 have to be formally agreed by the Regional Office. Such a procedure leads to fragmentation in formulating proposals and delays in finalising the agreements. In addition, since funds can only be obligated within the agreed biennium, dispersed up to six months after the end of the biennium and spent within 12 months after the biennium, there are frequently delays in starting and completing these programmes within the time available. Half way through the 1996-97 biennium the WHO Country Office estimated that only about 35% of the funds had been disbursed (after excluding support for long term staff, the WR's office and the International Health Division in the MoPH). At this point in time programmes can be reviewed and unused funds reprogrammed. New proposals can be accepted but funds have to be spent within one year, after the end of the biennium. Clearly more flexible mechanisms need to be developed for the management of the WHO funds allocated to the WHO Country Offices.

2.3 Interactions with WHO Regional Office and Headquarters.

There is a meeting of WRs in SEARO Delhi twice each year and, in addition, since Bangkok is a key regional centre, particularly for international travel, there are many other less formal meetings in Thailand involving the WHO country staff. However, as the availability of EBFs for Thailand is now markedly reduced compared to 10-15 years ago, the number of associated visitors has also declined. Exceptions are TDR and HRP at WHO Headquarters, which have been strong supporters of institutional strengthening in Thailand since the mid-1970s and more recently, in fact, these two Programmes have been drawing on this national capacity for support to international research activities. These two programmes operate fairly independently of the WHO Country Office staff, although they do keep them informed on new agreements and their progress. In fact, Thailand now makes considerable inputs to WHO. For example, experts from Thai universities and research organisations now make a considerable contribution to committees in WHO Headquarters and in SEARO and as STCs to neighbouring countries.

WHO Headquarters is generally perceived to be responsive to WHO Country Office requests for information and support, but the capacity and technical ability of programmes to respond is considered to be extremely variable. The Global and Regional Health Reports are considered to be very useful and they are much appreciated by the WHO staff themselves. However, it is important to emphasise that since Thailand now has many highly skilled professionals who can make requests for sophisticated advice, the country only wants high level consultants with specialised expertise, particularly as many of its own staff can give advice on general programme matters. Many senior health professionals now consider the level of the traditional WHO consultant to be totally inadequate, and even insulting, in the present Thai context. The poor quality of many of these consultants was frequently commented upon. This situation has led the MoPH to recruit many its own consultants directly rather than through WHO.

Partly due to a lack of confidence in the SEARO programme staff, there has been little direct involvement of the Region in the RTG-WHO planning process. This situation has been made worse because the competency of the WHORO expertise does not appear to be satisfactory to meet the sophisticated level of the Thai requests. Thus, most of the Thailand WHO Country Office contacts with the Region are for administrative matters, mainly involving the general services and budget sections. In fact it is the Regional staff who seem to initiate many more contacts for information on health projects in Thailand than do the Country Office staff for technical support from the Region. The stronger programmes at SEARO are thought to be EPI and Polio Eradication, ARI and CDD, Nursing and Medical Education, Environment Health, and Health Management. However, SEARO is seen as weak for technical advice in such areas as occupational health, rehabilitation, non-communicable diseases, smoking and health, and accidents and injuries. Regional capacity needs to be considerably stronger if it is to be useful to more advanced developing countries like Thailand. In addition, the Region has virtually no capacity for the rapidly emerging areas of health systems management and health sector reform, which are arguably Thailand's top priority over the next few years. The professional competency of the WHO Headquarters and Regional programmes is clearly being challenged by these new developments.

3. WHO Collaborative Programmes and Activities at Country Level.

3.1 WHO Country Programme of Work.

In terms of advocacy, the WHO's main strengths, particularly when viewed from the country level in Thailand, are its international 'normative' activities and its access to high level scientific and professional expertise. Statements and policies endorsed by the Organisation continue to carry great weight and its prestige is such that it can be very influential in initiating new health developments or in influencing the MoPH to adopt new policies. This was particularly true in the past for the more traditional areas to do with communicable diseases control and human resources, but it also remains true today in areas such as health sector reform where other organisations, such as the World Bank, are also seen to be influential. However, the Organisation's urgent need to strengthen its technical competence in these areas is also widely recognised and commented on.

The WHO's contribution to building Thailand's technical capacity, particularly in the 1970s and 1980s, is acknowledged and so to is its contribution to institutional capacity building for research into tropical diseases by the TDR and for human reproduction by HRP. For instance, between 1975-1995 TDR funding to Thailand amounted to over US\$ 14 million for 248 projects for research, training and institutional strengthening (See Figure 5.). This support also led to the SEAMEO TROPMED collaboration network and to the Thai Researchers Institution for development research for new drugs. In addition, Thai scientists have frequently served on TDR Scientific Committees. However, since Thailand now has its own high level of professional and research skills, together with well developed institutions, the need for such financial inputs from WHO has decreased considerably. In fact Thailand is already using this capacity in its own Thai-Aid Programme with neighbouring Indochina countries and through such joint activities as the SEAMEO collaboration for research and training tropical medicine and public health.

Figure 5. UNDP / World Bank / WHO Special Programme: for Research and Training in Tropical Diseases: TDR - Participation Summary for Thailand

TDR Funding in Thailand	US\$ 14,003,429
Number of Projects funded by TDR	248
Publications from TDR funded projects in Thailand	230
TDR Trainees hosted by Institutions in Thailand	46
Number of memberships on TDR Scientific Committees	36
TDR News Recipients	352
Contributions of Thailand to the Special Programme	US\$ 116,576

3.2 Study Tracer Programmes.

It is clear that WHO technical cooperation to the MoPH in the 1960s to 1980s, in the form of expertise, advice, financial support and fellowships, played a key role in establishing the very successful EPI, essential drugs and malaria control programmes that exist in Thailand today. These three tracer programmes owe a great deal to this earlier investment. The country also benefited from substantial coincidental support to the health sector in Thailand from other

organisations such as USAid and the Rockefeller Foundation. However, it is clear that today these programmes are now largely self-sufficient. If they do need further support it would be in the form of high level technical inputs and policy analysis rather than advice on programme implementation and the conduct of research. (See Appendix 3. for Tracer Programmes Implementation Profiles.)

The national position on **essential drugs** is relatively well developed, with the Food and Drug Administration (FDA) of the MoPH taking the main responsibility for implementing programme activities, including rational drug use, and the Government Pharmaceutical Organisation (GPO) concerned with registration, production and quality control. However, it is estimated that there are over 20,000 registered products. The FDA runs a mass media public information campaign and liaises with the RTG Department of Commerce on official pricing policy. It also has regular dialogues with the private associations. The ASEAN Subcommittee on Health and Nutrition has supported TCDC, particularly for pharmaceuticals, and the FDA is working closely with Thai-Aid in Cambodia, Laos and Viet Nam on their essential drugs programmes. The WHO Plans of Action for 1996-97 includes US\$ 256,000 for national drug policies and the essential drugs programme, together with an additional US\$ 33,000 in EBFs, plus another US\$ 50,000 for quality assurance of pharmaceuticals and biologicals.

A similar situation exists with Thailand's **EPI programme**, which is now well established and largely independent from international support. The MoPH looks after implementation while the GPO looks after vaccine production and quality control, which includes Hepatitis B. EPI has achieved high levels of coverage of the standard six vaccines, although there is variation by province, and the programme already includes Hepatitis B and MMR (Measles, mumps and rubella) vaccines. Where the country may require high level support is with technologies for producing the newer vaccines, such as *Haemophilus influenzae* B, and with scientific and expert policy advice on whether to include such a vaccine in routine programmes. The MoPH felt that the WHO Headquarters EPI had been slow to respond for information on such new vaccines, even though such requests are likely to come from the new middle income countries. The Thailand WHO Plans of Action for 1996-97 includes support for the production of diagnostic reagents and US\$ 150,000 for the surveillance of poliomyelitis. EPI has successfully been holding National Immunisation Days (NIDs) since 1993, with support from Rotary International.

The **Thai Malaria Control Programme** has achieved an impressive reduction in malaria morbidity and mortality over the course of its thirty year history and during its last decade reported cases dropped to just over 100,000 and mortality fell to 1.7/100,000 population. The essential contribution of WHO is widely acknowledged. The control programme was largely guided by WHO's global strategy and its manuals, technical reports and operational guidelines. The programme no longer relies on foreign expertise and it is, in fact, now providing technical assistance to other Mekong delta countries. Thai scientists have also made very significant research contributions and also act as advisers to the TDR Programme.

The Thai success in malaria control is now threatened by cross-border transmission from neighbouring countries. For instance, 40% of newly diagnosed cases were thought to be in persons who had crossed into Thailand from Myanmar. Hence, regional collaboration is now necessary if further control is to be achieved. No WHO funds are specifically allocated for malaria control, although most of the US\$150,000 allocated to Communicable Diseases Control (CDC) is for malaria, particularly in the context of strengthening Thailand's capacity for international cooperation.

3.3 WHO Budget Expenditures: RBFs and EBFs.

Thailand has the 8th largest country allocation from the WHO regular budget funds (RBFs). The present WHO financial allocation for 1996-97 is just over US\$ 6 million after deduction of the contribution for SEARO Intercountry Collaborative Programmes, of which about \$ 1.5 million will go for administration of the WR's Office and the International Health Division in the MoPH. The remaining \$ 4.5 million is being allocated as per the Permanent Secretary's guidelines given above. The only extrabudgetary funds (EBFs) included in the 1996-97 biennium Country Plan are US\$ 33,000 for essential drugs. However, other EBFs are still coming to Thailand from WHO Headquarters, particularly from HRP and TDR, but these largely go to institutes out side the direct control of the MoPH.

The five largest WHO Country programmes, which account for about 40% of the budget for the 1996-97 biennium, are as follows:

- \$ 500,000 for "Policy reform and restructuring of health systems (code 3.1.2.1)";
- \$ 329,000 for "Technical assistance to Member States for tuberculosis control (5.2.3.3)";
- \$ 300,000 for "Promotion of equity in health and health care (3.1.1.3)";
- \$ 300,000 for "Management of fellowships including placements (3.2.2.1)"; and
- \$ 256,000 for "Country support to national drug policies (NDP) and essential drug programmes (EDP) (3.3.1.1)".

These allocations do suggest that the RTG and WHO have made a concerted effort to direct funds to new priority areas, including initiatives in health sector reform. In addition, allocations for fellowships suffered in recent budget cuts. However, compared to the Plan for 1994-95, a major change is the sudden drop in WHO Country support for HIV/AIDS.

In the 1992-93 and 1994-95 biennia the EBFs for HIV/AIDS were \$ 957,000 and \$ 884,000 respectively, which compares to RBFs of \$ 223,000 for HIV/AIDS and sexually transmitted diseases in 1996-97. In theory most of the concerted action for HIV/AIDS amongst the UN agencies is now handled by UNAIDS, but in practice technical capacity and support still has to come from WHO Headquarters and SEARO. The Thailand WHO Office support for HIV/AIDS programme activities is now widely seen to be far too little and largely ineffective. UNAIDS has not, so far, managed to respond adequately to this widely felt need.

In addition, there is an unfortunate and false perception that Thailand now has sufficient capacity to handle the HIV/AIDS epidemic and that it does not need, therefore, external expertise. This view is not endorsed by the Thai's themselves.

3.4 Resource Mobilisation.

The WHO Country Office has no formal role in resource mobilisation or in raising additional funds to the health sector, other than through advocacy and liaison with other agencies. In addition, the MoPH does not see this as a function for the Thailand WHO Office. UNICEF is rapidly reducing its country commitment and the World Bank is not involved in the health sector. However, recently the Bank has been requested by the RTG Ministry of Finance to review the national situation on health financing.

4. Linkages Between WHO and Other Partners In Health Development.

4.1 Major Actors In The Health Sector and ODA.

It should be emphasised that by far the largest and most influential actor is the RTG itself, through the MoPH. Although WHO is linked directly with the MoPH, bilateral agencies work through the Department of Technical and Economic Cooperation (DTEC), as do most of the other UN agencies and foreign NGOs. However, UNICEF recently chose to work directly with the Prime Minister's office in the belief that this would give it greater support in its desire to work across several different ministries. Agencies coordinated by DTEC meet regularly to discuss issues of common concern. An example of joint action by WHO and UNICEF was their common approach to the RTG when they restated their global guidelines on breast-feeding, at a time when there was pressure to rescind the law banning the advertising of infant formula milks in hospitals and clinics.

