

HEALTH CARE PLANNING IN SELECTED DEVELOPING COUNTRIES

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ABSTRACT

Background: Health planning in developing countries differs from developed countries. They have more limited resources for health development. Therefore efficient health planning and resource allocation is critical to ensure optimal health outcome of the nation. Due to the nature of heterogeneity among the developing countries, the health approach may differ contextually among developing countries. This paper aims to compare practices of health planning development among selected developing countries.

Materials and Methods: This review encompasses relevant scientific articles and most recent official country report related to health planning. Searches only include articles or reports published in English. Based on the six WHO regions. Selection of countries based on availability of manuscript (article and report) fulfilling the criteria. The countries selected were Bangladesh, Belize, Jordan, Kenya, Malaysia and Turkey.

Result: A five or ten years of strategic plan for health is the most practiced among the studied developing country. It usually involves multi-sectorial within the country and international agencies and consultants. The advancement of technology helps in improving the administrative data utilisation to allow informed-decision making, deeper root cause analysis and timely monitoring and evaluation. Other than that, engagement with various stakeholders from different level – at all phase of plan development, together with political will is the key factor of the successful implementation. Despite that, these developing countries often suffer from limited resources in term of workforce, financing and technical expertise.

Conclusion: Although the health planning process is similar across countries studies, where the cycles start with situational analysis, prioritisation, options appraisal, implementation, monitoring and lastly evaluation. Each country may have slightly different approaches, depending on their context, resources and technology capacity.

Keywords: health care, planning, planning framework, developing countries

1.0 Introduction

Health planning is defined as a systematic process of defining health problem, identifying gaps (unmet needs) and how to address the issues, establishing realistic and feasible priority goals, and projecting action to accomplish the purpose of proposed programme (Hogarth, 1975; WHO, 2010). Planning involved a set of decisions that results from an agreement or consensus among relevant partners on the identified health issues addressed and on the approaches or strategies to deal with them, aimed at achieving defined goals for improving health (Micovic, 1984; WHO, 1994; Collins et al., 2002). Health care planning in developing countries differ from that in more highly developed countries because of the greater scarcity of resources manpower and facilities and the differences in population structure, and the different disease patterns.

1.1 Health planning framework

There are several model approaches used in health planning, which are rationalism, incremental and mix-scanning model approach (Green, 2007). Basically, rational model approach is the ideal where it involves rational decision to be made after undertaking a comprehensive analysis of all possible alternatives and consequences. However this approach requires deep understanding of the issues and enormous data to support the decision making. It also known as comprehensive approach. Whereas the incremental model approach is focusing more on improvement of existing plan or policies. This approaches is less complex and more realistic. The intermediate approach between the two is the mix-scanning approach where it generally combines rational-comprehensive with the realism of the incremental approach. Different from rationalism, mix-scanning approaches may consider or evaluates fewer options with some previous existing policies for basis.

Successful planning must combine strong technical skills with recognition of the political will, clear understanding of the desired end of planning through a systematic approach in all phase during the process. Figure 1 represents a cyclical set of activities in a planning process, which also known as a planning spiral, with the end-point of each cycle forming the start of the next cycle, depending on any gaps or areas of concern that need further analysis or newly identified.

First step in the planning spiral is conduct a situational analysis of the whole of the health sector, by assessing the present situation such as; assessing at the physical (infrastructure), socio economic characteristic organisational arrangements, policy and political environment and examine the resources needed for the services provision. Second step is the priority-setting where identified health problems then assigned a priority depending on current context of available resources, focusing on more pressing issues. Next step is the option appraisal where it involves generation and assessment of identified alternatives to achieve the target, after considering the resource implications, acceptability, and technical feasibility in order to come out with a list of preferred strategies or combination of approach to carry out the plan.

Programming and budgeting is the fourth step, is an appraisal of past resource allocation of related programmes that could help decision makers to optimise resources for the new plan. Fifth step is the essential part of the health planning where it transform the written strategies and programmes into a set off tasks and activities that can be monitored. This step is called implementation and monitoring. Final step in the spiral is the evaluation. Reflection upon the current process will provides the gaps or areas of concern for the further refinement of current existing plan or also could provide basis for the next situational analysis. Using the planning spiral could ensure that any past mistakes made or any weakness identified were taken into consideration for future planning and decision making.

