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WHO Country Cooperation Strategy Bhutan

CCS Core Team:

WR Office: Dr Orapin Singhadej (WR) and Mr Norbu Wangchuk

Regional Team Member (SEARO): Dr Sattar Yoosuf (SDE)

HQ Team Members: Dr André Prost (EGB/GPR) and
Ms Heather Christian (EGB/GPR)

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Table of Contents

	Pages
Introduction and Executive Summary.....	3
Part One: Situation Analysis.....	4
Section 1: Government and People: Health and Development Challenges.....	4
Section 2: Development Assistance.....	9
Section 3: WHO Current Country Programme.....	10
Part Two: Strategy Formulation.....	14
Section 4: WHO Corporate Policy Framework: Global and Regional Directions.....	14
Section 5: WHO's Strategic Agenda for Bhutan: Next Five Years (2003-2007).....	15
Section 6: Implementing the Strategic Agenda: Implications for WHO.....	21
Conclusion.....	22
Information Sources.....	23
Table 2: Cooperation Matrix for CCS.....	25

Introduction and Executive Summary

This WHO Country Cooperation Strategy (CCS) outlines the strategic framework for the WHO's work in Bhutan for the period end 2002 - end 2007.

The CCS is an attempt to articulate a coherent vision and selective priorities for collaboration between WHO and Bhutan. It is based on a systematic assessment of recent national achievements in health care, the current and emerging health needs and development challenges; the policies and expectations of the Government; and the activities of other development partners.

While a clear aim is to ensure greater responsiveness to country needs, the CCS also reflects WHO's own values, principles and corporate and regional strategies. Important elements include WHO's intention to be more selective in its range of activities and to foster strategic thinking and putting greater emphasis on its role as policy and technical adviser.

With the launch of the 9th Five-Year Plan, Bhutan is entering a phase of decentralization which parallels the political changes towards democratic representation at all levels. These changes will have profound implications for the health sector in terms of management, of upgrading competencies and quality of services, and of meeting the demand of the population for care while maintaining a strong preventive framework. WHO is engaged in rethinking its strategy and reviewing its operations to better support the Government's reform.

A first mission in 2000 had initiated the dialogue with the Ministry of Health and laid the basis for a revision of cooperative programmes. The beginning of the implementation of the 9th Plan, postponed to January 2003, is a particular opportune moment for WHO to adjust its strategy.

Part One: Situation Analysis

Section 1: Government and People: Health and Development Challenges

Development history and visions for the future

At the end of the 19th century, Bhutan was facing increasing internal and external political instability, creating the need for a source of strong national leadership. The establishment of the monarchy with the enthronement of the first King in 1907, not only unified the country under a central authority restoring stability, but also laid the foundations for a modern nation state. During the reigns of the second and third Kings, Bhutan continued to move towards modernization through various social, economic and political reforms. Bhutan formally embarked on the road to modernization in the early 1960's with a planned development process, which introduced the "Five Year Plans". Bhutan also became a part of the international community in 1971 when it joined the United Nations and is now considering joining the World Trade Organization. Bhutan has made enormous progress in its overall development, particularly over the last three decades.

The current King, His Majesty Jigme Singye Wangchuck (1974 – present), remains committed to pursuing a development policy and philosophy that balances economic gains with the spiritual, cultural, and social needs of Bhutan's citizens. For the last two decades, the principle objective of Bhutan's development efforts has been to maximize "Gross National Happiness" versus "Gross National Product", i.e. all development efforts must contribute to both the material and spiritual well-being of the people. The four major pillars of Gross National Happiness are: economic growth and development; preservation and promotion of cultural heritage; preservation and sustainable use of the environment; and good governance.

These four pillars are reflected in the objectives of the 9th Five-Year Plan (2002-2007), an ambitious development plan which strives to go beyond the aims of the previous eight Five-Year Plans. The most important result of the first three Five-Year Plans was the establishment of a road network within Bhutan and one that connected with India.

A turning point in Bhutan's economic development came with the 5th Five-Year Plan (1981-1987), which especially focused on economic self-reliance, e.g. such as promoting hydropower, mining and industry. Since then, Bhutan has aimed to conserve and promote its national identity, develop human resources, and decentralize governance. The 8th Five-Year Plan (1997-2002) focused on public provision of basic social services, particularly with an emphasis on further decentralization. The 9th Five Year Plan reflects the continued progress of the decentralization process, as it is based on the needs of local governments and gives them substantial autonomy and independence to execute development plans and activities¹. In addition to decentralization, the plan's strategic focus is on rural infrastructure, quality of health and education services, and private sector development.

Box 1	
Five-Year Plans	Allocation for Health
1. 1962-1967	2.9%
2. 1967-1972	8.3%
3. 1972-1977	8.0%
4. 1977-1982	4.9%
5. 1982-1987	5.1%
6. 1987-1992	4.2%
7. 1992-1997	6.7%
8. 1997-2002	10%
9. 2002-2007	6.4%

Source: *Partnership for Health – 15 Years of WHO Collaboration with the Royal Government of Bhutan*, WHO/SEARO, January 2000

¹ ADB, *Country Strategy and Program Update (2003-2005)*, July 2002

Economic outlook

Bhutan's economy has grown steadily for the past few years, with GDP rising from 6.5% in 1997/98 to 7.3% by 2001/2002. The main driving force behind this economic growth has been the construction of three major hydropower plants. With the planned commissioning of several mega-hydroelectric plants during the 9th Five Year Plan, it is anticipated that electric power will not only bring more domestic revenue, but also help boost growth in the industry sector itself. It is projected that GDP will grow by 7-9% annually under the 9th Five-Year Plan, mainly as a result of the production and sale of hydropower. However, it has been noted that primary reliance on the electricity sector increases the vulnerability of the economy and its growth. Despite good medium-term growth prospects, there remain internal and external risks that could arise, which would slow down economic progress. Given the heavy dependence on external financing to Bhutan's development plans, the flow of resources must be maintained. Any reduction could slow the overall implementation of the plan. Bhutan's close link with India has helped it avoid the direct impact of the global economic downturn, however, if India's fiscal situation worsens, hydropower projects could be delayed.² It will also be important that new jobs be created for the rapidly growing number of educated youth.