Although there are 17 UN agencies situated in Thailand, almost all of them are Regional Offices apart from WHO, UNICEF and UNHCR. For instance, the World Bank, ESCAP and UNAIDS, and some large international NGOs such as AIDSCAP, use Bangkok as a regional base and they make little direct contribution to Thailand. AIDSCAP has withdrawn from activities in Thailand altogether and the World Bank has no immediate plans for the health sector in Thailand, although it does support UNAIDS. Support from other agencies has been falling rapidly in recent years, with UNICEF having a five year plan to reduce its commitment to Thailand and AusAID announcing that it will no longer be supporting the country through bilateral ODA. Relationships between the WHO Country Office and these agencies is clearly very positive and mutually supportive.

Another group of actors are the private-for-profit health organisations, pharmaceutical companies and food manufacturers which are a rapidly growing force in Thailand, where government regulations and controls are not strong or well enforced. A few large NGOs are working in health and HIV/AIDS, such as the Thai Non-governmental Coalition on AIDS, but their influence is limited and they do not appear to receive many ODA funds for the health sector.

4.2 Mechanisms of Cooperation and Coordination.

Within the health sector it should be emphasised that these functions are largely now being carried out by the WHO Country Office directly with the MoPH and that no other major mechanism exists. For instance, these two organisations undertake the programming of the WHO Country funds and there is no open annual meeting that all interested parties can attend. However, the WHO Country Office is frequently contacted for advice and relations with other organisations appear to be excellent.

The UNDP produced the Country Strategy Note for Thailand in 1992 but it does not seem to carry much weight with either the RTG or other UN agencies. With the advent of the RTG 8th Plan the UNDP, as the lead UN agency, has worked with the NESDB to coordinate the United Nations inputs into the development of the Thailand-United Nations Collaborative Action Plan, called UNCAP. The focus is on human development, four priority themes and on projects for the integrated development of those Thai provinces in greatest need. HIV/AIDS is one of the themes and NE Thailand is a priority area for integrated development. UNCAP calls for consolidated financial contributions from the RTG and the

UN agencies, but the WHO and MoPH remain unconvinced and are reluctant to endorse the plan or commit any funds.

The Office for the UNAIDS Asia-Pacific Intercountry Team has recently been formed in Bangkok and UNDP has a staff member assigned to the Thailand HIV/AIDS theme group. UNAIDS in Thailand was only established in 1996 and so far the demarcation of responsibilities and tasks is not yet clear between the partner agencies. UNAIDS in Bangkok coordinates the inputs from the six UN cosponsoring agencies, as well as from other UN agencies as appropriate, and in 1996 it received a one off contribution from UNAIDS Geneva of about US\$ 100,000 that was divided between the RTG and the agencies, although the RTG returned its small share to the UN. In the UN Theme Group on HIV/AIDS, WHO is seen as a cooperative but reluctant partner. However, the Organisation is still being expected to take the lead on the technical aspects as it is the UN specialised agency for health matters. Since the closure of the WHO Global Programme on HIV/AIDS at the end of 1995 there has been a marked lack of technical expertise available to the MoPH and other groups in Thailand, which has created a creditability problem for both the WHO and UNAIDS.

4.3 Use Of WHO's Expertise By Other Organisations.

4.4 WHO As An Executive Agency.

The WHO Country Office has no such role or function in Thailand today, although it did do so in the past. In addition, no such future role is being anticipated.

5. WHO's Mandate and Role.

5.1 Relative Strength and Comparative Advantage Of WHO Support.

In Thailand WHO's main comparative advantage is its international and normative function and the authority and prestige that these carry. However, this advantage relies on it being technically and professionally very strong in specialised research areas and for its programmes, particularly in those areas that need to be centred in WHO Headquarters. From the country perspective, strong programmes commonly also have regional posts for specialist staff within the Thailand WHO Office. Although some programmes are acknowledged to be strong, many others are widely recognised to be weak. Unfortunately the same holds true for the WHO Regional Office, but there are areas where it has supported new initiatives, such as the Thai research for a dengue vaccine and the Healthy Cities project in Bangkok. While SEARO is seen as being supportive to Country Offices, it is also perceived to be highly political and bureaucratic. The Thailand MoPH also views the WHO Regional Office as being weak in many professional and technical areas of concern to Thailand. Even if they do approach SEARO for help, there is great scepticism about the quality of the consultants that will be sent. Hence the MoPH does not often seek help, preferring to bring in its own consultants.

with respect to the Indochina group of countries, there are two practical points that should be made about WHO support. Firstly, since health is often seen as being politically neutral, WHO can play a major role in coordinating health policies and disease control schemes across international borders in SE Asia and even for countries in different WHO Regions, such as SEARO and WPRO. Malaria, illegal drugs and HIV/AIDS are good examples of regional problems for which national borders make little sense. However, for Thailand the strong organisational barriers that separate SEARO and WPRO are clearly a big hindrance to the plans of Thai-Aid for TCDC with neighbouring countries. Secondly, WHO funds are very useful where a country wishes to tackle new priorities, such as health sector reform or establishing a tuberculosis control programme. For countries such as Thailand some of these funds could be used to support cooperation with neighbouring countries, particularly when there is some urgency to adopt new policies and programmes.

5.2 Balance Between Different Functions.

Thailand is sufficiently wealthy that it does not need WHO funds for technical cooperation. What Thailand now needs is high level scientific advice, mainly in such areas as new technologies, and specialist support for the development of national skills in policy analysis and formulation, particularly in the areas of health sector reform. Research priorities and capacity in the biomedical and social sciences in health are relatively well developed in Thailand. Advocacy by WHO at the national level is only really required for mobilising national agencies, including the RTG, to take action for new priorities or where there is a noticeable lack of action, such as for environmental and occupational health, or for promoting new policy initiatives of which achieving Healthy Cities is a good example.

With rapid advances in information technology, a major role that the WHO Country Office can support is the development of national documentation centres where copies of WHO documents and publications can be kept and which have access to international referenced materials. The computerised RTG/WHO Documentation Centre, which has been established in modern offices on the MoPH campus, has access to modern information technology and networks. It produces a regular newsletter with information on important new WHO

documents and it also answers many enquiries. Although at present it is mainly supporting the needs of the MoPH, the centre has plans to link up with national institutes and provincial health offices. The WHO regular budget support has been crucial in establishing this initiative. The dissemination of WHO materials, particularly the scientific consensus documents, is often very poor in developing countries and yet today it is precisely this kind of information that Thailand values very highly.

5.3 WHO Support to National Planning and Priorities.

Thailand now has well developed national planning capacity within the MoPH and it has also undertaken excellent health systems research, for example into health insurance. However, it has not yet really addressed the major issues involved in health sector reform, such as health financing, decentralisation and the regulation of the public-private mix. National planning relies on a centralised approach that has concentrated on expanding the range and quality of the public services, rather than on reforming the system. Unlike in many other countries these issues are not high on the agenda, which can be partly explained by the relative absence of the bilaterals and World Bank in the Thai health sector.

At present support for health reforms comes largely from the WHO Headquarters ICO Programme and to a much smaller extent from the WHO Country Office and SEARO. However, WHO support is still mainly organised through the use of the traditional mechanisms for technical cooperation, including consultancies and fellowships. Support could be more directly and efficiently organised between the appropriate sections within the MoPH, WHO Headquarters and others centres of excellence. It is doubtful if the traditional WHO approaches will benefit Thailand and, due to the comparatively weak consultants, they may even hinder progress!

5.4 Activities of other UN Organisations in Health.

Since the technical cooperation role of all of the UN agencies in Thailand has been reduced, including that of UNICEF, it is doubtful if they can now directly contribute much in future to development in the country's health sector. In fact, UNDP's approach has been to give priority to intersectoral human development in the more needy provinces in Thailand and through an action plan focusing on Coordinated Area Development for Provinces, as outlined in their policy initiative called UNCAP.

However, with rapid expansion taking place in other sectors it is important to see what are the effects of these developments on health, particularly for high risk groups and environmental exposures. New developments also need to be monitored for any other adverse effects on health status. For example, Thailand can expect to see changes in food consumption patterns that may worsen nutritional status, developments in road traffic will lead to an increase in road traffic accidents and injuries, increases in alcohol and tobacco consumption will lead to more cardiovascular diseases and lung cancers, and new manufacturing processes will lead to an increase in occupational accidents and illnesses.

6. Summary of Findings: Country Needs and WHO Activities.

6.1 Broad Achievements at the Country Level.

6.1.1 Thailand is an example of a developing country that has undergone rapid economic and social development to a point where it can now be classified as a new middle income country. In fact, many development agencies no longer see Thailand as such a needy country and are reducing their long-term commitment. In this context the future role of WHO at the country level is very unclear.

Thailand has achieved a very significant expansion in the government health services, as illustrated by the strength of the 'tracer programmes'. Thailand also has strong national research capacity and is now in a position to use its own Thai-AID programme with other developing countries, particularly its neighbours in the Mekong group of countries. The country also has strong NGOs and a rapidly expanding private health care sector. Previous investments by WHO and other development aid agencies have clearly made a very significant contribution to these achievements and the strong public sector in health.

6.1.2 Thailand is now well into the demographic and epidemiological transitions, with a rapid decline in fertility and an ageing population structure, the communicable diseases are largely under control, there is an increasing incidence of the non-communicable diseases of adulthood, and many of the newer concerns are due to changing social, behavioural, nutritional and environmental conditions. WHO programmes now face new challenges in such areas as health reforms and health promotion. How can the Organisation support these middle income countries with high level scientific advice and appropriate health policies?

6.1.3 Having rapidly expanded its commitments to the public health sector Thailand now faces many new issues in the organisation and management of the health sector, which commonly go under the term health sector reform. The country is at a point where it is facing the need for a large scale transition in its whole health system. Does WHO have the necessary strengths and can it meet this challenge?

6.2 Constraints For WHO at The Country Level.

6.2.1 Is WHO sufficiently independent from the Ministry at the country level?

The WHO Country Office has two main functions. Firstly, it has to serve the needs of its member states and hence it is often very closely allied with the ministry of health. Secondly, however, it also has to be an advocate for the Organisation's international policies. In Thailand the Office is located on the ministry campus and organisationally it links directly with the Permanent Secretary, who basically controls the priorities for the biennial Plan of Action and the release of funds. However, many agencies outside the MoPH believe that the WHO Country Office should be more independent and have greater autonomy, particularly to enable it to increase its relationships with other organisations such as NGOs, universities, professional groups and the private sector. It is also felt that there should be a more flexible system and wider allocation of the existing funds and training fellowships to agencies outside the ministry.

It can be argued that greater autonomy by the WHO Country Office will be essential if it is to be effective in tackling the new intersectoral challenges, such as those linked to health promotion and health systems reform. Such changes will be essential for supporting new priorities and non-government initiatives, particularly as the RTG has sufficient funds and

fellowships of its own. Comparisons are frequently drawn with UNICEF's independence, its ability to determine its own priorities and its freedom to operate with a variety of government and non-government agencies.

6.2.2 Does WHO have the technical strengths necessary for Thailand?

Although Thailand is not typical of the 12 countries in the South East Asian Region, WHO is widely seen as lacking high level technical and scientific expertise in many new areas of importance to middle-income countries like Thailand, as it faces up to all the challenges caused by the three transitions: demographic, epidemiological and health systems reforms. If the Organisation wants to support such countries as Thailand, it needs to strengthen its own professional and technical capacity, particularly at global level, in such areas as non-communicable disease control, health promotion, environmental health, and health policy analysis and planning. At present the Organisation is seen to be weak in all these areas.

6.2.3 Are the UN/WHO programme mechanisms still appropriate for Thailand?

The mechanisms that the UN agencies have traditionally used for supporting development cooperation, such as funds, consultancies, fellowships and supplies, may not now be appropriate for the new range of middle-income developing countries. The funds are usually small, consultants may not be of a sufficient quality, fellowships are often inappropriate and supplies can often be purchased locally. The challenge for WHO is to establish new mechanisms based on partnership, that build on the country's newly established wealth, institutions and expertise, rather than on importing these from outside the country. External funds are no longer a priority and paternalistic relationships fostered by external aid agencies are resented. What countries such as Thailand need most is access to the best international scientific advice and the experience of other similar countries. Although the WHO Country Office in Thailand can support such requests, it has very restricted ability to do much about them.