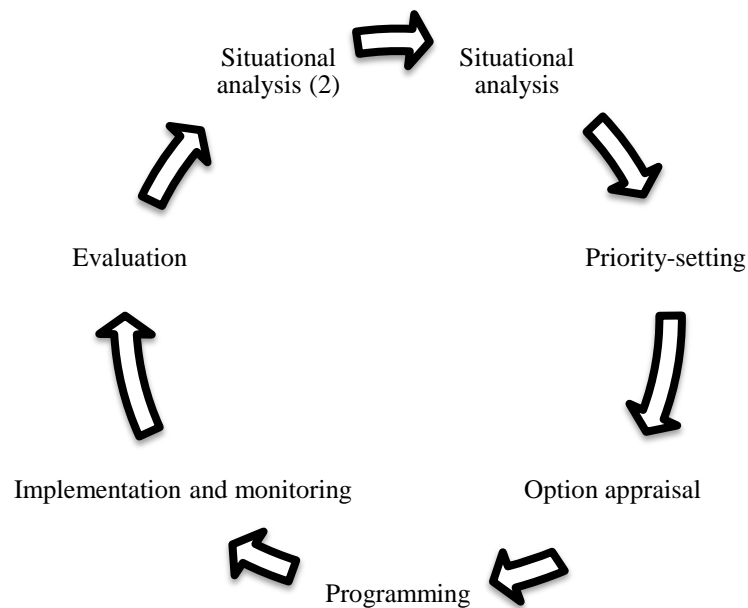


Figure 1: The Planning Spiral of health care planning
(Sources: Green, Andrew, (1992) an introduction to health planning in developing countries. 2nd Edition book)

Although the health planners may use different model in the planning but actually the component of the model is the same but it describe in deferent way or different name, all the steps go could be simplified as three phases: (1) plan formulation; (2) implementation; and (3) evaluation (Green, 2007). Plan formulation covers from step one to step four, it need enormous efforts of gathering the data, it usually starts with situational analysis, problem identification, assessing risk and benefit on the issue to be addressed, judging alternatives and prioritisation, assess requirements and allocation of resources, and to decides which among the alternatives evaluated. This phase often involves technocrats (technical working group), bureaucrats (administrators and managers) and politicians, but donors (WHO, UNICEF), and interest group from inside or outside government (e.g., non-government organisation, community leaders) also sometimes involved (NPHP, 2000).

Once the plan is firmed, the programs shall be self-sufficient during the implementation, followed by close monitoring of the progress and practicality of the plan during implementation. Finally monitoring and evaluation phase, which is the appraisal for the plan and this stage provides the basis for the next situational analysis and then continue the next planning cycle.

1.2 Health planning in developing countries

In World Bank reports, the term “developing country” is defined as middle-income economies, which categorised by gross national income (GNI) calculated using World Bank Atlas method (WHO, 2001). Health planning in developing countries differs from developed countries because developing countries have lower income per capita therefore they have greater limitations on the resources (in term of both manpower and facilities), different population structures and disease patterns, and those countries also commonly associated higher burden of disease (Green, 2007; Nambiar et al., 2007; Gish, 1970; WHO, 1967). Limited resources to provide the majority of population with essential health services of health services. The developing countries also may not be able to put health development as their top priority, equally to economic and social development as their national goal (Ergör & Öztekin, 2000). This also reflected by the amount that the annual government spend on health per capita. It is reported the amount spent in developing countries is less than 10 USD in average, compared to developed countries that they spent about 800 USD on health care for per capita annually (Green, 2007).

Developing countries also generally had lower government spending on health, which may affect the availability of number of hospital bed and affordability of adequate supplies of essential life-saving drugs (Nambiar et al., 2007; Gish, 1970). Workforce shortage, imbalance distribution and emigration of skilled workers to richer countries also have been an issue, especially in African countries (Nambiar et al., 2007; Fitzhugh, 2007).

Low community participation also indicated by the under-utilised community-based intervention (Costello & Osrin, 2005; Costello et al., 2004), and some people may opt to seek traditional health before accepting modern medicine services (Cohen et al., 2007). But this also possibly due to difficulty of educating an illiterate population in health matters and limited communication between regions or between social groups (WHO, 1967). Health problems in these countries were also linked with poverty (WHO, 2003). Approaches in reduction of morbidity and mortality is focused more by improving the delivery system – more efficient of distribution of health services, rather than focusing on utilising further technological advances in medical science (Green, 2007).