Health profile

Until the early 1960's, Bhutan had no organized health care system, with much of the infrastructure development only taking place as of the early 1980's.³ By mid-2002 at the end of the 8th Five Year Plan, 90% of the population⁴ was covered by basic health care services through a network of 4 regional hospitals, 28 district hospitals, 160 basic health units, 447 outreach clinics and over 1000 village health workers.⁵ The National Referral Hospital in Thimphu serves the entire country and is linked with the district hospitals. Traditional medicine, which was introduced in the 17th century in Bhutan, is an important part of the general health care system with an institute of traditional medicine, one indigenous hospital and 17 indigenous dispensaries which are attached to district hospitals. Both allopathic and traditional health care are provided from the same hospital in the districts and there is often inter-referral of patients between the two systems. All traditional medicines and remedies are produced centrally in Thimphu and distributed to the districts. General health care services and essential medicines are provided free of cost.

Reviews conducted in 1984, 1994 and 2000 revealed good progress in the health sector since the start of the planned development four decades ago⁶. The maternal mortality ratio has decreased from 770 per 100,000 live births in 1984 to 255 in 2000. The infant mortality rate has also dropped from 102.9 per 1,000 live births to 60.5 during the same period. The population growth rate of 3.1%, which is a concern for the government, has also dropped to 2.5% by 2000 through intensified reproductive health education and increased access to contraceptives. Given Bhutan's mountainous landscape, access to trained birth attendants remains low (10.9 % in 1994), but has been improving in recent years (23.6% in 2000),

² ADB, *Country Strategy and Program Update (2003-2005)*, July 2002

³ *Partnership for Health – 15 Years of WHO Collaboration with the Royal Government of Bhutan*, WHO/SEARO, January 2000

⁴ Current national population estimate is 680,000.

⁵ *National Health Surveys, 1984, 1994 & 2000*, Department of Health, Research and Epidemiology *Annual Health Bulletin, 1989-2002*, Department of Health Services

⁶ *National Health Surveys, 1984, 1994 & 2000*, Department of Health, Research and Epidemiology

thereby lowering the delivery risks. There have also been significant achievements in the control of communicable diseases.

Major achievements in the control of communicable diseases:

1. Efforts continue to maintain immunization coverage above 80% for vaccine preventable diseases. The sub-National Immunization Days occur twice a year to reach the “un-reached” to achieve polio eradication by 2005. Although there has not been a case of polio reported since 1986, focused surveillance continues for acute flaccid paralysis (AFP).
2. The cure rate for tuberculosis is 90% and the case fatality rate has declined steadily in the last couple of years from 48.8 per 1000 cases in 1995 to 45.6 in 2001. The DOTS strategy has been used since 1997 and standard reporting and recording systems for patients are in place, although there are still cases of double recording or patients lost to follow up.
3. For malaria, capacity for control has been increased with the strengthening of the programme and the establishment of an entomological unit. Efforts are bearing fruit as there has been a steady decline in cases. Since all the malaria districts are a mere expansion of the malaria districts in India bordering Bhutan, control activities continue in coordination with the Indian programme.
4. Bhutan had established a programme on STDs/AIDS before the first HIV/AIDS case in the country in 1993. As Bhutan shares a porous border with India and is connected with Myanmar, Thailand and Nepal by air, it will most likely not be spared from the regional AIDS pandemic. Although 80% of the population has knowledge about the dangers of HIV/AIDS, social and sexual behaviour continues to put them at risk for STDs and HIV/AIDS. Taking into account the small number of detected HIV cases (38 to date), there has been almost 100% increase in cases between 2001 and 2002.
5. Leprosy is currently under control with a prevalence rate of 0.61 per 10,000. The programme had been managed with the support of the Leprosy Mission (UK) and the Santhal Mission (Norway) using a vertical approach until 1998-99. Although this programme has now been incorporated into the general health service system, efforts still need to be made to ensure that the right amount of resources and attention are dedicated to the leprosy problem so as to continue to keep it under control and reach elimination.
6. Acute respiratory infections in winter and diarrhoeal diseases in summer still top the list for infant/child morbidity. This is usually attributed to poor living conditions in the rural communities, indoor air pollution, dry air in the winter, and poor quality of drinking water and sanitation in the summer. The programmes on Integrated Management of Childhood Illnesses, Nutrition, and Water Supply and Sanitation have been working to improve the situation, but more work is required to coordinate their efforts to achieve greater gains for child health.

As progress continues to be made in controlling communicable diseases, non-communicable diseases are emerging as a threat to health. With changing life-styles, Bhutan is also experiencing a double-burden of disease with rheumatic heart disease, diabetes and cancer on the increase. Preliminary surveys reveal that the mental health situation is not much different from any other country. Presently, most cancer cases are referred outside the country which currently drains a large proportion of the health budget. While the battle will continue against

HIV/AIDs, TB, malaria, etc. , the problem of emerging non-communicable diseases will require the strengthening of surveillance systems, developing and following strategies for prevention and control of non-communicable diseases, and expanding the capacity of tertiary care facilities.

Health sector development: progress made and current challenges

The Royal Government of Bhutan gives great importance to the social sectors, especially education and health. The allocation for the health and education sectors varied between 10 to 13% of the total development budget for the 8th Five-Year Plan, with the health sector expecting to receive 6.4% during the current Five-Year Plan (see Box 1). As approximately 60% of the health budget comes from external assistance and with a view towards long term sustainability of financing for drugs and vaccines, the Ministry of Health established in 1997 a Health Trust Fund based on the positive experience the Government had with the creation of the Environment Trust Fund (see Section 2). Private practice has not been introduced in the country and this policy will be continued, particularly given the limited number of medical doctors and physicians qualified in traditional medicine (109 and 31 as of 2002 respectively).

Not only has the Government aimed to ensure adequate resources for the health system, it has also aimed to ensure that the continued development of the health system is in line with the needs of the country. As such and in following the overall long-term objective of the Ministry of Health, “attaining a healthy living standard by the people living within the broader framework of the overall development of the country”, there has been a shift from the “expansion of services”, which had been the emphasis up to the 8th Five-Year Plan, to the “quality of services”. Decisions have been taken and strategies developed to reach the unreached through the decentralization of planning and management systems as well as of operations and logistics, and the strengthening of management information systems. This will require establishing standards at the various levels of health care, guidelines for case management and for operating health facilities, and a reliable supply system. This will also require emphasis on creating a system of continuing education in order to meet human resource needs.