6.2.4 Are the WHO management procedures supporting Thailand?

The WHO's present top-down financial and administrative structure, that relies on bureaucratic procedures at global, region and country levels, is far too cumbersome and inefficient, both for the country governments and the WHO Country Office. The WHO Offices in countries like Thailand, where there is a sophisticated ministry of health, need to be given far greater responsibilities and freedom to act as a broker in the best interests of the country, rather than constantly deferring to Regional Offices for financial and administrative decision making. For countries like Thailand, it is certainly debatable whether the WHO Regional bureaucracy is inhibiting rather than facilitating the Organisation's support to country programmes. The situation is made far more complicated by the political nature of the Regional Offices and the often close relationships that appear to exist between some senior staff in SEARO and the Ministry of Health.

6.2.5 Do the present Regional country memberships make sense to Thailand?

The WHO's arbitrary Regional structure in areas like SE Asia makes little sense when it actually inhibits local opportunities for South-to-South collaboration and TCDC, such as those already being pursued by the countries in the Mekong river valley. For instance, a meeting of the associated Ministers of Health in 1993 identified malaria as an important priority that required joint action. WHO urgently needs to develop new ways of supporting such initiatives by building upon the expertise and exchanges that already exist, particularly in a country such as Thailand that has clearly benefited from previous investments by the Organisation. If the Organisation does not solve the problem of inter-country relationships across its Regional boundaries, it will be dismissed as largely irrelevant to Thailand's future.

6.2.6 How is WHO responding to HIV/AIDS and other emerging diseases in Thailand?

Since the WHO General Programme on HIV/AIDS (GPA) was disbanded and UNAIDS was given the role of coordinating agency for HIV/AIDS for the UN at country level, although the process is still dominated now by UNDP. There has been a sudden loss of international technical health expertise available to Thailand, which is widely assumed to be well able to cope with its own epidemic. This may be true for the well established disease control programmes but it is less true for the new and emerging diseases, where it is very important that Thailand obtains the latest and best advice quickly. The loss of such technical backup support to the WHO Country Office, MoPH and other agencies at country level, has been noticeable in Thailand. WHO is still the main UN agency that should have global level expertise in this area and, therefore, it must make plans to respond appropriately.

6.3 Missed Opportunities For WHO at Country Level.

6.3.1 Why are WHO's policies and documents so poorly disseminated?

A priority for sophisticated countries like Thailand is the ability to draw on the most recent scientific evidence and policy advice before making major decisions, in such areas as new vaccines or plans for health insurance. They also want to know what other countries may have experienced, particularly those with similar levels of development. The new RTG/WHO Documentation Centre in the MoPH is an important initiative that is attempting to tackle this need.

WHO has a strong comparative advantage in producing the best consensus advice by reviewing and synthesising the scientific evidence and the results of country experiences. Although the Thailand WHO Office has supported the setting up of a new documentation centre in Bangkok, the Organisation's documents and publications are frequently hard to access, even in capital cities. However, rapid and easy access is clearly essential for high level decision making in the MoPH. This situation is even more difficult and unsatisfactory for non-government organisations. In Thailand there is, in addition, a serious language problem and the use of long documents in English are often avoided. Translation would help a great deal and WHO supports the translation of key documents.

A major opportunity exists for the global dissemination of such information. However, it appears that the Organisation as a whole has been slow to take advantage of networking through modern information technology, both internationally and within countries. So far this appears to be a missed opportunity.

6.3.2 Can WHO do more to support South-to-South Cooperation?

Although the Mekong River group of countries make up a natural geographical unit, Thailand and Myanmar are in the WHO SE Asia Region whereas Cambodia, Laos, Viet Nam and China are in the Western Pacific Region (WPRO). However, these countries are discouraged from cooperating across the WHO Regional boundaries, since all communications have to go via the WHO Regional Offices in New Delhi and Manila respectively. Rigid regional demarcation no longer makes sense to these countries. If the Organisation wants to play a supportive role in TCDC, WHO will have to find much more effective ways of facilitating local cooperation that it now has. If it fails to do this the Organisation will be largely ignored by the SE Asian countries. A major opportunity now exists for WHO to take the leadership and promote closer sub-regional links and collaboration between such countries.

6.3.3 How can WHO improve the quality of the consultants it recruits?

WHO is largely judged in countries by the quality of the professionals it employs. Thailand is now a sophisticated nation and when it requires consultants and advise, it wants the best it can get since it now has most of the professional expertise and technical capacity it needs to plan and implement its health services. However, a recurring theme was the poor quality of many of the consultants and the inappropriate ways used to hire them. There are also serious questions about how thorough is the recruitment process and whether the WHO salaries and consultant rates are competitive with other agencies. The WHO Regional Office appears to have recognised these issues and is in the process of reviewing its role in recruitment.

Unfortunately such criticisms were being made about staff and consultants hired for both the more traditional areas of expertise, such as EPI and essential drugs, as well as for topics included within health systems development, such as human resources and health financing. In all these areas Thailand now has a high level of expertise. The quality of the WHO staff, both long and short term, is an area that the Organisation must urgently pay more attention to if it wants to continue to be held in high regard.

6.3.4 How can WHO support the control of HIV/AIDS and other emerging diseases?

Programme support to the WHO Country Office for the control of HIV/AIDS and STDs declined abruptly when the WHO General Programme on HIV/AIDS (GPA) in Headquarters was stopped in December 1995. Although UNAIDS began operating in January 1996 little progress appears to have been made in coordinating the work of the UN agencies while WHO's own technical capacity has been severely curtailed. Thailand still looks to the international organisations for the high level advice and support it seeks. The same situation exists with a number of the other emerging diseases, where all other agencies expect WHO to have the necessary expertise.

6.4 Future Possibilities and Directions for the Thailand WHO Country Office.

6.4.1 WHO and the changing role of Thailand.

In many ways Thailand is in a transitional phase as a member state of WHO. It is now both a contributor to the Organisation, particularly at global and regional levels, and it has also benefited from its policies and programmes at the country level. Thailand illustrates very well how, as such countries become wealthier and more self-sufficient in terms of their health capacity, the country's own needs for technical cooperation are reduced while at the same time it becomes able to contribute far more to support the Organisation and other member states. Since Thailand is now in a position where it can actively contribute as a partner member state to WHO's global and regional activities, it is not clear that the country still needs a Country Office, or regular budget funds, to benefit from the Organisation. In this context it becomes increasingly difficult to justify the large regular budget that is currently allocated for Thailand, particularly when there are many other more needy developing countries. In addition, many of the routine functions associated with the WHO Country Office could be transferred to the international section within the MoPH in Bangkok.

Focusing on the future of the Thailand WHO Office, there appear to be three main options, which largely revolve around how Thailand relates to the Organisation and the use of its regular budget funds. These options are for no substantial change, to phase out the office, or to refocus these funds in support of sub-regional cooperation.

6.4.2 First option: No substantial changes.

A policy of maintaining the status quo is perfectly feasible but probably difficult to justify in the context of Thailand's economic success and the obvious needs of many other poorer countries, including those in the Mekong group in SE Asia. In addition, now that Thailand has its own well developed institutions and human resources, it is difficult to justify such relatively large amounts of RBFs being spent on fellowships and consultancies. However, it is also not clear what other extra benefits the Organisation, as it is presently organised, could actually bring to such a new middle-income country. Thus at some point in the near future the WHO regular budget to Thailand will almost certainly have to be reduced. WHO EBFs going to Thailand are already at a low level. One way in which the WHO Country Office could be made smaller and more efficient is to transfer many of its international functions, such as those to do with fellowships and procurement of supplies, to an international office within the MoPH. The Ministry is perfectly able to under take these responsibilities directly.

One strategic direction would be to focus only on a few high priority areas, where new initiatives are necessary and flexible funding and procedures would speed up implementation.

However, such priorities are likely to involve areas where WHO is not at present sufficiently strong in the developing country context, such as in health promotion and health sector reforms. In addition, its bureaucracy is not sufficiently flexible for it to respond quickly and in an autonomous manner.

Longer term the 'no substantial changes' option is not an attractive one, particularly as it would almost certainly lead to the gradual run down of the WHO Country Office and a marked loss in status of the Organisation at the country level.

6.4.3 Second option: Phase out the Thailand WHO Country Office.

In view of the fact that Thailand is now a relatively wealthy country, this option is one that has to be considered very seriously if WHO is to conserve its funds for the most needy developing countries. This option would be in line with the actions already taken by some other UN agencies, bilateral donors and international agencies. In addition, Thailand has well developed international links and most of the routine functions presently carried out by the WHO Country Office could be transferred to an international office within the MoPH.

In this situation the MoPH 'international office' would be responsible for liaising directly with WHO programmes at the Region and Headquarters and the Organisation's direct technical cooperation functions with Thailand would be curtailed to a low level. In this situation it would be the Organisation's 'normative functions' that would become of most relevance to the country. Thailand, as a member state of WHO, could then continue its international and regional activities, much as many other developed countries already do.

It is likely that this option would be a difficult one for WHO to adopt, in view of the lack of a policy based on clear precedents. It would also probably be resisted by Thailand unless it received considerable reassurance that its influence would remain strong.

6.4.4 Third Option: A new WHO initiative to support cooperation for TCDC.

Rather than withdraw regular budget funds from Thailand, an attractive alternative would be to dedicate them to supporting TCDC amongst the Mekong group of countries, in a way that would reinforce the efforts of other development agencies. Such funds could be held by Thailand for sub-regional cooperation but come under the management of a Mekong consortium for such priority issues as malaria and dengue control, manufacture of essential drugs and vaccines, or exchanges of experience on decentralisation and health financing.

Such an initiative would build on regional and political collaborations that are already ongoing, as well as facilitate the use by the sub-region of the well developed human and institutional resources that now exist in Thailand. Many of these resources are, in any case, the longer term result of previous technical cooperation by WHO and other agencies. Since WHO policies already support TCDC, all that would be needed is for an agreement to be reached amongst the countries concerned and for the initiative to then be agreed by the World Health Assembly. Clearly SEARO and WPRO would have to be supportive.

Such a model of sub-regional cooperation is one that could be used in many other areas, particularly in other parts of Asia and in Africa and Latin America. Thus a start with the Mekong group would have valuable lessons for others countries, as well as the WHO as a large international organisation.

7. List of Annexes: Thailand

1. List of people interviewed and organisations represented
2. Country Programme Expenditure
3. Tracer Programmes Implementation Profiles
4. Profiles of WHOCO use of tools and functions
5. Gaps in National capacity and WHO's role in filling them

A Study of Who's Support to Programs at Country Level

THAILAND

LIST of INTERVIEWS DURING COUNTRY VISIT

Name	Position / Organization
Dr Jumroon Mikhanorn	Deputy Permanent Secretary, MoPH
Mr Anthony Hewett	Unicef Area Representative
Mr Khun Permsiri Nitimanop	Unicef Project Officer (Health)
Dr Pornphan Boonyarattaphan	Dean, Faculty of Public Health, Mahidol University
Mr Khun Sombat Chutinun	Director, Division of Social Development Programme, NESDB
Dr John Ungphakorn	Director, Thai NGO Coordination on AIDS
Dr Pakdi Pothisiri	Secretary General, The Food and Drug Administration, MOPH
Dr Edward Van Roy	Director, Social Development Division, ESCAP
Dr Nibhon Debavalya	Director, Population Division, ESCAP
Dr Piya Siripant	Director, International Health Division, MOPH
Dr Prakrom Vuthipongse	Director-General, Department of Health
Dr Suwit Wiboonpolprasert	Assistant Permanent Secretary, Ministry of Public Health, MOPH
Dr Aumnauy Kajina	Deputy Director, Bureau of Health Policy and Planning, MOPH.
Dr Mongkol Na Songkla	Director-General, Department of Medical Sciences, MOPH
Dr Vason Pinyowiwat	EPI Programme Manager, General CD, Division
Dr Somsak Chunharas	Director, Health System Research Institute, MOPH.
Dr Krongthong Timasarn	Director, Malaria Division, CDC, MOPH
Prof Chitr Sithiamorn	Dean, College of Public Health, Chulalongkorn University
Dr Wicharn Panich	Director, The Thailand Research Fund
Mr Arnaud M. Guinard	Chief of Mission, World Bank
Mr Natsuki Hiratsuka	Deputy Regional Representative, UNDP
Prof Tan Chongsuphajaisiddhi	Secretary-General. Coordinator, SEMEO-TROPMED Network
Prof Sornchai Looareesuwan	Dean, Faculty of Tropical Medicine, Mahidol University
Prof Prawes Wasi	Faculty of Medicine (Siriraj Hospital) Mahidol University
Dr Sanguan Nitayarumphong	Assistant Permanent Secretary for Public Health