Among developing countries, there were quite heterogeneity among them. Some developing countries may have higher GNI and had similar characteristic as developed country, while some may had otherwise. Therefore the health planning approach may differ contextually among developing countries. This paper aim to discuss and to compare practices of health policy and health planning practices among these developing countries.

2.0 Materials and Methods

Based on the World Health Organization (WHO), the countries were grouped into 6 WHO regions: African Region, Region of the Americas, South-East Asia Region, European Region, Eastern Mediterranean Region, and Western Pacific Region. For each region, one developing countries has been selected for the review based on availability of materials (manuscripts and report) fulfilling review criteria.. The term “developing countries” were defined by World Bank, as of 2017 which is categorized as middle income country. Reviews were made based on the most recent available official country report that have information related to “health planning”, “planning framework”, “health policy development”, “national health plan” or other words with similar meaning. However the review only include articles or reports published in English. This paper reviews on how the health planning development process, strength, weakness (limitation) as well as lesson learned from the country in implementing their health related initiatives or policy.

3.0 Results and Discussion

Countries included in this review are Kenya (African Region), Belize (Region of the Americas), Bangladesh (South-East Asia Region), Turkey (European Region), Jordan (Eastern Mediterranean Region) and Malaysia (Western Pacific Region). Based on World Bank’s definition, Kenya and Bangladesh are classified into lower middle income countries whereas for the rest (Belize, Turkey, Jordan and Malaysia) are upper middle income countries. The findings will be discussed on the health planning process based on the six step in the planning spiral.

Kenya is WHO African Region state member, located in east Africa. It borders the Indian Ocean to the east, Somalia to the northeast, Ethiopia to the north, Sudan to the northwest, Uganda to the west and Tanzania to the south. Kenya health sector plan is guided by the Kenya Vision 2030 document (MOH Kenya, 2013), aiming to “transform Kenya into a globally competitive and prosperous country with a high quality of life by 2030”. The theme for the strategic plan called ‘accelerating attainment of Universal Health Coverage (UHC)’, focusing on medium term goals such as improving numbers of available services, scale up coverage of required services, and reduce financial implications of accessing and using health services.

Belize is a state member of WHO Region of Americas. Located in Central America, it has a culturally diverse population. This paper mainly refers to Ministry of Health (MOH) Belize’s health sector strategic plan 2014-2024 report (MOH Belize, 2014). The Commission on Social Determinants of Health Conceptual (CSDH, 2008) framework is the platform used in the development of Belize’s Health Sector Strategic Plan (HSSP). Belize’s health plan was developed under the direction of the MOH in collaboration with other social partners, stakeholders, international agencies (e.g., United Nations, Pan American Health Organisation), Non-government organisations (NGO) and the private sector.

The goal for the health plan closely follows WHO health system building blocks, with slight variations reflecting the unique priorities and context of Belize, where a “systems thinking” approach adopted for the plan’s development.

Although Bangladesh located in south of Asia, it falls under WHO Western Pacific Region. The reviews was based on Bangladesh Health Systems Review report (WHO, 2015). The health sector plan is an integral part of the national five-year plan. The Planning Commission is the central agency, which is responsible for preparing the framework of the plan. The Ministry of Health and Family Welfare (MOHFW) provides key input to the commission, to develop guidelines describing the broad sectorial goals, targets and strategies. Four key actors that involved in the health planning are government, private sector, NGOs and donor agencies. In policy formation donor agencies do have some influence, particularly in agenda setting. Externally generated issues have ultimately shaped the health policy of Bangladesh, although political parties play the most important role in setting the policy agenda (Osman, 2004).

As a state member of the European Region, Turkey has adopt the new European policy framework – Health 2020 for strategic orientations and priority areas for action which guided the revision of Turkey’s 5-year cycle strategic plan (Johansen, 2015; WHO Regional Office for Europe, 2012; MOH Turkey, 1990). Recently, Turkey undergone Health Transformation Program to achieve UHC, aiming equal access to health services for the citizens as individuals with equal rights (Bump et al., 2014; Akdağ, 2009). Although it did not mention it explicitly in the Turkey’s strategic planning document, the planning process is closely resembled mix-scanning approach (Johansen, 2015). Turkey has made collaboration with World Bank (for funding) and also getting technical support from WHO experts in developing and evaluating their health policies before being official. It recognised the concept of multi-sectorial policy development and public participation from various ministries, political parties, medical associations, universities, private sector and non-governmental organizations.