While the Ministry of Health will place significant focus on the quality of services provided by the health system, it will also continue to intensify the prevention and control of prevailing health problems and to tackle emerging and re-emerging diseases. Other objectives, some of which have been carried over from previous Five-Year Plans are: intensifying reproductive health services and sustaining population planning activities; promoting community-based rehabilitation and mental health services, particularly, finding innovative means to enhance the mental well-being of people; and maintaining a balance between primary, secondary, and tertiary health care. (See Section 5)

Challenges

Much progress has been made in health since the 1st Five-Year Plan. To achieve the objectives for the 9th Five-Year Plan, the Ministry of Health has to overcome a host of challenges.

1. Insufficient resources for human resources for health:

To strengthen the overall health service and to decentralize management and services, sufficient human resources are required at all levels within the health system. Thus far, the government has been able to train only about 3-5 medical doctors per year, which barely meets the attrition rate. The situation has improved in recent years with more students pursuing medical studies in neighboring countries as Bhutan does not have its own medical school. The number of specialists are even less. As the training of paramedics can be carried out within the country, the situation is much better in this area. Given the shortage of medical doctors, it is the paramedics who provide a majority of the general health services, and who manage the primary health care system, including most of the public health programmes in the Department of Health Services. Recently more college graduates are being conducted into the Health Department and further trained in different paramedical specialities.

As the Government's own funds are limited, the Ministry of Health primarily relies on collaborating partners to develop human resources for health. However, many collaborating partners exclude commitments for basic medical training. Thus, unless the gap in this key component in human resources development is filled, health programmes will continue to lack sufficient human resources.

2. Harsh geography and scattered population:

Bhutan is situated in one of the world's most rugged and mountainous regions with scattered and remote settlements and many parts of the country being inaccessible. This makes delivery of health and other social services extremely difficult. Coupled with the scarcity of qualified manpower at the district and regional levels, this poses a great challenge to efforts in curbing morbidity and mortality. In order to overcome these challenges, the Government with support from WHO has initiated a telemedicine/health telematics programme, linking one of the two Regional Referral Hospitals to the National Referral Hospital, enabling the Regional Hospital to consult the specialists about their patients. The telemedicine/health telematics facilities are also being used by the hospital staff to access important health literature via the web. An expansion to all district hospitals is urgently required.

3. Dependency on imports for all health supplies:

Bhutan imports 100% of its health supplies such as medical equipment, essential drugs and vaccines. Although the quality of drugs and vaccines can be assured by purchasing them from WHO authenticated suppliers in the region, hospital equipment and other supplies are another problem. The long time taken to procure equipment or spare parts and consumables (like reagents and x-ray films) continues to hinder daily work at the hospitals.

4. Political disturbances:

Bhutan has not been spared from political disturbances in the region. Ethnic Bodo and Ulfa militants in north-east India who are fighting for independence have taken unauthorized refuge in the forests in southern Bhutan. This situation has made providing services in these districts very difficult. If the negotiations between the Government and the two groups fail, military action may ensue.

Section 2: Development Assistance: Policies, Coordination, Aid Flows and Mechanisms

Bhutan has adopted a balanced approach to development, seeking to achieve its development goals without creating social alienation or excessive economic inequality. “Gross National Happiness” is the defining principle of Bhutan’s development efforts to achieve not only economic progress, but also spiritual well-being. Development policies are outlined in a myriad of documents, e.g. Bhutan 2020, the 9th Five-Year Plan (2002-2007) as well as previous Five-Year Plans, the Human Resources Development Plan, and the Annual Country Plans.

Bhutan differs from most other aid-dependent countries in that the government has a very strong sense of vision and development priorities and determines on this basis where technical and financial assistance is most needed, and which donors can best provide it. The Government is very proactive in managing donor assistance, fitting aid into a well-defined framework instead of allowing donors to drive its development programs. Assistance efforts are well managed to avoid duplication, with each donor active in a preferred area of assistance. Bhutan’s development practices are consistent with the World Bank’s Comprehensive Development Framework (CDF). As of yet, a Poverty Reduction Strategy Paper (PRSP) has not been drafted.

Bhutan encourages close liaison between donors, which is facilitated by limiting the number of donors, both overall and within each sector. This framework has resulted in partnerships with relatively small donors, with the exception of India, which has remained Bhutan’s largest development partner over the past 40 years. Other important partners include: Austria, Denmark, Germany, Japan, Netherlands, Norway, Switzerland, the Asian Development Bank, the European Commission, and other UN agencies (UNDP, UNICEF, UNFPA and the World Bank).⁷

In terms of aid-coordination, one of the important coordination mechanisms is the donor Round Table Meetings (RTM), organized and chaired by the government, UNDP and the World Bank. The 8th RTM will be in February 2003 in Geneva, Switzerland. It will cover poverty, decentralization and the 9th Five-Year Plan, including resource gaps. The last meeting was in November 2000 in Thimphu, Bhutan. In addition to these meetings, there are also sector-by-sector aid coordination meetings held among resident donors⁸ in Thimphu, with the participation of non-resident donors when possible. Health sector donors informally meet about every month to discuss ongoing efforts to avoid duplication. The UNDAF process was completed in August 2001 and the initial draft is currently under revision. The Common Country Assessment was completed in 2000 and updated in early 2001. The government has also taken on other initiatives to further strengthen aid coordination, such as the creation of a Department of Aid and Debt Management to specifically manage all external resources.