A.1. RESOURCE USE BY PROGRAMME COMPONENT 1992-95

Thailand

Information from SEARO

New code	1992 RBF	1992 EBF	1993 RBF	1993 EBF	1994 RBF	1994 EBF	1995 RBF	1995 EBF
1.2.4								
subtotal 1	0	0	0	0	0	0	0	0
2.3.1	116,221	30,121	84,686	52,336	29,996	125,456	220,456	14,808
2.3.2	1,056,308		329,577	15,957	1,463,414	30,457	422,964	6,757
2.3.5								
2.4.0	487,926		427,512		68,351		1,073,104	
2.5.0	515,286		476,124		217,077		417,311	
2.6.0	118,541		110,877		31,569		330,990	
subtotal 2	2,294,282	30,121	1,428,776	68,293	1,810,407	155,913	2,464,825	21,565
3.7.0			61,858		5,000		116,091	
3.8.1					11,600		20,503	
3.8.2	7,933		25,002		8,000		144,881	
3.9.1	9,271	-100	200,878		6,018		74,797	
3.9.4	9,511		12,043				56,873	
3.9.5			17,071		23,000		14,730	
3.10.1	93,134		85,510		80,655		156,106	
3.11.5		-1,072						
3.11.4	15,970		213,374		3,280		213,008	9,707
3.12.1	13,636		64,931		4,920		73,929	
3.12.2		62,771	12,382	20,653	14,120	32,809	55,642	37,162
3.12.3	16,991		22,925		10,300		32,480	
3.12.4			25,980		9,920		7,227	
3.12.5	2,253		24,288				71,158	
subtotal 3	168,699	61,599	766,242	20,653	176,813	32,809	1,037,425	46,869
4.13.1							28,803	
4.13.2		1,901,695		645,663		876,444		1,047,636
4.13.13	85,963		234,833		16,040		452,620	
4.13.15								6,775
4.13.17		8,560		-8,560		13,560		
4.13.18	37,332		60,606					
subtotal 4	123,295	1,910,255	295,439	637,103	16,040	890,004	481,423	1,054,411
5.14.0			51,318		52,672		26,950	
subtotal 5	0	0	51,318	0	52,672	0	26,950	0
total expend	2,586,276	2,001,975	2,541,775	726,049	2,055,932	1,078,726	4,010,623	1,122,845

Thailand

Budget	5,864,000	2,298,200	6,406,300	2,408,000
Difference	735,949	-429,824	339,745	206,429
% implemented	87.4%	118.7%	94.7%	91.4%

Information from Audited reports: ACT/94.1 29 April 1994 ACT/96.1 April 1996.

Expenditure as in Audited Repo	5,161,843	2,408,777	6,110,000	1,827,238
Expenditure as from SEARO	5,128,051	2,728,024	6,066,555	2,201,571
Difference	33,792	-319,247	43,445	-374,333

Differences in EBFs are apparently mostly unliquidated obligated funds - see fax from SEARO dated 16 Ju

National Drug Policy Implementation Profile

Fill in Y for Yes and N for No representing the indicator(s) which identify(ies) the actual situation in **Thailand**.

	Functional areas	Indicators	Yes No	Comments / Changes
Policy and Manage ment	<u>Policy</u>	- National Policy on drugs updated during the last 10 years - National Policy is in early stage - Low interest/under consideration	Y N N	
	<u>Legislation and regulation</u>	- Legislation and regulations exist - Updated during the last 10 years - Licensing of distribution and manufacturing premises and persons is occurring - Inspection of distribution and manufacturing premises is occurring - Product registration is done - Basic In-country QC* is done - Basic ADR** reporting is operational - Full range of in-county QC done - Post-marketing surveillance system operational	Y Y Y Y Y Y Y Y Y	
	<u>Essential Drugs list (EDL)</u>	- EDL by generic name for the public sector exists - EDL updated during the last 5yrs - EDL distributed countrywide - EDL is used for drug management	Y Y Y Y	
	<u>Public sector financing policy</u>	- Public drug expenditure is more than 20% of the MoH operating budget per year. - Public drug expenditure represents more than US\$1 per capita per year.	Y Y	
Supply and logistics	<u>Procurement procedures</u>	- Public sector procurement is by competitive tender - Public sector procurement is between pre-qualified suppliers - Public sector procurement is limited to drugs on EDL	Y Y Y/N	EDL:Non EDL = 8:2
Quality Assurance (QA)		- QA system exists - Control laboratory is functioning - Operational research / surveys related to drug management implemented during the last 5yrs	Y Y Y	
Rational use of drugs	<u>Information</u>	- National publication providing objective information on rational drug use exists. - National publication providing objective information on rational drug use revised during the last 5 years.	Y Y	
	<u>Manpower development</u>	- National Therapeutic guide with standardised treatment exists - National Therapeutic guide with standardised treatment updated during the last 5 years. - Concept of EDL included in basic training curricula - Systematic continuing education for health workers & QA personnel exists	Y Y Y	

* Quality Control

** Adverse Drug Reaction

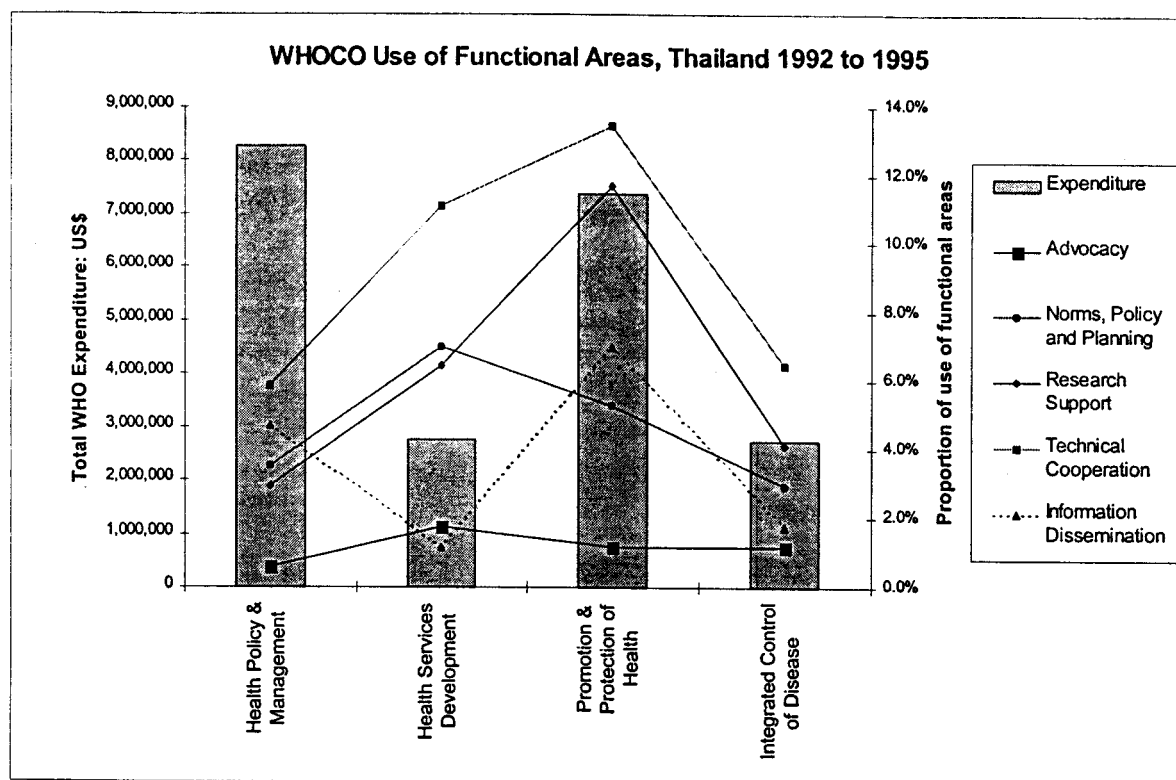
National Immunisation Policy Implementation Profile

Functional areas		Indicators	Yes No	Comments / Changes
Policy and management	Policy	• National Policy updated during last 5 yrs	Y	i.e. JE and HB
		• National EPI strategic plan exists	Y	
	Specific strategies	• Needs assessment done during last 5 yrs	Y	
		• Strategies for linking EPI with the Sick Child initiative initiated	N	
	Public sector financing policy	• Specific targets and strategies for Polio eradication exists	Y	
		• Specific targets and strategies for neonatal tetanus elimination exists	Y	
		• Specific targets and strategies for measles control exists	Y	
		• Specific targets and strategies for the introduction of new vaccines exists	Y	
		• National Immunisation days organised	Y	
		• A budget line within the national health budget for EPI exists	Y	
• A proportion of the operational costs of the programme are covered by the national budget (note proportion)		Y		
• National funds are used towards vaccine purchase		Y		
• Basic vaccines are provided to public and private or NGO facilities on equal financial terms	Y	100%		
Integration		• Policies for integrated management at district level exists	Y	
		• Integration of service delivery at district level and below achieved	Y	
		• Integration of supervision at district level and below achieved	Y	
		• Co-ordination between public and private service delivery at the operational level in place	Y	
Supply and logistics		• National vaccine supply plan exists	Y	training materials but not for routine operation.
		• Guidelines for vaccine procurement exists	Y	
		• Procurement is planned and under-taken by the National Immunisation Programme	Y	
		• Annual distribution plan for EPI prepared	Y	
		• Strategies for reducing vaccine waste exists	Y	
		• Written procedures for receipt, storage, distribution & destruction of vaccines exists	Y/N	
Infra-structure		• Inventories of fridges exist	N	
		• EPI cold chain monitoring system in place	Y	
		• Information systems that monitor urban / rural coverage are in place	Y	
Quality assurance		• Information system that permits regular (monthly or quarterly) monitoring of coverage by district exists	Y	for Tetanus
		• Information system that permits regular (monthly or quarterly) monitoring of disease incidence exists	Y	
		• Strategies for safe injections established	Y	
		• Strategies for monitoring missed opportunities developed	N	
		• Strategies for targeting high risk groups established and used	Y	

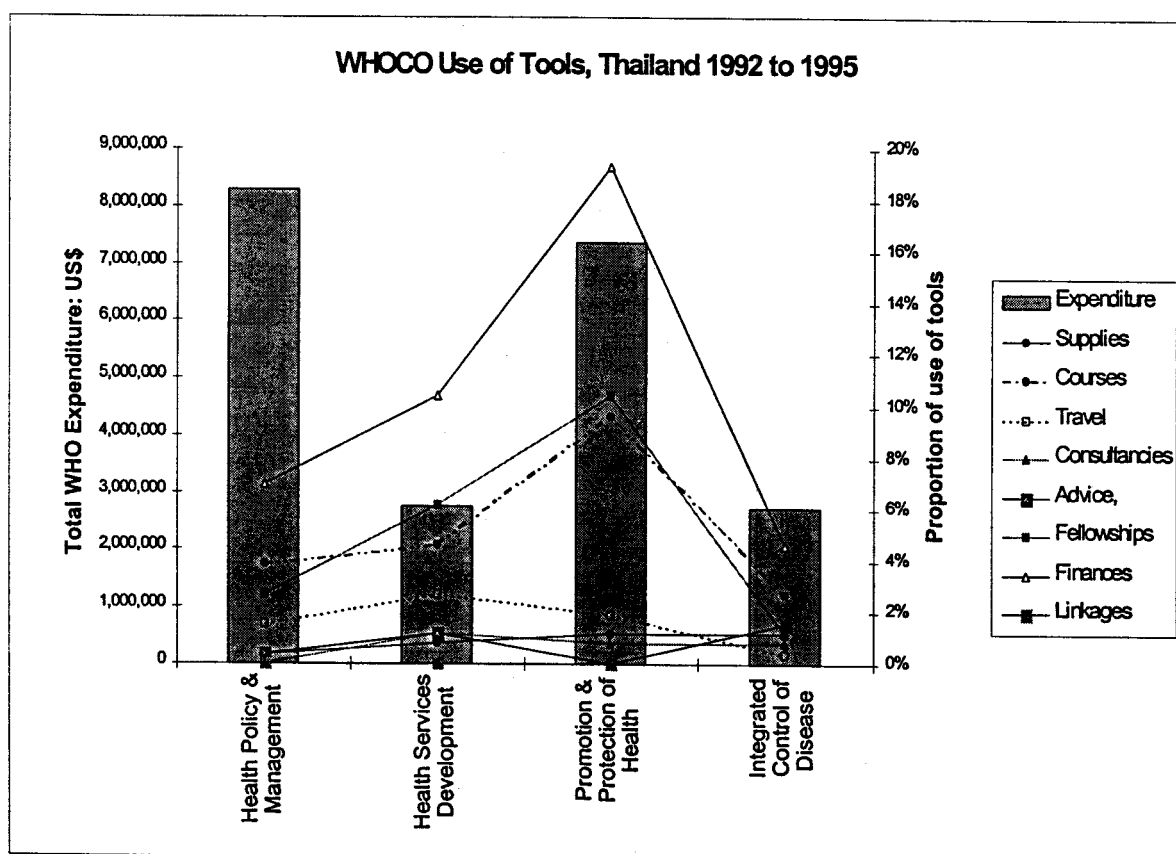
National Malaria Policy Implementation Profile

