

Cooperation for Health Development

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

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ACRONYMS

ACHR	Advisory Committee on Health Research
AFRO	African Regional Office
AIDS	Auto Immune Deficiency Syndrome
ASEAN	Asian Economic Association
CLP	Classified List of Programmes (for WHO Budget and Financial Management)
COHRED	Council on Health Research for Development
CSN	Country Strategy Note (for coordinated UN action).
DANIDA	Danish International Development Assistance
DAP	Drug Action Programme
DFID	Department for International Development, UK (ex - ODA)
DG	Director General
DPM	Deputy Programme Manager (Regional Office)
EB	Executive Board
EBFs	Extra Budgetary Funds
EDL	Essential Drugs List
ENHR	Essential National Health Research
EPI	Expanded Programme of Immunisation
EU	European Union
FTS	Fixed term staff
GPV	Global Programme on Vaccination
GPW	WHO General Programme of Work - usually covering 6 years
GTZ	Deutsche Gessellschaft fur Technische Zusammenarbeit
HFA	Health For All by the year 2000
HIS	Health Information System
HR	Human Resources
HRP	Special Research Programme in Human Reproduction
ICC	Inter-Agency Coordinating Committee
JICA	Japanese International Cooperation Agency
MoH	Ministry of Health
NIDs	National Immunisation Days
NPO	National Professional Officer
OECD	Organisation for European Community Development
PAHO/AMRO	Pan American Health Organisation/American Regional Office
PHC	Primary Health Care
PNG	Papua New Guinea
RACHR	Regional Advisory Committee on Health Research
RBFs	Regular Budgetary Funds
RCMs	Regional Committee Meetings
RD	Regional Director
SEARO	South East Asia Regional Office
Sida	Swedish International Development Cooperation Agency

SILAIS	Local Systems for Integrated Attention in Health
SSAs	Special Service Agreements (contract for work)
STC	Short Term Consultant
STP	Short Term Professional
TA	Technical Assistance/Assistant
TCDC	Technical Cooperation among Developing Countries
TDR	Special Programme on Tropical Diseases Research
UNAIDS	United Nations AIDS Programme
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WB	World Bank
WHA	World Health Assembly
WHOCO	WHO Country Office
WHOHQ	WHO Headquarters
WHORO	WHO Regional Office
WPRO	Western Pacific Regional Office
WR	WHO Country Representative

PREFACE

Founded half a century ago, the World Health Organisation has often been in the centre stage of international health action. In recent years, there has been increasing scrutiny of its role, critical analyses of its performance and speculation about its future. This study of WHO's support to countries took place at a crucial stage in the life of the Organisation. It is under a variety of pressures, both internal and external, to redefine its goals, re-examine its strategies, modify its procedures and mechanisms, and to strengthen its management.

In order to ensure that this Study would make a meaningful contribution to the current debate about the future of the Organisation, the Study Team approached its task by collecting objective data from many different sources. Quantitative data were supplemented with qualitative information obtained from interviews with officials of various institutions and agencies, whose work in the health field brings them into contact with WHO at the country level. The report summarises the most important information which formed the basis for the main conclusions of the Study and guided the major recommendations to the Organisation and its partners. The Study was completed prior to announcements from the Secretary General regarding proposed reforms for the UN system, and the Study Team was not able to take these into account. However, it is hoped that the findings, conclusions and recommendations presented in this report will be useful in informing the ongoing discussion and implementation of UN reforms.

The Study was sponsored by the Governments of Australia, Canada, Italy, Norway, Sweden and the United Kingdom. The co-operation and help of the World Health Organisation was critical to the Study, and we acknowledge and appreciate the enormous help from WHO staff at headquarters, regional offices and country offices, who provided the team with a large amount of data and were most generous in giving time we requested for interviews and questions. However, neither the sponsoring governments nor the Organisation are responsible for the information, conclusions, recommendations or views expressed in this report, which are solely those of the Study Team. Thanks are also due to the representatives of other agencies: UN, bilateral, and nongovernmental organisations, national and international, who assisted with our enquiries. The Study team warmly acknowledges the contributions of the national consultants who gathered important data locally and facilitated the work of the visiting teams during the country visits; and the international consultants who led the country teams. Throughout the Study, from the design of the data gathering instruments to the analysis of the findings and the preparation of the report, the team benefited enormously from the knowledge and wisdom of its Special Advisers. We are also appreciative of the work of the Steering Group, representing the sponsors, WHO and developing countries, for guiding the Study and interacting with the team at crucial stages. Finally, the Study Team gratefully acknowledges the contributions of colleagues in DiS (Centre for Partnership in Development) and the London School of Hygiene and Tropical Medicine and the support from the management of their respective home institutions.

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EXECUTIVE SUMMARY

A. Conclusions and Major Recommendations

1. WHO's specificity at country level is rooted in its nature as a specialised UN membership organisation, which confers a perception of neutrality and authority. It is further legitimised by its acknowledged scientific and technical expertise, and its development and implementation guidelines for disease prevention and control, and for health promotion. This specificity should be protected, but needs clearer projection and differentiation from bilateral aid and development bank assistance.
2. The Study classifies WHO's activities into common global and country specific functions. All member states participate in the identification, formulation and implementation of **common global functions** which include global consensus building, shared values, common vision, cross-learning and interdependent activities for which national action in isolation cannot achieve the desired results; they are relevant to all countries regardless of the level of their health development. **Country specific functions** vary with the needs of particular countries and evolve over time; they include support for development of country health systems, policies and strategies, and for the implementation of programmes, the promotion of research and research capacity building, and the dissemination of information.

The Study's major proposal is that the concept of *essential presence* be employed by WHO and member states in order to tailor more effectively WHO's support to country needs, country capacity and in relation to other actors in the health sector.

3. The Study revealed wide diversity in the health situation in the case countries, a wide range in national capacity, variations in the number and activities of external agencies and in their relationships with WHO, as well as marked differences in the performance of WHO at the country level. These observations led the Study Team to propose the concept of "*essential presence*" as a means of devising and adjusting WHO's relationships with its member states at the country level. "Essential" is used in the sense of being necessary and sufficient for fulfilling an agreed role. The nature of essential presence would vary from country to country and over time in the same country. The Study Team proposes five potential models of WHO's essential presence, each with a different mixture of common global and country specific functions. The five categories reflect a continuum of support by WHO, ranging from category 1 with a maximum physical presence in countries of greatest need, to category 5 in developed countries where national institutions perform WHO's common global functions.
4. WHO should agree on a set of precise criteria for assessing country needs and capacities in a regular and systematic way. Such criteria should replace historical precedents for planning WHO's country programmes and for allocating WHO resources. Essential presence should be reassessed regularly to ensure that country specific activities and the size of the Country Office are adjusted in response to changes in national capacity and the health policy environment over time. Criteria and strategies are needed for reducing and phasing out Country Offices. In order to establish and effectively use criteria to determine essential presence, WHO should

strengthen its analytical capacity at all levels of the Organisation. This will include techniques for mapping health sector actors at the country level.

5. WHO physical presence should be based on a time-limited, renewable contract negotiated with the country concerned, with agreed rights and responsibilities for both partners specified. It should include criteria that would be used to monitor performance and evaluate achievements. Such a contract could be part of a broader agreement between the country and other agencies, especially other UN agencies.
6. Having different levels of essential presence has implications for the skill mix in each Country Office, with a full essential presence demanding greater managerial and specialist competencies, and a minimal physical presence needing more generalist, inter-personal and communication skills.

WHO funding for countries should be based on the level of *essential presence* in order to achieve a more equitable distribution of funds to countries across regions and to direct more funds to countries in greatest need.

7. WHO funding for countries should be based on the level of essential presence and the finances required to support the concomitant country specific functions. In this way there would be a more rational and equitable distribution of funds to countries across regions, rather than the present anomalies that exist between relatively rich and relatively poor regions. WHO should review the use of extrabudgetary funds and develop a policy framework for managing their use to improve integration with regular budget funds. WHO, with major donors of additional funds, should develop guidelines on handling extrabudgetary funds so as to achieve more effective coordination of all WHO's programmes at the country level.
8. WHO should maintain its special relationship with the Ministry of Health, build closer partnerships with other Ministries to promote intersectoral action, and build strategic alliances with other actors in the health sector, especially UN agencies, in order to maximise the benefit of its financial and technical input for the country.
9. Member states would benefit from greater stability and institutional memory within top management of the Ministry of Health, in order to enhance their representation and contributions to the WHO governing bodies. The WHO Country Office should work more with Ministry of Health to review background papers and resolutions before and after the World Health Assembly and Regional Committee Meetings.
10. In some countries WHO may be compromising its independence by being an executing agency for other organisations, and through playing a strong implementation role it may be undermining national capacity. WHO should develop more critical criteria for deciding the circumstances under which it should act as an executing agency and incorporate plans for capacity building and the transfer of activities to national institutions.
11. WHO's neutral role and technical expertise give it a comparative advantage in coordinating inter-country programmes. The organisation should strengthen its inter-country programmes coordinated through the Regional Office or in a Country Office serving as a sub-regional focus.

12. A Study (Phase I) of the role of extrabudgetary funds (EBFs) in WHO at the global level which was undertaken in 1994-95, drew attention to the need to review and evaluate the effectiveness of the Organisation's activities at the country level. Sponsored by the governments of Australia, Canada, Italy, Norway, Sweden and the United Kingdom and with the full agreement and cooperation of WHO, this follow-up Study (Phase II) was designed to:
 - review WHO's achievements at the country level in relation to needs and capacities
 - identify the potential for more effective support programmes; and
 - contribute to the improvement of WHO's overall performance
13. The Study Team collected background information on, and visited, twelve selected case study countries: Bangladesh, Cambodia, Cameroon, Ecuador, Ethiopia, Haiti, Mali, Mozambique, Nicaragua, Papua New Guinea, Tanzania and Thailand, as well as the Regional Offices responsible for these countries: the African Regional Office (AFRO); the Pan American Health Organisation/ American Regional Office (PAHO/AMRO); the South East Asia Regional Office (SEARO); and the Western Pacific Regional Office (WPRO). This Report synthesises the findings from the twelve countries and four regions. There are companion volumes containing the country case study reports.
14. Health, economic and other indicators showed wide diversity in the situation and health system capacity of the twelve countries. There is a twenty-fold range in the gross national product, nine-fold range in the under five mortality rate and a 23 year gap in the life expectancy at birth between the most advanced country (Thailand) and the least developed country (Mozambique) in the Study.
15. The Study compared each of the twelve case studies in its ability to meet basic health needs and sustain its own health system, and grouped them in three capacity clusters: high, medium and low. Three of the five AFRO case studies fall in the low capacity cluster (Ethiopia, Mali and Mozambique) with the other two in the medium group (Cameroon and Tanzania). Conversely, two of the three PAHO/AMRO case studies are in the high capacity cluster (Ecuador and Nicaragua) with the third in the low capacity group (Haiti). One case study from each of SEARO and WPRO is in the low capacity cluster (Bangladesh and Cambodia) while the other two countries are in the medium (Papua New Guinea) or high capacity clusters (Thailand).
16. The nature of WHO as a membership organisation, involving the Ministers of Health of member states in its governing bodies has resulted in a special relationship at the country level, between the WHO Country Office and the Ministry of Health. WHO global priorities are outlined in successive General Programmes of Work (GPW). The Eighth GPW, covering the period 1990 to 1995, has four cross-cutting themes which were used to assess WHO support to countries:
 - allocation of resources to countries most in need,
 - equitable distribution of health resources,
 - programmes that build national capacity,
 - improved managerial processes and effective use of WHO resources.

17. The policy environment within which the MoH and WHO interact with other health actors, has changed over the past three decades. In the 1960s the focus was on health service coverage, with few actors in the health sector. The MoH and WHO had a close and relatively exclusive relationship. By the 1990s, however, concern about constraints on the public health sector led to a shift in focus to reform of the health system. This in turn encouraged many more actors to enter the health policy arena, committing the MoH to relate with multiple actors, and changing its relationship with WHO. Given these changes and continuing weaknesses in country capacity, WHOCOs are having to respond to a very different set of expectations in the 1990s than they were in the 1960s.
18. To examine WHO's responses to change and its support to countries, the Study Team derived its analytical framework from the Terms of Reference for the Study which covered four key areas:
- *Mandate and goals*: What is WHO's mandate and role, its relative strength and comparative advantage at country level? To what extent does the mandate provide sufficient direction and flexibility for effective country support?
 - *Structures and processes*: What are WHO's operational and institutional arrangements in country, and between country and regional offices and headquarters? What is the quality and relevance of procedures used? How do they influence program performance and inter-organisational collaboration?
 - *Programmes*: What are the broad characteristics of WHO collaborative programmes, and to what extent do they include advisory, facilitating, resource mobilization, and coordinating functions? How far are WHO supported activities and programmes relevant and appropriate to country needs and supportive of country efforts?
 - *Linkages*: What are the links and relationships with partners in health cooperation? In particular, what is the role of WHO in relation to the Ministry of Health, multi- and bilateral organisations, national and international non-governmental organisations? To what extent is WHO building strategic alliances to meet country needs through collaborative efforts?

C. Findings

19 Mandates and goals

Over many years WHO has made significant contributions to the development of human resources and the overall service delivery framework in the health sector of most of the countries visited. Major progress has been made in control of diseases such as leprosy, which has taken years of diligent effort and demonstrates the importance of an organisation that has continuity, persistence and presence over time. Despite these known achievements, this Study emphasises that there is little that can be said about WHO that is true for all countries. It is evident that there is a discrepancy in many of the case studies between WHO's mandate, the intended role, and the actual role and achievements at country level.

The Study Team found that:

- 19.1 WHO common global functions, policies and products are generally seen as valuable, and provide the WHOCO with credibility and authority. WHO scientific and technical information is universally acknowledged as being of high quality and value. However, more could be done to stimulate, facilitate and support member state engagement in common global activities at the country level.
- 19.2 WHO's mandate and actual presence at country level has not been adequate across all case studies. The strongest presence, in terms of financial (both regular and extrabudgetary funds) and human resources, has been in the PAHO/AMRO case studies, Bangladesh and Thailand. The weakest has generally been in the AFRO case studies. The overall match between WHO support and country needs was not found to be sufficiently strategic, and the application of WHO's mandate not optimal in many of the case studies.
- 19.3 WHO shows varying effectiveness in advocacy, as a neutral adviser or broker, from being at the forefront in countries to being barely visible. On some politically sensitive issues the Organisation generally was found to avoid conflict at the expense of its advocacy role, and to be reactive rather than proactive in policy initiatives at country level.
- 19.4 WHO's high international reputation creates expectations at the country level. It means that there is a growing demand for WHOCO staff who have the right skills as enablers and facilitators and who can participate with authority in policy dialogue in support of the Ministry of Health.
- 19.5 While WHO is not automatically recognised as the lead agency among external partners supporting health activities at the country level, it had this role in nearly half of the countries visited. In none of the five case studies in AFRO was WHO perceived as the lead agency. In contrast, the three PAHO/AMRO countries and the two WPRO countries all showed WHO in a lead position. The two SEARO countries were both special cases, Bangladesh being a country with a large and dominant donor consortium, and Thailand a country where no external partner is competing for the lead role. WHO's actual opportunity to function as a lead agency in a country is not primarily created by statements of the WHO Governing Bodies, but is constructed through formal and informal mechanisms for interaction and contest among stakeholders in health development within each country in a complex interplay of WHO system related factors, the way MoH uses WHO and the country specific mix of other external partners and their perception of what WHO's role is and ought to be. Contradictory expectations of WHO's role among partners and unclear terminology used for describing WHO's functions, inhibit discussions about WHO's future role at country level.
- 19.6 Even where WHO does not have a lead role, WHO has considerable comparative advantage because of its reputation for technical skills, expert advice and materials. However, many WHOCOs are failing to take advantage of this recognised status. Consultants are sometimes poorly selected, technical materials are not sufficiently accessible or disseminated throughout the country and WHOCO libraries are under-utilised.

20 Structures and processes

The unique character demonstrated by each of the four Regional Offices covered by this Study demonstrates the difficulty of such a large organisation maintaining a single coherent structure. The Regions have decentralised control and considerable autonomy. Although they follow standard WHO procedures, these have been adapted to their own systems in management and support of activities in groups of very diverse countries. However there are differences between the four regions which cannot only be explained by the need for relevance in different contexts. While difficult to characterise the WHO operations in the regions from studying only a few countries, a picture emerges which at least raises some issues for further discussion.

- 20.1 The Study found regional differences in the organisational culture, management style and efficiency of administrative procedures, in the autonomy permitted to WRs, in programme profile, approaches to programme monitoring and evaluation, in the way WHOCOs and ROs related to WHOHQ, differences in resource mobilisation and reputation as an executing agency.
- 20.2 Most countries value their WHO Country Office (WHOCO) for its continuity of presence and long-term commitment. However, WHO has not sufficiently adapted the size and role of all the Country Offices to the needs and contexts of the countries in which they are located. The professional and administrative capacity, and technical and logistical support, has been uneven across the case studies, and WHOCO size and programme budget are not related to country capacity or need.
- 20.3 The 3 low capacity AFRO countries have the smallest WHOCOs, whereas the 3 low capacity countries from the other regions, have the largest number of national and international staff. All 3 case studies in the high capacity cluster have WHOCOs larger than those in 3 low capacity and 3 medium capacity countries. The difference is more extreme for the PAHO/AMRO high capacity countries. *Within* the regions, there is some relationship between capacity and WHOCO size, but this is less so for the 5 AFRO case studies.
- 20.4 WHO's skill base remains predominantly medical, with only a slow increase in the wider range of skills associated with financing and managing health services. This restricts the Organisation's ability to assist governments to assess health sector projects and reforms proposed by the development banks and other donors.
- 20.5 The procedures for selection and recruitment of Country Office staff and consultants are inadequate and continue to be influenced by Organisational politics. The main problems identified during the Study are: limited search for staff, the protracted process causing delays in filling vacancies, and the poor quality of some consultants. The low level of WHO consultancy rates in comparison with UNDP or World Bank impedes WHO's ability to recruit top quality specialist consultants. WHO Representative and staff inservice training, management and performance appraisal tends to be weak in all regions, but less so in PAHO/AMRO.
- 20.6 Selection of WHO Representatives (WRs) has been an issue for the Organisation for several years. The process of selection is exclusive rather than inclusive, restricted to WHO fixed-term staff, and involves only the Regional Director and Director General. The MoH is invited for comment only at final approval. There are past and present examples of poorly functioning WRs being left in place, even though MoH and other partners have made critical comments and requested WHO to take action. Some of the present WRs are struggling to overcome the loss of the

Organisation's reputation in the country due to poor performance of their predecessors, particularly in the AFRO case studies.

- 20.7 There is considerable variation in the extent of autonomy permitted to WRs. Ability to move finances between budget lines, use of initiative and discretion, especially in emergency situations, and mobilisation of resources, all differed between the regions. In addition, WR autonomy is generally less than that of some UN organisations such as UNICEF and UNFPA, contributing to the perception of WHO as weak at country level, especially in AFRO countries.
- 20.8 In taking measures to cope with inflation and zero growth in WHO's regular budget, some full time posts have been frozen, with more use of short-term contracts of 11 to 24 months. Shorter contracts have the potential of making COs more responsive to changing country needs. However, this requires that such needs are correctly assessed, that WHO can draw on staff with appropriate skills and has procedures to facilitate timely recruitment. Information from the case studies indicated that these requirements were often not met, particularly in the AFRO and SEARO regions. Frequent or automatic renewal of short-term contracts can be counterproductive to needed flexibility.
- 20.9 There is unnecessary complexity of procedures within WHO regarding the identification, selection and support of health priorities at country level. Planning and priority setting occur at all levels of the Organisation with varying degrees of relevance and benefit to individual countries. The Study found evidence of difficulties harmonising priorities from the three different levels. Availability of EBFs earmarked for specific countries or programmes influences priority setting.
- 20.10 The planning and budget process for each biennium is lengthy and ponderous, achieving little ownership in Ministries of Health. It starts in a top-down manner with regions being notified two years prior to the biennium, of their indicative planning figures, and they in turn, decide how much of their total allocation will go to countries (e.g. in AFRO the figure is 60%, SEARO 75%). WRs then negotiate a collaborative work programme with the MoH. However, headquarters and regional inputs to specific countries are not coordinated with this country level planning with MoH involvement. In some countries substantial amounts, up to 40% of total WHO expenditure at country level, come through Headquarters and the Regional Office. Funds from Regional Offices may be for country specific activities, or inter-country activities. HQ funds are mostly from the special programmes such as TDR and HRP, and usually go directly to national institutions. The Organisation's call for a unified approach to activities at country level has not yet been achieved.
- 20.11 The allocation of regular budget funds (RBFs) for the Country Collaborative Plan, is generally based on historical precedents rather than country needs. The process is not transparent, and the Organisation plans to improve the rational basis of allocations. The countries with the smallest total country programme budgets (RBFs and EBFs) are in AFRO, and those with the largest are in PAHO/AMRO, and SEARO. Thus WHO is not achieving its own objective to direct resources to countries in greatest need.
- 20.12 WHO regular budget funding for the Country Collaborative Plan (i.e. not including funds direct from RO or HQ) is different in nature from that of other donors because the government can have a stronger voice in setting objectives for their use. Although the amounts of WHO RBFs are relatively small compared to

funding from other donors, they are more dependable over time, and the government retains some flexibility in the way they are used. For example, RBFs can be used in "non-fashionable" areas.