Bhutan is heavily reliant on foreign external assistance, mainly in the form of grant aid. This situation is expected to continue over the medium term and to steadily improve in the longer term as the large hydropower projects are completed. In 2000, recorded donor disbursements

⁷ *Memorandum of the President of the IDA to the Executive Directors on a Country Assistance Strategy of the IDA for Bhutan*, Bhutan Country Unit, South Asia Region, February 20, 2000

⁸ UN Agencies represented in Bhutan are: FAO, UNDP, UNICEF, UNFPA, UNV, UNESCO, UNV, WHO and WFP. DANIDA has an office in Thimphu and the Netherlands opened an honorary consulate in November 2002.

totalled \$98.54 million, of which approximately 13% (\$13 million) were loans.⁹ Health, including population and reproductive health, received total disbursements of \$16.2 million. Health is the third largest sector behind energy conservation and supply, and government and civil society. Of the UN agencies with programs in Bhutan, UNICEF has the largest assistance program, with UNDP and WHO following. Denmark is the most important bilateral donor to the health sector and has been supporting health activities since 1990. Planned Danish support for the 8th Five-Year Plan for health was to be approximately DKK 90 million¹⁰. As of 2002, Denmark is providing direct budget support to the Ministry of Health and Education. Other bilateral donors for health activities include Australia, Germany, India, Japan, and Norway. External assistance is primarily from bilateral and multilateral donors as there are no international non-governmental organizations active in Bhutan.

As part of an effort to move toward self-reliance and financial sustainability, particularly in the health sector, a Health Trust Fund was initiated in 1997 and officially chartered in 2000. It is similar to the Bhutan Trust Fund for Environmental Conservation that had been set up in the early 1990s. The primary objective of the Health Trust Fund is to enhance accessibility and quality to primary health care by ensuring the continued availability of vaccines and essential drugs. With an endowment target of \$24 million, the Fund is expected to generate enough interest to cover annual expenditures for vaccines, essential drugs and other consumerables. The Fund is maintained in U.S. dollars and the assets invested to maximize interest earned. As of November 2002, the Fund had reached \$18 million with contributions from the Bill & Melinda Gates Foundation, Summit Foundation, Norway and New Zealand as well as the Government's one-to-one matching contribution.

Section 3: WHO Current Country Programme

Although Bhutan officially joined WHO on 8 March 1982, its cooperation with WHO extends back further. For example in 1979, Bhutan adopted the Declaration of Alma Ata as its core focus in the development of modern health services.¹¹ From the very beginning, cooperation between Bhutan and WHO has been based on mutual confidence and a close working relationship. Bhutan has always relied upon WHO for technical guidance in developing its programmes.

Bhutan has an excellent performance record on programme implementation. During the biennia 1998-1999 and 2000-2001, WHO planned activities have been implemented on time, and Bhutan has benefited from re-allocations within the regional country programme (up to 1.1 million in 1998-1999, a 65% increase of operating budget for the biennium). WHO resources for Bhutan come exclusively from the SEARO regular country budget, inter-country programmes and regional reallocations during a biennium. Access to extrabudgetary contributions is almost non-existent, with small amounts transferred from Headquarters for essential drugs in both 1998-1999 and 2000-2001 and even a smaller contribution for control and surveillance of communicable diseases in 2000-2001.

⁹ *Development Cooperation: Bhutan Joint Donor Database Report 2000*, UNDP, October 2001

¹⁰ *Country Strategy for Bhutan*, DANIDA, 1997

¹¹ *Partnership for Health – 15 Years of WHO Collaboration with the Royal Government of Bhutan*, WHO/SEARO, January 2000

Table 1

Structure of Programme Expenditures for Bhutan (US \$)		
Programme Areas	1998-1999	2000-2001
Research	57,076	0
Health Information	75,752	79,039
Telemedicine	0	69,677
Health Planning and Management	162,700	93,760
Health Systems	240,519	721,318
Human Resources	586,550	
Essential Drugs	228,118	209,678 (Essential Drugs)
Quality Assurance	63,586	
Traditional Medicine	38,304	
Blood Safety	0	34,108
Vaccines + Polio	154,806	128,550
Reproductive Health	51,797	29,000
HIV/AIDS	44,066	24,152
Child Health	26,424	42,444
Mental Health	48,630	20,218
Rehabilitation	80,369	10,477
Health Promotion	91,669	66,775
Surveillance/Control NCDs	104,612	46,632
Nutrition	36,896	49,821
Emergencies	0	26,022
Water & Sanitation	405,466*	133,917
Tuberculosis	37,267	117,288 (Communicable Diseases)
Malaria	143,941	
Surveillance/Control Communicable Diseases (+Leprosy)	35,178	
	2,713,726	1,902,876

* In 1998, the government transferred rural water supply from the Ministry of Communication to the Ministry of Health and Education, resulting in a shift in WHO assistance in this area.

Source: WHO ACT/00.1 and ACT/02.1

The structure of the current cooperation programme reflects the priorities of the country and was developed in coordination with the Planning Unit of the Ministry of Health (Table 1). However, over the years, and with successive additions, WHO's contribution to a large number of activities gives a picture of a piecemeal programme. Human Resources Development absorbs about 30% of total expenditures, followed by health systems strengthening (25% - health planning & management and health information – telemedicine), essential drugs programme (10%), and vaccines and control of communicable diseases (10%). The remaining 20-25% of the budget is spread over a number of programmes, each of which receives a small amount of funding that can be considered either as seed money or as a necessary input to retain technical ownership recommended by the Ministry of Health when other donors are involved.

Key Programme Areas

Human Resources for Health:

Given the lack of human resources and its effect on all health programmes and services in Bhutan, WHO has dedicated about one third of its country budget for developing national capacity in the last two biennia. Of this allocation, about 35% is spent on training paramedical workers, including nurses at the Royal Institute of Health Sciences, another 35% on fellowships for undergraduate medical training outside of the country, and the remaining 30% on speciality training for existing doctors and other health specialists.

WHO continues to assist in improving the training at the Royal Institute of Health Sciences by revising the teaching curricula and by encouraging the Institute's affiliation with La-Trobe University in Australia to develop a post-training programme in nursing. WHO also supports training programmes particularly in the area of disease control and management by introducing health workers and students to new approaches like the DOTS strategy, Healthy Districts and IMCI concepts, etc.

Disease Control:

Technical support continues to be provided for immunization and control of communicable diseases like malaria, STD/AIDS, and leprosy. Over the past biennia, WHO was involved in identifying new insecticides for vector control to replace DDT. Other strategies for environmental management of vectors were also put into place. Studies were supported for carrying out the problem of drug resistance in malaria control. WHO is the sole contributor to the malaria programme, which is implemented in close collaboration with the Indian programme along the India/Bhutan border. For HIV/AIDS, WHO was the primary adviser in developing the country's first control programme. WHO has also supported conducting of KABP studies on sexual practices so as to assess the risk of HIV/AIDS. Jointly with UNICEF and using Japanese financed vaccines and supplies, WHO has continued to support the immunization programme. During the current biennium, the EPI programme has been assessed together with the cold chain system. The old cold-chain refrigerators are now being systematically phased out and replaced by CFC-free refrigerators along with training for EPI technicians in this respect as well as in the use of vaccine vial monitors.