Functional areas		Indicators	Yes No	Comments / Changes
Policy and management	<u>Policy</u>	• National Policy updated during last 10 yrs • National Malaria strategy exists • Needs assessment done during last 5 yrs • Strategies for including Malaria in the Sick Child initiative adopted	Y Y Y Y	no direct budget line yet
	<u>Specific strategies</u>	• Malaria control plan exists • National therapeutic protocols exist • Vector control strategy exists • Local research results have influenced the national malaria control programme	Y Y Y Y	
	<u>Public sector financing policy</u>	• Operational costs of the programme are fully covered by the national budget • National budget used towards purchase of antimalarial drugs • Procurement is planned & undertaken by the National Malaria Programme • Annual distribution plan for insecticides, bednets and antimalarial drugs prepared. • National budget is used towards purchasing bed nets • Antimalarial drugs and bed nets are provided to public and private or NGO facilities on equal financial terms.	Y Y Y Y N Y	
	Supply and logistics	• National Malaria drug supply plan exists	Y	
		• National insecticide plan exists	Y	
		• Procurement is planned and under-taken by the National Malaria Programme	Y	
		• Annual distribution plan for insecticides, bednets and antimalarial drugs prepared	Y	
		• Strategies for reducing waste of insecticides and antimalarial drugs exists	Y	
		• Written procedures for receipt, storage, distribution and destruction of insecticides and antimalarial drugs exists	Y	
	Infra-structure	• Inventories of spraying equipment exist	Y	
		• National laboratory is in place	Y	
		• Information system that monitors urban and rural coverage is in place	Y	
	Integration	• Policies for integrated management at district level exist	Y	
		• Integration of service delivery at district level and below achieved	Y	
		• Full integration of supervision in place at district level and below	Y	
		• Co-ordination between public and private service delivery undertaken	Y	
	Quality assurance	• Recent survey done of the coverage of major interventions outlined in the Malaria Control Programme	Y	
		• Disease incidence data available and updated	Y	
		• Information on prevalence of parasitaemia available and updated	Y	
		• Strategies for safe handling of insecticides exist	Y	
		• Strategies for targeting high risk groups established and used		

WHOCO profile on use of functional areas



WHOCO profile on use of tools



Evaluative Summary Of Country Case Study: THAILAND

Adetokunbo O. Lucas

1. Context

1.1 Economic Development

With a GDP of over US\$2,000 and a rapidly growing economy, Thailand is the most advanced country included in this study. It has abundant financial and human resources including highly trained health professionals: doctors, nurses, biomedical scientists, researchers.

1.2 History of Primary Health Care

WHO has made major contributions to the development of Thailand's health system and of its technical programmes as well as the strengthening of research capacity. The long and intensive involvement of WHO included a period during which, Dr. Halfdan Mahler, the Director General of WHO (with his chief adviser, Dr. Josh Cohen, and under the national leadership of Dr. Amorn of the Ministry of Public Health) took a personal interest in the process of developing primary health care in Thailand. Through this and other initiatives, WHO helped to shape the Thailand's health system. WHO also made significant contributions to the training of the staff of Ministry of Public Health through its fellowship programme, workshops and seminars.

2. National Capacity

2.1 Health care

As compared with many other developing countries, Thailand has a high degree of capacity to manage its health sector. Not only in the public sector, but with increasing affluence, there has also been a considerable growth of the private sector. But there are some gaps for which Thailand seeks support from WHO and from other sources. For example, Thailand needs to acquire expertise in the design of national insurance scheme and in tackling the emergent chronic diseases -- cardiovascular, cancers, etc. -- which now characterise its epidemiological transition.

Is WHO filling the right gaps? Some concern was expressed about the quality of the technical assistance that WHO is providing on these advanced subjects. Some of the WHO consultants were apparently not of the quality that Thailand needed for tackling some of these complex issues.

2.2 Research Capacity

WHO, through the regular budget and special programmes, has been instrumental in strengthening the research capacity in Thailand and in turn, the organisation has made extensive use of Thai scientists and institutions in carrying out important research projects of great value to developing countries. For example, grants from TDR totaled over US\$14 million. Some of these grants were for training and institution strengthening but increasingly, Thai scientists have been contracted to carry out critical research studies. Data generated from Thai studies formed an important component of the package that was submitted to drug regulatory agencies all over the world for the formal registration of the anti-malarial drug, mefloquine. The South East Asia Region Advisory Committee on Health Research identified Dengue haemorrhagic fever as one of the research priorities. Thai scientists participating in this initiative, have made significant contributions to the clinical research that led to a marked fall in the case fatality rate and have developed a vaccine that is currently being evaluated.

3. Activities of WHO's Country Programme

3.1 Traditional programmes

Current activities of the WHO country office reflects this transitional stage of Thailand. One part of the function is the traditional function of responding to requests from the Ministry of Public Health, for technical support, training grants and exploration of pilot projects. Indigenous capacity for operating the health services is well developed and there are abundant resources. In spite of this, WHO continues to provide relevant inputs. One example is WHO's initiative in promoting the intensified effort to eliminate poliomyelitis. In developing the National Immunisation Day the WHO established an interagency coordinating group including UNICEF, Rotary international and JICA. The Thai experience provided a useful model for other countries in the region and Thai experts formally assisted Bhutan in developing their national programme.

3.2 Thai technical services through WHO

Increasingly, Thailand is providing services to neighbouring and other developing countries through the WHO office:

- **Individual Training:** In 1995, the WHO office processed about one thousand applications and placed over 500 candidates in Thai institutions;
- **Group Training:** Seminars and workshops to enable other countries in the region to share some of Thailand's experience, e.g. management of hospital wastes; Technical Services Quality control of drugs, diagnostic services for the identification of pathogens by Thai institutions; and
- Thailand institutions provide technical services for neighbouring countries *through WHO*: laboratory services including diagnostic virology, quality assurance of drugs, etc.
- Joint research and action programmes *organised through WHO*, e.g. malaria control;
- Training workshops based on Thai projects *organised through WHO*, e.g. disposal of hospital wastes; and
- Consultants and advisers recruited *through WHO* for other developing countries.

3.3 Cross-border collaboration

For several reasons, Thai authorities are anxious to intensify their sub regional collaboration with neighbouring states in Indo-China, and with other developing countries:

- Cross-border re-introduction of infection is a threat to the gains that Thailand has made in controlling some of its endemic diseases e.g. over 40% of new cases of malaria diagnosed in Thailand in 1995 were from across the Burmese border;
- Thailand regards its wider contributions to WHO as recognition of its status as a technologically advanced country.

WHO's should further promote TCDC in the Indo-China peninsula with Thailand playing an important role. WHO provides a neutral base for such collaboration especially in situations where political problems make direct bilateral collaboration difficult.

One constraint is that some of Thailand's closest neighbours belong to two WHO regions -- SEARO and WPRO. Some initiatives have taken place involving countries from both regions but the heavy hand of WHO bureaucracy sometimes makes the process unduly tedious and complicated. for example, a letter from the WHO office in Thailand to the office in Cambodia goes through Delhi (SEARO) and Manila (WPRO). One can easily identify a shorter route.

4. Linkages

4.1 Other external agencies

Few other international have significant in-country health programmes in Thailand. Interviews with UNICEF and other agencies indicate the WHO office is highly regarded and provides for the other organisations appropriate technical guidance. One area of concern is the new programme on AIDS which has as yet not effectively replaced the technical expertise that WHO provided before UNAIDS was established.

4.2 UNAIDS

The UNAIDS programme has not settled down to be productive. It has so far been unable to provide the quality of technical support that Thai institutions obtained from WHO on HIV/AIDS.

4.3 WHO guidelines

Personnel of national institutions and of other external agencies have a high regard for WHO publications and technical guidelines. The documentation centre at the Ministry of Health is a useful facility but additional effort is required to achieve wide dissemination of WHO publications.

5. The Way Forward

5.1 Innovative methods of technical cooperation

WHO is exploring new ways of meeting the needs of Thailand. For example, a "Healthy Cities" project, uses Flinders University in Australia as a resource for training and research. In spite of its highly developed institutions, Thailand still derives benefit from WHO traditional programmes. For example, WHO was instrumental in stimulating and supporting the National Immunisation Day in the thrust for eliminating poliomyelitis. WHO's influence can still be of value in addressing such issues a equity.

5.2 Changing the character of the WHO country office

The character of the WHO office has changed and needs to adapt to the changing needs of Thailand. WHO has not established criteria for determining when a country can graduate from needing a WHO office to being like other developed countries, linking to WHO through its own national mechanisms. Thailand could be a candidate for deriving such criteria.

Transition to Graduation Thailand could now enter a transitional phase in which the host country takes over specific services that are currently being performed by the WHO office, e.g. processing of fellowship applications, provision of technical services;

5.3 Sub-regional role and Cross-border Collaboration

The WHO office could more formally be a sub-regional office specifically aimed at supporting cross-border collaboration with neighbouring countries. WHO could thereby provide a neutral platform for health collaboration in the Indo-China peninsula. Such collaboration should logically involve neighbouring countries that belong to the SEARO and WPRO WHO regions. Such an arrangement would be a rational use of WHO's resources to promote technical cooperation among developing countries, not as an empty political slogan but in reality engaged in substantive projects. Thai institutions and professionals have an established track record of such collaboration e.g. SEAMEO-TROPMED -- a collaborative research and training programme that has been successfully managed from Thailand.

6. The National Response

6.1 Residual problems

In this period of national development, there has been some tendency to create new entities with the concomitant risk of duplication of effort and lack of coordination. For example, there has been an explosion of institutions and programmes on health research but there is no overall mechanism for determining national priorities. The national government should consider working with WHO and COHRED to review its current programmes and take corrective actions where needed.

6.2 Facilitating Thailand's International Role

Thailand is anxious to play a key role in cross border health collaborative effort under the auspices of WHO. In order to play this role effectively, it would need to establish and improve mechanisms for operating inter-country projects smoothly and efficiently. For example, it would need to facilitate the travel of WHO appointed consultants, short term advisers and other participants. This would require careful briefing of its immigration authorities at home, at border stations and at Thai visa offices abroad.¹ If Thailand is going to play a significant role as a sub-regional hub for international health collaboration, it would need to entertain WHO related individuals regardless of race, ethnic origin, nationality or religion.

¹The Thai consulate in one country initially denied a visa to one of the consultants involved in this study on the grounds of nationality. In spite of letters of support from WHO, Thailand and WHO, Geneva, the Consulate demanded a certificate to state that the consultant was not involved in the illegal drug trade.

**THE WORLD HEALTH ORGANISATION
AT COUNTRY LEVEL**

**REGIONAL OFFICE REPORT
SOUTH-EAST ASIA REGIONAL OFFICE**

Professor Adetokunbo Lucas

January 1997

Study of WHO support to programmes at country level:

Regional Office Report : **SEARO**

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NOTES ON INTERVIEWS AT SEARO

Adetokunbo O. Lucas

December 1996

These notes highlight the information that I gathered during discussions with WHO staff of SEARO in New Delhi with particular reference to the two target countries: Thailand and Bangladesh. No verbatim statements are included in these notes nor are any specific points attributed to a particular individual or group.