- 20.13 Extrabudgetary funds (EBFs) flow into countries from all levels of WHO and constitute 40% to 80% of total funds spent at country level. EBFs are relatively less long-term and less reliable than RBFs, and decisions on their use are influenced as much by the donors as by WHO. WHO acknowledges the present lack of a policy framework for managing EBFs to improve integration of activities funded through RBFs and EBFs, and lack of guidelines on handling EBFs in the context of overall WHO priorities. It can be difficult to plan for the coordinated use of RBFs and EBFs, as during WHO's long planning process, the anticipated level of EBFs that will actually be available is not accurately known.
- 20.14 The patterns of expenditure for RBFs and EBFs show that they differ in stability over time and the types of activities and programmes supported by them. RBFs have been generally more stable across the two biennia in the case studies, and more broadly deployed across the four strategic programme areas. In contrast, EBFs fluctuated more, and tended to be concentrated on Integrated Control of Disease.
- 20.15 The implications of a frozen regular budget, and decreasing EBFs in some regions, require WHO to have good financial management information in order to maximise the use of its resources. However, Study findings indicate that financial information on total support to individual countries is generally unclear, and there was no one source from which to obtain an overall picture of expenditure. Moreover, information received from HQ, ROs and COs often conflicted. The nature of financial information currently available to WHOCOs and the MoH is not conducive to effective management.
- 20.16 The Study explored WHO's role in mobilisation of resources in broad terms: financial, human, institutional, physical, information management resources and political support. There is regional variation in levels of resource mobilisation activities, which in part corresponds to stated regional policies on resource mobilisation, and in part to the size and capacity of the WHOCO. It is clear that the WHOCO does not play a major role in the mobilisation of financial resources. However, there are activities undertaken by the WR and WHOCO staff in other resource mobilisation that make significant, incremental contributions to capacity in national health systems.
- 20.17 WHO frequently takes on a role as executing agency ranging from administering to actually implementing projects with resources from other donors. As would be expected, WHO has high activity in executing projects in some low capacity countries (Mali and Bangladesh). However, WHOCOs still execute projects in higher capacity countries such as Nicaragua and Ecuador. This would appear to be beyond the needs of those countries, and contrary to WHO's stated policies of capacity building and focusing effort on countries in greatest need. The quandary is that the experience with WHO as an executing agency, in terms of efficiency and effectiveness, has been positive in higher capacity countries and certain regions (Nicaragua, Ecuador, Haiti and Cambodia), but less positive in lower capacity countries and other regions (Mali, Cameroon, Mozambique) where donors were critical of WHO bureaucratic procedures and low levels of project implementation. Minimum criteria for WHO to function as an executing agency should be: WHO

involvement with project design, a specified time frame, strategic capacity building and planned transfer of responsibilities to national institutions.

- 20.18 Monitoring and evaluation of WHO country specific activities have been too closely tied to inputs, and insufficiently linked to outcomes or achievements, and monitoring systems are built on the assumption that what is planned is relevant and appropriate. Monitoring and analytical skills and practice, whether in finance or evaluation of programmes, were lacking in most WHOCOs. Although procedures exist to monitor progress regularly, reports were seldom problem or solution oriented and there was little evidence of feedback or support from ROs. This lack of analytical capacity in monitoring and evaluation exists in spite of recognition by the Organisation, over a number of years, of the need for improved evaluation. This deficiency severely inhibits the Organisation's opportunities for critical reflection and learning. Lack of penetrating evaluation of the fellowship programme, in relation to meeting the human resource needs of countries, is not excusable, given the size of the financial input, the length of time involved and the relative simplicity of identifying long-term outcome measures.

21 Programmes

While the Study sought to establish an overview of all programmes and activities related to the presence of the WHOCO, the three tracer programmes on drugs (DAP), immunisation (EPI) and malaria control, were used for more in depth analysis of the role, effectiveness, appropriateness and relevance of WHO Collaborative Programmes. These programmes are well defined and structured in terms of WHO policy and approaches. They were chosen because they are systems dependent, but also sufficiently diverse to provide a broad view of WHO operations at country level. WHO has directly or indirectly supported the development of all these programmes, through well formulated and widely accepted policies, standards and guidelines. Study findings on programmes in general include:

- 21.1 Collaborative programmes vary greatly, both in the scale of operations, their strategic orientation, the mix of activities and tools, the balance among functions and the source of funding. WHO is most typically seen to be strong in the technical areas of preventing and controlling specific health problems (integrated disease control), and has lowest overall involvement in the area of promoting and protecting health, particularly in the AFRO region. In dealing with actual implementation of health programmes WHO becomes more similar to other partners in health, and does not present any clear and specific advantages.
- 21.2 There is strong evidence of the utility of WHO inputs to the development and implementation of national technical standards and norms. This is one of the key inputs and most highly valued contribution by WHO to health development at country level. However, no specific strategic focus for WHO support was evident across regions in the case studies with lowest capacity and greatest need, neither in terms of volume and use of resources, collaborative programme profile or in better managed and more effective partnerships. There was no consistent match between critical gaps in national policy and WHO involvement.
- 21.3 Country Collaborative Plans often lack a coherence that demonstrates an internal logic between the programme components. On the other hand, the activities are tailored to some capacity gaps in the health system, and based on requests from the

MoH. Often the activities supported by WHO serve to encourage new initiatives, or to facilitate development of a programme area until it can be funded through other sources.

- 21.4 There is no evidence from this Study to indicate that WHO resources to a country would have been spent more efficiently if concentrated in one or two areas, in contrast to current practice. There is however, reason to believe that any effort to create a standardised "WHO-package" of priority interventions to be pursued in all countries, would not be appropriate in meeting specific country needs.
- 21.5 The relatively low funding level and the WHO approach to working with national counterparts to build capacity in national systems make WHO programmes small in terms of visibility, but potentially robust in terms of sustainability. However, case studies indicated that capacity building was often not approached strategically, in some cases was neglected, and at times was even undermined by the implementing activities of the WHOCO staff.
- 21.6 There was wide variation among the WHOCOs regarding which of the five functional categories they concentrated their effort in programme implementation: advocacy; establishing norms, policies and plans; research; information dissemination; and technical operations support. The most important function for implementing activities was judged by the WHOCOs to be technical operations support, with 29% of total effort across the 12 case studies. Its importance varied from 44% in Bangladesh to between 10-20% in other countries, being surprisingly high in Thailand and Ecuador and surprisingly low in Mozambique and Cameroon. Research was the most neglected functional category with only 10% of total effort across the case studies.
- 21.7 While there is strong support from HQ (notably from the research programmes such as TDR and HRP) to countries for developing research capacity, most WHOCOs do not see support to research as their role, and rank research as a low priority compared to other activities. This may be due to a lack of interaction between HQ and countries, or a lack of opportunity to demonstrate how local health research can inform policy. Another important factor is a general lack of research background in the WHOCO staff. In many case studies, health systems research was relatively poorly developed and the type of research that would inform the reform of the health sector has been relatively neglected.
- 21.8 WHOCOs also used a wide range of tools in implementing programmes. Financial assistance, supplies and equipment accounted for 31% of tools used across the 12 case studies, while fellowships, courses and seminars accounted for 26%. Financing, supplies and fellowships were not concentrated to the low capacity countries as would have been expected. Another surprising feature in the analysis of tools used was the lack of emphasis on linkages with other actors in health. Ethiopia, Haiti, Nicaragua and Bangladesh place no emphasis at all on linkages among the tools they use for implementing programmes.
- 21.9 Critical gaps in national capacity that are not being filled by WHO in the case studies include quality-assurance, service management (including information systems for management) and appropriate service models; reproductive health; issues related to health sector reforms; and issues concerning human resource management.

Study findings on the tracer programmes include:

- 21.10 In terms of policy context, many of the case studies had reasonably updated policies and strategies for the tracer programmes, but this varied more or less in line with the capacity clusters assessed for this Study. A striking feature is however, the gap between policy and implementation. In terms of national ability to fund programmes, only three of the case studies cover more than 80% of the EPI costs from the national health budget, contrasting with other countries, particularly in Africa, which cover almost none. Public spending on drugs is very low for some countries, while others still cover only somewhat more than 20% of the total public drug budget. With the exception of Thailand, among the case studies, the public sector is not able to contribute significantly to the national malaria control programmes.
- 21.11 Many of the case studies have enjoyed considerable WHO financial and human support to the tracer programmes, others negligible. Across the twelve countries for 1992-95, EPI funding was \$10 million, nearly twice as much as DAP (\$5.5 million) or Malaria (\$5.6 million). However, the DAP funds have been somewhat more evenly spread between the countries. All three tracer programmes have been highly dependent on EBFs (79% for EPI, 70% for DAP and 60% for Malaria.).
- 21.12 The WHO role in the case studies has varied from heavy operational support, to a marginal observer role, or contributing to very specific components of the tracer programmes. The striking finding is that there is no obvious match between the country needs and capacity, and WHO level and profile of activities in the tracer programmes. The HQ established criteria for involvement in countries did not appear to influence WHO's actual presence and profile. The level of involvement depended more on the availability of donor partners wanting to work through WHO in that particular country. In relation to DAP, donor earmarking of funds for activities in specific countries has clearly influenced the choice of countries for more intensified WHO support. MoH commitment and ability to use WHO in policy development and as a technical resource are also important factors determining WHO's role and activities in the countries.
- 21.13 The effectiveness and relevance of WHO established global norms and instruments for country level policies and strategy formulation was affirmed for all the tracer programmes in all the case studies. The policies developed and agreed through the work of WHO at the global level were taken up and accepted as basic to both national and donor policies.
- 21.14 The effectiveness of WHO programme operation at the country level is harder to judge, because of the complex pattern of multiple partners for both EPI and DAP, and the dependency on national system factors for all the tracer programmes. The national immunisation day strategy, where implemented, has served as an instrument for raising general immunisation coverage and for re-establishing infrastructure and motivation for EPI, and thereby demonstrated results, at least in the short-term. In several countries doubts were raised about the use and effectiveness of WHO consultancies, as measured against the low rate of advice and recommendations actually implemented.
- 21.15 Effective linkages and partnerships are critical elements in overall effectiveness in the tracer programmes. WHO has been instrumental in establishing links between partners in EPI, but in the case studies, this has been much less the case for DAP.

22 Linkages

The health policy environment has become much more pluralistic, with many different stakeholders. The Study notes that:

- 22.1 The key linkage for WHO at country level is the MoH. This special relationship, along with its nature as a technical rather than a financing resource agency, gives WHO its specificity.
- 22.2 The concept of partnership has been on the WHO agenda since the mid 1980s, and there are a number of policy statements at global and regional levels that underpin WHO's work with government ministries in addition to health, other UN organisations, nongovernmental organisations, academic institutions and private enterprise.
- 22.3 WHO's main strengths for the MoH are its relative neutrality in comparison with the interests of other agencies, and its technical knowledge, whether through consultants, or in guidelines, norms, standards or training materials. For other agencies WHO is seen to be in a strategic position for communication and influence with the MoH. However, some feel its independence and neutrality can be threatened because of its closeness to the MoH. Occasionally, in some countries, WHO strategic partnerships with selected bilateral agencies are questioned in a similar way.
- 22.4 WHO's role as neutral broker, advisor and facilitator at country level is dependent on many factors beyond the capacity and interest of the WR. The MoH ability and interest in using WHO as a close ally and privileged partner in health development, and the dominance of other actors also influence what WHO can achieve at country level.
- 22.5 Despite WHO's mandate to coordinate international health work, the WHOCOs seldom take the lead in formal mechanisms for coordinating the activities of the various actors in the health sector. However, in a number of the countries WHO was actively building strategic alliances to meet country needs through collaborative efforts.
- 22.6 Bilaterals are often major external financial contributors to national health systems. There are examples in these case studies where the WHOCO plays a facilitating role as broker or negotiator between MoH and bilateral donors, and where WHO and a bilateral work collaboratively in capacity building and health system development. However, several bilaterals stated that they did not see the WHOCO as a resource of excellence, and that they were more likely to call on their own technical expertise. The weakness of WHO at country level has resulted in some missed opportunities for WHO to develop strategic partnerships with bilaterals and to provide core support or advice.
- 22.7 The Country Strategy Note (CSN) as an effort to establish an overall development cooperation framework for the UN inputs to countries was found to have limited usefulness. Five of the case studies had developed a CSN and others were in the process of developing them. Several countries complained that the different UN organisations operate with separate and sometimes conflicting strategies for health sector support.

- 22.8 There are a number of examples in the case studies of other attempts by agencies within the UN system to coordinate activities such as: in major emergency situations (Haiti and Mozambique), on particular health issues (AIDS) and for particular regions (The Special Initiative on Africa). In some countries, UNICEF and WHO seem to draw on each others strengths and financial abilities, but in other countries the "operational culture" of UNICEF and the "technical culture" of WHO has not always been compatible.
- 22.9 The World Bank is the most significant of the development banks in health programmes, having increased its loans to the social sector to US\$2.3 billion of new commitments in 1996. WHOHQ and the WB have developed a collaborative framework to support country health development, combining the Bank's financial resources, with WHO's policy guidance, technical expertise and privileged interaction with MoHs. However, translation of these high level intentions into practice at country level was not evident in many of the case studies. WB loans form major contributions to the health sector placing the Bank in a position to influence policy through what is funded, regardless of advice from WHO. The case studies provide examples of where WB and WHO have established good working relationships (e.g. Cambodia), but also where the Bank works with little reference to WHO (e.g. Bangladesh). In countries where WHO currently has a lead role in the health sector, the WB was identified as a potential threat to that position.
- 22.10 WHO has maintained few linkages with nongovernmental organisations, both indigenous and international, in the case studies. This has been so even where NGOs have been prominent actors in the health sector, but links are more widely established in PAHO/AMRO and WPRO case studies than in AFRO and SEARO. NGO's perceive WHO as associated with government and not interested in working with nongovernment sectors. However NGOs do use and appreciate WHO guidelines, information and advice from the WHOCO. One area where WHO aspires to a stronger relationship with NGOs is with regard to monitoring equity indicators and providing a corrective voice on human rights in health. However the Study found little evidence of such collaboration at the country level, either by WHO or by the NGO community.
- 22.11 While WHO should develop stronger linkages with other health actors, assert its organisational strengths more prominently, and support the MoH in strengthening coordination of health development, the Study concludes that many WHOCOs do not have the capacity at present to achieve these objectives. As previously discussed, the formal mandate of WHO at country level remains poorly articulated. The Constitution states that WHO should "act as the directing and co-ordinating authority on international health work", and to work "in co-operation with other specialised agencies where necessary" on a range of other functions. This broad remit is not supported, for example, by the job description of the WR which says little about his/her role in developing linkages with other partners in health development. Furthermore, while the mandate to act as the "directing and co-ordinating authority" is consistent across WHO regions, the Study finds that the capacities of the WHOCOs are not. There is a need to develop and apply more explicit criteria that, inter alia, would enable WHOCOs to play a more prominent role in developing linkages to better support activities at country level.

CHAPTER 1. BACKGROUND AND CONCEPTUAL FRAMEWORK

1. Introduction

The decade of the 1990s has been characterised by widespread debate on the reform of the United Nations and its constituent bodies, stimulated by the need for institutional and functional changes and financial concerns. As part of this debate, a number of studies have reviewed the functions and role of the World Health Organisation - the UN's specialised agency for international health. While many of these studies have drawn attention to WHO's Country Offices, which are widely perceived to need strengthening, studies of WHO's role at country level remain limited in scale and detail.¹

A Study (Phase I) of the role of extrabudgetary funds (EBFs) in WHO at the global level was undertaken in 1994-95, sponsored by the Governments of Australia, Norway and the United Kingdom.² One of its key recommendations was the need for in-depth analysis to review and evaluate the effectiveness of WHO's activities at country level. The aim of such a follow-up study would be to strengthen the Organisation's activities at the country level, to inform member states, and to contribute to the overall debate on WHO reform.

This recommendation was endorsed at a meeting in London in October 1995, at which a group of interested donors agreed to sponsor a follow-up study, focusing on WHO's support to, and involvement in, programmes at the country level. Following this meeting, the governments of Australia, Canada, Italy, Norway, Sweden and the United Kingdom commissioned this Study (Phase II), with the full agreement and cooperation of WHO. A Steering Group representing the sponsors, developing countries and WHO was then established (Annex 1), and in July 1996 the Terms of Reference (Annex 2), objectives and approach to the Study were agreed. The translation of the terms of reference to the design of the study is detailed in the Inception Report.³

1.2 Underlying premises of the Study

Two fundamental premises guided this Study. One, that WHO support for countries to improve the health of their populations represents the common end point for the diverse activities of the Organisation, as financed by both regular and extrabudgetary funds.⁴ Therefore the Study focused on *all* WHO's activities at the country level. Two, since WHO is only one of many actors in the health sector at the country level, the study should examine WHO activities in relation to other actors, notably national stakeholders such as the Ministry of Health, and other international and nongovernmental organisations. WHO Regional Offices and their relationship and support to the Country Offices were also a focus of attention.

Twelve countries in four regions were selected for the Study⁵: Bangladesh, Cambodia, Cameroon, Ecuador, Ethiopia, Haiti, Mali, Mozambique, Nicaragua, Papua New Guinea, Tanzania and Thailand. The Regional Offices responsible for these countries were visited: the African Regional Office (AFRO); the Pan American Health Organization/American Regional Office (PAHO/AMRO); the South East Asia Regional Office (SEARO); and the Western Pacific Regional Office (WPRO). This report synthesises the

findings from all the countries and regions. There are four companion volumes containing the country case study reports.

This chapter gives the objectives of the Study, the analytical framework for the Study, and the basis for understanding WHO as an organisation. It ends with a brief description of what is found in subsequent chapters.

1.3 Objectives of the Study

The Terms of Reference, as agreed by the Steering Committee, presented the following broad objectives:

- to review WHO's achievements at the country level in relation to needs and capacities
- to identify the potential for more effective support to programmes
- to contribute towards the improvement of WHO's overall performance

As such, the Study has both a summative and formative function: to review and assess performance and achievements, but also to contribute to the improvement of policies, operational strategies and programmes.

The Study assumed that the currently accepted overall purpose for WHO physical presence at the country level is, on invitation of the government, to support and strengthen national capacity for establishing and implementing national health policies according to globally agreed commitments, norms and standards. In examining country level activities, the main question for the Study to answer is therefore whether WHO, within the scope of its mandate, makes a relevant and optimal contribution to supporting and strengthening national capacity in the health sector.

In order to answer this question, the Study addressed three different, but interrelated sets of questions:

- What are the critical needs of, and challenges to, the health sector in the country case study concerned?
- What are WHO's activities and experiences in the selected countries? In what areas does WHO demonstrate particular competence, capacities and strengths? How far do these activities match the countries' most critical needs?
- How does WHO's mandate, role and strategy express its mission, identity and comparative advantage at country level?

1.4 Analytical Framework for the Study

In order to answer these questions derived from issues raised in the Terms of Reference (Annex 2), the following analytical framework, covering four key areas, was used for the Study (see Figure 1.1):

Mandate and Goals: What is WHO's mandate and role, its relative strengths and comparative advantage at country level? To what extent does the mandate provide sufficient direction and flexibility for effective country support?

Structures and Processes: What are WHO's operational and institutional arrangements in country and between regional and Country Offices? What is the quality and relevance

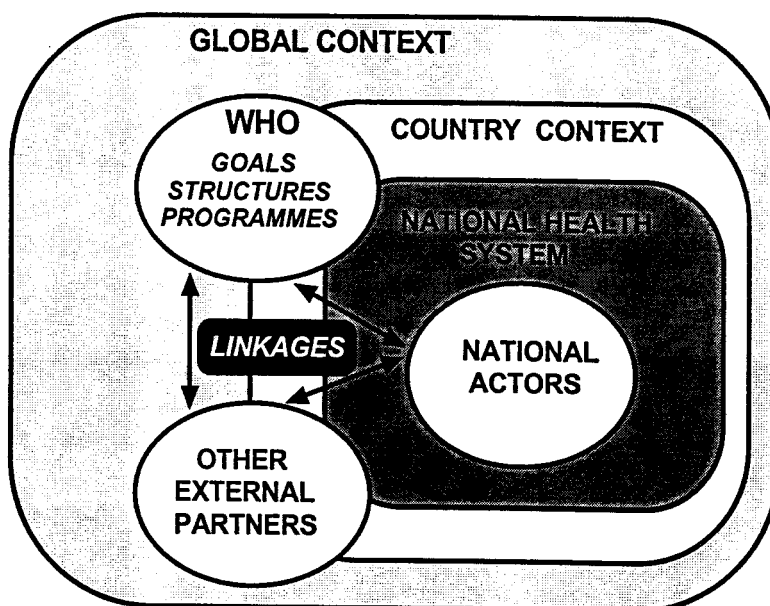
of procedures used? How do they influence programme performance and inter-organisational collaboration?

Programmes: What are the broad characteristics of WHO collaborative programmes, and to what extent do they include advisory, facilitating, resource mobilisation, and coordinating functions? How far are WHO supported activities and programmes relevant and appropriate to country needs and supportive of country efforts?

Linkages: What are the links and relationships with partners in health cooperation? In particular, what is the role of WHO in relation to the Ministry of Health, multi- and bilateral organisations, national and international non-governmental organisations? To what extent is WHO building strategic alliances to meet country needs through collaborative efforts?

In order to apply this conceptual framework, it was necessary to define what sorts of activities WHO undertakes at the country level. The Study Team made a clear differentiation between common global activities, and specific activities at the country level:

Figure 1.1 Conceptual framework for assessing WHO's support to countries



Key functions

Common global and country specific functions

In the Phase I report *Cooperation for health development: extrabudgetary funds in the World Health Organization*,⁶ the difficulties defining WHO's activities were discussed. It is common to differentiate between activities that are 'normative' and those which are described as 'technical cooperation'. Normative activities are to do with the formulation of values, setting goals, standards and advocacy, and are said to be salient to all member states of WHO. Technical cooperation on the other hand, '...can help to strengthen the national health planning process or develop such a process where one does not exist'.⁷ It

is frequently asserted that normative activities are formulated and developed at the global level, while technical cooperation activities use the products of those normative activities, and are of relevance to developing countries in the planning and implementation of their own health systems.