Health Promotion:

The main thrust of the programme has been on reproductive health, particularly sexually transmitted diseases as well as child health, nutrition, and water supply and sanitation. Advocacy campaigns also include mental health and substance abuse. WHO provided some of the advocacy materials and formats for the campaigns. An impact assessment of the advocacy campaigns was conducted during the early part of 2002 by DANIDA, with the results not yet finalized.

Sustainable development and environment:

With the transfer of the water supply and sanitation programme from the Public Works Department to the Health Department in 1998/1999, support has been provided since then to strengthen the overall aspects of the programme, especially with regard to related health education. Water quality guidelines have been provided to the government so that it can

develop its own standards in water quality. Support has also been provided to improve the capacity to test water quality. In addition, training was given to paramedical staff on nutrition issues, and the foundation for a food safety programme has been laid in collaboration with agriculture and veterinary services.

Health systems strengthening:

The Planning Unit of the Health Ministry has been strengthened through staff training in health economics, planning, etc. Much effort has been placed on introducing the International Classification of Diseases in order to streamline the reporting system. WHO has also supported the review of reporting systems to simplify reporting forms and to include new areas of information as relevant. To improve the referral system, WHO supported the introduction of solar-powered radio links between basic health units and district hospitals, which now forms an extension of the telemedicine project into communities. Internet links have been introduced between the National Referral Hospital and two district hospitals as part of the telemedicine project, facilitating patient referrals and consultations. The hospitals also use the internet links to access reference materials electronically.

Health technologies:

With UNFPA and UNICEF, WHO continued to collaborate on reproductive health issues. WHO provides technical and financial support for in-country training of mid-level managers in reproductive health and making pregnancy safer. Medical officers are being training to deal with obstetric-gynaecological problems in the district hospitals.

In the area of essential drugs, WHO has been instrumental in revising and updating the national drug formulary and promoting rational use of drugs. It has provided guidance on quality control of drugs, policy development, and on regulation and legislation of essential drugs. At the pharmaceutical unit of the National Institute of Traditional Medicine, support has focused on improving quality control and promoting Good Manufacturing Practices (GMP).

Improvement of laboratories is a component of several programmes like HIV/AIDS, Water Supply and Sanitation, etc. Reagents and consumables continue to be provided to ensure safe blood transfusion.

Coordinating activities with UN and other collaborating partners:

The number of UN agencies active in Bhutan is limited. In addition, the UNDAF process is still in a preparatory phase and a PRSP strategy has been not developed. The government has decided that the WFP should withdraw from the health sector. Thus, coordination is especially active with UNICEF, UNFPA and UNAIDS, which are the main UN agencies involved in the health department. WHO is an active participant in the theme groups on nutrition, HIV/AIDS and reproductive health.

Part Two: Strategy Formulation

Section 4: WHO Corporate Policy Framework: Global and Regional Directions

The objective of the WHO/Bhutan Cooperation Strategy is to translate into action the WHO Corporate Strategy adopted by the Governing Bodies and the Regional directions established by the Regional Committee with respect to Bhutan's specific needs and priorities set out in its 9th Five-Year Plan. At the same time the Country Cooperation Strategy draws upon the guidelines for reform of WHO's work at country level.

The mandate given to WHO for international action within the framework of the Corporate Strategy is four-fold:

1. Building healthy communities by emphasizing healthy life-styles and reducing risk factors to human health;
2. Reducing excess mortality, morbidity and disability by combating ill-health through addressing not only communicable diseases but also the growing problems of non-communicable and chronic diseases especially in poor and marginalized populations;
3. Developing health systems that equitably improve health outcomes, respond to people's legitimate demands, and are financially fair; and
4. Improving working relationship with other actors in the health sector, especially UN agencies, development banks, and development agencies, to promote an effective health dimension to social, economic, environmental and development policy.

The regional emphasis is primarily on the reduction of disease burden through implementing programmes on major communicable diseases like TB, leprosy, malaria and HIV/AIDS; reducing risk factors to health through greater focus on NCD surveillance, addressing violence, disability prevention, and targeted health promotion to vulnerable and marginalized populations; improving the quality of health services by making it more responsive and equitable to population health needs; and integrating health into sustainable development through advocacy and local area initiatives such as the settings approach.

The increasing reliance of WHO on voluntary contributions has made it necessary to focus more on cooperative actions which maximize health outcomes and to develop performance assessment and accountability at country level. Action in the health sector should be guided by an overall development perspective and contribute to the reduction of poverty and attainment of the Millennium Development Goals set up by the United Nations General Assembly. Although daily activities will be implemented by each of the WHO technical programmes with measurable impact, the overall objective is the sustainability of progress within the context of sustainable development, which was re-emphasized at the September 2002 UN Conference on Sustainable Development (WSSD) in Johannesburg.

Therefore, the WHO/Bhutan Country Cooperation Strategy is based on an assessment of country needs and of an evaluation on how best can WHO help Bhutan meet its development objectives expressed in the 9th Five Year Plan of 2002-2007. It draws a framework to make further progress in improving the health situation, within which inputs from multilateral and bilateral programmes of other agencies are duly taken into account under the overall coordination of the Ministry of Health. The purpose of the Cooperation Strategy is not to develop in Bhutan the whole range of WHO technical programmes. It is to determine which

programmes can best contribute in the medium term to the attainment of Bhutan's development objectives, given the limited resources of WHO.

Based on the Strategy, specific and time-limited action plans should be developed and propose targeted activities which can attract additional financing, beyond the allocations of WHO's regular budget, out of which all programmes have thus far been financed.

Section 5: Strategic Agenda for Bhutan: Next Five Years (2003-2007)

WHO's Mission in Bhutan

WHO's mission in Bhutan is to collaborate with the Government and other concerned parties in improving the health of the population by supporting health promoting policies, sustainable development of health services, and the development and support to programmes aimed at reducing the burden of disease, and by contributing to the reduction of risk factors.