Annex 1 shows the organogram of the Regional.

Annex 2 shows Office the schedule of my appointments with SEARO staff.

Apart from discussions with the Regional Director and the acting director of programme management, I met with the following groups:

- A. Family Health & Research
- B. Environmental Health
- C. Health Policy and Management
- D. Health Services Development
- E. Health Promotion and Protection Group
- F. Administration and Finance
- G. Control of Infectious Diseases

I attended part of a staff workshop on Programme Development and Management. I include some brief notes on this workshop as it gives some insight into some of the mechanisms that SEARO uses to strengthen the staff performance.

A. Family Health and Research

This Division manages the following programmes:

1. Reproductive Health
2. Child Health
3. Control of Diarrhoeal Diseases and Acute Respiratory Infections (CDD/ARI)
4. Expanded Programme of Immunisation
5. Special Research Programmes: HRP and TDR
6. Regional Advisory Committee for Health Research

Staff present at the meeting

Dr. S. P. Tripathy	Director
Dr. Cato B. de Savigny	Vaccine Supply, & Quality, Cold Chain, Training
Dr. R.N. Basu	STC/EPI Measles, Tetanus, etc.
Dr. S. Pattanayak	STC/EPI Hepatitis
Dr. J. Seeberg	Social Scientist/Medical Research.
Dr. Suniti Acharya	Regional Adviser MCH
Dr. Vijay Kumar	Medical Officer CDD, ARI, (CDR)
Dr. Jean Clare Smith	Medical Officer, EPI Surveillance and Epidemiology
Dr. Imam Machny	Regional Adviser, EPI
Dr. Jon Anders	Medical Officer , EPI, Poliomyelitis
Dr. Tom G. Ortiz	STC/EPI, Polio surveillance
Dr. S. Orapin	Medical Officer Safe Motherhood Initiative
Dr. G. Acciari	Medical Research Officer TDR, HRP, etc.

Major Activities

1. Reproductive Health

There is concern about the high level of maternal mortality in most countries in the region. The rates are relatively lower in Thailand, Sri Lanka and N. Korea. The secretariat has had to deal with angry comments from some countries about the data released by WHO/UNICEF as the revised estimates of the maternal mortality ratios (MMR). Some of the published figures are several times the official figures given by the national governments. The revised data were compiled in Geneva without involvement of nor consultation with the WHO Regional Office nor the Country Offices. SEARO is assisting member states to strengthen their Management Information Services to improve the quality of data on maternal health.

The regional strategy to improve maternal health include the training of traditional birth attendants, the strengthening of emergency obstetric services and the training of doctors and other professionals.

2. Health Research

The Division is responsible for promoting health research involving three main activities:

- Strengthening health research in individual member states;
- Management of the Regional Advisory Committee for Health Research; and
- Support for Medical Research Councils.

National Programmes

Thailand: Recent activities included a meeting aimed at identifying research priorities. The meeting was jointly sponsored by COHRED.

Bangladesh: Attempts to strengthen research capability has met with limited results. Following a variety of workshops and other training activities, there is some evidence of improved quality of research proposals and improved dissemination of research results.

Regional Advisory Committee for Health Research (ACHR)

The ACHR meets annually to consider regional priorities for health research and to organise collaborative programmes. One outstanding project that the ACHR initiated was the development of a vaccine against haemorrhagic fever. The work of Professor Nath of Thailand received support from SEARO in the initial stages. A candidate vaccine, showing promising efficacy is now being scaled up by a pharmaceutical company.

Medical Research Councils (MRC)

Directors of MRC's meet every two years to exchange information and develop collaborative activities.

Bangladesh: From 1993, SEARO has been providing partnership assistance to the Bangladesh Medical Research Council. Short term consultants, sponsored by SEARO, have provided technical assistance to the Medical Research Council.

3. Immunisation

A specific highlight of the immunisation programme was the introduction of National Immunisation Days (NIDs), an initiative aimed at the elimination of poliomyelitis. SEARO staff recall the initiation of the programme in Thailand on 12 August 1994. The involvement of the Queen and other high profile sponsors demonstrated the strong political commitment to the programme. WHO established an interagency co-ordinating group including UNICEF, Rotary international and JICA. The Thai experience provided a useful model for other countries in the region and Thai experts formally assisted Bhutan in developing their NIDs programme.

With WHO guidance, Thailand and other countries in the region are including Hepatitis B vaccine in their routine immunisation programme. The Thais are producing the vaccine locally.

Documents

- A.1. Regional Reproductive Health Strategy for South-East Asia: April 1996
- A.2. Operational Research on Reproductive Health Scientific Working Group: report of First Meeting, New Delhi, 2-4 September 1996
- A.3. A Reproductive Health Approach to Safer Motherhood --SEARO
- A.4. National Programme Managers for Safe Motherhood: Report of Intercountry Workshop 25 February - 3 March 1995

- A.5. Intercountry Consultation on Development of Standards of Midwifery Practice for Safe Motherhood. WHO/SEARO, New Delhi 29 October to 1 November 1996
- A.6. Documents on Training Bangladesh doctors in Nepal on Emergency Obstetric Care 1992-95
- A.7. Memorandum dated 18 October 1996 on "Maternal Mortality Estimation in Thailand 1995"
- A.8. Yearly Report on Immunisation & Vaccine Development in South-East Asia Region, 1996
- A.9. Partnership in the 21st Century: Expanded Programme on Immunisation
- A.10 A Note on Support to Bangladesh and Thailand on Hepatitis B control and Strengthening of Countries' capacity on diagnosis and control of Hepatitis B
- A.11 Vaccine Supply and Quality Situation Analysis, Thailand, 23-29 April 1996
- A.12. SE Asia Advisory Committee on Health Research Reports for 1992, 93, 94, 95 & 96
- A.13. Meetings of Directors of Medical Research Councils Reports for 1992 & 1994
- A.14 Lists of TDR/HRP and Regional Office research grants
- A.15 WHO Collaborating Centre for Research in the Development of Dengue Vaccine and for the Production of Immunological Reagents.
- A.16. Interim Report for Project "Health Economic Research Strengthening" Chulalongkorn University
- A.17 Proposed Collaboration between DTEC, Royal Thai Government and the Special Programme of Research, Development and Research Training in Human Reproduction.
- A.18 Regional Linkage Programme for Research Training in Tropical Diseases
- A.19. Poliomyelitis Eradication by the year 2000 World Health Day 1995

B. Environmental Health

This Division manages the following programmes:

1. Community Water Supplies
2. Urban Environmental Health
3. Health Risks and Environmental Hazards
4. Chemical Safety Programme
5. Health and Environment

Staff present at the meeting

Dr. Abdul Sattar Yoosuf	Chief, Environmental Health
A. Pierre Hirano	Environmental Health Engineer /Promotion of Env. Health

Highlights of the Environmental Health Programme

Bangladesh: Activities include community water supplies and sanitation projects with emphasis on the training of local staff.

Thailand: A "Healthy Cities" project was initiated during the 1996-97 biennium with a vote of \$200,000. Bangkok is the first city in the region to undertake this exercise. The project uses Flinders University in Australia as a resource for training and research. In the first phase, Thai nationals were sent to Flinders. Later, teachers from Flinders will go to Thailand to train Thai teachers. The WHO vote provides fellowships for the study visits. The global programme is co-ordinated from Geneva by Gregg Allston. SEARO managed to get a resolution passed at ESCAP on healthy cities.

The Health and Environment Programme started in 1996. This programme is a follow up of the Rio conference. The programme aims at developing a healthy route to sustainable environment. It will involve the development of a regional strategic plan as well as national plans.

Intersectoral Action: In response to my question, staff gave some examples of how WHO mobilised collaborative effort on environmental issues involving the health and other relevant sectors. (See example from Ghana: Document B7).

Thailand's leadership role: WHO has made use of expertise from Thailand in supporting programmes in neighbouring states. One example was Thailand's experience in hospital waste management.

Documents

- B.1. Regional Strategic Plan for Health and Environment: 1993
- B.2. Building a healthy City: A practitioners Guide
- B.3. WHO Healthy Cities: A Programme Framework
- B.4. ESCAP Resolution Promotion of Environmentally Sound and Healthy Cities
- B.5. Integrating Health Concerns in national Sustainable Development
- B.6. The Healthy Route to a Sustainable World
- B.7. Some Examples of WHO Collaborative Activities outside the Ministry of Health

C. Health Policy and Management (HPM)

Staff present at the meeting

Dr. Than Sein	Director, HPM
Dr. N.T. Cooray	Planning Officer
Dr. M.J. Wysocki	Regional Adviser, Health Statistics and Trends
Mr. S.G. Muktader	External Relations Officer
Mr. Akinori Kama	Inter-Agency Affairs

The HPM division is responsible for the following:

- WHO programme development and management including servicing the governing bodies
- Secretarial support for various meetings: Health Ministers, Health secretaries, WHO Country Representatives with the Regional Director, and the consultative committee on programme management (an internal group aimed at improving management in the Regional Office), senior staff management committee, management working group, country support team (to support WR in programme development, evaluation and review);
- External Co-ordination involving resource mobilisation and liaison with bilateral and multilateral donors and NGO's as well as interagency co-ordination with other UN agencies.
- Preparation of programme budget, annual plan of action and monitoring of WHO programmes at country level;
- National health policy and programmes: this is to assist countries in implementing managerial processes for health development. The major interest now is on health care financing (the post is temporarily filled by short term consultant);
- Health Information programme that aims at strengthening national and regional health information services. The regional health situation analysis is updated every 3 - 4 years but will soon be produced annually and will include trend analysis, evaluative analysis and comments on major issues. In 1998, the emphasis will be on gender differences in health. The health database is accessible to all staff. There is a World Bank project in Bangladesh aimed at improving the health information system. Problems encountered include the duality of the national health system, lack of laboratory services to confirm diagnoses, and the extensive use of lay reporting: the system is rather fragmented. In Thailand, the aim has been to improve the quality of the data, including implementation of ICD10 in hospitals both public and private, training and a Health Futures programme for 2020;
- Advisory committee on programme policy: chaired by the Director of programme management, the committee tries to ensure cross-programme co-ordination in policy development.

Programme Planning Process for the 1998-99 biennium

1996	July/August	Regional allocation is decided
	September	Discussed at Regional Committee
1997	January	Executive Board in Geneva
	May	World Health Assembly

Programme Budget

Because of zero growth of WHO's regular budget in recent years, the regional budgets have been stressed. It has had to accommodate new member states: North Korea, Maldives and Bhutan as well as accommodating inflation and other cost increases. The main effect has been on the budget of the Regional Office including the reduction of inter-country programmes. About 75% of SEARO budget goes to country programmes and 25% used at the Regional Office. Country programmes support inter-country programmes that have been recommended and agreed by the countries themselves. These inter-country programmes involve:

- Advocacy for new initiatives;
- Technical co-operation among developing countries; and
- Standard setting and other normative actions.

Extra-Budgetary Funds (EBFs)

With the possible exception of Thailand, there is no donor country in the region. EBFs are mobilised through Geneva and at the country level:

- EBFs from Headquarters: these are mainly related to items on the global health agenda e.g. leprosy, HIV/AIDS, Nutrition, Sick Child Initiative, Expanded Programme of Immunisation;
- EBFs at country level: through the WHO Country Office, including executing programmes that are funded by other agencies and donors. In some countries, e.g. Bhutan, Burma, some donors prefer to pass grants through WHO for political and technical reasons.

Executing Agency Function

WHO implements programmes funded by UNFPA (off and on) and UNDP. The latter works with NGO's but some countries are resistant to having UN funds channeled through NGO's. Bangladesh represents the largest group of projects implemented by WHO on behalf of the World Bank.

Interactions with Countries

Ministers of Health rarely attend the Regional Committee Meetings: usually represented by technocrats. For this reason, SEARO established a meeting of Health Ministers. It is convened at the invitation of the host minister. WHO provides secretarial and logistic support at a cost of about US\$30-40,000. The meeting functions as a forum and includes exchange of visits.

SEARO also runs a meeting for Secretaries of Health. The February meeting reviews reports from the Executive Board and Regional Committee Meetings. It also attempts to operationalise the meeting of Health Ministers. This initiative has now broadened into a mechanism for more vigorous interaction among the Ministers of Health in the region. The Minister of Health in the host country chairs the meeting and remains the chairperson of the forum until the next formal meeting of the group. In the interval various activities take place including the exchange of visits among the Ministers.