As the report showed, however, these terms are not only used inconsistently, but in practice the distinction is blurred, and it is not helpful to describe normative activities as occurring only at the global level, and technical cooperation occurring only at the country level.

The present Study builds on the analysis of the Phase I report, and differentiates between WHO's common global functions and its country specific functions *both of which are relevant at the country level*. **Common global functions** are characterised by their universality, and are of relevance to all countries. All member countries are concerned and may be committed to these common global functions, and participate in their identification, formulation and implementation. They also provide the collective basis and justification for WHO as an membership organisation. Country specific functions vary with the needs of particular countries and evolve over time. Box 1.1 suggests what would be relevant as global or specific level functions. The distinction is not between headquarters and country level activities, but in breadth of relevance: common global functions cover all member states; country specific are specific to country needs and time.

Activities undertaken as common global functions:

1) Global consensus building on shared values, common vision and defined goals

The WHO Constitution declares WHO should 'act as the directing and coordinating authority on international health work'.⁸ Activities include global health policy formulation, and advocacy. An example is the Alma Ata declaration on primary health care. The process, involving extensive consultation and vigorous interaction among all member states is as important as the outcome. Activities include agreeing values and norms and priority setting for the Organisation as a whole.

2) Cross-learning and transfer of knowledge

Activities utilise WHO's unique ability to convene scientists, practitioners, academics, researchers and other experts across political and other barriers, to provide up-to-date assessment of, and consensus on, specific health issues. WHO's production and distribution of norms and standards, reports, manuals, guidelines, as well as seminars, workshops and exchanges of visits, and other mechanisms are used in the transfer of knowledge, both new and well-tested.

3) International public goods

This essentially covers those interdependent activities for which national action, in isolation, cannot achieve the desired results, and for which inter-country collaboration is required. It includes conventions for disease control, technical standards, surveillance, classification of diseases, and health research on subjects of high priority or on topics for which cross-national and cross-cultural collaboration is judged to be valuable. It includes action over pollution, antibiotic resistance, and health care for refugees or displaced populations where this has clear spillover benefits from one country to others.⁹

Activities undertaken as country specific functions:

All country specific activities are dependent on the capacity, needs and interests of a country and would evolve over time. They may be short-term, supporting or filling gaps in country capacity, or longer-term, strengthening capacity in country. Much would depend on the country context. For example, in countries where professional or skilled human resources were scarce, activities might focus on capacity building; in countries where human resources were developing, activities might focus on capacity strengthening; and in countries with significant numbers of trained human resources, activities might focus on performance enhancement.¹⁰ These could be within any of the functions mentioned, from advocacy to research.

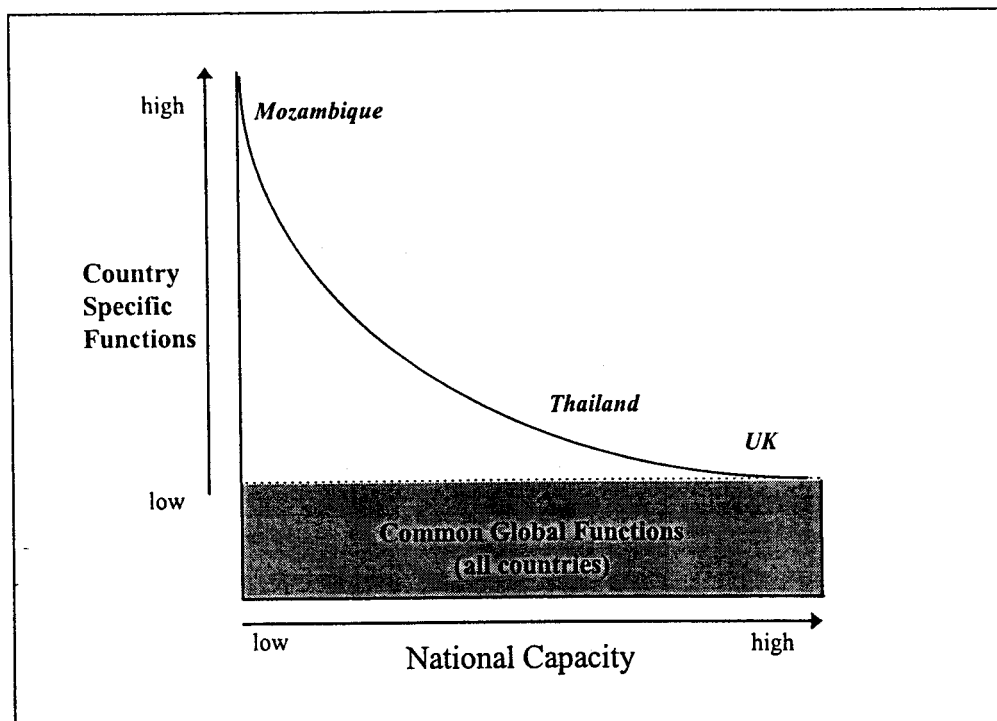
In this Study, it is assumed that, (i) WHO functions at the country level include the common global functions as well as the country specific functions; (ii) all member states are involved in common global functions, but the country specific functions are country dependent; and (iii) common global functions are characterised by a specific body of knowledge regarding health and disease, of interest to all, while country specific functions are locally tailored, and dependent on national needs, the availability of support from other sources and the interest of the government.

Box 1.1 WHO Functions at the Country Level

	COMMON GLOBAL	COUNTRY SPECIFIC
Functions	• Consensus building and advocacy on shared values and norms • Cross-learning and transfer of knowledge • Producing and sharing International public goods ◊ Conventions on technical standards e.g. vaccines, drugs ◊ Research on problems requiring international collaborative action. ◊ Surveillance	• Support for development of country health systems, policies, strategies • Dissemination of information • Support for implementation of health programmes and capacity building • Promotion of country specific research and capacity building • Cross-border interventions on country and regional health problems
Involvement	• All member states	• Selected member states, based on need & opportunity
Content	• Common body of knowledge • WHO involvement not conditional on individual member states but broader global interest	• Tailored to local situation • WHO involvement conditional on request of government and activities of other agencies

Figure 1.2 shows schematically that all countries are involved in the common global functions, which are coordinated by (but not limited to) WHO headquarters, and fewer member states are involved with WHO in additional activities that are country specific, depending on their economic and political context.

Figure 1.2 Common global and country specific functions in relation to national capacity



Thus, those countries with high levels of resources (such as the industrialised countries) may not have any country specific activities, but be fully engaged in common global activities. At the other end of the continuum, where countries have few resources, or are in emergency situations, there may be many WHO country specific activities. As shown in Figure 1.2, all countries would be involved in the common global activities, but the UK, with high resources, would have no WHO country specific activities, Thailand would have some, while Mozambique, with few resources, would have many WHO supported activities.

Although not indicated in the figure above, there may be situations in which countries which are extremely unstable, or at war, have no WHO country specific activities, but rely on non-governmental organisations to fill gaps temporarily.

1.5 WHO as an organisation

Any analysis of WHO's activities at country level begins with the need to understand the nature of WHO as a membership organisation. It is unique among international health organisations in that the Ministers of Health of its member states constitute its governing bodies, the World Health Assembly (WHA) and the Executive Board (EB), and therefore define and participate in the Organisation's activities. Table 1.1 compares delegation of certain decision-making responsibilities in some UN organisations. The WHO and FAO are most similar, with the member states directly involved in a wider range of decisions. The WHA meets annually and provides the opportunity for member states' delegations to voice their concerns, and to participate in the formulation of policy for the Organisation as a whole. These meetings are followed by Regional Committee meetings (RCMs), also

usually attended by Ministers of Health and senior ministry officials, to discuss resolutions from the WHA as they apply in the region. Country Office activities are thus strongly inter-related with HQ and RO activities, and cannot be isolated from them.

Table 1.1 Involvement of member states in decision making in WHO and in a sample of other UN agencies.

	WHO	FAO	UNFPA/ UNDP	UNICEF	WORLD BANK
Selection of the Chief Executive	Member States through EB	Member States at General Conference	By appointment UN Secretary General	By appointment UN Secretary General	Board of Executive Directors
Selection of heads of Regional Offices	Member States through RC and WHA	Director General	none	Executive Director	none
Selection of members of Governing Board	Member States through WHA	Member States at General Conference	Elected by ECOSOC; negotiated criteria	Elected by ECOSOC; negotiated criteria	Constituencies as per article of agreement, weighted by contributions
Approval of programme budget	Member States at WHA	Member States at General Conference	Executive Board	Executive Board	Board of Executive Directors

Thus overall, the Organisation's role has been defined by collaboration with the Ministers of Health of member states and their collective and individual needs, rather than by a focus on specific health programmes. This is basic to the intrinsic strength of the Organisation, but at the same time constitutes a potential risk in terms of making the decision-making processes more complex and cumbersome.

Finally, it is important to recognise that WHO activities at country level are influenced by the three levels of the Organisation: Headquarters (WHOHQ), Regional Offices (WHORO) and Country Offices (WHOCO). This interaction encompasses, not only policy-making, but financial and resource flows, mechanisms and procedures for defining and undertaking activities.

A special situation exists in the WHO Region for the Americas, with the dual existence of PAHO and AMRO, each with its own constitution, budget, staff and systems. The same person functions as the director of both PAHO and AMRO facilitating the two organisations to function as a single entity. PAHO/AMRO is often described as a unique organisation, different from the other regional offices. It is constitutionally part of the inter-American system, has a long historical background as an independent interagency organisation specialising in health and is based on a strong constitutional pan-Americanism. In financial terms, the Regional Office is more independent than other WHO regions, as member countries pay a contribution directly to PAHO, in addition to their membership fee to WHO. The portion of WHO contributions to the regional budget has declined over the last 10 years.

WHO global priorities are outlined in successive General Programmes of Work (GPW) which are used to guide country level planning and activities. The two biennia of this Study were covered by the Eighth General Programme of Work 1990-1995,¹¹ the focus of which was to promote, coordinate and support the efforts of Member States individually and collectively in implementing the Global Strategy for Health for All by the Year 2000. The Eighth GPW has 15 objectives¹² in addition to the following cross-cutting themes:

- allocation of resources to countries most in need,
- more equitable distribution of health resources among and within countries,
- programmes that build national capacity and self-reliance, and which are sustainable when WHO is no longer involved,
- the need for improved managerial processes to ensure effective use of WHO resources,
- Resource mobilisation.¹³

The Ninth General Programme of Work 1996-2002,¹⁴ identifies six major managerial tasks to be accomplished to ensure that the Programme has greatest impact:

- (1) priority-setting;
- (2) programme development, implementation and evaluation;
- (3) ensuring a more unified Organization;
- (4) mobilisation and allocation of resources;
- (5) maintaining WHO's technical excellence; and
- (6) clarification of WHO's role in the United Nations System.

The policy and programme framework of the Ninth GPW provides the main *structure* for presenting the qualitative and quantitative data collected, although the quantitative *data* reflects activities implemented during the Eighth GPW. Themes from both the Eighth and Ninth GPWs are used in examining the support of WHO to the case studies.

1.6 Outline of the Report

Chapter 1 provides a brief background to the Study, and describes the conceptual framework used for analysis. Annex 3 describes the study design and the methods used to assemble information. Chapter 2 explores how contextual factors influence WHO's support to countries. Chapter 3 examines *how* WHO is carrying out its activities, looking at structures and procedures, and Chapter 4 at *what* WHO is doing in countries in terms of where funds are directed and what programmes are supported, and the following Chapter 5, describes the findings from the in-depth coverage of the three tracer policies. Chapter 6 describes the links and partnerships between the various actors in the health sector at the country level. These chapters are all descriptive, and are based on the findings from the country visits and various instruments used. Chapters 7 then analyses and evaluates how well WHO is doing in relation to its mandate, programmes, structures and processes and links. Chapter 8 provides some prescriptive options for the future, to stimulate discussion, and Chapter 9 presents selected recommendations. Up to and including Chapter 7 focuses primarily on the case studies, while Chapters 8 and 9 are forward looking.

1.7 Summary of main issues: Background and Conceptual Framework

1. The Study focuses on *all* WHO's activities at the country level, whether supported by RBFs or EBFs, and whether channelled through the WHO Country Office WHO Regional Office or Headquarters. WHO country level activities cannot be isolated from WHOROs and WHOHQ.
2. In the twelve case studies, WHO is only one of many actors in the health sector, so the Study explores the roles of all actors in the health system, including the Ministry of Health, other multi- and bilateral agencies and nongovernmental organisations, their interactions, and their perceptions of the WHOCO and WHO support.
3. Two sets of functions undertaken by WHO are differentiated: common global functions, which have relevance for, and involve all countries, and country specific functions which vary with the needs of the country, are tailored to it, and evolve over time. The main distinction is in breadth of relevance rather than level of operation. Both sets of functions are applicable in the twelve case studies.
4. The nature of WHO as a membership organisation, involving the Ministers of Health of member states in its governing bodies gives it a unique position among international organisations, and has resulted in a special relationship at the country level, between the WHOCO and the Ministry of Health.
5. WHO global priorities are outlined in successive General Programmes of Work. The Eighth GPW has four cross-cutting themes which are used in examining WHO support to countries:
 - allocation of resources to countries most in need,
 - equitable distribution of health resources,
 - programmes that build national capacity,
 - improved managerial processes and effective use of WHO resources,
 - resource mobilisation.

Endnotes: Chapter 1.

- ¹ For example: COWI consult (1991), Effectiveness of multilateral agencies at the country level (Copenhagen: DANIDA); Daes E & Daoudy A (1993) Decentralization of Organisations in the United Nations System: Part III: The World Health Organization (Geneva: UN Joint Inspection Unit); and WHO (1995, 1996 & 1997) WHO reform and response to global change: role of WHO Country Offices, Reports to the 97th, 98th and 99th sessions of the Executive Board: EB97/5; EB97/13; EB98/??; EB99/15; Tomorrow's global health organization: ideas and options (1996) Ministry of Foreign Affairs, Sweden.
- ² Vaughan JP, Møgedal S, Kruse SE, Lee K, Walt G and de Wilde K (1995) Cooperation for Health Development: Extrabudgetary funds in the World Health Organization (Oslo: Governments of Norway, Australia and United Kingdom).

Vaughan JP, Møgedal S, Walt G, Kruse SE, Lee K, and de Wilde K (1996) WHO and the effects of extrabudgetary funds: is the Organization donor driven? *Health Policy and Planning*; 11(3)

Vaughan JP, Møgedal S, Kruse SE, Lee K, Walt G and de Wilde K (1996) Financing the World Health Organization: global importance of extrabudgetary funds; *Health Policy* 35 (1996) 229-245
- ³ Lucas A.O., Møgedal S, Walt G, Kruse SE, Lee K (1996) Inception Report: A study of WHO's Support to Programmes at Country Level (London: Oslo: LSHTM, DiS).
- ⁴ Regular budget funds (RBFs) are made up of the assessed contributions of member states to the Organisation. Extrabudgetary funds (EBFs) are those funds which are given voluntarily to the Organisation, from a number of different sources, defined by the UN as "all resources other than those of the regular budget".
- ⁵ The selection of the case studies is discussed in Møgedal S, Walt G, Hodne Steen S & Lee K (1996) Selection of Countries and Contribution to Study Framework (Oslo: DiS).
- ⁶ Vaughan JP, Møgedal S, Kruse SE, Lee K, Walt G and de Wilde K (1995) Cooperation for Health Development: Extrabudgetary funds in the World Health Organization (Oslo: Governments of Norway, Australia and United Kingdom). See page 7-8
- ⁷ PAHO's Re-thinking International Cooperation in Health discusses the definition and nature of technical cooperation in the light of the change in health policy environments in the Americas. Report of Technical Discussions, March (1996) (PAHO/DAP/26.11.29).
- ⁸ Constitution of the World Health Organisation, 1946; chapter II Article 2(a)
- ⁹ Jamison D, Frenk J, Knaut F, Essential functions of International Health Organisations, *The Lancet* (forthcoming)
- ¹⁰ Sepulveda J, Lopez-Cervantes M, Frenk J, Gomez de Leon J, Lezana-Fernandez M, Santos-Burgoa C, 1992 Key issues in public health surveillance MMWR Supplement 41; 61 - 76.
- ¹¹ WHO Health for All Series No. 10 Eighth General Programme of Work covering the period 1990-1995, WHO Geneva, 1987.
- ¹² Eighth GPW, page 10-11.
- ¹³ Eighth GPW, page 20.
- ¹⁴ Ninth General Programme of Work Covering the period 1996-2001 World Health Organization Geneva, 1994, page 52

CHAPTER 2. THE COUNTRY CONTEXT

2.1 Introduction

This chapter explores the interaction between contextual factors (economic, social, political or cultural) and health system activity in any individual country, and how that in turn, may affect the work of WHO at country level.

The 1980s and 1990s witnessed major changes in the global political and economic environment. The end of the cold war had repercussions that went well beyond Eastern Europe and Soviet-American relationships. Many countries experienced a withdrawal of aid from the Eastern bloc; democratic and neo-liberal market systems received enhanced attention; and in Latin America and Africa specifically, the focus was on establishing, restoring and sustaining democracy and good governance. The same period was dogged by global economic recession, (except for Asia), with some countries fighting for economic and social survival, and with partial recovery only apparent for some parts of the world at the end of the 1990s.

While such factors were largely experienced at the country level, they also had their effect on international organisations such as WHO. Member states' economic difficulties meant that over this period full contributions to the regular budget were often delayed or unpaid, and with the regular budget set at zero growth, the Organisation is operating in a situation of declining resources in its core budget. WHO's annual budget is around US\$1 billion, compared with UNICEF's at just over \$1 billion, and the World Bank's loans on population, health and nutrition which are around \$2.3 billion annually. With the break up of the Soviet Union, many new members joined the Organisation, with urgent and extensive needs. Some dissatisfaction with WHO among donor member states put Extrabudgetary funds at risk, although not across all programmes. WHO was thus, not only itself affected by global and political change, but its Country Offices were witness to what was often painful economic and political reform.

These contextual changes influence what WHO can and should be doing in countries, and need to be considered as a background to the working of the Organisation.¹

2.2 Changes in the policy environment

The shift from health service consolidation to health system reform

Until the late 1970s there was little challenge to the role and function of Ministries of Health, which were vested with responsibility for state health policy, including the provision of health care, even though there were differences between different parts of the world. In Latin America, Ministries of Health usually provided services for the poor, while much richer Institutes of Social Security looked after workers and their families; in many Asian countries Ministries of Health functioned in very pluralistic health systems, where private practice flourished; and in Africa Ministries of Health were often the main providers of health services for urban, and with the extension of primary health care in the 1980s, for rural, populations.

By the 1980s, however, dissatisfaction with the role of the public sector, economic recession and structural adjustment policies, combined with the rise of neo-liberal policies led to a much more complex environment, in which many different options were explored. Many Ministries of Health which once had dealt largely with WHO and possibly UNICEF, were now faced with introducing policy changes conditioned by World Bank loans, and were approached by many different actors offering advice, assistance and alternative options in the health sector. The entry of the World Bank as a major financial lender in health in the 1980s, had a significant effect on the interactions of the different players within the health sector.

Thus, where WHO was once seen having a relatively exclusive relationship as international servant to the Ministry of Health, in expanding and improving health service delivery, in the 1990s this was no longer necessarily the case, partly because the focus of health policy had changed. New issues in the health sector included financing, decentralisation, regulation, and attrition with less emphasis on health services expansion. The reform movement was spearheaded by the World Bank and certain bilaterals, and WHO was slow to recognise the changing emphasis. Thus, by the 1990s, many MoHs had shifted their focus away from delivery of health services towards system reform issues.

All twelve countries in this Study are undergoing health sector change in some form, although in most it is an incremental process. Most are decentralising, quickly or slowly (Bangladesh and Haiti appear to be the exceptions currently); most have expressed a desire to encourage greater private investment; and where the public sector has dominated health care delivery, countries are exploring ways of limiting the public sector and expanding the private sector (Mali, Ethiopia, Mozambique, Tanzania, Cameroon, Nicaragua). In Thailand there is a serious attempt to look at alternative methods of financing the health system.

The growth in the number of health sector actors

As the context shifts interest from health services expansion to systems reform, so more actors - most notably the World Bank and the regional development banks - become important players in the policy environment. As is clear from Table 2.1 below, the twelve countries in this Study all have a myriad of different external agencies working in different ways with the MoH. In almost every study country the World Bank is a major provider of resources for the sector, and in some countries the regional development banks are playing that role too. Because of their funds and policy conditions, these financial agencies have easy access to, and considerable influence in, the MoH. They sometimes influence the attitudes of bilaterals too, so that the MoH may be faced with a coalition of donor interests in favour of a particular policy, for example the Consortium in Bangladesh. In a few countries, the policy environment may be dominated by a particular bilateral which has close ties for historical, geographical or other reasons: in Tanzania, DANIDA plays this role, as does AusAID in Papua New Guinea. How these relationships are played out, how alliances form and break down, are unique to each country context and over time. In one of the case studies, the MoH, WHO, and the World Bank formed a coalition to counterbalance the actions of one bilateral.