Justification for the WHO Strategic Agenda of Work

In dealing with the variety of partners, who contribute to the development of the health sector, the government of Bhutan assigns two major functions to WHO based on its comparative advantage.

First, it relies on WHO to develop policies and strategies and to help ensure that activities remain technically sound and retain the necessary coherence. The expressed wish that WHO retain technical ownership of programme development is reflected in the desire that such programme activities remain part of the overall cooperative program, even though minimal appropriations are allocated from the WHO country budget and the bulk of financing is received from other partners.

Second, the Ministry of Health emphasizes continuity as a comparative advantage of WHO as a partner. Contributions from other agencies to the health sector are either one-time inputs, or based on time-limited agreements, with a view to generate visible impact in the short term. The objective of the strategic agenda is to agree on a five-year framework that guarantees a reasonable degree of continuity in pursuing Bhutan's health development goals.

Four priorities expressed by the Ministry of Health are:

1. *Human resources development (paramedical training, undergraduate medical training, and specialized training)* - Paramedical training is completed at the Royal Institute of Health Sciences in Thimphu; curricula have to be constantly adapted and the level of studies upgraded. Undergraduate medical students are trained outside the country in the region (Myanmar, Bangladesh, India) with an enrolment rate that currently only matches the attrition rate. WHO is the only supporter of undergraduate medical training, as it requires long term commitment that other partners cannot accommodate. Specialized training is aimed at meeting the most urgent needs in specialties such as public health and epidemiology.
2. *Decentralization* - The government has engaged in a decentralization policy, largely to bring appropriate services closer to the communities in a country with a scattered population in remote areas and to reduce the constraints resulting from long distances and

poor communication. This policy calls for a coherent development of health facilities at the peripheral and regional levels and for modern tools such as telemedicine and information technologies.

3. *Double burden of disease* - Whereas communicable diseases are still a problem, non-communicable and chronic diseases are surfacing. Urgent concerns are rheumatic heart disease, diabetes, hypertension and cervical cancer. There is a need to screen the population at risk, to develop secondary prevention and more gradually to tackle the risks for non-communicable disease.
4. *Balance between primary and tertiary care* - The demand for advanced care is increasing and the need to reduce the financial burden of patient referrals outside the country is becoming urgent. One third of the Bhutan's medical workforce is absorbed by the National Referral Hospital in the capital. The sustainability of the policy of delivering health care free of charge is at risk as costs continue to increase, particularly as more and more tertiary care patients are referred outside Bhutan. Both World Bank and the Asian Development Bank are assisting with the identification of sustainable strategies, such as user-fees and other cost recovery mechanisms, with marginal input from WHO at this point.

The principles/criteria used for prioritizing support actions were:

- Country needs and challenges
- Fit with WHO's strategic directions and core functions
- Potential for partnership with others
- Fit with WHO's comparative advantage
- Potential for generating ownership

These were assessed as to the fit with WHO functions at country level:

- supporting routine long-term implementation;
- catalyzing adoption and adaptation of technical strategies, seeding large-scale implementation;
- supporting research and development, monitoring health sector performance; and
- information and knowledge sharing, providing generic policy options, standards, advocacy providing specific policy advice, serving as broker, influencing policy, action, and spending.

WHO Strategic Agenda for Country Cooperation

The strategic focus of WHO's work in support of health development in Bhutan in the next five years is derived from the policies and priorities enunciated in the 9th Five-Year Plan. The main strategic policy direction change from the 8th to the 9th Plan has been the categorical shift from capital intensive infrastructure development to system capacity building. This is to be met through creating enabling systems and promoting further decentralization. As such and given the needs of the health system, the case is made for improvements in human resources development, health systems capacity development, and a greater focus individual responsibility for one's health through a process of district level empowerment.

The specific health objectives set out for the 9th Plan, to which WHO could make a contribution, are:

- Enhancing the quality of health services
- Targeting health services to reach the unreached
- Enhancing self-reliance and sustainability of health services
- Strengthening health management information systems and research and their use
- Developing appropriate secondary and tertiary health care services, while maintaining the balance between primary, secondary and tertiary health care
- Intensifying the prevention and control of prevailing health problems and the emerging and re-emerging ones.

In addition to the 9th Five-Year Plan, the “Bhutan 2020: A Vision for Peace, Prosperity and Happiness”, a 20 year perspective of development vision for the country, outlines several critical priorities with implications for national health development:

- Extension of primary health care services to reach even the most remote populations
- Further improvements in the quality of health care (PHC, disease control, specialized institutions)
- New or strengthened programs for special groups (disabled, elderly, mentally ill)
- Continue provision of traditional medicine in health care facilities;
- Greater attention to multi-sectoral issues;
- Address sustainability of the free health care provision (health trust fund, selective user fees, etc);
- Continued priority on training of health personnel; and
- Use of new technologies (e.g. telemedicine).

The CCS process

The first CCS mission was in February 2000. In developing a preliminary Country Cooperation Strategy document, the WHO team from SEARO had intensive consultations with the Ministry of Health and several other related ministries, UN agencies, and bilateral donors. The second mission was undertaken in November 2002 with a team from the Country Office, SEARO, and Headquarters. In-depth follow-up discussions were held in order to develop the framework for the strategic areas of work for WHO support to Bhutan over the next five years in relation to the 9th Five-Year Plan. The WHO team participated in a thorough dialogue with various staff in the health department to identify new challenges and to further clarify the overall objectives of the CCS and its implications for planning, resource use, and management of the WHO/Bhutan collaborative program. The process was facilitated by the active participation of two staff from the Ministry of Health’s Planning Department.

Implications

The Country Cooperation Strategy (CCS) is intended to provide a strategic framework for the development of the detailed plans of action for WHO/Bhutan cooperation for the next two biennia, which will be based on additional consultations between the WHO and the Government. It is intended that the Strategy will facilitate the overall planning process as the planning group will not have to spend too much time on the situational assessments. The priorities identified in the Strategy will focus collaborative efforts in specific areas. It was

agreed that having identified priorities does not preclude the addition of other areas or a shift in programming as necessary. For example, it may be justified to spread some of the WHO regular budget funds to other areas if used for the purpose of WHO providing up-front or upstream support that can catalyze another development partner into action. Having a detailed plan of action for WHO/Bhutan Cooperation based on a strategic framework will also allow for better program management for the WHO Country Office. The CCS will also provide government officials greater clarity on the WHO/Bhutan cooperation process, in the context of the elements of the WHO Corporate Strategy, has been provided in Section 4 of this document.