Documents

- C.1. Overview of Programme Development, Implementation and Evaluation of WHO Collaborative Programme in S.E. Asia Region
- C.2. Meetings of Ministers of health: Report of 1994 and 1995 meetings
- C.3. WHO Regional Committee Sept. 1996
- C.4. Programmes under Health Policy and Management WHO/SEARO, Nov. 1996
- C.5. Meeting of the Ad Hoc Working Group on Allocation under the WHO Regular Budget New Delhi 31 Oct. - 1 November, 1995
- C.6. Regional Health Report -1996
- C.7. Fifty Facts from the Regional Health Report -1996
- C.8. Regional Consultation on Health Indicators WHO/SEARO, New Delhi, November 1996
- C.9. Regional Health Situation and Future Scenario

D. Health Services Development

Staff present at the meeting

Dr. George Fernando	Director
Dr. M.N. El-Naggar	Regional Adviser, Primary Health Care
Dr. Rita Thapa	Regional Adviser, Community Health Services/District Health Systems
Dr. Palitha Abeykoon	Regional Adviser, Human Resources for Health and Medical Education
Dr. Sally A. Bisch	Regional Adviser, Nursing/Midwifery Education & Service
Dr. S. Duangvadee	Nursing Officer, Nursing/Midwifery Education & Service
Dr. Sandarsan Kumari	Regional Adviser, Clinical Laboratory, Radiological & Imaging Technology in support of PHC
Dr. M. Otgon	Fellowships
Ms. W.M. Van de Weil	Emergency & Humanitarian Action

This Division is responsible for the following:

- **Primary Health Care (PHC)** - "Objectives of the programme are to promote and support in a co-ordinated way the development of health services based on primary health care in the countries of SEARO. It involves the organisation, planning and the essential elements of PHC for rural and urban districts and provides linkages at the community level with the referral and specialised services for the support and continuity of care, and mobilisation of community and health related sectors for action in health development." Activities include "analysis of the current situation with respect to PHC and advice on alternative strategies towards making the health system and resource utilisation more effective."
- **Community Health Services** - "Objectives of the programme are to promote and support the organisation and the effective operation of comprehensive health systems based on PHC, through community support, also involving health and health related sectors in a responsible and co-ordinated manner." It also places emphasis on strengthening district health systems and urban PHC. It promotes and supports studies on patterns of health care systems, decentralisation of health services, development of human resources for PHC, national research for strengthening health infrastructure including planning, implementation and evaluation of PHC.
- **Human Resources for Health** - the objectives of the programme are to collaborate with member states in the development of human resources policies, to ensure that national plans are balanced, relevant, economical, and realistic, and that education and training programmes are needs-based and of high technical quality. In Thailand, the aim is to further strengthen institutions to support national and international activities. Thai institutions are extensively used for training in the region. For example, Chulalongkorn University ran a workshop on problem based learning. On the other hand, Bangladesh still needs basic inputs. It is being assisted to develop a national Human Resources for Health masterplan. This project involves WHO/Geneva and a group in Montreal and a wide net of partners: World Bank, SIDA, Australian AID, and UK/ODA. UNDP and WHO established

a centre for medical education in 1987. WHO trained 10 persons at the masters level on medical education and these graduates helped to develop proposed revisions of curriculum for training doctors but the proposals have not been fully adopted. UK/ODA is funding two medical schools: Chittagong and Dhaka: to improve teaching. So far, 45 teachers have been trained in Dundee. In support of nursing education, a WHO long term staff is working in the Bangladesh Directorate of Nursing Services. There is an apparent lack of co-ordination between training and deployment: some 5,000 nurses are unemployed and yet many institutions have acute shortages of nursing staff!

The auditor was critical of the fellowship scheme. It has been decided that fellowships will mostly be awarded for study within the region. A corollary of this new policy is the need to increase the capacity of training institutions in the region.

In response to my question, it would appear that SEARO does not regularly monitor the deployment of trainees after the completion of their fellowship; they do not collect data to show what proportion of trainees remain in relevant posts 3 year or so after their fellowship.

- **Clinical Laboratory, Radiological & Imaging Technology in support of PHC** - Activities of this Unit include strengthening of health laboratories in support of PHC through the award of fellowships, group educational activities and the provision of essential supplies. In 1994 it issued a document, SEARO Technical Series No. 24: "Strengthening Health Laboratories in Support of Primary Health Care"; it contains policy guidelines for the establishment and management of health laboratory services, the introduction of appropriate technology, and quality assessment of laboratory procedures. The Unit also co-ordinates the participation of national laboratories in International Quality Assessment Schemes in Clinical Chemistry, Clinical Microbiology, Haematology and Immunochemistry. In collaboration with the Laboratory and Blood Safety Units in WHO/HQ, the Unit supports national policy on Blood Transfusion services, co-ordinated testing for transmissible agents as well as training through distance learning. In collaboration with the Bacterial and Viral Infections Unit of the Division of Communicable Diseases in WHO/HQ, the Unit supports laboratory aspects of microbial infections, the development of appropriate simple and rapid diagnostic methods, and surveillance of antibiotic resistance and hospital infections. It also supports the development of basic radiological systems, and of simplified ultrasound equipment capable of meeting the needs of PHC as part of Basic Imaging Systems. In collaboration with the International Atomic Energy Authority (IAEA), it runs a programme on radiation protection and quality assessment. Other activities include the provision of information on diagnostic test kits, strengthening polio testing laboratories, production and quality control of vaccines, in three WHO Collaborating Centres: Kasauli (India), Bangkok (Thailand) and Jakarta (Indonesia).
- **Emergency Humanitarian Action** - The two aspects of the programme are
 - a) **Emergency Preparedness and Disaster Prevention:** to strengthen the capacity of Member states and promoting their self reliance at national and district levels, and to assist them to mitigate the effects of major emergencies through achieving better levels of readiness to respond to emergency situations; and
 - b) **Humanitarian Action** "to furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of Governments". One

example cited was that WHO was the first international organisation to respond to the disaster caused by floods in North Korea.

Documents

D.1. National Plan of Action for Nursing Development in Bangladesh

D.2. Plan of Operation for National Plan of Action for Nursing Development in Bangladesh

E. Health Promotion and Protection Group

This Division is responsible for the following activities:

- Health promotion including school health, health and behaviour, chronic diseases, care of the elderly and drug abuse, accident prevention, oral health, nutrition and food safety;
- Public Information; and
- Essential Drug Programme.

Personnel

Dr. S. Jadamba	Director	
Dr. H. Sell	Regional Advise	Health and behaviour
Dr. Kim Shein	Regional Adviser	Essential Drugs and vaccines
Dr. Li Bon You	Medical Officer	Non-Communicable Diseases
Mrs. Martha Osei	Regional Adviser	Health Promotion and Health Education

Essential Drug Programme

Both Bangladesh and Thailand have developed national drug policies. WHO continues to support efforts to ensure quality assurance, provision and distribution as well as the rational use of drugs. In Bangladesh, WHO executes a World Bank project for strengthening drug testing laboratory.

Health Education

The national programme in Bangladesh is fragmented. The Health Education Bureau receives no national funds for its activities. WHO concentrates its efforts on capacity building.

Integrated Approach on Control of Non-Communicable Diseases

Following a meeting in October 1995, SEARO is developing a regional strategy to tackle such issues as smoking, and other life style problems.

One contentious project on cancer prevention in Bangladesh was planned to establish a 9 site cancer registry at a running cost of US\$2 million per annum but there was no provision for treatment. This led to a misunderstanding between WHO and some of the other external agencies including the World Bank.

F. Administration and Finance

Staff present at the meeting

R. Spina Helmholtz	Director
V. Fedenev	Regional Personnel Officer
P. MacMillan	Personnel Officer
Y. Younan	Budget and Finance Officer
J. Kobza	Assistant Budget and Finance Officer
A. Kama	Administrative Supplies Officer
H. Stephenson	Medical Supplies Officer

In my discussions with SEARO staff, they indicated that they were aware of administrative and managerial problems affecting WHO programmes at the country level.

Recruitment of Staff

Problems identified included the following:

- Limited search for qualified candidates. There is a tendency to rely on the central roster of potential candidates that is held in Geneva, and data held by regional advisers in selecting new staff members and consultants. The central roster is updated every 2 years but it has not introduced new categories of expertise. It is therefore, not a good source of data for the types of expertise required to tackle the new challenges confronting the organisation. Until recently, posts in field projects were not advertised; but with effect from December 1996, the posts will be advertised.
- Low consultant fees: WHO offers a maximum of US\$120 per day for consultants, considerably lower than UNDP, the World Bank or the private sector.
- Long delays in processing recruitment: some of the delays are outside the control of WHO. Sometimes, it takes 6 to 12 months to obtain national clearance from the Bangladesh government.

Procurement of Supplies

Some effort has been made to identified the causes of delay in processing procurement. In one study, it took some 32 weeks from the request to completion. It was noted that many of the items procured are not specifically medical and thus WHO does not have specific expertise in choosing computers, vehicles and other general equipment. Some of the solutions discussed included:

- Reviewing the role of WHO in providing this service. Should WHO now concentrate on strengthening national capacity in procurement and thereby promote self-reliance rather than continuing to carry out this task?
- Parallel processing. At present, the processing of orders cannot begin until the project funds are available. This means that a good part of the first year of the project is spent in waiting for supplies. Could the processing of orders be carried out in parallel with the project development and negotiation so that as soon as the funds are available, the orders could be placed without further delay?
- Out-sourcing of procurement: Could the task be contracted out to an NGO or some other company?
- Moving the supplies section of WHO from Geneva to a low cost site? For example, a move across the border to France would result in large savings.

G. Control of Infectious Diseases

This division is responsible for programmes for the control of the following diseases:

- Tuberculosis
- Leprosy
- HIV/AIDS
- Malaria and other vector borne diseases
- Other communicable diseases

The division is also involved in promoting disease surveillance.

Highlights of the Programmes

The malaria programme in Bangladesh was constrained by the conflicting policies within the national government. Two years ago, there was a period when no single insecticide was available for malaria control because another ministry had banned the importation of all insecticides! Later, malathion and decamethrin were licensed.

Leprosy control is progressing well in the region and most countries expect to achieve the target of less than 1 case per 10,000.

The tuberculosis control programme is being revitalised by promoting the DOT ("directly observed therapy"). WHO is collaborating with the World Bank and the ODA in promoting this approach. In Bangladesh, this approach is being implemented in collaboration with NGO's e.g. BRAC.

WHO has contributed to important advances in the control of Dengue Haemorrhagic Fever. In Thailand, 30-40,000 cases occur every year with a case fatality rate of 0.2 to 0.3 %. Elsewhere, the case fatality rate is usually 5 to 10 %. The better outcome is attributed to the standard case management that was developed and implemented country wide. The training on Dengue is included in the training programmes of paediatricians. WHO also provides diagnostic reagents for screening febrile patients. WHO will participate in the forthcoming trial of the new vaccine developed by Thai scientists.

Staff Workshop on WHO Programme Development and Management

My visit to SEARO coincided with a staff workshop on Programme Development and Management.

The Terms of Reference of the Workshop were:

1. To review the main principles and components of WHO managerial processes, particularly programme development, budgeting and implementation of WHO collaborative programmes;
2. To acquaint and orient WHO Country Office staff on the guidelines for elaboration of detailed Plans of Action;
3. To orient these staff on programme monitoring, reporting and evaluation systems for improving implementation of WHO collaborative programme at country level; and
4. To discuss fellowships management (including study tours) at country level.

The 18 participants were drawn from the three countries in SEARO. (See Annex 3.)

The presentation and discussions covered such topics as:

- Ninth General Programme of Work
- Joint Government/WHO Coordination Mechanisms
- Review of 6 monthly reporting of WHO collaborating programme
- Country Level Monitoring System
- Guidelines for the preparation of detailed Plans of Action
- Management of Fellowships and Study Tours
- Programme Implementation: administrative issues

The background documents included items that were prepared specifically for this workshop as well as papers that had been used on other occasions. For example, SEARO guidelines for the "Preparation and Processing of Supplies and Equipment Requests" that was published in 1992 was included in the package. Papers presenting country experience were also included e.g. "The Indonesian Experience in in-country Fellowships", prepared by the WHO Representative's Office in Jakarta, Indonesia.