Jordan is a state member of the WHO Eastern Mediterranean Region. The Higher Health Council of Jordan developed the National Health of Health Sector for 2015-2019 with the cooperation of WHO (High Health Council Kingdom of Jordan, 2016). The national strategy is developed to represent the general framework for developing and strengthening capacity of the health system in Jordan. The strategy is based on the core structure adopted by WHO for health system.

Malaysia is WHO Western Pacific region state member. Malaysia’s health plan is a five year plan, firstly implemented in 1966 and has been evolving, where more systematic approach to monitoring and evaluating the plans, the use of translation of policy-to-practice approach and strategic planning approach was introduced gradually along the way till current health plan: Country Health Plan under 10th Malaysia Plan 2011-2015 (MOH, 2011). According to the document, Malaysia’s health planning adopted the mixed scanning planning approaches. The process has evolved from a vertical approach which is purely top-down pragmatic approach into a mixed top-down, bottom-up process that is rational and evidence based.

3.1 Situational analysis

The first critical step in health planning is the situational analysis. This involves the analysis of current available data, information and any relevant studies that related to health such as: (1) demographic situation, (2) overall population health status, (3) investment made in health, (4) service delivery (5) social and economic situation, and (6) outcomes from the previous policy implementation, previous strategic and operational plan. Policies are then developed to

solve specific problem identified. Some countries (such as Belize, Kenya and Turkey) had actively done international collaboration or getting technical support from WHO from their region or international consultant. Global health goal such as Universal Health Coverage (UHC) has growing popular among the studied countries, as their national health plan's goal

3.2 Priority Setting

Limited resources such as funding, or technical expertise is common in developing countries. Therefore, health planners requires to set priorities for all the identified problems in order to determine which area needs attention urgently. Ministry of Health (in Bangladesh it is called Ministry of Health and Family Welfare) plays central role in coordinating the priority settings related to health issues, usually is a joint effort between multi sectorial and ministries. Some country such as Belize and Turkey involves academic institution, while some countries such as Jordan and Malaysia even form a specific technical working group (TWG) committee to discuss and make consensus on more specific issues. Inter-agencies for example donor agencies also might have some influence in giving the input to the agenda setting.

3.3 Option appraisal

Series of discussions among TWGs, health planners and key stakeholders often take place in the option appraisal. Some country like Kenya carry out systematic reviews on priority health topics identified (MOH Kenya, 2013). Various identified alternatives and strategies were assessed with focusing on improving the populations' quality of life with realisation of fundamental human rights to health as well as contribution to economic development. This also hugely influenced by available budget and time to implement it. Based on the group's' deliberation, several outcomes and strategies were consolidated and proposed as outcomes, strategies and key performance indexes (KPIs) for the MOH.

3.4 Programming and Budgeting

The planning process through a participatory process involving all stakeholders in health including government ministries, departments and agencies; clients, counties, constitutional bodies, development partners (multilateral and bilateral) and implementing partners (faith-based, private sector, and civil society). Health planning in the six studied countries focusing on ensuring equity, people centeredness and involves multi-sectorial approach such as political parties, medical associations, universities, private sector and non-governmental organizations (NGOs) to harness and synergise health services delivery at all levels and engaging all actors to develop the detailed strategies, and for specific programmes (CSDH, 2008; Ergör & Öztekin, 2000; MOH Malaysia, 2011; Osman, 2004).

It also may often involves external consultants and experts in formulating the specific programmes (MOH Kenya, 2013). Country like Turkey disseminates their initial proceedings of the policy formulation through the mass media to inform the public (Ergör & Öztekin, 2000). Annual operational plans and program budgeting were conducted to ensure that implementation and achievement is possible, and efficient use of resources. These countries also often received extramural funds from internal agencies or global fund such as United Nation Development Programme (UNDP) or World Bank to aid their national budgeting to address health related issues.