Table 2.1 The most influential health sector external donors in the case studies*

Countries	External donors**		ODA as % of GNP***
	Multilateral	Bilateral	
Bangladesh	World Bank, EU	Australia, Belgium, Canada, Germany, Japan, Netherlands, Norway, Sweden, UK, USA	5%
Cambodia	World Bank, Asian Development Bank, EU	Australia, France, Germany, Japan, UK, USA	27%
Cameroon	UNICEF, UNFPA, World Bank, EU	Belgium, China, France, Germany, Italy, Care International****	6%
Ecuador	World Bank, UNICEF, UNFPA, EU	Belgium, France, Japan, Netherlands	2%
Ethiopia	UNICEF, UNDP, UNFPA,	Italy, Japan, Netherlands, GLRA, Sweden	23%
Haiti	UNICEF, UNFPA, World Bank, UNDP, EU, FAO, IDB	USA, Canada	5%
Mali	World Bank, UNICEF	Belgium, Germany, Switzerland, USA	13%
Mozambique	World Bank, African Development Bank, EU, UNICEF, UNDP,	Denmark, Finland, Netherlands, Norway, Switzerland	85%
Nicaragua	UNICEF, EU, World Bank	Denmark, Finland, Germany, Netherlands, Spain, Sweden	24%
PNG	Asian Development Bank, UNICEF, UNFPA	Australia, Japan	8%
Tanzania	World Bank, UNICEF, UNDP, UNFPA	Denmark, Germany, Japan, Norway, Sweden, Switzerland, UK, USA	39%
Thailand	UNICEF, UNDP, UNFPA	Australia, Denmark, Germany, Japan, Sweden, Redd Barna****	1%

* Source: National Consultant's Data Instrument. National Consultants were asked to list the ten most important donors to the health sector. This list does not therefore, include all donors, and is based on perceived importance and financial assistance. In Haiti, Ecuador, Ethiopia, Nicaragua and PNG, WHO was mentioned as one of the most important donors.

** External donors are listed alphabetically and not according to importance.

*** Source: UNICEF: The State of the Worlds' Children, 1996 (Figures all for 1993)

**** Cameroon and Thailand were the only countries where a non-governmental organisation was named as one of the ten most important donors to the health sector.

What this table does not show is the role of WHO in relation to the other actors. From the country case studies, WHO plays, or has played, a key role in a number of countries: in Cambodia, through its alliance with particular bilaterals; in Papua New Guinea, where there are relatively few large actors; and in the three examples from the PAHO/AMRO region, WHO has been a central health sector actor, often working closely with bilaterals and the MoH. In other countries WHO has been less important: in Mozambique, Tanzania, Cameroon, Mali and Ethiopia the WHOCO's role has been low profile, although in Ethiopia and Mali there is a close relationship with the MoH. In Thailand the health sector is firmly led by the MoH.

2.3 Countries are diverse

As is clear from Table 2.2 the twelve countries are diverse. Arranged according to GNP per capita, they start with very poor countries such as Mozambique, with \$90 per capita, and include Thailand with over \$2,000 per capita. Their population size ranges from 4 million in Nicaragua and PNG to 118 million in Bangladesh. Other indicators also demonstrate the wide variations between countries.

Table 2.2 Socio-economic and health indicators for twelve country case studies

Country	Total population 1994 (millions)	GNP per capita 1993	% govt budget on health 1986-1993	Population annual growth rate 1980-1994	Under five mortality rate 1994	Life expectancy at birth 1994
Mozambique	16	90	5	2.6	277	46
Tanzania	29	90	6	3.1	159	51
Ethiopia	53	100	3	2.7	200	47
Cambodia	10	200	6	3.1	177	51
Bangladesh	118	220	5	2.1	117	55
Mali	11	270	2	3.0	214	46
Nicaragua	4	340	13	3.0	68	66
Haiti	7	370	4.5	2.0	127	56
Cameroon	13	820	3	2.8	109	56
PNG	4	1,130	8	2.2	95	56
Ecuador	11	1,200	11	2.5	57	69
Thailand	58	2,110	8	1.6	32	69

Sources: UNICEF 1990, 1996 *The State of the World's Children* and The World Bank, *World Development Report* 1993.

Key

3	Poor indicator compared to the twelve case studies
4.5	↓
8	↓
13	Positive indicator compared to the twelve case studies

What Table 2.2 demonstrates is huge variation: a twenty fold difference in gross national product, a ten fold difference in under five mortality rates, and a 23 year gap in life expectancy. It also shows the dangers of assuming what these indicators mean for outcomes. For example, Nicaragua's health performance is better than might be predicted by looking at its gross national product, whereas Mali and Cameroon's are worse. Nevertheless, the table suggests that it is possible to group the countries into different, although overlapping categories. The countries at the top of the table are those in greatest need by economic criteria, some of which fall into another group of countries, which may not be as poor, but are 'post' conflict societies, recuperating from low or high intensity conflicts over many years. Then is the group of countries, whose political and economic profile puts the government under some level of stress. And finally, comes Thailand, an institutionally robust country in positive economic development.

The fluctuating nature of the groupings is important, because it is clear that countries in greatest need may also be vulnerable to conflict and violence, and countries which are in 'post' conflict situations still have great needs and are likely to be fragile politically and economically. Indeed, 'post' conflict needs to be seen against a continuum of 'sporadic peace' to 'continuing rehabilitation'. Finally, even countries in positive economic growth may suffer political or economic stress at certain times.

2.4 Countries health systems capacities are diverse

Central to this Study is the capacity in each country to plan, manage and sustain its own health system, and to participate with other countries in activities that promote health and control disease. The role, relevance and effectiveness of WHO at country level is closely related to the health system capacity in each country. Thus, while a country's health system capacity is affected by the broad contextual factors (political, economic, social and cultural), some of which have been described, it is also determined by the availability and use of financial and human resources, established health policies and the structure of health services.

Table 2.3 National Health system capacity.²

Indicators	Low capacity						Medium capacity			High capacity		
	Mali	Ethiop	Moz	Cambd	Bang	Haiti	Camrn	Tanz	PNG	Nicar	Ecuad	Thai
Access to health services	40	46	39	53	45	60	80	93	90	83	80	90
MMR	2,000	560	300	500	600	600	430	340	900	160	170	50
IMR	117	114	158	110	85	71	66	100	67	46	31	27
Immunisation coverage	46	51	46	79	69	34	46	38	85	85	74	94
Literacy rate	29	35	40	35	37	44	62	67	71	65	90	94
HDI	0.23	0.22	0.28	0.35	0.37	0.34	0.47	0.36	0.53	0.53	0.78	0.83
Human resources	25 1	79 5	48 6	10 0.6		7 2	12 2	23 8	6 1	1.5 0.5	0.8 0.6	6 2

Access; % of population with access to health services (urban + rural), source State of the World's Children

Immunisation coverage: Fully immunised, DPT, 1yr, source State of the World's Children 1997

Literacy rate, adult, both sexes, source Human Development report 1997: HDI same source

Infant mortality rate 1995, source State of the World's Children 1997

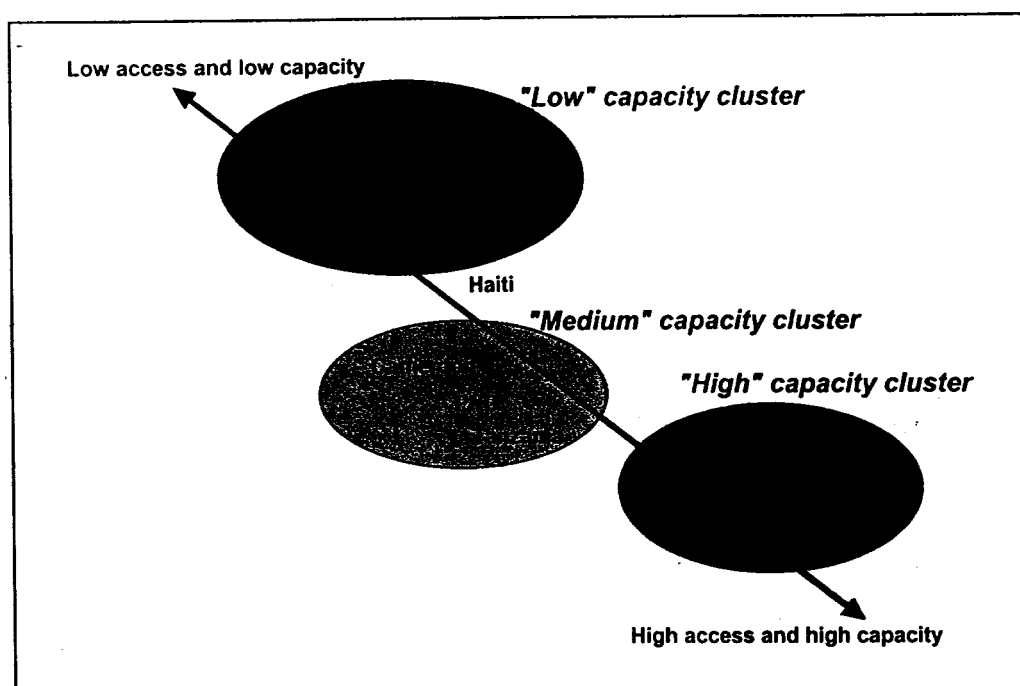
Maternal mortality rate 1980-92, source State of the World's Children 1996

Human resources: Population pr physician (top) and population pr nurse (bottom) (population in 1000), source Social indicators Development 1996 (World Bank)

The twelve case studies differ considerably in both financial resources and in the health and social sector policies they have pursued. Human resources and skills also vary greatly, for example, from Ecuador's physician-population ratio of 1:804 to Ethiopia's of 1:78,936 or Cambodia's nursing-population ratio of 1:1,348 in comparison with Tanzania's of 1:7,988.³ In order to compare the twelve countries, the Core Team classified the countries using a number of secondary health indicators which provide indirect measures of the capacity of specific aspects of a health system.

While there are obvious similarities between Table 2.2 and Table 2.3, there are also some interesting differences. The criteria that most clearly separate the countries in terms of what the Study refers to as “capacity”, is access to health services, literacy rate and the Human Development Index (HDI). For example, in spite of being one of the poorest countries among the twelve (Table 2.2) Tanzania is closer to countries such as Cameroon and Papua New Guinea, probably because of its early demonstrated commitment from government to provide services. Similar indications of the importance of established health policies can be noted also for Nicaragua. In spite of higher GNP and human resources, Mali is the country with the weakest capacity in their health system, according to the criteria used here. Based on a combined assessment of the indicators presented in Table 2.3 the countries are, for the purpose of this study, grouped in three clusters, as illustrated in Figure 2.1.

Figure 2.1 Country capacity clusters



While the distinction between the three clusters is not great and is relative to the sample of countries in this study, it still provides a basis for exploring differences and similarities. Any such classification, given that it depends on aggregate and insufficient data must, however, be treated cautiously.

Three of the five AFRO case studies fall in the low capacity cluster, with the remaining two in the medium group. Conversely, two of the three PAHO/AMRO case studies are in the high capacity cluster. The two case studies from SEARO and WPRO each fall into different groups, one in the low capacity cluster, and the other in either the medium or high group. The evident disparity between the AFRO and PAHO case studies is a finding that recurs throughout the report. In general, the countries in greatest need, according to social and economic criteria, are also those which have the lowest capacity in their health systems. One factor that makes a clear distinction is that PAHO/AMRO and WPRO have

rich partners within the region which contribute to the countries directly and through WHO. Conversely, AFRO has no rich partners within the region.

The similarities and differences were explored across four dimensions of country capacity: capacity for policy and planning, for service implementation, for human resources and for research. Details of this information as synthesised from the findings in each of the case countries, are found in Annex 7, p.A54 to A69.

Policy and planning

Although all twelve countries had planning units in the MoH, some established 20 years ago, only in Thailand did all the most senior planners have relevant higher degrees (PhDs and MSc's). Certainly among the low capacity cluster (countries in greatest need) the Study Team observed that policy and planning were often poorly coordinated. Information was fragmented and there was sometimes a mismatch between policy initiatives and implementation capacity. Mozambique for example, even with an unusually clear MoH health policy and commitment to reform has had to spend considerable resources on rehabilitation of the health infrastructure after years of conflict, impeding the implementation of health reforms. In the middle group of countries, many of the same features of weak policy and planning are repeated, with poor quality services and information systems. In the better-off cluster of countries there is more capacity for planning (Thailand stands out in this regard), although Ecuador is dogged by poor consensus and discontinuity of policy formulation and implementation. However, these last are the countries where reforms (especially financial reforms such as insurance options) are being seriously considered.

Service implementation

Service coverage is relatively poor in the countries of greatest need, either because the infrastructure was never extended to the periphery, or because it has been damaged, and with this goes poor or uneven distribution of drugs, poor quality services and, often, demoralised staff. Those 'post' conflict countries are faced with huge regional discrepancies and the need to rehabilitate and rebuild structures and policies. A similar picture is painted for the medium capacity cluster of countries (which are often politically and economically fragile) where the health facility infrastructure may have been developed, but not sustained, where non-governmental organisations may be providing many rural services, and where the quality of service is uneven, reflected in low utilisation rates. Tanzania stands out as a counter example in this cluster. Finally, in the better-off group of countries there is a definite primary health care system (although less true for Ecuador than Thailand and Nicaragua), and problems the countries face concern appropriate service packages, the public/private mix and equity issues.

Human resources

Not surprisingly, the poorest countries have a very thin layer of skilled personnel, public sector salaries are low, conditions and terms of service poor, and there are few incentives and opportunities for training. In the medium cluster of countries there are more skilled human resources, although skills probably need updating, and terms and conditions of service are also poor. There is a loss of personnel to the private sector. Even in the better off countries, many of these features are familiar to the health landscape, although less true in Thailand. In most of the twelve country case studies, there were external advisers

(expatriates) in the MoH, providing technical assistance. In Tanzania, for example, between 1992 and 1996 there were 6 Danes, supporting primary health care and AIDS control programmes. The only country which had no external advisers in the MoH was Thailand.

Human resource deficits are exacerbated in many countries by a lack of continuity of senior staff within ministries. The average stay in office of the Minister of Health in these twelve countries was two years. In Bangladesh there have been 6 changes of minister and 9 of permanent secretary in ten years, as is shown in Table 2.4.

Table 2.4 Changes in top personnel in Ministries of Health, 1987 - 1996

Country	Number of Ministers of Health	Director of Medical Services (Professional Head)	Number of top Administrative officers
Bangladesh	6	9	9
Cambodia	4	5	4
Cameroon	4	1 until 1989. From then a system of 5/6 Directors	3
Ecuador	7	7	9
Ethiopia	4	4	3
Haiti	11	12	NA
Mali	4	5	8
Mozambique	3	4	2
Nicaragua	4	5	4
PNG	8	NA	5
Tanzania	4	4	7
Thailand	7	NA	5

Source: National Consultant's Data Collection Instrument

NA: No information available.

Such turnover may lend evidence to the perception that the government's health policy lacks vision, but this depends on the country. Where there is a firm infrastructure and health policy, turnover at the top may not have severe repercussions. In Thailand there have been 7 changes of Minister and 5 of top civil servant in 10 years, but this does not appear to have undermined the Ministry of Health. However, such turnover means that there may be little continuity among the delegations to the WHO Regional Committees and the World Health Assemblies, which may weaken the country's position in being able to contribute to governance of the Organisation or to argue a particular position.

Research

It is not easy to differentiate between the low and medium capacity clusters of countries when it comes to research capacity. Mostly the health research base is limited and fragmented, and depends markedly on the MoH interest in research. Often research is initiated from outside the country, and supported by external organisations such as WHO. There are examples in many of the case studies, including those in greatest need, of attempts to encourage local research, through the Essential National Health Research initiative in collaboration with COHRED (Council on Health Research for Development) and the Joint Health Services Research project. There are also pockets of excellence in countries with very limited resources (such as malaria research in Mali). Again, Thailand stands out as an exception, with a fast developing research base of national

researchers, now advising at the international level, and contributing to WHO common global functions.

Finally, it is also clear that whatever the health system capacity, all twelve countries face considerable constraints and difficulties. For example, policy and planning capacity, monitoring, quality assurance and information systems, are quite weak (except for Thailand), regardless of whether the country has had a history of disruption by war or conflict or has no institutional memory of a previously well-functioning system. The problems related to human resources also affect almost all the countries, and call for renewed efforts to improve incentive and support systems to avoid inequities developing into schisms between public and private systems, between rural and urban and within urban areas.

Weak capacity in all these areas makes the countries vulnerable to multiple actors competing in a changed policy environment with different interests and health policy options, and provides a major challenge to WHO's role and contribution.

2.5 Summary of main issues: The Country Context

1. The policy environment within which the MoH interacts with other health actors, including WHO, has changed over the past three decades. In the 1960s there were few actors in the health sector and the MoH and WHO had a close and relatively exclusive relationship. The focus during these decades was on coverage and consolidation of the public sector health service. By the 1990s, however, concern about the constraints on the public health sector led to a shift in focus to reform of the health system. This in turn encouraged many more actors to enter the health policy arena, committing the MoH to relate with multiple actors, and changing its relationship with WHO.
2. The twelve case studies are diverse, and demonstrate substantial differences in GNP per capita, life expectancy at birth, under-five mortality, percentage of government budget spent on health, and so on. In examining capacity and outcomes, it is essential that a wide range of information is used. For example, Nicaragua's health performance is better than might be predicted by looking at its gross national product, whereas Mali and Cameroon's are worse.
3. Although these twelve countries are diverse, and demonstrate substantial differences on a range of indicators, they can nevertheless be grouped into four overlapping categories: countries in greatest need, countries in 'post' conflict, countries under political and economic stress and countries in positive economic development.
4. While each country's capacity is affected by broad political and economic factors, its capacity to plan, implement, and manage its own health system has been determined by the availability of financial and human resources. It is possible to cluster countries into low, medium and high capacity, and these capacity clusters are used in subsequent chapters.

5. Three of the five AFRO case studies fall in the low capacity cluster, with the remaining two in the medium group. Conversely, two of the three PAHO/AMRO case studies are in the high capacity cluster. This contrast between the AFRO and PAHO case studies is a finding that recurs throughout the report and highlights the question of WHO's ability to respond appropriately to the different needs of countries.
6. Given the changes in the policy environment towards a reform agenda, the multiple actors in the health policy arena, and continuing weaknesses in country capacity, WHOCOs are having to respond to a very different set of expectations in the 1990s than they were in the 1960s. The report examines WHO's response and its support to case studies in coping with this changed environment, and their specific needs in the health sector.

Endnotes: Chapter 2

- ¹ "Who should be doing what in International health: a confusion of mandates in the United Nations". K. Lee et al. (1996) *BMJ* i, 302, (Table 1 on page 312).
- ² See Møgedal S, Hodne Steen S, Walt G and Lee K 1996 *Selection of Countries and Contribution to Study Framework* Oslo/London. Most of the indicators are self evident, and were taken from figures given in UNICEF 1995 *The State of the World's Children* and the 1995 World Bank's *Development Report*. Health services coverage (antenatal care and health staff attended delivery); Immunisation coverage (DPT immunisation); Literacy rates (adult literacy rates); infant mortality rates (per thousand live births) and human resources (numbers of doctors and nurses per 100,000 population). For each country these indicators were combined for an overall ranking of low, medium or better health system capacity. The analysis was checked with country case study reports and visits.
- ³ Social Indicators of Development 1996, World Bank

Chapter 3. WHO STRUCTURES AND PROCESSES

3.1 Introduction

This Chapter describes the Country Offices and human resources, the processes and procedures used by WHO to develop, implement and evaluate its work in member countries. It explores how these are utilised, and the roles and relationships between the various levels of the Organisation. In discussing structures and processes, it is important to recognise the wide variation between regions and also within each region. This applies to a whole range of contextual factors such as economic and social factors, distance, communication and management cultures, and is reflected in the commonly stated expression that WHO is not one but seven organisations. Even so, in all the regions WHO operates with a common set of structures and processes, which will be described here. Implications and analysis are provided in Chapter 7.

3.2 WHO Country Offices

All the case studies have a WHO Country Office (WHOCO) with a WHO Country Representative (WR), some other technical staff and some support staff.¹ At present the criteria for establishing a WHOCO include a specific request from the government and a general assessment of a range of factors including the socio-economic development and health needs of the country, and the importance of the WHO input. However, there is no systematic approach to this assessment, nor is there any formal mechanism for reassessing the size, role and functions of the WHOCOs that are in place.

The WHOCOs may be co-located with the MoH or in separate buildings. In either case, the rental and maintenance of the office is meant to be borne by the MoH, though this is usually not the case when premises are separate. Among the twelve case studies, only Nicaragua, Ethiopia, PNG and Thailand WHOCOs were co-located with the MoH. The main potential advantage of being located in the Ministry buildings is the proximity to MoH staff and counterparts to promote a cooperative working relationship and ease of information flow. Conversely, the primary disadvantage stated by some WRs and other key informers for the study is that the WHO staff may lose their advantage as independent and neutral advisors. The ease of interaction facilitated by close vicinity, such as in PNG, was in some cases emphasised as a special advantage, both by the WR and MoH. Opinions expressed by major external donors indicated apprehension over the potential risk for WHO to be "captured" by the MoH and thereby become too limited in its strategic scope. However, concern about "WHO capture" were found whether the CO was located in the MoH or not. It does not appear that co-location with the MoH militates against cooperation with other parts of the UN system, or with other donors, unless there is concern about capture. The study did not examine the potential impact on WHO's functioning if it were to move to common UN premises.