The discussions were lively and frank. Not only were the participants given useful ideas on how to manage their programmes more efficiently but the staff of the Regional Office obtained useful feedback from country staff.

Discussions with the Regional Director

In discussions with the Regional Director, I reviewed some of our findings during the country visits and my interaction with SEARO staff. I expressed particular concern about two specific questions:

1. The role of WHO in Bangladesh: It seems that WHO had been relegated to a minor role of implementing on contract a large number of specific projects on behalf of a consortium of external aid agencies. On the other hand, the World Bank presides over the meetings of the consortium and seems to be the chief adviser to the government on health development. During his recent visit to the country, the Regional Director had met with the Prime Minister and offered WHO's desire to play an even more active role in support of health development. He hoped that acceptance of this offer would lead to an enhanced partnership between the Bangladesh government and WHO.
2. Inter-regional collaboration among countries in the Indo-China peninsula is somewhat constrained by the fact that the subregion involves two WHO regions - SEARO and WPRO. The Regional Director stated that he was conscious of this need and has taken some steps to promote and facilitate inter-regional collaboration. He cited the example of an inter-regional meeting that involved participants from both regions.

Summary and Conclusions

The South East Asia region of the World Health Organisation covers 10 countries and about 25% of the world's population. As in other parts of the developing world, the countries in the region are undergoing transition: epidemiological, demographic, technological, etc. Important determinants of the health situation include poverty, level of education, (specifically, female literacy), and public spending on health. There is much diversity between and within countries as shown for example by the 10 fold difference in the gross national product between the poorest and the richest nations in the region. The epidemiological transition means that many of the countries are currently facing the double challenge of traditional health problems characterised by infectious diseases aggravated by malnutrition and at the same time they have to contend with the emergent diseases, especially the chronic diseases associated with Western lifestyle. WHO has to respond to this wide diversity of needs and changing priorities.

Major Issues

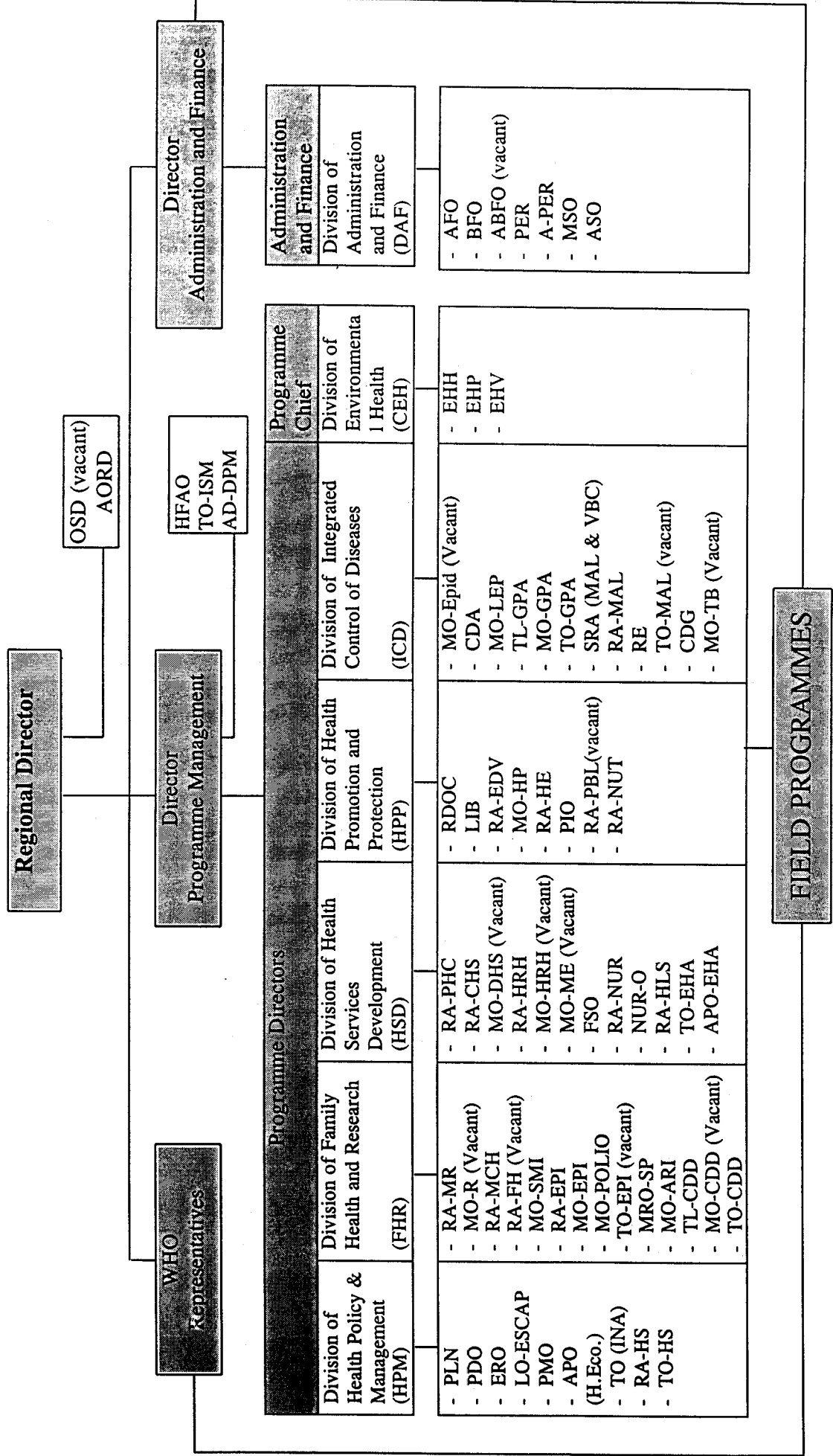
The discussions at SEARO clarified some of the questions that were raised during the country visits to Bangladesh and Thailand but also raised some questions:

- To what extent is the WHO Regional Office able to respond adequately to the wide diversity of needs within the member states?
- In view of declining resources from the regular budget, can SEARO continue to offer the very broad range of services to member states or should there be a deliberate attempt at focusing on a narrower range of activities?
- How can SEARO ensure that its staff and consultants match the changing needs of member states, especially in dealing with the more advanced countries like Thailand that no longer require the traditional inputs in support of basic health services, but need more sophisticated inputs?
- How can WHO ensure that its regional structure does not inhibit cross national collaboration among neighbouring countries that are allocated to different WHO regions?
- With its spartan conditions dictated by pressure to reduce costs, has WHO priced itself out of the market for recruiting short term consultants and long term staff? Since other agencies pay market prices for consultants and provide other perks (e.g. business class travel), should WHO offer reward packages similar to those provided by the World Bank other UN agencies and bilateral donors?

List of Annexes

1. Organogram of WHO/SEARO
2. List of appointments at SEARO for the study
3. List of Participants for the SEARO staff workshop on Programme Development and Management
4. SEARO: Major milestones in the preparation of the Programme Budget

ORGANOGRAM OF WHO/SEARO



WORLD HEALTH ORGANIZATION

REGIONAL OFFICE FOR
SOUTH-EAST ASIA

16 December 1996

SCHEDULE OF APPOINTMENTS WITH OSLO GROUP***WEDNESDAY, 18 December 1996 (Room No. 220)**

- 0900 - 1030 Dr S. P. Tripathy, Director, Family Health & Research
(along with FHR Group).
- 1030 - 1200 Dr A. Sattar Yoosuf, Chief, Environmental Health (along
with CEH Group)

TUESDAY, 19 December 1996 (Committee Room)

- 0900 - 1200 Dr Than Sein, Director, Health Policy & Management (along
with HPM Group)
- 1300 - 1430 Dr George Fernando, Director, Health Services Development
(along with HSD Group)
- 1430 - 1500 Dr Uton Muchtar Rafei, Regional Director - in RD's Office
- 1500 - 1630 Dr Z. Jadamba, Director, Health Promotion & Protection
(along with HPP Group)

FRIDAY, 20 December 1996 (Committee Room)

- 0900 - 1200 Mr R. Spina Helmholtz, Director, Administration & Finance
(along with DAF Group)
- 1400 - 1600 Dr M.V.H. Gunaratne, Ag. Director, Integrated Control of
Diseases (along with ICD Group)
- 1600 - 1700 Wrap-up meeting with Dr George Fernando, Acting Director,
Programme Management (along with all PDs/CEH/DAF)

*Prof Adetokunbo Lucas and Prof Patrick Vaughan

cc: PDs/CEH/DAF/DPMO/RDO



ORIENTATION WORKSHOP ON WHO PROGRAMME DEVELOPMENT AND MANAGEMENT. SEARO, NEW DELHI, 16-18 DECEMBER 1996

List of Participants

Bangladesh:	Dr Lokk Wai, WHO Management Officer
Bhutan:	Mr N. Wangehuk, National Programme Officer Mr Wangehuk, Dorji, Assistant II
DPR Korea:	Mr Jong Bong Ju, National Programme Officer
India:	Mr Manmohan Singh, Special Assistant Mr Pradeep Diwan, Finance Assistant Mr K. K. Khatar, Programme Assistant
Indonesia:	Mr J. W. Sikkens, Administrative Officer
Maldives:	Dr Stephen Jost, Technical Officer
Myanmar:	Dr Lin Aung, National Programme Officer Ms Julie Nay Winn, Administrative Assistant
Nepal:	Dr Harry Feirman, Technical Officer Ms Patricia Brice, Administrative and Programme Officer Mr Arun K. Pradhan, Clerk II
Sri Lanka:	Dr A.S. Abdullah, Medical Officer Mr Nandana de Silva, National Programme Officer
Thailand:	Mr R. B. Kalina, Administrative Officer Dr Somchai Peerapakorn, National Programme Officer
Resource Persons:	Mr R. Spina Helmholtz, Director, Administration and Finance

WHO Secretariat

Dr Than Sein, Director, Health Policy and Management,
 Dr N. T. Cooray, Planning Officer,
 Dr M. Khalilullah, Programme Development Officer,
 Dr M. Otgon, Fellowships Officer, Mr Y. Younan, Budget and Finance Officer,
 Mr S. Vedanarayanan, Administrative Officer to Director, Programme Management,
 Dr N. A. Doraiswami, Special Assistant, Programme Coordination Unit,
 Mrs Radha Swaminathan, Programme Assistant, Programme Coordination Unit,
 Mr Gulshan Malhotra, Secretary to Programme Development Officer,
 Mr Yogesh Kapoor, Clerical Assistant, Programme Coordination Unit

Observers

Mr V. K. Malhotra, Administrative Assistant, ICD,
 Mr K. L. Gera, Administrative Assistant, FHR, Mr M. R. Kanagarajan, Assistant, DPMO
 Mr J.S. Narula, Administrative Assistant, HPP,
 Mr K. D. Banota, Administrative Assistant, CEH

SEARO: Major milestones in the preparation of the Programme Budget

Budget year minus 3	
Mid-July	Receive procedural guidelines.
August-October	Briefing and guidance provided to the countries through WHO country offices (WHOCOs). Preparation of draft country and inter-country programme budget proposals.
September	Submission to the RC of the process and mechanism as outlined in the procedural guidelines.
November	Review of the country PB documents at the meeting of the RD with the WRs.
November - December	Revision and submission of Country and Inter-country programme budget (PB) proposals.
Budget year minus 2	
January-March	Preparation of the Proposed Regional PB incorporating contributions from country as well as inter-country. Regional PB is classified into the appropriate programme areas according to the approved Classified List of Programmes (CLPs).
April	Submission of Regional Draft PB to HQ for the preparation of the global PB proposal Final discussion and revision during the meeting of the CCPDM in which WRs also participate.
May-June	Finalisation and transmission of the Proposed PB document to HQ.
September	Endorsement by the Regional Committee, after detailed analysis by the Sub-Committee on PB of the RC.
October - November	Final review and contribution to the global Programme Budget.
Budget Year Minus 1	
January	Review of the global Programme Budget by the Executive Board.
January - February	Transmission of the regional contributions, based on the Executive Board Decisions and Resolutions.
May	Review and endorsement by the World Health Assembly.
June	Issuance of guidelines for the preparation of the Annual Detailed Plan of Action. (DPoA)
July- September	Formulation of Annual DPoAs at country and inter-country levels
November	Review and endorsement of DPoA at the meeting of RD with WRs.
November-	Revision of DPoAs, if required.
December	Government endorsement of approved DPoAs.