3.5 Implementation and Monitoring

Before the plan being implemented, political support often plays major role in the initiation of the activities. Usually, specific programmes will have its own framework which presents the input and output throughout the implementation process (such as Belize and Kenya). This will ease monitoring process to be carried out as in the framework has already identified the outcome indicators outlined that need to be monitored regularly, as a performance measurement. For newly designed policy special technical team may be formed to do regular monitoring. Monitoring process actually can be carried out at various step. For example, in Malaysia, monitoring was carried out throughout the planning, preparation and during the implementation phase. Regular monitoring is very crucial as financing and governance cuts across all service provision and support programmes therefore it needs to be monitored closely and at specified period.

In some country like Belize, there are special units for the central and regional, which will ease data collection and even possible at health facility level using standardised tools and guideline. In some occasion, programmes that was designed at national level is somewhat rigid therefore it is difficult decentralise or tailor it based on specific provincial or local need. This could possibly due to the objectives sometimes too ideal to achieve because it was based on regional goal (Ergör & Öztekin, 2000). Other than that, data quality issue has always been challenging in these developing countries and yet the use of information for decision making is still limited. For some reason, data integrity also was not a top priority therefore it was not regularly audited. Some comprehensive set of health indicators had higher reporting requirements and in some locality, information technology is very limited and still rely on manual hardcopy database.

This had somewhat hindered the monitoring process in term of getting high quality and accountable data. The advancement of the information technology (IT) will ease performance assessment and monitoring for specific programmes even at sub district level. The complexity of the mixed health systems also demands good governance, good linkage and coordination across ministries, and well defined chain of accountability which some the developing countries (such as Bangladesh) lacks. Other than weak legislation to support electronic health records, these developing countries often suffers from limited resources in term of workforce, financing and technical expertise.

3.6 Evaluation

Most studied countries uses 5-year plan cycle in their health or strategic planning, however feedback to the central government coordinating agency were done periodically, either annually or monthly. As this process includes a scientific methodology to collect huge amount of information and critically evaluate the outcome of the program such as effectiveness and benefit of the investment made, it do requires a good and valid data, together with standardised set of indicator so that comparison can be made throughout the plan or for benchmarking with other countries. However, to measure or evaluate objectively is a challenging task due to the fact that many of the programmes are long term processes and sometimes results are hard to specify and quantify. Assessing the population health outcome

usually done by using secondary data from the health administrative records, or household survey.

4.0 Lessons learned

Most countries in this review adopted a 5-year or 10-year planning cycles. Development of the health plan involves multi-sectorial (within public and private sectors) and often involve consultants or experts from international agency to aid in developing the national health plan. The sharing of experience between WHO region states manifest a remarkable contribution and benefits. In order to develop realistic and achievable objectives for national strategic plan, it must consider sufficient resources (human, financial and time frame), administrative and managerial capacity, political will, valid and reliable up-to-date data and appropriate technology to do so. Good M&E assessment tool also required to be able to respond timely of the ever changing situation during the implementation phase. In addition, comprehensive and good administrative data integration is essential to carry out the kind of subgroup analysis needed to further analyse situational analysis, as well as performance assessment during the M&E. Valid data is important to promote evidence-based (or –informed decision) policies and programs to carefully address the root causes. This requires strong collaborative work between the technocrats, bureaucrats and politician, which may act in both ways; top-down and bottom-up approach. Political leadership within MOH and the top level of the government or states is critical element of the success of the implementation of evidence-based policy, which becomes popular globally. Continuous engagement with the stakeholders from various field and level can build trust and benefit for long-term health development of the nation, especially when to develop policy to tackle localised issue which some national policy might need some flexibility of implementation tailored to the distinctive local context.

5.0 Conclusion

Health planning approaches commonly used in developing countries were either mix-scanning or rational comprehensive model. The process and its component might have been described differently; however the steps can be simplified as three phases: (1) plan formulation; (2) execution; and (3) evaluation. Health planning in developing countries share same challenges which are mainly due to limited resources in term of financial, human, technical skills to formulate, implement and evaluate the plan.

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7.0 Declaration

Authors declare that there is no conflict of interest.

Author's contribution

Author 1: Information gathering, preparation and editing of manuscript

Author 2: Information gathering, preparation and editing of manuscript

Author 3: Information gathering, preparation and editing of manuscript

Author 4: Information gathering, preparation and editing of manuscript

Author 5: Information gathering, preparation and editing of manuscript

Author 6: Information gathering, preparation and editing of manuscript

Author 7: Initiation of idea, review and proof read of the manuscript

Author 8: Initiation of idea, final review, final editing and proof read of the manuscript.

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