Major areas for action

Based on the priorities expressed by the Minister of Health and his senior assistants, keeping in mind the overall framework of the 9th Five-Year Plan, and in direct relation to the WHO corporate strategy, the CCS team proposes that the cooperation programme with Bhutan over the next five years focuses on five areas and related objectives (Table 2):

1. *Human resources development at all levels*: paramedical, medical undergraduate, public health specialization
2. *Health system strengthening*, with special attention to the decentralization of management and decision-making being undertaken by the government
3. *Reducing risks to health* and promoting healthy lifestyles
4. *Reducing the burden of disease*, with a move to integrating surveillance and control of chronic and non-communicable diseases while continuing WHO's traditional support to major epidemic diseases
5. *Promoting health environments for sustainable development*.

Human Resource Development: To strengthen the capacity of the health system to diagnose, prevent, treat, control, and manage the prevalent diseases (communicable and non-communicable disease) in the community.

This need was expressed by the Ministry of Health as its highest priority. The needs are both in quality and quantity. Decentralization requires setting up at various levels standard teams with increased competence. These teams will require appropriate support, both technical and logistical. In addition, poor communication makes it necessary to upgrade district health centers to regional referral hospitals to meet the demand of people who are often isolated. In the meantime, primary health care services, which have successfully achieved a reasonable coverage of the population with quality services, have to be maintained and further developed. Doctors and specialists are in very short supply (109 nationals and 23 foreigners) with the number of new graduates, which barely meets the attrition rate (10% per year). There has been no increase in numbers for the past 10 years. A specific request is made to WHO to give consideration to undergraduate medical training, which is completed outside the country and which other partners refuse to support because of the resulting long term commitment of funds. This would imply that WHO makes special concessions in its policy of priority to public health specialized training.

The specific demands are: on the policy front for technical advice on the review of the human resources master plan; on technical assistance in the training of paramedical personnel with adjustment of the curricula of the Royal Institute of Health Sciences and upgrading the level of competence to bachelor degree; on support to undergraduate medical training, mainly at

Myanmar and Bangladesh universities; on support to specialized public health training (health planning, health economics, epidemiology, management, etc.); and on the provision of technology to HINARI for accessing information and related training of staff. **The CCS mission proposes that the demands on training be met through future collaborative programmes, within a maximum limit of one-third of the total amount of each programme, and with a guarantee that undergraduate medical training does not absorb more than 30% of the overall training allocation.**

Health System Strengthening: To continue the development of health systems in an environment of constant change, including economic development and local autonomy in a decentralized administrative system.

Over 60% of health sector funding is currently coming from donors and technical agencies. Bhutan is looking for ways to reduce the reliance on external aid while continuing to support and build health care coverage for the entire population, especially the most vulnerable. An innovative mechanism to address long term sustainability of financing certain health system costs has been the establishment of the Health Trust Fund with an endowment goal of US\$24 million, from which interest earned will be used to cover the recurrent costs for essential drugs and vaccines. Instituting user-fees is another approach the Government, in partnership with the Asian Development Bank, is cautiously exploring.

Health system strengthening is also being approached by improving service delivery through better procedures and standardizing delivery methods; strengthening clinical and referral support; and mobilizing community ownership. With regards to health policy, specific input by WHO will be to assist in integrating the government's overall decentralization policy into health sector policies. As for technical support, WHO will work with the Ministry of Health in promoting healthy settings in districts and communities; improving health services at the peripheral level; developing ICT for Health; providing access to drugs through their rational use; and promoting safe motherhood. Support towards greater effectiveness of programme management would be through developing national standards and procedures for health care.

Reducing Risks to Health: To address risk factors for health through strong attention to promoting healthy lifestyles and the emerging concerns of non-communicable diseases (NCDs).

With the changing economic status of the population, diseases related to behaviour and lifestyle, such as diabetes and hypertension, are becoming more of a public health issue. With increased development and virtually full coverage of primary health care in Bhutan, NCDs are beginning to become a larger economic burden. The lack of health infrastructure and staff capacity to treat many NCDs means that patients are referred outside of the country for treatment at a large cost to the health system. The true burden of many NCDs is not known due to the weak health information system in this area. NCD surveillance and control needs strengthening. Risk factors will be addressed through vigilant health promotion programmes in the areas of tobacco and alcohol abuse, reproductive health, and sexual behaviour. Technical support from WHO will also be sought also on screening risk groups for NCDs such as cancer, diabetes, hypertension and other cardiovascular diseases. Cervical cancer is a special concern in Bhutan. On the policy and advocacy front, WHO will promote the idea of healthy promoting schools.

Reducing the Burden of Disease: To capitalize on progress made in communicable diseases to integrate surveillance and control of a new range of health conditions, including non-communicable diseases.

WHO has traditionally been the main support for the malaria programme, especially as a border issue, and for the leprosy programme. Malaria, TB and STD/HIV/AIDS have been identified as priority areas for continued WHO technical support due to their potential threat to health and economic development and their disproportionate impact on the poor. Current problem areas such as measles, influenza and pneumonia also should be addressed. To tackle these diseases requires not just cost-effective technologies, but also sustained efforts and effective systems which bring together and mobilize the resources of several diverse players - in the public and private sectors, and within and beyond the health system. WHO is well placed to initiate and develop partnerships at global and national level with bilateral and multilateral sources. Specific important areas for WHO support include establishing surveillance systems to capture disease burden information with respect to both communicable and non-communicable diseases, introducing health promotion/education activities, and reducing cross-border disease transmissions (e.g. malaria and HIV/AIDS). Crucial in relation to the fight against HIV/AIDS, prevention and blood safety are also related priorities. Integrated health promotion across all health areas is needed, and the IMCI approach will be continued to address children's health concerns in an integrated way.

Healthy Environments for Sustainable Development: To promote health through improving the environmental quality of settings where people live, work and play.