Volume and profile of WHOCO staff

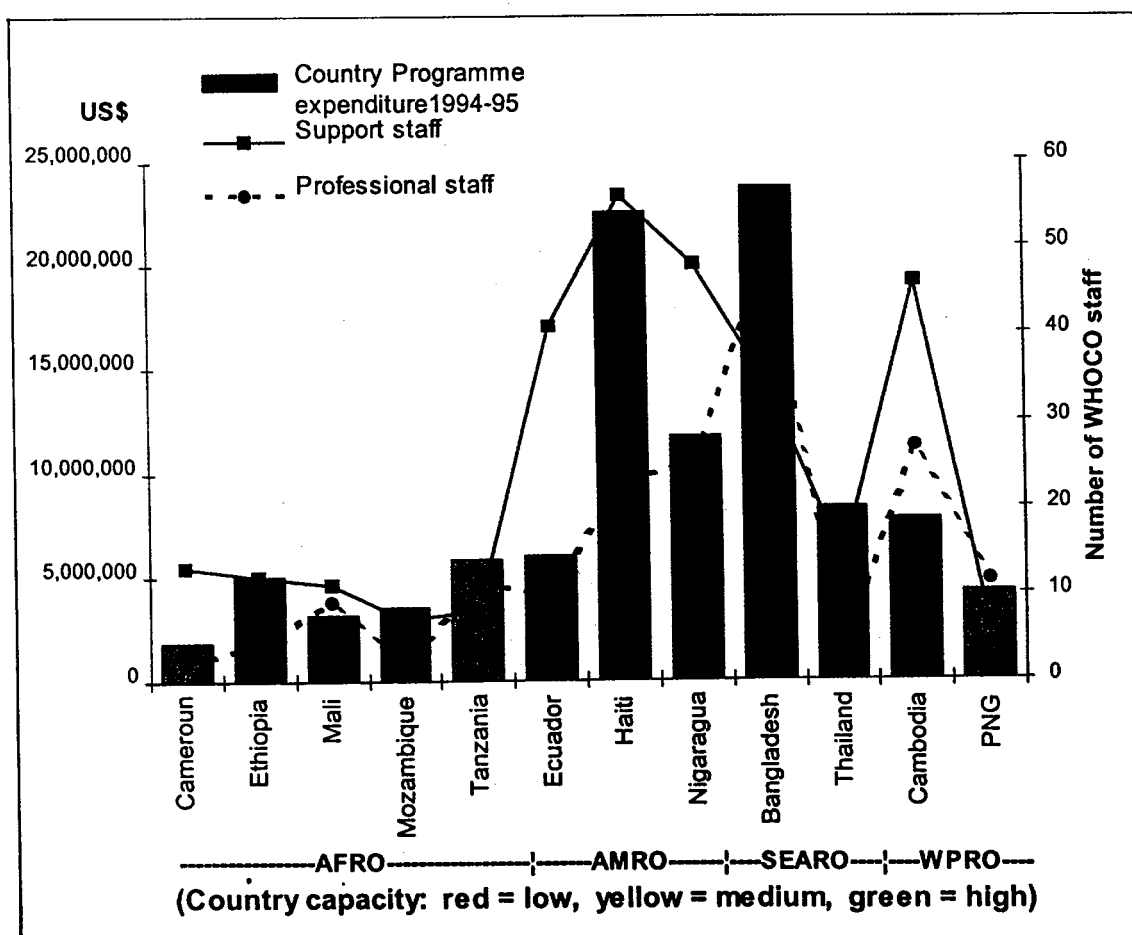
WHOCOs have both professional and support staff. The twelve offices studied vary in number of staff from nine (2 professional and 7 support) in Mozambique, to 83 (49 professional and 34 support) in Bangladesh (Figure 3.1 and Annex 3, p.A27). From a

region wide perspective, the AFRO WHOCOs have the smallest number of staff with an average of 2.1 professional and 3.8 support staff across the 46 countries in the region. In contrast, the largest WHOCOs can be found in PAHO/AMRO where the average number of staff is 4 professional and 5.6 support staff across 30 countries.²

The 3 AFRO case studies in the low capacity cluster (Table 2.3, page 15) have the smallest WHO Country Offices, whereas the 3 low capacity countries from each of the other regions, have the largest number of WHO staff in this sample. The 3 countries in the high capacity cluster (two from PAHO/AMRO) have WHOCOs that are the same size or larger than those in all 5 of the AFRO case studies and PNG. This means that the higher capacity countries have WHOCOs larger than 3 low capacity and 3 medium capacity countries. The high capacity PAHO/AMRO countries have WHOCOs that are substantially larger than all the AFRO countries, PNG (medium) and Thailand (high). The conclusion is that, across the case studies and regions, WHOCO size is not related to country capacity or need (as assessed in Chapter 2).

Within the regions, there appears to be some relationship between need and capacity, and WHOCO size. The low capacity case studies in PAHO/AMRO, SEARO and WPRO have WHOCOs larger than the other case studies in the region with medium or high capacity. However within AFRO the distinction is less clear. Tanzania, a medium capacity country is of similar size or larger than the low capacity case studies in AFRO.

Figure 3.1 WHOCO Staff 1995, and Country Programme Expenditure 1994-95

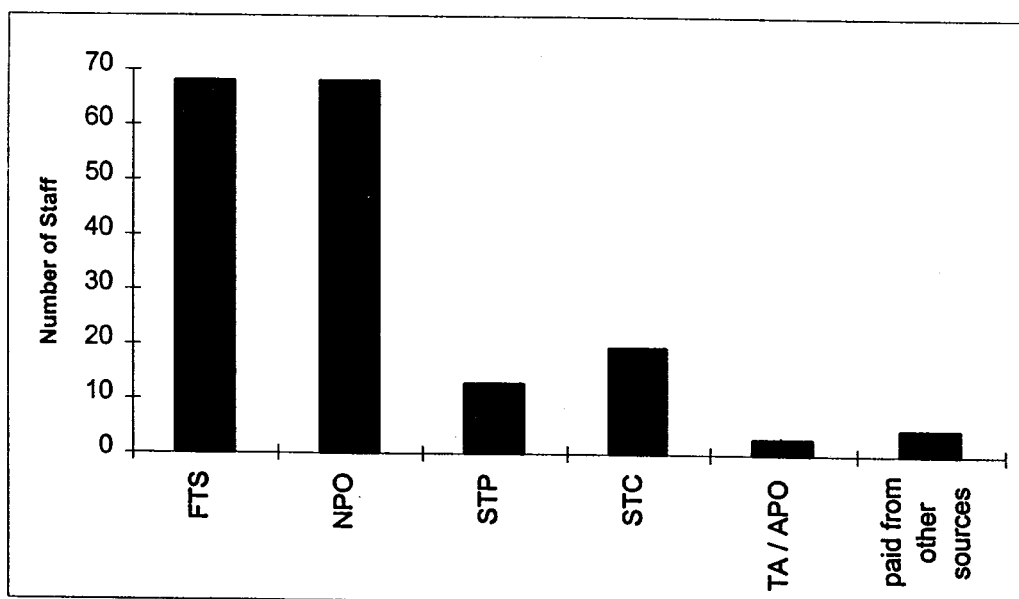


It should be noted that, in some countries, there may be additional staff located within a WHOCO to work on projects for which WHO is the executing agency. In Bangladesh in 1995, for example, there were 53 professional staff working through the WHOCO in this category in addition to the numbers shown in Figure 3.1.

Professional staff can be appointed as fixed-term professionals (FTP), short-term professionals (STP), short-term consultants (STC), technical assistants (TA), programmes officers or national professional officers (NPO) using UN system wide procedures and reward systems. Among the twelve WHOCOs, the proportion of fixed-term professional staff of total professional staff ranged from 22% in Mali to 100% in Thailand (see Figure 3.2). NPOs are national professionals who work on contract for one or more years, but are not always regarded as WHO fix-term staff as they are less likely to work for WHO in other countries. In total, in 1995 there were as many NPOs as FTP (68) across the twelve WHOCOs, mainly in Bangladesh (30) Nicaragua (15) Haiti (12) and Mali (6). There were no NPOs in Mozambique, Thailand, Cambodia or Papua New Guinea, and Cameroon has only recently recruited two.

The WHOCOs in the low capacity case studies in AFRO have fewest FTPs, and all the AFRO case studies have fewer FTPs than the WHOCOs in all the other case studies except Thailand, which only has fewer FTPs than Tanzania (see Annex 3, p.27). Of the total number of professional staff across the twelve countries in 1995, 13 full-time equivalents were STPs and 20 full-time equivalents were STCs, with Cambodia using the highest number of each, and very few in the SEARO or AFRO countries with the exception of Tanzania which had 4 STPs. Haiti, Nicaragua and PNG each used several STCs (see Annex 3). STPs and STCs are often renewed so that such staff can stay with the Organisations for lengthy periods. Frequent or automatic renewal of short-term contracts can be counterproductive to needed flexibility.

Figure 3.2 Professional staff across the 12 WHOCOs, 1995



WHO has evolved a human resource base which reflects its traditional biomedical focus and historical involvement in disease control, surveillance and medical education. It also reflects a bias towards doctors rather than other health professionals, with a remarkably low proportion of nurses in posts. In a period of widespread reform of health systems in countries around the world, the Study found that WHO faces a relative shortage of knowledge and skills required to support many of the case studies, including a lack of health system planners, health economists, hospital administrators and managers, financial management and budgeting specialists, human resource development expertise. Such skills are needed if WHO is to assist Ministries of Health to assess reforms and any associated conditionality.

For example, in SEARO there is limited capacity in the increasingly important areas of health systems management and health sector reform. This was notable in Thailand too, where reform was reported as one of the top priorities. The Thai case Study report stated that the professional skills available at WHOHQ and SEARO were being seriously challenged by this country need (Thailand p.12). Nepal and other less developed countries still need the traditional inputs from WHO whilst Thailand, an outlier in SEARO, needs very different types of support. In the PAHO/AMRO case studies, the need for greater support in health sector reform was noted in all three countries. Yet PAHO/AMRO, has four staff with health economics expertise.³ Similarly, of the 34 health professional staff based at AFRO, 19 have medical backgrounds, 2 are nurses, and only one is an economist (the other backgrounds are dentistry, health education, sanitary engineering, pharmacology). However, in the 46 WHOCOs in AFRO, there are 19 health economists and 16 health service managers, most of whom are NPOs.

Although strengthening health systems was regarded as an important strategy for achieving the overall objective,⁴ little mention is made in the Eighth GPW of the newly emerging field of health sector reform. However, the Ninth GPW identifies the need for better allocation and use of human resources, new financing mechanisms, ways of controlling increasing health costs, new means of enhancing efficiency and improving performance in the health sector.⁵

3.3 Personnel Policy⁶

The quality and competence of WHO staff reflects on the work and reputation of the Organisation. Personnel issues discussed in this section include those around the Country Representatives, other staff and National Professional Officers.

Selection and Recruitment of WRs

WR selection has been on the WHO agenda for four years and is clearly an issue of concern, as 3 of the 7 recommendations made in 1993 for reform of Country Offices relate to WR selection. WR candidates are required to be regular long-term WHO staff members, preferably medical doctors (or have equivalent academic preparation in the provision of health services) with post-graduate training in public health, and extensive experience at senior management level in a national health administration.⁷ In 1995 the DG issued guidelines for WR selection,⁸ which states that vacancy notices are no longer

to be issued for WR posts. The procedure requires the RD to select 3 internal candidates, note order of preference and forward their names, CVs and performance appraisals to the DG for selection. The selected candidate's CV is then submitted to the MoH for final approval. Whether this procedure always produces the right people for the job can be questioned. Clearly, many of the WRs in the case studies had good reputations with their Ministries and other partners in the health sector. However in other countries, there have been in the past, and there are at present, WRs left in place when Ministries of Health, and other partners in health, have requested their removal due to poor performance.

In all but one of the case studies, the current WR is a medical doctor generally with a public health background. In Nicaragua, the WR is a health planner. In none of the twelve case studies is the WR a national of that country, although PAHO/AMRO and AFRO WRs are often nationals from within their respective regions. This is less so in the SEARO and WPRO countries. Because of the importance of WRs understanding Regional Office procedures, AFRO has set an additional requirement of one year's experience working at regional level. In the AFRO and PAHO/AMRO countries, WRs are often from other countries within the region. In AFRO six (of 46) WRs are women, two WRs are nationals, and in South Africa, there is a National Liaison Officer, rather than a WR. It is generally considered that there are too many political and financial pressures on WRs for them to be nationals.⁹

The current WR job description is generic for all WRs globally and was developed around 1987. It is very broad giving WRs little specific guidance but considerable scope. Details need to be adjusted to fit each country situation, but this is left to the WR to work out, rather than being done formally. The broad areas covered in the job description for WRs are presented in Box 3.1. and each has 5 to 10 sub-points covering, for example, support for Health For All, briefing for WHA, mobilisation of resources, transfer of WHO knowledge and information, programming and evaluation, media contact, coordination with other organisations including NGOs, and supervision and support of other WHO staff. WR post grading depends on the size of the country, the size of the WHO country programme and the Country Office. The grade is usually P5, but can range from P3 to P6.¹⁰

Box 3.1 Main areas of work in the WR job description, with percentage of time.¹¹

Assist the government to plan and manage the national health services	25%
Work with the government to plan and manage WHO's work programme	30%
Represent WHO in the country	20%
Manage the WHO Country Office	25%

Briefing for new WRs and ongoing in-service education varies in the different regions. WHOHQ is presently developing a new 2 week course for WR orientation in Geneva which will add some standardisation to the process. PAHO/AMRO, SEARO and WPRO provide leadership and management training for their WRs. Some WRs in PAHO/AMRO and WPRO are invited each year to participate in the RCM and other regional meetings. In AFRO it is assumed that staff employed for WHO should have the

required skills and that the WRs will keep up with issues via communications and meetings. Hence, in-service-training is not provided.

WHO Country Representatives (WRs)

The delegation of authority within WHO is formally:¹²

Director General → Regional Director → Country Representative
--

The strength of this line of delegation and the level of autonomy permitted or taken by the Country Representatives at country level varies considerably across the twelve case studies. WHO Headquarters sometimes works directly with country institutions with little reference to either the Regional Office or the WR. Although direct contact may facilitate ease of functioning for both WHOHQ and the country institution, it can undermine the strength and validity of the WR's role and the reputation of WHO at the country level by reflecting lack of cohesion within the Organisation.

In all regions the WRs must be supported by the Regional Director in order to survive politically in the country. In Ecuador the RD has actively supported the WR in a vulnerable situation with the MoH. On the other hand, the RD is elected by the Ministers of Health at the Regional Committee, so s/he has to be careful about taking a stand in support of a WR in any controversy between the WHOCO and the MoH. This web of necessary political support influences WHO procedures and activities at both Regional and Country levels, and gives the Organisation both unique strengths and profound difficulties.

The level of WR autonomy not only varies in the different WHO regions, but is also less than that of UNICEF and UNFPA at country level. Issues of autonomy relate to independence in decision-making, use of initiative and discretion, especially in emergency situations, movement of finances within budget strategic areas, and mobilisation of resources. There does not appear to be a rational basis for the differences in level of autonomy observed. An example of inconsistency between the regions is that SEARO countries are permitted to reprogramme up to \$25,000 without permission from RO, in WPRO countries the limit is \$10,000 whereas in AFRO countries nothing is permitted. In PAHO/AMRO the WRs appear to have greater autonomy, particularly with regard to the use of different types of approved budgets. If needs in the country change, PAHO/AMRO WRs are permitted to move RBF country level funds from one programme to another, provided they stay in the same Strategic area and within the approved human resource envelope.

In the AFRO countries several WRs complained of lack of autonomy, particularly in relation making financial decisions in emergency situations. However, in Mozambique, a newly appointed WR was proactively seizing greater autonomy, for example demanding information on expected HQ interventions in Mozambique. In the WPRO countries, although financial and personnel management are highly centralised, there is some scope for country specific negotiations for delegated authority, for instance in terms of local purchases if this is more efficient and of lower in cost than if centralised to Manila. The WRs in the PAHO/AMRO region can be directly involved in negotiating with donors

and raising EBFs locally, and therefore can have more influence on the focus and direction of the work of the WHOCO on donor projects.

UNICEF has a much less substantial regional level in its structure than WHO. One consequence is that at country level, UNICEF staff are permitted to make a wider range of decisions independently. This in turn contributes to the perception of the WHOCO as weak and dependent on the regional level. In some of the AFRO case studies, UNICEF clearly saw itself as the leader in international health work, rather than WHO.

Performance Appraisal

Performance appraisal of WRs is not consistent across all countries. In the PAHO/AMRO Regional Office there is an associate director who is responsible for all the WRs of the region, and meets with them regularly. In one case, poor performance was recognised and the WR was removed after 6 months because there had been no satisfactory improvement. Other regions do not appear to have a similar system of dedicated supervision and support for WRs. In AFRO there are a few country examples of where WRs have been left in place even though they were perceived to be functioning poorly and in one case requested by MoH to be removed. In PAHO/AMRO there is some discussion suggesting that as circumstances and the role of the WHOCO changes it may be desirable to change the WR in order to achieve a change of approach more effectively.

Other Staff

Selection and Recruitment

The importance of WHO as a knowledge-based Organisation is significant for the other professional staff as well as the WRs. Access to top quality professionals and their selection and recruitment are important procedural issues faced by the Organisation. Problems identified by the Study include:

- Limited search for qualified candidates for long and short-term international staff. 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 has not introduced new categories of expertise. It is therefore, not a good source of consultants for the types of expertise required to tackle the new challenges confronting the Organisation. Until recently, posts in field projects were not advertised; but this has changed with effect from December 1996.
- Low consultancy fees: WHO offers a maximum of US\$120 per day. Some other UN Organisations pay significantly higher: UNDP consultancy rates range from \$220 to \$400/day, while World Bank rates range from \$220 to \$700/day depending on the skill and seniority of the consultant, and can go as high as \$1,000/day in special circumstances. UNICEF pays \$80 to \$120/day, similar to WHO. Bilateral aid agencies usually pay high commercial rates. Low fees may limit WHO's ability to attract top specialist consultants.
- Long delays in processing recruitment: it can take more than a year from advertisement to commencement of duties. However, some of the delays are outside the control of WHO. For example the Study team were told that it can take 6 to 12

months to obtain national clearance of a proposed candidate by the Bangladesh Government.

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. (Thailand Report, p.12)

Use of short term staff

Because of zero growth of WHO's regular budget, the Regions and Country Offices have had to take coping measures to accommodate inflation and other cost increases, e.g. in some regions, staff vacancies have been frozen or deleted and duty travel reduced. In the WPRO countries the 1992-93 biennium was the first period this struck really hard, resulting in a series of frozen and semi-frozen posts. Meanwhile, where there are donors willing to provide funding, STPs and STCs are used to cover essential work.

Partly in response to budgetary pressures, WHO is making greater use of shorter contracts (STPs and STCs) of 3 to 24 months.¹³ A consequence of this, in addition to giving greater control over personnel expenditure, is that it gives the Organisation the opportunity to be responsive to the changing staff skill mix needed within countries. Long-term staff who stay in the same position over many years can become resistant to change, inhibiting implementation of new initiatives (e.g. in Ecuador). The time of long-term professionals within WHO may be over, with more frequent change on the horizon. This means that there is a need to create selection, recruitment, monitoring and evaluation systems that can cope with frequent changes in staff. The customary practice of frequently renewing STPs and STCs will also have to change.

In-service Training

In-service training and professional development of staff also varies between the regions. It is given most importance in PAHO/AMRO, where emphasis is placed on upgrading the formal qualifications of staff (masters degrees for example). This includes the use of educational leave. Officials at AFRO clearly stated that they expected staff employed for WHO to have the skills required and therefore not need in-service education. With greater use of shorter contracts, rather than long-term staff, then approaches to the necessity and type of in-service training will have to be considered.

National Professional Officers

Local professional staff, or National Professional Officers (NPOs) are used most extensively in AFRO and PAHO/AMRO, with few in SEARO or WPRO (but 30 in Bangladesh). NPOs are recruited and employed locally, with salaries established by the UN system, between the WHO Professional and General Service levels, making them significantly less expensive than international staff. In AFRO, NPOs are presently employed on SSAs (special short assignments) but the intention is for them to become

fixed-term WHO staff with 2 year contracts. This has to be approved by HQ, after a one year probation period. However, the lengthy procedure involved in establishing the posts as fixed-term, causes long delays and staff shortage problems for some AFRO Country Offices (e.g. Cameroon). In PAHO/AMRO, NPOs are fixed-term WHO staff, usually with more definite employment status than the international staff.

The employment of national experts in WHO offices is a contentious issue. In favour of the using national experts in WHO offices is that, apart from their technical expertise, they have the advantage of greater degree of familiarity with the local culture than expatriate staff. Furthermore, national staff cost less to employ than expatriates of similar grades. But there is an inherent anomaly in this policy in that WHO normally provides expertise that is not available within the country. National experts, who would normally be employed by national institutions, are not available to the Ministries of Health because of low national salaries and other poor conditions of service. The use of nationals in WHO's Country Offices, widely practised in the African region, provides a short term solution to a deeper problem about the human resources policies of many developing countries. WHO should use its influence to persuade member states to develop more realistic human resources policies that would enable them to recruit and retain their own trained nationals. In addition, WHO should review and make explicit its policy and rationale with regard to recruiting national staff.

Employment of NPOs has advantages of providing the WHOCO with local knowledge of the country situation, at less expense, and with more control, as MoH and WRs select NPOs. Thus, with greater numbers of NPOs, there will be fewer international posts, so the Regional Offices will be less involved in staff selection. On the other hand, WRs may face pressures from government to select individuals not best suited for NPO positions. Thus criteria and procedures must be transparent and WRs need training and RO support in staff management and appraisal. In PAHO/AMRO such management training has recently been introduced.

In the AFRO countries NPOs were the primary mechanism used to make up Country Teams in order to strengthen the Country Offices from about 1986. The aim was for all countries to have at least one NPO for the Disease Control Programme, and then select 3 or 4 additional NPOs to cover other programme areas. The structure and composition of Country Teams has to be approved by the RD. In AFRO and PAHO/AMRO, some NPOs receive briefing/training at the Regional Office. In PAHO/AMRO, others may receive training by participating in sub-regional meetings.

In the AFRO countries, there are few international staff (other than the WR) in the Country Offices. There is more of a combination of international staff and NPOs in the PAHO/AMRO Country Offices with the WR usually supported by at least two other international staff who tend to be in leadership and coordinating positions. It seems that this is a deliberate policy. There does not appear to be any other rationale as to whether staff recruited should be international or NPO.

3.4 Communication

Both contextual factors outside the control of WHO (such as communication infrastructure) and the multilevel and hierarchical structure of the Organisation influence

the nature and speed of communication. The possibilities for effective communication within and outside the Organisation across all the regions have recently been improved by using local computer networks, computerised financial and administrative systems, e-mail and the Internet. The WHOHQ website provides the opportunity to obtain a wide range of technical documents as well as EB, WHA and RCM resolutions and documents.

Communications with Regional Offices

The ROs are a main source of administrative and technical support for the WHOCOs. The strength, relevance and speed of this support varies between the different regions. For example, in WPRO, the RO style of operation is highly centralised but responsive to country needs and requests. In PAHO/AMRO the WRs appear to have greater autonomy, and receive significant support through sub-regional meetings. In SEARO communication between the WRs and RO is less direct or supportive, and WRs are viewed as lacking skills for effective programme implementation.¹⁴ There have been improvements in AFRO in recent times, especially with wider availability of e-mail, improved disbursement procedures and the possibility for the WRs to have direct contact with the RD if there are any problems.

AFRO has introduced a system of a week long orientation in Brazzaville for new Ministers of Health. However, the WR does not accompany the Minister to AFRO during this formative time. WPRO provides new Ministers with orientation packages and arranges visits to the RO. PAHO/AMRO uses sub-regional meetings to assist new ministers in becoming familiar with the Organisation.

Regional Meetings

Countries send a delegation to the annual Regional Committee Meetings (RCMs), usually consisting of the Minister or a Secretary of Health and selected technical staff. Some WRs also attend. In all the Case studies the RCMs are seen as more relevant fora for discussion of country issues than the WHA. Several regions can demonstrate important regional or subregional policy initiatives which are seen as very relevant for countries. RCMs thereby have a potential political impact on countries' health systems, probably stronger than the WHA. Key interviewees for the Study did however express some concern that Ministers of Health may be more concerned about potential future work with WHO and thus not voice their true opinions. Also, the RDs are elected by the Regional Committee. Thus the membership nature of the Organisation creates a "two-way need to please" that can bias interaction and voting.

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.
(Bangladesh Report, p. 12)

Ministers of Health from the SEARO countries rarely attend the RCMs so SEARO established a special meeting for Health Ministers at a cost of about US\$35,000. This initiative has now broadened into a mechanism for more vigorous interaction among the Ministers of Health in the region. SEARO also runs a meeting for Secretaries of Health to review reports from the Executive Board and Regional Committee Meetings.

Communications with Headquarters

In the Case studies there seemed generally to be little direct interaction between the WHOCOs and WHOHQ. The situation does however vary greatly between regions. Whereas there is very little direct interaction in WPRO and PAHO/AMRO countries, countries in SEARO and in particular AFRO are practising much more of an open door policy, where initiatives may be taken as much by HQ than by the countries/regions themselves. Most HQ direct interaction with the country is in relation to the special programmes, and then often with the relevant institution and less through the Country Office. The various HQ programmes attempt to keep the WHOCOs informed through copies of relevant written communication which is forwarded to the ROs for distribution. However, it seems that in some regions/countries there is either insufficient or a breakdown in this form of communication. One WR commented that he only hears from HQ when there is a problem, and that he resented being used as a post-box for messages, when he is not involved in any other way.

TDR and HRP at WHO Headquarters 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 WHOCO staff, although they do keep them informed on new agreements and their progress. (Thailand Report, p.11)

Staff from one headquarters division, in providing information for this Study, identified the following as factors presenting critical barriers to their effectiveness at country level:¹⁵

- Complex administrative procedures that prevent quick action, notably in the supply of drugs, monitoring and evaluation activities and in organising workshops,
- Lack of quick and efficient channels of communication with WRs and national programme managers,
- Difficulties in coordinating activities with Regional Offices.

Channelling all WHO's work in a country through the WHOCO is seen by WHO as the best means of ensuring effective coordination of work at the country level. "Briefings prior to meetings of Regional Office and headquarters staff with high-level national officials and immediate feedback following such meetings, keep the WHO Representative informed about direct contacts between WHO and the government and/or other national institutions".¹⁶ WHO recognises that there is a need for improved communication in order to give the fullest support to the WHOCO and to promote unity of the Organisation's action at country level. The experiences in the case studies show that the complexity of the Organisation, in addition to regional differences, can create

difficulty in communication, especially when there appear to be no consistent procedures or management to ensure their implementation.

World Health Assembly

The Study found that the RCMs are seen as more relevant to individual countries than the broader, more global WHA. This has implications for communication and dissemination of policy decisions from HQ to country level. One role of the WHOCO is to brief country delegates attending the WHA. Information from the case studies indicated that preparation for the WHA (and RCMs) tends to be scanty, and depends on the timing of arrival of the briefing documents from Headquarters and the Regions. Overall it seems that depth of value of these global meetings are not being achieved in many countries. Some country officials, in comparing the RCM and the WHA, noted that the politics and dynamics of the WHA was largely determined by the traditionally strong "northern/western economies", they have more resources for preparation and pursue their agenda through the WHA, whereas many delegations from developing countries feel disempowered.

Briefing of MoH Staff to the WHA: Tanzania

WHO delivers the agenda and papers on the various items for debate and discussions for the World Health Assembly (WHA) to the MoH. The MoH might on occasion ask for explanation from the WHOCO, but there is no mechanism for detailed discussion between WHO and the MoH. For the past two WHA sessions, the WR planned his home leave to coincide with the meetings in Geneva and has therefore been able to attend (not as a formal member of the Tanzania delegation). It did not appear that Tanzania prepares a strategic plan for attendance at the WHA. No major briefing meetings are held among the various divisions of the MoH by way of preparation for the WHA. There are also no formal debriefings of MoH, when the delegation returns from the WHA, but reports are made to Regional Officers meetings. Currently Tanzania is a member of the Executive Board of the WHA. Thus, preparations for the WHA need to be improved. (Tanzania Report, p. 16)

4.5 Costs of running WHO Country Offices

Concern is often expressed about knowing and controlling the administrative costs of running a service. However, identifying what this means is not straight forward. The costs of running a WHO Country Office could be specified to include: facility rent and maintenance (electricity, cleaning, grounds); salaries of the WR, his secretary and administration officer; vehicle costs and maintenance; related office costs: phone, fax, postage, stationary etc. These types of costs that are linked to a specific programme (such as Malaria Control) are most correctly called programme administration rather than costs of running the office. Thus very specific and detailed activity and financial information is needed, and must be consistent across countries and regions before any comparisons can be made on administrative costs. This level of detailed financial information is not easily available and was not collected by WHO for the two biennia covered by this Study.

It is important to note moreover, that the role of the WR is technical rather than administrative. Functions of advocacy and advice require WR time and skill, and can have a significant impact on policy and planning within a country, without using additional WHO funds. The question of administrative costs, as with other programming and financial issues, should be aimed specifically at achieving the most effective focus and use of WHO's scarce resources. Information on some major components of costs for running the Country Offices has been obtained from WHOHQ for 1996-97 and compared across the case studies, as presented in Table 3.1. These amounts include: salaries of the WR, the administration officer, secretary and driver, plus costs of stationary and supplies etc. In all countries the WR, and in several countries the administration officer are international staff members, which has important cost implications.

Table 3.1 WHO Country Offices: selected "administration" costs

	Country Programme RBFs 1996-97	Total WHOCO Staff	No. of staff included in Admin	International staff included in Admin	Total Admin Components	Admin % of RBFs
Cameroon	1,409,627	15	4	2	780,600	55.4%
Ethiopia	2,612,245	16	8	1	730,000	27.9%
Mali	2,184,861	20	4	1	698,800	32.0%
Mozambique	1,973,753	9	4	1	697,900	35.4%
Tanzania	1,918,212	19	7	1	614,900	32.1%
Ecuador	1,507,937	51	5	1	671,200	44.5%
Haiti	3,569,563	79				
Nicaragua	2,140,344	70	4	1	590,000	27.6%
Bangladesh	11,097,459	58	16	2	1,010,700	9.1%
Thailand	5,595,088	17	11	2	967,200	17.3%
Cambodia	2,081,580	73	5	2	943,200	45.3%
PNG	3,121,952	18	8	2	865,200	27.7%

Source: WHOHQ

Administration costs showing as a high percentage of total RBFs may be as a result of the country programme being small, with little other support than the WR himself (e.g. in Cameroon) or recent one-off acquisitions of office equipment (as in Cambodia). Regions record these expenditures differently, and there is a need to go to the detailed accounting level to trace expenditure in a comparable way. Where there are heavy executing or operations support functions including the management of a high volume of funds, the administrative capacity needs to match this. Whether this is the cost of the CO office per se, or an overhead expenditure that should be recorded under the programme concerned, needs to be defined. The same applies to the growing interest in technical cooperation among countries, and how expenditure incurred in WHO's facilitation function should be accounted for. Hence, such figures must be treated very cautiously.

3.6 Processes for planning, implementation and evaluation of WHO collaborative programmes

WHO managerial process and regional applications

In the Eighth GPW reference is frequently made to WHO managerial processes, and the importance of ensuring optimal use of WHO resources in support of HFA and strengthening country health systems based on primary health care, in a sustainable way. The components of this managerial process are listed in Box 3.2, and form the framework for the next sections of this chapter.

Box 3.2 Key Components of the WHO Managerial Process¹⁷

1. Policy Planning - Global - General Programme of Work (6 years)
2. Strategic Planning - Programme Budget (2 years) - Regional
3. Programming - Plan of Action (1 year) - Country
4. Implementation - Interventions, Monitoring, Reporting
5. Evaluation - Annual, Biennial and Four Yearly

3.6.1 Planning and Programming

Each region has a detailed set of procedures which guides the implementation of the 5 key managerial components listed above, for example AFROPOC¹⁸ and AMPES.¹⁹ An overall summary of the process and timing is presented in Box 3.3. The details differ from region to region, with the only points of convergence being the submission of proposals to the Executive Board and the World Health Assembly.

Box 3.3 Summary of the Planning Programming Process for the 1998-99 biennium

1995	Aug./Sept. October Dec./Jan.	ROs receive indicative figures and procedural guidelines from HQ Calculate Regional Office and Country Budget allocations. Notify WRs of indicative country allocation
1996	Feb.-May July/August September	Country Office and MoH plan Country Programme Budget outline Regions compile Country and Regional Office budgets. Proposed Regional budget discussed at Regional Committee Meetings
1997	January May July/August Sept./Oct.	Proposed budgets discussed/adjusted at Executive Board in Geneva Proposed budgets reviewed/approved at World Health Assembly Regions do any recalculations needed based on EB adjustments. Country Offices and MoH prepare detailed Annual Plans of Action and submit to Regional Office for approval.

Note: months specified vary in the different regions.

The planning and budget process for the 1998-99 biennium started in August/September 1995 with the regions notified of their indicative planning figures by the Director General. The Regional Directors review their indicative figure and decide what percentage of their total allocation will go to Country and Regional budgets. For

example, in AFRO approximately 60% goes to Countries, in SEARO it is 75%. Country allocations are calculated and WRs notified of the indicative country budget figure for technical activities for the biennium in about January 1996 (2 years before the start of the biennium). Initial plans from the countries are forwarded to the Regional Offices and RCMs, and thence to the EB and WHA.

The DG has the authority and prerogative to change the proposed regional budgets. It can be seen from examining subsequent regional budget proposals that the approved budgets are often somewhat adjusted from the original proposals. When this happens the Region has to cascade the adjustments to its divisions and country budgets. Once the country budget is approved, WRs and MoH prepare detailed action plans in about September/October for the following year. The RO provides budget figures for each programme (based on MoH/WHOCO earlier planning), but these can be altered on request of the MoH if the country priorities have changed. The Country Collaborative Plan forms a contract between the MoH and the Regional Director²⁰ (rather than the WR).

Planning and RBFs

WHO's regular funds are obtained through contributions levied against member states. In recent years less than 100% of calculated contributions have been received. Despite this, RBFs have the advantage of being relatively reliable and under direct WHO control. The allocation of WHO's regular budget is made in the first instance by making block grants to regions which are then subdivided to individual country programmes, with anomalous results (see Chapter 4). The process is not currently transparent, and is to be reviewed to take into account the population of the region, health needs, percentage of GDP devoted to health, and specific health indicators.²¹

PAHO member countries pay a contribution directly to PAHO in addition to their WHO membership fee. Thus the PAHO/AMRO budget includes both PAHO and WHO funds. In 1990-93 PAHO RBFs were more than twice the AMRO share of WHO RBFs, and the EBFs represented half of the total budget. The WHO contribution to the region was 17% of the total budget, and this proportion has been declining over recent years.²²

The RBF allocations from Regions to countries are generally based on historic levels, and can be difficult to change, or to make allowance for new member states, e.g. Cambodia. In PAHO/AMRO the calculation of the RBF allocation for each country was originally based on a formula involving population, GDP per capita and incidences of key diseases, with the intention to promote equity in the allocation. However the formula is not applied rigorously and simply sets the framework for the budget allocation. Care is taken that each year's RBF allocations relate to the previous year's level.

AFRO attempted to rationalise and improve equity in the budget allocations to the countries using a formula involving thirteen health based criteria.²³ The formula was meant to be applied to one third of the budget for 1996-97, two thirds for 1998-99 and 100% for the biennium 2000/01. However, when realising that applying this would mean that some countries would lose 30% to 40% of their country allocation, the formula was not approved by the Ministers of Health at the RCM in 1995.²⁴ Thus, the aim for

rationalisation and equity in the budget allocations had to be abandoned, and the historical basis continues.

In all the case studies, in addition to the country programme budget, RBFs were received from HQ and RO programmes (see Figure 4.1, page 49). These funds had been planned at HQ and RO and not coordinated with the WHOCO/MoH planning process. The EB acknowledges the importance of coherence between all WHO inputs, and suggests that there should be only one WHO country strategy, planned and monitored at country level under the WHOCO responsibility.²⁵

The nature of technical operations support between WHO and the country is in many ways different from the way other donors assist the countries. The *volume* of RBFs available for the countries is agreed upon as part of the budgeting procedure well in advance of the actual year of implementation, and through a process of negotiation that largely takes place *outside* the country, collectively through the RC. RBFs are small but predictable and dependable. How the funds should be *used*, is generally a matter between the WHOCO, the MoH and the Regional Office. This is not usually coordinated by the government's external aid or planning division, and not reported in the same way as other donor programmes in aid coordinating meetings, where such exist. Other partners in health are often not aware of the use of the WHO contribution within the national health system. In some countries MoH staff expressed the desire to have more direct control over the WHO resources.

Priority Setting and RBFs

Through the WHA and WHO's role as the directing and coordinating authority on international health work, member states collectively identify priority health problems throughout the world and define policies, strategies and targets to cope with them. These are outlined in the successive General Programmes of Work. Thus WHO does not infringe on national sovereignty, but advocates the adoption of policies that member states have themselves collectively defined. Priority areas within the overall GPW are arrived at within country through dialogue between government officials and the WR, and an assessment of the country's needs, and reflected in the Country Programme budget.

WHO's resources are intended to supplement and develop national resources, and to mobilise external resources.²⁶ Governments assume responsibility for the work of WHO and the use of WHO resources in their country, under the condition that WHO resources are used only for activities that are consistent both with defined national policies and with the international health work policies agreed upon collectively by member states. WHO's resources should therefore be "invested primarily in spearheading development; they are much too limited to share national recurring expenditures".²⁷

As outlined in chapter 4 the size and focus of WHO collaborative programmes in the twelve case studies varied considerably. Detail on the overall focus and strategies for the WHO country presence also varied greatly. In some countries this could only be determined by examining the budget proposals, whereas in other countries it was clear that priorities were developed first, and the planning and budgeting followed. Priorities

and focus of functions such as advocacy, advice and capacity building could not be determined in several countries.

Priorities specified in the GPW and RCMs are meant to be reflected in the Country Collaborative Plans. In turn, country priorities collectively feed into the GPW at the WHA, EB and RCMs, reflecting a complementary top down and bottom up process. However, there is no systematic mechanism for achieving this in relation to specific country contexts, and particularly health service capacity and the actions of other donors in the health sector in each country.

The Eighth GPW lists criteria for selecting areas for WHO involvement generally, and for determining country level activities.²⁸ Programmes should:

- be directed towards problems of major importance in terms of public health, particularly for underprivileged and high-risk population groups
- have the potential to make progress in solving the problem
- have a strong rationale for WHO's involvement: covered by the constitution, resolutions, or national, regional or global strategies for HFA
- give rise to the establishment and sustained implementation of countrywide health programmes
- build national capacity and self-reliance
- involve activities that can be satisfactorily developed and maintained by member states at a cost they can afford and with the human resources available, or which could become available with appropriate training.
- be likely to attract external resources

The delineation of these criteria are too broad and non-specific alone to be helpful in priority setting in any individual country, especially where information and human resources for planning are weak. The resource criterion, with no time-span, appears to contradict other stated objectives of directing resources to countries in greatest need, and especially to populations at risk. The criteria of focus, capacity building and sustainability appear to question the appropriateness of fragmented programmes that were seen in several countries especially in Africa (e.g. Mali and Cameroon).

Global level priorities such as Drugs and Reproductive Health are not necessarily given priority at regional level, even though they may be country priorities. On the other hand, if a designated Regional priority area is not covered in the proposed country budget, the Region can suggest changes or use RO funds to fill the gap. In WPRO, this applies particularly to eradication of poliomyelitis, and Health Policy and Systems where the region has made special efforts to get WHOCOs to prioritise activities in these areas. Some programmes, such as TB, need to stay at a certain size to be effective. Sometimes countries are encouraged to adopt programmes that they might not consider priorities.

WHO regional policies act as a push for the adoption of policies at country level. Following Government endorsement, the New Horizons in Health initiative in association with the Healthy Islands concept now forms the main thrust of 1996-2000 National Health Plan. Polio eradication has also been pushed at WHO Regional level. While the PNG Government was initially reluctant to adopt the campaign it subsequently did so. (PNG Report, p. 16-17)

This type of encouragement is an important part of WHO advocacy, requiring skill to avoid tension. In AFRO it was acknowledged that there are problems in accommodating different sets of priorities from the three levels of the Organisation.

Finally, in many of the regions, Ministries of Health have a number of strong fora in which to meet and develop regional and sub-regional priorities, programmes and policy positions. For example, the Andean and Central American Group of countries, the Southern Cone, and ASEAN provide opportunities, among others, for sub-regional policy priorities and discussions. As a result, health sector development priorities may be established at a regional level by the Ministries of Health themselves.

Planning, priority setting and EBFs

As outlined in Chapter 4, EBFs form a significant portion of WHO funding in all the case studies. EBFs coming into a country may be for Common Global Functions as well as for Country Specific Activities. Although the study has not separately examined the amounts of financial support to these two main sets of functions, important differences are recognised. This section deals with EBFs for Country Specific Activities rather than Common Global Functions. Whereas programming and priority setting for WHO RBFs are controlled by the the organs of WHO and Ministries of Health, EBFs are somewhat more under donor control. In addition, EBFs are relatively less long-term and less reliable than RBFs.

At the time of preparation of biennial budget proposals, WHO Regional and Country Offices have uncertain and incomplete information on the amount of EBFs that will eventually be available for country programmes during the biennium in question. For example, in the 1994-95 budget *proposal* for Ecuador, (dated July 1993) \$721,600 was listed for total EBFs.²⁹ In the budget for the following biennium (dated August 1995), where the *approved* budget for 1994-95 was presented, the amount listed for Ecuador EBFs was \$6,217,400, representing a nine-fold increase. In several countries the level of EBF expenditure (compared to approved budgets) is over 100% (Ethiopia, Mozambique and Nicaragua) and in some cases, over 200% (Tanzania and Cambodia). This is partly because more EBFs were made available to WHO for its country programme during the biennium, than could be confidently budgeted for. Conversely, \$74 million of EBFs was anticipated for 1994-95 in Bangladesh but only \$14 million was spent, due to slow project implementation and non arrival of funds. The implications for this on programming and priority setting depend on the extent of discussion and project planning that has been done with the donor (which is often extensive) prior to the arrival of funds. In some countries EBFs tend to be for specific, relatively short-lived projects, rather than longer-term development, though there are some notable exceptions such as in Cambodia. WHO has to determine how to balance the use of RBFs in relation to EBFs, and as ongoing EBF availability is uncertain, this can at times be a difficult juggling act. In regions such as PAHO/AMRO and WPRO, the RO served an important function in optimising and managing the RBF/EBF mix.

In addition to those managed through the WHOCO, EBFs may also flow to the country directly from HQ to other national institutions, making it difficult to manage the totality of WHO resources as a unified whole. WHO acknowledges the present lack of a WHO

policy framework for managing EBFs to improve integration of activities funded through RBFs and EBFs,³⁰ and lack of guidelines on handling EBFs in the context of overall WHO priorities.³¹

There appears to be a trend for negotiations regarding EBFs to be held more often at the country level providing the opportunity for creating country-specific strategic partnerships between a donor, the government and WHOCO. There are obvious strengths and weaknesses to this approach. If EBFs are not focused on country priorities there are potential problems of sustainability when the EBFs are phased out, and the government is expected to continue funding. In some case studies this opportunity was missed by WHO, e.g. the WHOCO in Bangladesh missed the opportunity to participate in planning the use of some World Bank funds due to an oversight of budgeting.³²

WHOROs and COs can assist in mobilising additional EBFs, but formal acceptance of any EBFs must be by the DG, to ensure compatibility with WHO priorities and values. This is somewhat different for PAHO/AMRO, where, if the EBFs are raised under the auspices of PAHO rather than WHO, it is not necessary to obtain approval from the DG.

In the twelve case studies EBFs have been more concentrated on specific strategic areas (i.e. Integrated Control of Disease, see Figure 4.7 page 54), while RBFs are generally spread more evenly across strategic areas. EBFs cover a greater percentage of priorities established by the Executive Board than RBFs do, and this trend is expected to continue through 1998-99.³³ The level of EBFs to AFRO have declined across the region which has created serious resource implications. PAHO/AMRO has received the largest amounts of EBFs. EBFs provided by specific donors can be flexible or rigid depending on the degree of earmarking applied by the donor(s) providing them. The “tying” of EBFs to specific programme and project activities becomes a critical issue at country level when funds either arrive late or are cut at short notice by a donor. The WHOCO cannot use RBFs to substitute for EBFs because of the very large risk that the activities budgeted for using RBFs would go un-funded due to further delays or set-backs in expected EBFs.