One focus of the 9th Five-Year Plan is decentralization and promoting capacity at local levels. As such, health concerns in sustainable development take on increased relevance as a priority focus of WHO support. The move towards the devolution of political and financial authority to the Dzong (district) and Gyog (block) levels calls for both administrative and technical capacity enhancements at these levels. Although Bhutan has improved the coverage of water and sanitation (70% for water and 80% for sanitation), aspects of further expansion, repair and maintenance, etc. necessitate engaging local ownership for sustainability. Furthermore, as Bhutan moves ahead in economic development, the related issues of urbanization, solid waste management, air and water pollution, chemical safety, occupational safety, and food safety loom large as potential health concerns that need serious attention. The heavy reliance on the use of bio-mass for cooking in rural communities contributes to indoor air pollution that has serious bearing on the incidence of acute respiratory infections (ARI), especially in children. WHO support will focus on advocacy for healthy environments through developing concepts and models of practice for implementing healthy settings (districts, village, markets, schools etc). WHO technical input will support implementing programmes on healthy districts (such as Bhutan's Community Health Development programs), drinking water quality, sanitation, indoor air pollution, hospital waste management, food safety, and occupational health. As actions relating to mitigation of environmental concerns imply multi-sectoral engagement, this area of WHO support will be executed through forging productive programme linkages with other government sectors and other development partners in Bhutan (UNICEF, UNDP, UNFPA, Ministry of Environment, Agriculture, Communication, etc.).

In all these areas, the supportive functions of management, quality assurance, health promotion, and research would be mainstreamed in the preparation of the biennial detailed plans of action for Bhutan based on this CCS.

Section 6: Implementing the Strategic Agenda: Implications for WHO

It has been clear to the CCS mission members that the WHO Office in Bhutan is playing a strategic function. Not only is WHO involved in the development of key programmes, but the Ministry of Health values its technical expertise, relies on its policy advice, and desires that it remains active in all programmes, irrespective of their specific funding by WHO, i.e. WHO retains “technical ownership” as expressed by the Minister of Health.

In order to transfer the CCS into a proper plan of action, to ensure its effective implementation, and to monitor and evaluate the impact of country collaboration with WHO, a number of key changes are to be made.

- *Strengthening of human resources* – The first and foremost priority is to review the staffing of the Country Office to reflect the CCS agenda. It is not possible to anticipate a balanced development of cooperation as long as the WR lacks adequate programmatic staff support. The National Programme officers should continue being trained and introduced to WHO mechanisms and to public health programmes. There is an additional need for a P4 international staff member who could work on programme matters and who could be the daily counterpart of the Ministry of Health staff, both in planning and implementing activities. The required skills are of a general public health specialist/epidemiologist.
- *Planning* – WHO and the Ministry of Health will be able to use the CCS to prioritize areas for allocating funds, whatever the source. WHO functioning as a development partner will change its operations from being supply-driven to demand-led. Within the architecture of the CCS, which proposes five directions, workplans should be limited in number, focusing on key priority areas during the period concerned.
- *Evaluation* – A key function to be worked out together with the various departments of the Ministry of Health is to set up a proper evaluation mechanism with proper progress indicators to be determined in the plan of action and subsequently monitored. A justified evidence base for action, used in the development of the plans of action, will result in the identification and monitoring of specific indicators.
- *Management* – A number of proposals have to be considered, among which a rapid implementation of the Activity Management System (AMS) with assistance from SEARO, in order to ensure monitoring on an ongoing basis; an extension of the GPN connectivity to Bhutan (data, voice, video) in 2003 as proposed by SEARO to EXD/GMG in November 2002; and a better linkage between the Country Office and the Planning Unit of the Ministry of Health, using similar formats and guidelines for both planning and evaluation.

Conclusion

The strategic agenda builds upon the actual strength of the country and its excellent record on programme implementation. Developing further the dialogue with the departments of the Ministry of Health and developing a sound monitoring and evaluation system requires as a priority a review of the staffing of the WHO Office and the recruitment of additional staff with competencies in public health.

WHO's role as the long term supporter of training of health professionals, including undergraduate medical training, is fully justified as well as the traditional function of being the main provider of assistance for malaria, leprosy and TB control.

Proposed reorientation includes a stronger involvement in supporting: the reform of the health sector, especially on managerial issues; greater attention to environmental issues in relation to health, ranging from water quality to indoor air pollution; a progressive shift from vertically oriented programmes such as malaria and AIDS towards surveillance of a large range of pathological conditions; and a greater focus on the emerging burden of non-communicable diseases.

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Table 2. – Cooperation Matrix for CCS

Priority areas for WHO Support	Policy and advocacy	Information and research	Technical support	Partnerships/collaboration beyond the MOH	Norms and standards	Tools/guidelines/technologies
1. Human resources development	Advise on the review of Human Resources Master Plan for Health.		<ul style="list-style-type: none"> Support human resources training: paramedical, undergraduate and specialized medical/public health (based on Human Resources Master Plan) Assist in the upgrading of the Royal Institute of Health Sciences curriculum for a bachelor degree program 			Access to HINARI and related training
2. Health systems strengthening	Assist decentralization process		<ul style="list-style-type: none"> Promote healthy settings in districts and communities, focusing on decentralization process Improve services at peripheral level Develop ICT for health (ICTH) Provide access to drugs/rational use of drugs Promote safe motherhood 	<ul style="list-style-type: none"> Safe motherhood (UNFPA) Support the Health Trust Fund 	Managerial process for setting standards for health care	
3. Reducing risks to health	Implement health promoting schools	Screening risk groups for NCDs, (RHD, hypertension, diabetes, cervical cancer)	<ul style="list-style-type: none"> Health promotion for tobacco/alcohol, reproductive health and sexual behavior 			
4. Reducing burden of disease		Surveillance of CD and NCD	<ul style="list-style-type: none"> Vaccines Child health issues Major diseases –malaria, TB, HIV/AIDS IMCI 	Facilitate relations with GFATM and GAVI	Setting blood safety standards	
5. Healthy environments for sustainable development	Develop concepts of healthy environments		<ul style="list-style-type: none"> Water, sanitation Indoor air-pollution Hospital waste Healthy settings Occupational health Food safety 	Ministries of Environment, Agriculture, and Communication; UNDP, UNFPA and UNICEF	Develop quality control systems for food and alcohol production facilities	