Financial Management and Planning

The Study found a general lack of clarity in financial information regarding total WHO support to individual countries from the multiple, and seemingly uncoordinated, sources of WHO funds to a country (see Figure 4.1, page 49). The Study Team were not able to obtain from any one source a clear and total picture of all WHO funds to each individual country. The WHOCOs and WHOROs, for example, may not have details on funds entering the country from HQ. (e.g. TDR, HRP and UNAIDS). This may weaken country level planning and mar the reputation of the Organisation, demonstrating lack of cohesion. At present there is no collaborative effort from the three levels of the Organisation to develop a unified WHO programme with government to underpin the country's own national health strategy, despite frequent calls for this by the Executive Board.

In addition, information on expenditure at country level received from HQ, RO and COs often conflicted due to incomplete or lack of understanding of information, especially at the country level. Some of the information obtained for this Study from the Country

Offices in AFRO and SEARO could not be used, as there were too many discrepancies with the information received from the Regional Offices. SEARO was not able to give its specific RO Intercountry budget expenditure for the two case studies in that region.

3.6.2 Implementation and Monitoring

The Eighth GPW states that it will be implemented as a cooperative effort of governments, WHO, people in all walks of life, health personnel, NGOs and other concerned organisations.³⁴ While ideally this may be so, such a statement has the potential to dilute WHO's responsibility for implementation (and evaluation) of the GPW.

The results of the planning procedure culminates in detailed programme and budget documents for each region, outlining the budget and focus for each country and the Regional Office divisions. However the overall process (6-year, 2-year and 1-year cycles) is cumbersome and time consuming, placing heavy administrative burdens on the WHOCO and MoH (Cambodia p.11; Tanzania p.38; Bangladesh p.15). The administrative workload for a Ministry to receive WHO funds involves at least:

- participation in the 2 year planning cycle (with revisions until signed)
- development of an annual plan of action (with revisions until signed)
- submission of a specific request for an item on the plan of action to CO then to RO.
- submission of justification of funds used when activity completed to CO then to RO.

This long process, is not easily responsive to changing country needs, and often results in the need for reprogramming budget lines at a later date, further adding to the MoH administrative burden. Reallocation of funds between budget lines seems to be possible in all regions, once requested by the MoH and substantiated by the WR. In some countries, the observed low expenditure of the WHOCO budget, even though the country was desperate for funds, was attributed to the high administrative workload and lack of MoH capacity (e.g. Cameroon, p.9). This has been acknowledged by PAHO where it has been proposed to abolish the annual budget plan and to make less frequent work plans (six monthly). It is notable that there is little support offered from the Regional Offices where there is low capacity in government and/or the WHOCO for preparing the Country Collaborative Plan.

Overall it appears that RBFs and EBFs are treated in the same way for disbursement and accounting (but not in planning and priority setting), that is, the same procedures of approval for staff recruitment and disbursement of funds are used for EBFs and RBFs.

Reporting Procedures and Monitoring Activities

The Eighth GPW states that continuous monitoring against targets will ensure that activities selected for implementation are proceeding according to plan.³⁵

Activity monitoring and financial management are closely linked in all the regions. PAHO/AMRO and WPRO have computer-based monitoring systems that show progress of activities implemented and the financial consequences. This is an interactive system that can be managed at the country or regional level. Such a system is planned to be implemented in all regions. The country governments, in accepting responsibility for

management of WHO resources, are also expected to have sufficient accounting control and auditing procedures to demonstrate appropriate use of WHO funds, but this level of capacity is often not available and adds a further burden on the MoH. A consequence is either to dilute the responsibility of the WHOCO in some cases (e.g. in AFRO and SEARO - "the MoH doesn't cope so we can't do anything") or, to cause the WHOCO to assume the role of the MoH (as indicated to some extent in the PAHO/AMRO countries).

The type of financial information available at some of the Country Offices is accounting rather than financial management information and thus not readily helpful to overall management. There are no documents showing original budget figures against expenditure to date. The information the WRs are provided involves disbursed and unliquidated obligations. The 1998-99 proposed budget document provides for the *first time*, information showing original budget figures against expenditure.³⁶ It also includes products to be achieved at each of the 3 levels of the Organisation. However, many of these are not very specific, and/or not easily measurable, and WHO acknowledges that there remains a considerable amount of work to be done in this area to support monitoring and evaluation of implementation.³⁷

Despite many monitoring and reporting activities the Study found a general lack of analytical and evaluation skills in WHO at the country level. The quality of monitoring depends on the required procedures, the WHOCO capacity, the available information and the use made of the activity reports. In many of the case studies at least one of these factors was found to be weak, as indicated in the example below from PNG.

(In PNG) importance is placed upon financial accountability, with detailed financial reports sent to Manila on a monthly basis. In Manila, a readily accessible storage and record retrieval data base is operational. The extent, and success to which programs are monitored was however found to be variable. The Study Team found that whilst Country Representative semi-annual reports and mission reports documented activities undertaken within a specified reporting period, it was difficult to gauge overall program impact and the extent to which progress had been made over time. Critical appraisal of program activities was generally absent. An annual report appraising WHO country activities would be a useful adjunct to present reporting requirements. Similarly, infrequent reference to previous consultant recommendations were made making it difficult for the reader to judge whether recommendations had been instituted or not. Assurance was given that this was in fact the case. There was a recognised need to revise the evaluation process. Monitoring, particularly of disease control programs is constrained by deficiencies within the health information system. (PNG Report, p. 18)

Similar findings were recorded in several of the case Study reports, including those for Ethiopia, Mozambique and Haiti.

In the PAHO/AMRO countries activity and financial monitoring occurs through the Four Month Progress Reports. In the AFRO countries, WRs send reports every 3 months to explain what activities have been implemented and why other activities have not been undertaken. Generally the reports are not problem oriented, nor is there any feedback from the Regional Office to the WRs on the contents of these reports. An examination of the expected and actual outcomes provided by the WHOCOs as part of the data

collection for this Study, also shows a general lack of analysis or problem recognition. As a consequence the Organisation loses important opportunities to learn from problems and improve implementation.

Auditing

There is external auditing of WHO Headquarters and Regional Office financial accounts, but not at Country Offices, (as they do not keep separate accounts). The Regional Offices do periodic internal audits of Country Office procedures, and the use of local imprest funds. In PAHO/AMRO countries, an internal audit is done on appointment of a new WR so that they can start the new regime with a 'clean slate'. If there is to be increased WR autonomy in other regions, with more wholesale allocation of authority to spend "stickers",³⁸ then more frequent auditing at Country Office level will become necessary. Whether auditing at country level should be external or remain only internal is an issue that the Organisation will need to consider. The costs of external post-auditing could be offset by more simplified planning and expenditure approval processes (or pre-auditing). The external auditors reports for 1994-95 and 1996 discuss the need to strengthen the role of the Organisations internal audit units.³⁹

3.6.3 Evaluation

The final step in the WHO managerial process is evaluation. The Eighth GPW states that the efficiency of activity implementation and its impact will be evaluated against the targets specified.⁴⁰ Although there is regular monitoring of routine activities and financial expenditure at Country Office level, there appears to be less longer term evaluation of products or outcomes of WHO activities, PAHO/AMRO countries possibly being the exception.

The Ninth GPW acknowledges that the evaluation of WHO's own work needs to be strengthened and recommends that there will be increased use of external evaluations.⁴¹ However, many WHA and EB documents have previously and repeatedly stated the need to improve evaluation: for example, in 1985 "... urged the regional committees to increase their monitoring, control and evaluation functions.....and to include in their programmes of work the review of WHO's action in individual member states..".⁴² and in 1996, "Evaluation was the weakest component of the Organisation's management process. ... Objectives and appropriate indicators were often not well defined ...".⁴³ These are just two of many examples where the Organisation itself recognises its weaknesses in these areas, but appears slow, and/or uncertain as to how to overcome the difficulties, or to improve its skills and activities in monitoring and evaluation. As part of the process on the WHO Response to Global Change, efforts are underway to provide overall guidance for a Programme evaluation process.⁴⁴ However, this guidance is not yet tested or implemented.

At present there is still no overall system of monitoring and evaluation which sets principles and criteria to cover all WHO activities financed by regular and extra-budgetary resources, and which define what kind of evaluations should be carried out (and by whom) at country level. The Study finds considerable regional variation in monitoring and evaluation policy and practices, and low priority given to evaluation as a tool for critical reflection and learning in the Organisation. Few evaluation reports were

found of large individual programmes in most countries, and most evaluations reports were of programmes with large extra-budgetary funding initiated by external donors.

At the country level there is no established practice of carrying out programme reviews to assess the overall policy and direction of the collaborative programme and the operations of the WHOCOs. PAHO/AMRO has introduced an Annual Evaluation of Technical Cooperation (EAP), and a joint evaluation of overall PAHO/AMRO effectiveness at country level which is conducted by the CO and MoH every four years, but there seems to be irregular practice and little substantive evidence of use of evaluation results found in the case countries.

The complex area of impact measurement of WHO collaborative efforts has so far received little attention. Some individual programmes have developed performance indicators - mostly at output level and rarely at outcome or impact levels. In Thailand, a number of “products” are listed for each programme, and the programme later evaluated against these products.

There is also a lack of effort to assess WHO activities with low specificity and often marginal monetary inputs, like strategic objectives for advocacy, health promotion, interaction and facilitation through other actors, and against overall goals like national capacity building, or equity. It is not reasonable to expect that WHO’s relative contribution to complex long term national goals should be measured precisely, but it is important to assess whether WHO inputs are relevant to such issues, and discuss how WHO contributes jointly with other actors.

The principle of **self-evaluation** has been adopted in WHO to ensure optimal use of the evaluation process and its results, and in order to provide an opportunity to learn from experience.⁴⁵ There seems however to be an unclear definition of “self” and consequently who initiates, coordinates and responds to evaluations. The WHOCO and national stakeholders should be part of joint evaluations, but external participation and active involvement of a third party in initiating and following up evaluations would have strengthened the legitimacy, regularity and utilisation of evaluation results.

There are both aspects of control and learning in evaluations, where the control function provides better accountability, while the critical assessment and reflection contribute to internal learning and improvements - and both seem to be missed (or under-utilised) opportunities for WHO at country level.

The procedures adopted by the special programmes in evaluation, using peer review and independent external evaluation, are more rigorous than for other aspects of WHO’s work. Whilst HRP and TDR regularly subject their activities to careful evaluation, the regular budget programmes rarely do so. For example, TDR has periodically reviewed and reported on its capacity strengthening programmes to assess to what extent trainees have completed their studies, have returned home and are being productive. Various objective measures of performance have been devised to measure the performance of institutions: ability to compete successfully in getting research grants, number of scientific publications in peer reviewed journals, etc.⁴⁶

One of the largest individual areas of WHO expenditure, the fellowships programme, has not been thoroughly evaluated, despite the greater simplicity of identifying appropriate outcomes, and EB and WHA resolutions going back to (at least) 1987. Several meetings on the Fellowship Programme have been held by WHO since 1988 to strengthen procedures and administration.⁴⁷ Problems identified include non-adherence to selection criteria, unclear objectives and lack of mechanisms for evaluating the longer-term impact of the programme. The recent evaluation reports on the Fellowship programme that have been seen from AMRO,⁴⁸ SEARO⁴⁹ and WPRO focus on numbers of fellows, length and area of study, and expenditures. However, there is no analysis of the actual role of the programme in meeting gaps in national human resource capacity. There is little critical analysis (beyond description) of spread of fellowships across professions or areas of study. PAHO/AMRO and SEARO are trialing new evaluation tools in an attempt to meet the EB resolution which urged member states to "evaluate their use of fellowships resources in order to ensure that their selection mechanisms are effective and that returning fellows are utilised in the best interest of the national health system".⁵⁰

3.7 Summary of main issues: WHO Structures and Processes

1. Across the twelve case studies and four regions WHO Country Office size is not related to country capacity or need. The 3 low capacity AFRO case studies have the smallest WHOCOs, whereas the 3 low capacity case studies from the other regions, have the largest number of WHO staff. All 3 case studies in the high capacity cluster have WHOCOs larger than those in 3 low capacity and 3 medium capacity countries. The difference is more extreme for the PAHO/AMRO high capacity case studies. *Within* the regions, there is some relationship between capacity and WHOCO size, but this is less so for AFRO.
2. Among the case studies, only four countries have the WHOCO co-located with the MoH. The others are located in separate buildings and pay for their rent and maintenance.
3. Selection of WRs has been an issue for WHO for several years. The process of selection is exclusive rather than inclusive, restricted to WHO fixed term staff, and involves only the RD and DG. MoH is invited for comment only at final approval. It can be questioned whether this procedure produces the right people for the job. There are past and present examples of poorly functioning WRs being left in place, even though MoH and other partners in health have submitted requests or suggestions to WHO for their removal and replacement.
4. There is considerable variation in the extent of autonomy permitted to WRs. Ability to move finances between budget lines, use of initiative and discretion, especially in emergency situations, and mobilisation of resources, all differed between countries and regions. In addition, WR autonomy is generally less than that of other UNICEF and UNFPA, contributing to the perception of WHO as weak at country level, especially in AFRO countries.
5. WHO's skill base remains predominantly medical, with only a slow increase in the wider range of skills associated with financing and managing health services. This restricts the Organisation's ability to assist governments to assess proposed health sector projects and reforms.

6. There are a number of problems in recruitment of professional staff. Some countries complained about the limited search for staff, the protracted process causing delays in filling vacancies, and the poor quality of some consultants. There appears to be increased use of short-term staff, which, if well managed, provides the opportunity to be more responsive to country needs. The low level of WHO consultancy rates in comparison with, UNDP or the World Bank may impede WHO's ability to recruit top quality specialist consultants.
7. WR and staff inservice training, management and performance appraisal tends to be weak in all regions, but less so in PAHO/AMRO.
8. In taking measures to cope with inflation and zero growth in WHO's regular budget, some full-time posts have been frozen, with more use of short-term contracts of 11 to 24 months. Shorter contracts have the potential of making COs more responsive to changing country needs. However, this requires that such needs are correctly assessed, that WHO can draw on staff with appropriate skills and has procedures to facilitate timely recruitment. Information from the country case studies indicated that these requirements were often not met, particularly in the AFRO and SEARO countries.
9. In most of the case studies communication between WHOCOs and the Regional Offices is relatively frequent, and regions are perceived to be more in touch with local issues than HQ. There is little interaction between COs and HQ, and HQ programmes often deal directly with institutions in the country, informing rather than involving the CO. Although COs are in close contact with MoHs, they often miss opportunities for briefing around the World Health Assembly and Regional Committee meetings.
10. Planning and priority setting occur at all levels of the Organisation with varying degrees of relevance and benefit to individual countries. The study found evidence of difficulties harmonising priorities from three different levels. Global level priorities may or may not be promoted at regional levels and regional priorities are promoted in countries. Sub-regional meetings between Ministries of Health may also set priorities, and within countries, the MoH may have an articulated health policy establishing its own sectoral priorities. If the country is the focus of WHO activity at country level, then it is the priorities most salient to the country's needs which should be reflected in the WHO country collaborative plan, rather than more broadly derived global or regional priorities.
11. The planning and budget process for each biennium is lengthy and ponderous, achieving little ownership in Ministries of Health. It starts in a top down manner with regions being notified of their indicative planning figures, and they in turn, decide how much of their total allocation will go to countries (AFRO the figure is 60%, SEARO 75%). WRs then negotiate a collaborative work programme with MoH. Headquarters and regional planning for activities in specific countries is not coordinated with planning at country level with MoH involvement. The allocation of RBFs, is generally based on historic levels rather than country needs. The process is not transparent, and the Organisation plans to improve the rational basis of allocations.

12. EBFs flow into countries from all levels of WHO and constitute 40% to 80% of funds spent at country level. EBFs may go directly from HQ to national institutions, making it difficult to manage the totality of WHO resources as a unified whole. EBFs are relatively less long term and less reliable than RBFs, and decisions on their use are influenced as much by the donors as by WHO. WHO acknowledges the present lack of a policy framework for managing EBFs to improve integration of activities funded through RBFs and EBFs, and lack of guidelines on handling EBFs in the context of overall WHO priorities.
13. The financial information system currently used does not allow a clear calculation of the recurrent costs of running a WHOCO, as separation of administrative from technical costs is not straight forward. Compiling HQ information for 1996/7, using salary costs of the WR, the administration officer, secretary and driver, plus office stationary and supplies, showed a range from 9% of regular budget funds in Bangladesh, to 55% in Cameroon. However, these figures need to acknowledge context and be treated with caution. For example, some costs are higher when an office is first established; and administration will be a large proportion if the overall budget is small. In addition, the WR is a technical, not administrative, position, and therefore costs related to his/her work are directly relevant to programme goals.
14. Financial information on total support to individual countries is generally unclear, and there was no one source which was able to give an overall picture. Moreover, information between HQ, ROs and COs often conflicted. Financial information available to WHOCOs and the MoH is not conducive to effective management. However, the Organisation is developing and implementing a finance and activity monitoring system which is anticipated to assist country level management.
15. Monitoring and analytical skills and practice, whether in finance or evaluation of programmes, were lacking in most of the COs. Although procedures exist to monitor processes regularly, reports were seldom problem oriented and there was little evidence of feedback or discussion. This lack of analytical capacity in monitoring and evaluation exists in spite of recognition by the Organisation, over a number of years, of the need for improved evaluation. This deficit severely inhibits the Organisation's opportunities for critical reflection and learning.

Endnotes: Chapter 3.

- 1 None of the case studies have a Country Liaison Officer.
- 2 Staff Information: Roster of the Pan American Health Organisation, Regional Office World Health Organisation, November 1996, page 109
- 3 Interview , PAHO/AMRO, Washington DC, January 1997.
- 4 Eighth GPW, page 20.
- 5 Ninth General Programme of Work, covering the period 1996-2001, WHO Geneva, 1994, page 13.
- 6 EB99/16, Personnel Policies and Practices, November 1996.
- 7 Post Description for Professional Posts: WHO Representative, obtained from WHO Headquarters 14 April 1997.
- 8 Guidelines for submission of recommendations for post of WR to the Director-General, July 21, 1995
- 9 EB99/15, Provisional agenda item 11.3, 21 October 1996, page 6., and
WHO (1980) " Study of WHO's structures in the light of its functions: WHO's processes, structures and working relationships". Report by the Director-General, Dr H Mahler, prepared for *thirty-third World Health Assembly*, 1980.
- 10 Professional grades range from P1 (lowest) to P6. Then there are the Director grades.
- 11 Post Description for Professional Posts: WHO Representative, obtained from WHO Headquarters 14 April 1997.
- 12 WHA38/1985/REC.1, Annex 3
- 13 EB99/16, p.2
- 14 Interview with SEARO staff at WHOHQ, May, 1997.
- 15 Study data collection from WHO Headquarters, Geneva, October, 1996.
- 16 EB96/7, page 13.
- 17 WHA 38/1985/REC/1 Annex 3 pp:44-94, and Eight GPW, page 189
- 18 AFROPOC: the Management System for Technical Cooperation with the Countries of the African Region, WHO Regional Office for AFRICA, Brazzaville, April 1993.
- 19 American Region Planning, Programming, Monitoring and Evaluation System (AMPES), PAHO/AMRO, Office of Evaluation and Strategic Planning, 1996.
- 20 EB98/3, p.2
- 21 EB100/4, p.2-3; EB/Constitution/4/2, p.3
- 22 1994 - 1995: WHO RBF: 18.2%, WHO EBF 8.1%, PAHO RBF: 37.5% and PAHO EBF 36.2% from Annual report of the Director 1995.
- 23 The formula involves 13 parameters, each with a different weight: Population (25), Maternal mortality (8), Infant mortality (10), Malnutrition (10), Assisted births (3), Vaccination coverage (5), Water (8), Sanitation (7), LDC (5), Landlocked country (4), National budget to health (6), Operational districts (6), Literacy rates (3). Nine of the parameters are considered as corrective parameters, while four are incentive parameters.
- 24 AFR/RC45 R2, referring to revised criteria and weighting.
- 25 EB96/7, p.8
- 26 Eighth GPW, 1987, p 15.
- 27 Eighth GPW, 1987, p 40.
- 28 Eighth GPW, 1987, p 8 and pp. 46-47.
- 29 PAHO/AMRO Program Budget, July 1993, Official Document No. 254, page 270
- 30 EB100/6, p.7
- 31 A50/4, p.3
- 32 Interview with DPM SEARO at WHOHQ, 15 May, 1997.
- 33 EB100/6, p.4
- 34 Eighth GPW, page 190-91
- 35 Eighth GPW page 13
- 36 Proposed programme budget for the financial period 1998-99
- 37 A50/A/SR/1 page.7
- 38 "stickers" are a central part of the procedure for monitoring financial expenditure.
- 39 WHO (1997) Interim financial report for the year 1996". First report of the Administration, Budget and Finance Committee to the Fiftieth World Health Assembly. A50/24, 5 May 1997.
- 40 Eighth GPW, page 13

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- ⁴¹ Ninth GPW, page 51
- ⁴² EB75.R7, Jan.1985
- ⁴³ AFR/RPM/19 page 5-6
- ⁴⁴ Programme evaluation process, Report by the Director General, EBPDC3/2, 15 November 1996.
- ⁴⁵ Ibid p. 2
- ⁴⁶ A.M. Pearce (editor) 1992, Strengthening Health research capacity: A Review and Major Policy Directions in Tropical Diseases Research.
- ⁴⁷ These meetings include the 3rd Fellowships Conference of SEARO which endorsed "Guidelines and Indicators for Monitoring and Evaluation of the WHO Fellowships Programme" in 1988; Executive Board Resolution EB87.R23 adopted in January 1991; Report of the External Auditor to the WHA in 1994 on the AFRO and SEARO Fellowship Programmes in 1990-91 and 1992-93; and the Fellowships Officers Meeting held in Copenhagen, Denmark in July 1995.
- ⁴⁸ Pan American Health Organisation, World Health Organisation, Fellowship Program Annual Report and Directory 1994, February 1996.
- ⁴⁹ Dr. Topo Harsono, Report of the Evaluation of the Fellowship Programme in the South-East Asia (not dated);
SEARO, Briefing Notes - Regional Committee Meeting, Seoul, September 1996,
A/HRH/FEL/IM/106/96
SEARO, Fellowship Policy and its Evaluation in the South-East Asia Region, January 1997
- ⁵⁰ EB87.R23

CHAPTER 4. AN ANALYSIS OF WHO'S CURRENT ACTIVITIES AT COUNTRY LEVEL

4.1 Introduction

This Chapter presents characteristics of the WHO collaborative programmes at country level. The Chapter begins by describing WHO's financial support to planning, programming and management of country health programmes.¹ This concerns the overall resources provided by WHO to the twelve case studies, as well as detailed analysis of how they are allocated by strategic areas. It goes on to describe the WHO collaborative programme profile using four different perspectives:

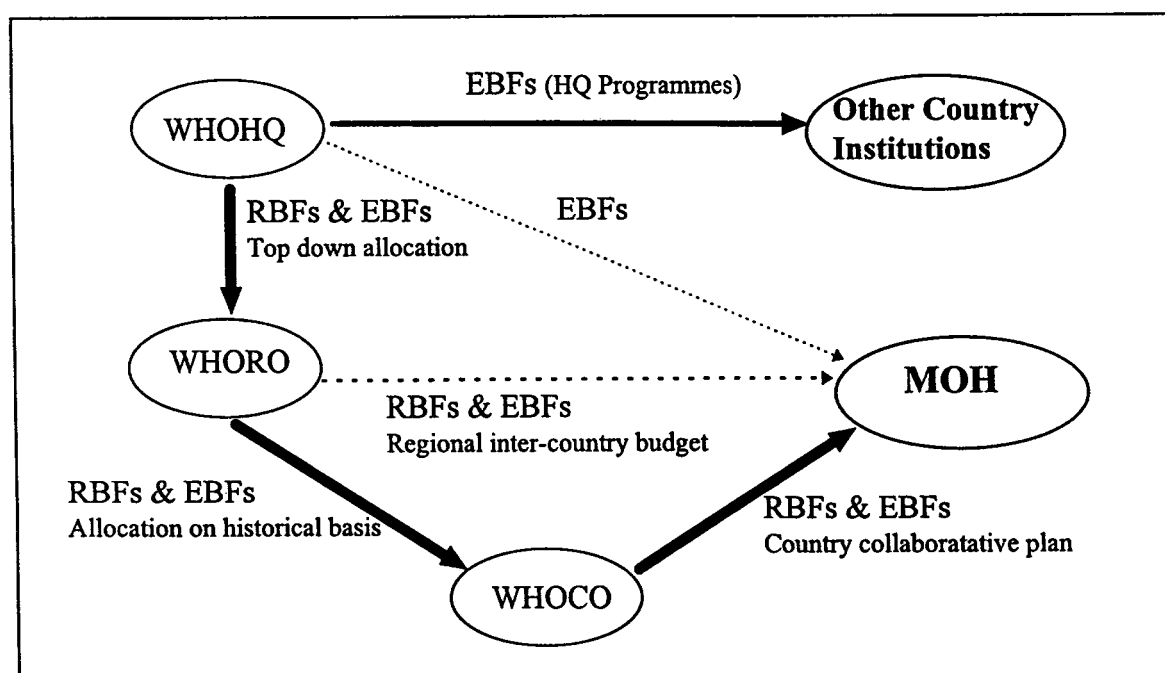
- (i) grouping the activities in terms of functional categories according to intended purpose,
- (ii) grouping the activities in terms of the use of tools for implementing the activities,
- (iii) identifying activities contributing to health policy development and research, and
- (iv) examining the extent to which WHO supports the mobilisation and rational use of financial and other resources for health development at country level.

4.2 WHO Financial Support to Countries

Overall resource flows to the countries

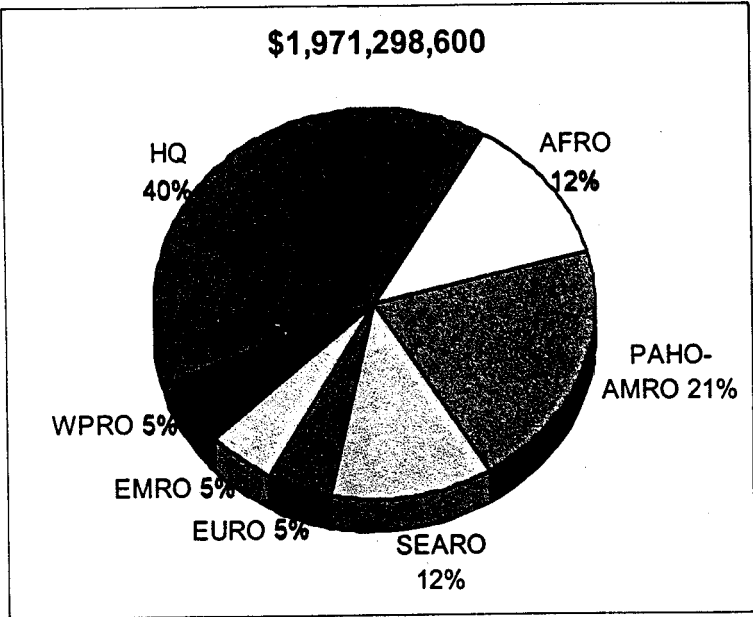
Analysis of WHO activities at country level must take account of the totality of resource flows from all three levels of the Organisation. Figure 4.1 shows that countries receive RBFs and EBFs in varying combinations from: (a) WHOCO Programme Budget; (b) WHORO Inter-country Budget; and (c) specific divisions or programmes at WHOHQ. Funds from HQ and RO may be for either common global functions or country specific activities. HQ funds do not necessarily go to the MoH or WHOCO, but are more likely to go directly to other national institutions within the country, making it difficult to manage the totality of WHO funding as a coherent whole.

Figure 4.1 Flow of RBFs and EBFs from WHO to the country level



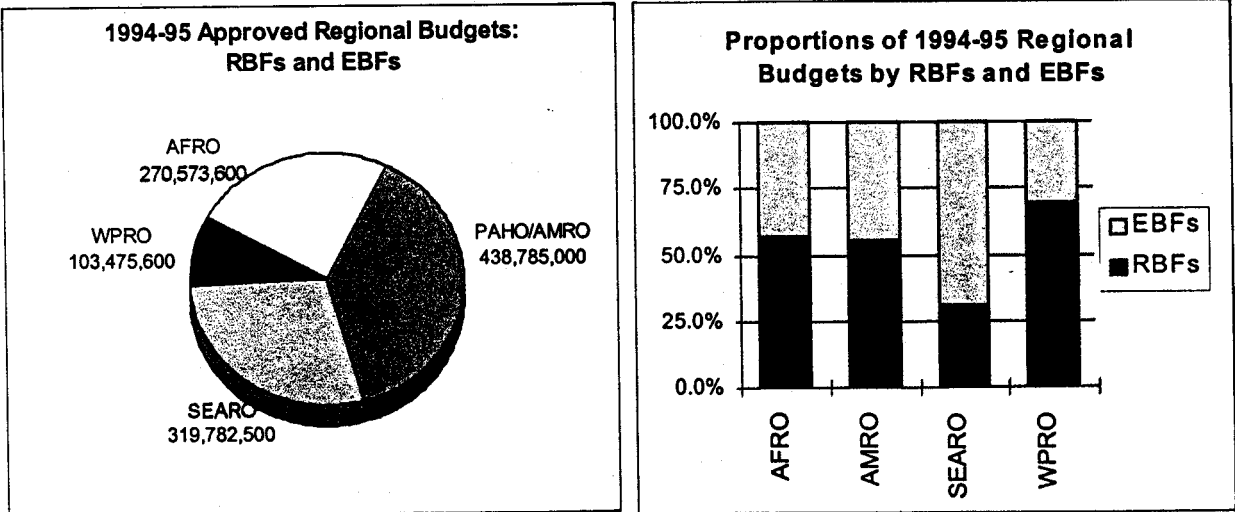
Total WHO (and PAHO) funding globally across all regions for the 1994-95 biennium was almost US\$2 billion, with 40% spent by Headquarters and 60% by the regions and countries (Figure 4.2). The Americas Region, with WHO and PAHO funding, has by far the highest level of expenditure of any of the regions, at 21% of global funds in 1994-95. As described in Chapter 3, allocations to the regions and countries are based on historical precedents.

Figure 4.2 WHO Estimated Global Obligations: RBFs and EBFs, 1994-95



Source: 1996-97 Programme budget, WHO Headquarters, Geneva.

Figure 4.3 Regional Budgets, 1994-95



Source: 1996-97 Regional Proposed budgets.

The approved regional budgets for 1994-95 (Figure 4.3) range from \$103 million for WPRO to \$438 million for PAHO/AMRO. These budgets comprise 27% EBFs in WPRO to 73% EBFs in SEARO, with AFRO and PAHO/AMRO around 50%. In relation to these 1994-95

regional budgets, the twelve case studies represent 8% of the RBFs and 12% of the EBFs for the four regions. Thus, the study analysis covers approximately 10% of the total funding to the four regions.

In this section summary findings from the twelve case studies are presented on WHO financial resources expended at country level for the combined 1992-93 and 1994-95 biennia. Detailed tables are presented in Annex 4, and referred to as necessary.

There are wide variations in the level of WHO funding to the twelve case studies. For example the 1994-95 biennial *budgets* for RBFs in the Country Collaborative Programme ranged from \$1.6 million in Cambodia to \$6.4 million in Thailand and \$10.7 million in Bangladesh, while anticipated EBFs for 1994-95 ranged from \$0.9 million in Mali to \$18.9 million in Haiti and a huge \$74.9 million in Bangladesh (budget table in Annex 4, p.A22).

Figure 4.4 shows total WHO *expenditure* for 1992 to 1995 combined, RBFs and EBFs from all levels of the Organisation. Highest levels of total expenditure were in Nicaragua (high capacity cluster) Haiti and Bangladesh (low capacity cluster), with lowest levels of expenditure in Ethiopia, Mali, Mozambique and Cameroon (low and medium capacity clusters). In regional terms, the AFRO case studies received the smallest amounts of total funds (\$4 to \$13 million), while the PAHO/AMRO (\$14 to \$37 million) and SEARO (\$21 to \$41 million) case studies were among the largest recipients. The conclusion is that level of funding is more related to the region than to country capacity or need.

Figure 4.4 Total WHO Expenditure at Country Level, 1992-95, from all levels, RBFs and EBFs

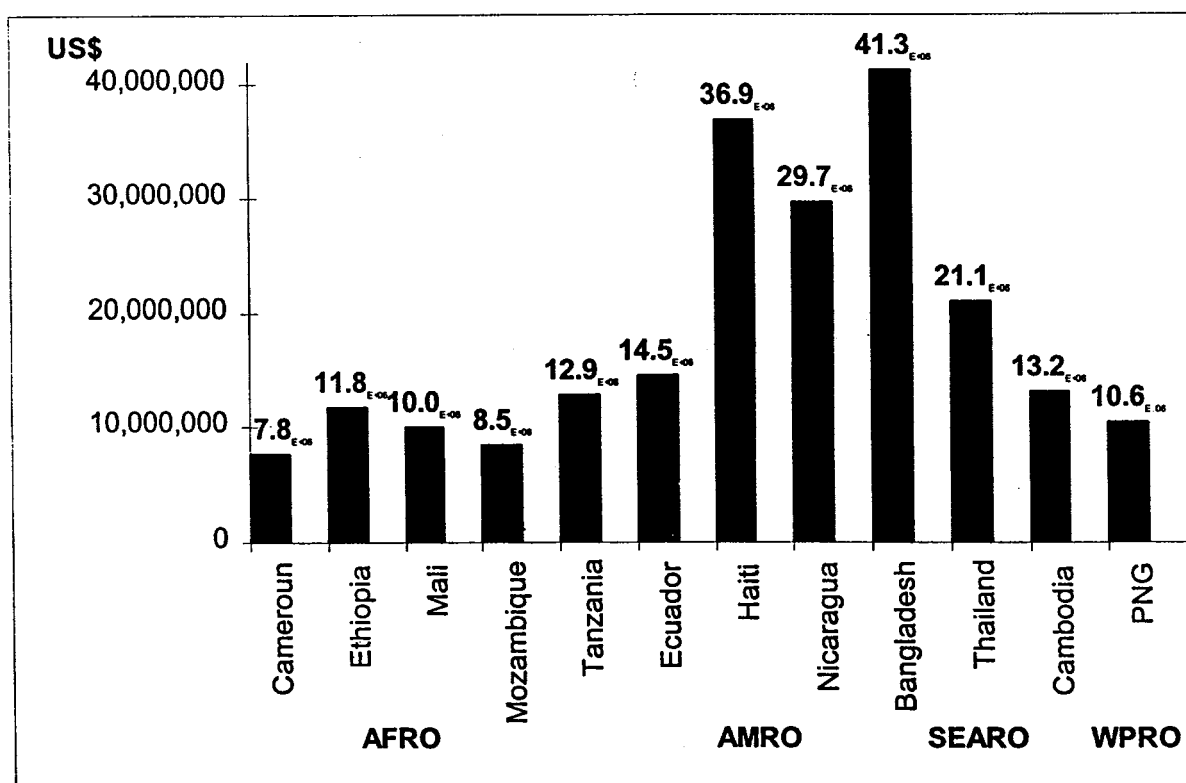
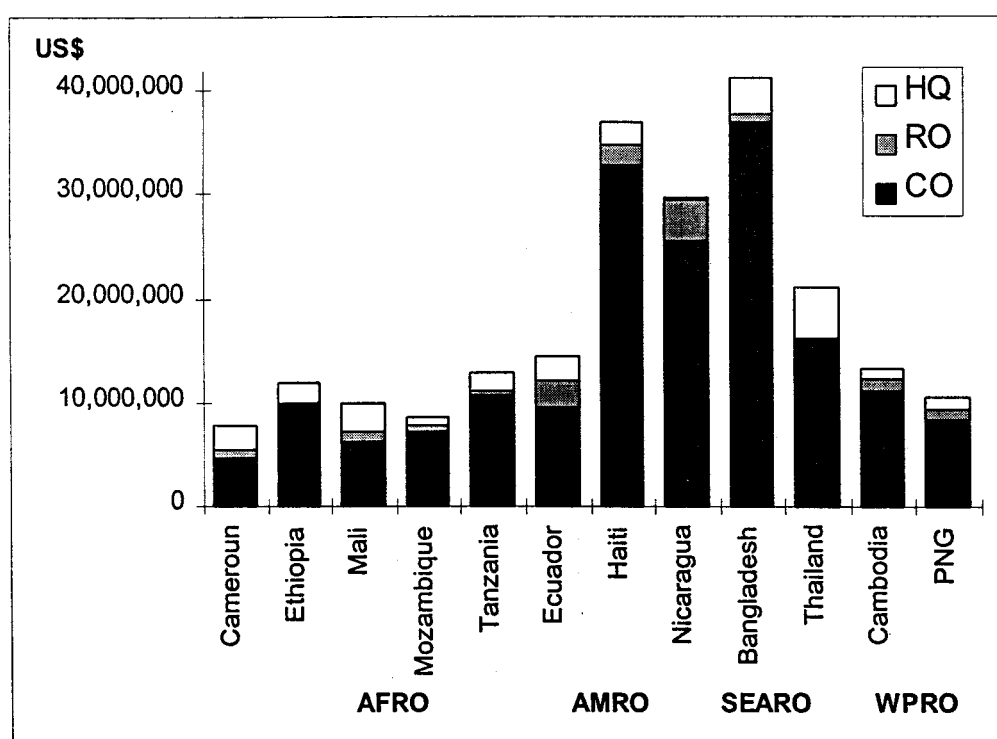


Table 4.1 Total WHO Expenditure at Country Level, 1992-95, showing percentages of expenditure from different levels of WHO, and by RBFs and EBFs.

Countries by Region	Total expenditure 1992-95 (millions)	%CO	%RO	%HQ	% RBFs	% EBFs
Cameroun	7.8	61.4%	8.9%	29.7%	45%	55%
Ethiopia	11.8	82.2%	2.2%	15.7%	50%	51%
Mali	10.0	63.3%	9.1%	27.6%	57%	43%
Mozambique	8.5	84.3%	7.3%	8.4%	53%	47%
Tanzania	12.9	83.9%	3.3%	12.8%	33%	67%
Ecuador	14.5	66.5%	17.6%	15.9%	38%	62%
Haiti	36.9	89.2%	5.2%	5.6%	25%	75%
Nicaragua	39.7	86.2%	13.2%	0.6%	17%	83%
Bangladesh	41.3	89.4%	1.8%	8.7%	51%	49%
Thailand	21.1	76.4%	0.0%	23.6%	54%	46%
Cambodia	13.2	83.6%	9.4%	7.0%	60%	40%
Papua New Guinea	10.6	79.6%	8.4%	12.0%	48%	52%

Figure 4.5 Total WHO Country Level Expenditure from CO, RO and HQ, RBFs and EBFs, 1992-95

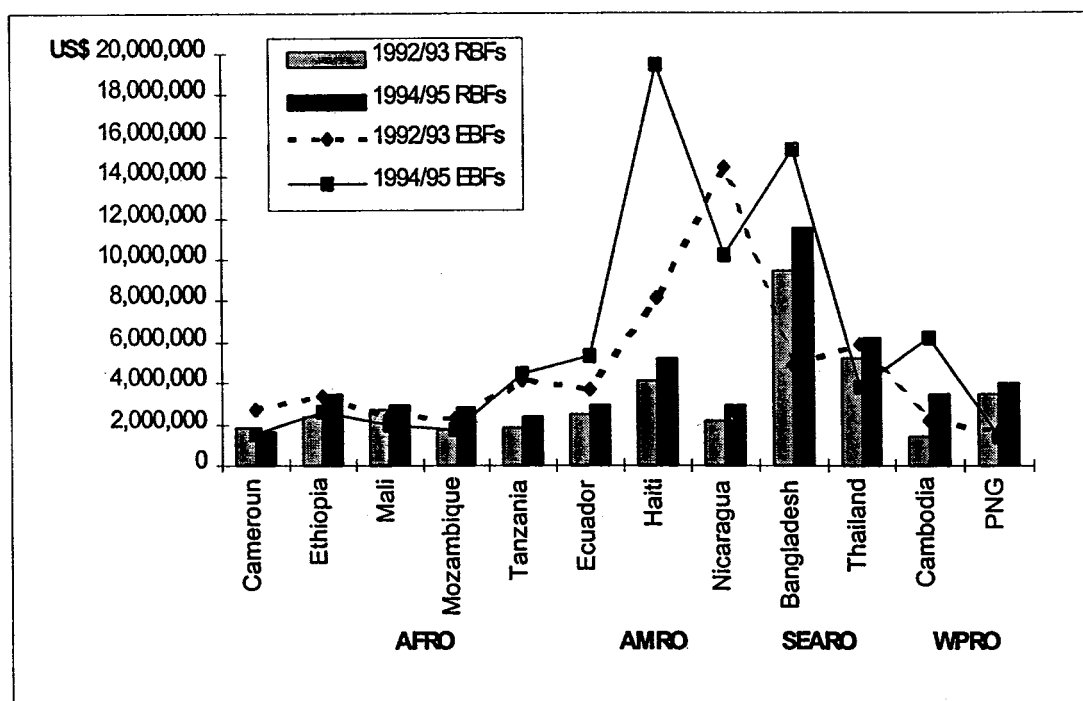


From the three levels of the organisation, (Table 4.1 and Figure 4.4) the Country Programme Budget contributed the largest share of total expenditure at country level ranging from 60% to 90% in all the countries. (Table 4.1 and Annex 4, Scale of Operations p.A17-18). Funds provided by WHOROs were a relatively small proportion of total expenditure, though somewhat larger for the PAHO/AMRO case studies. For example, WHORO funds as a percentage of total WHO funds in 1992-95 ranged from 2.2% to 9.1%

in the AFRO countries, 5.2% to 17.6% in PAHO/AMRO and 8.4% to 9.4% in WPRO. SEARO was not able to give country specific expenditure from the regional budget. Funds from WHOHQ for 1992-95 represented less than 10% of total expenditure in five countries (Mozambique, Haiti, Nicaragua, Bangladesh and Cambodia), with highest proportions in Cameroun (30%), Mali (28%) and Thailand (24%). Largest amounts of HQ funding were to Thailand (\$2.6 million) and Bangladesh (\$1.7 million). In all countries except Ecuador, Nicaragua and Cambodia, HQ funding is greater than that from RO, though with similar amounts in both Haiti and Ecuador.

EBFs were a major source of funding to all the case studies, being more than 40% of 1992-95 total expenditure in all the countries (Table 4.1 and Figure 4.6) The countries most dependent on EBFs, both in absolute amounts and as a proportion of funding, were Nicaragua (83%), Haiti (75%), Tanzania (67%) and Ecuador (62%). This PAHO/AMRO regional emphasis on EBFs is striking, and reflects the rich partners within the region. Tanzania is an exception amongst the AFRO case studies with the other four having 43% to 55% of their total expenditure from EBFs. Similarly the EBF proportion of total 1992-95 expenditure in the SEARO and WPRO countries ranges from 40% to 52%.

Figure 4.6 Total WHO Expenditure at Country Level, 1992-95



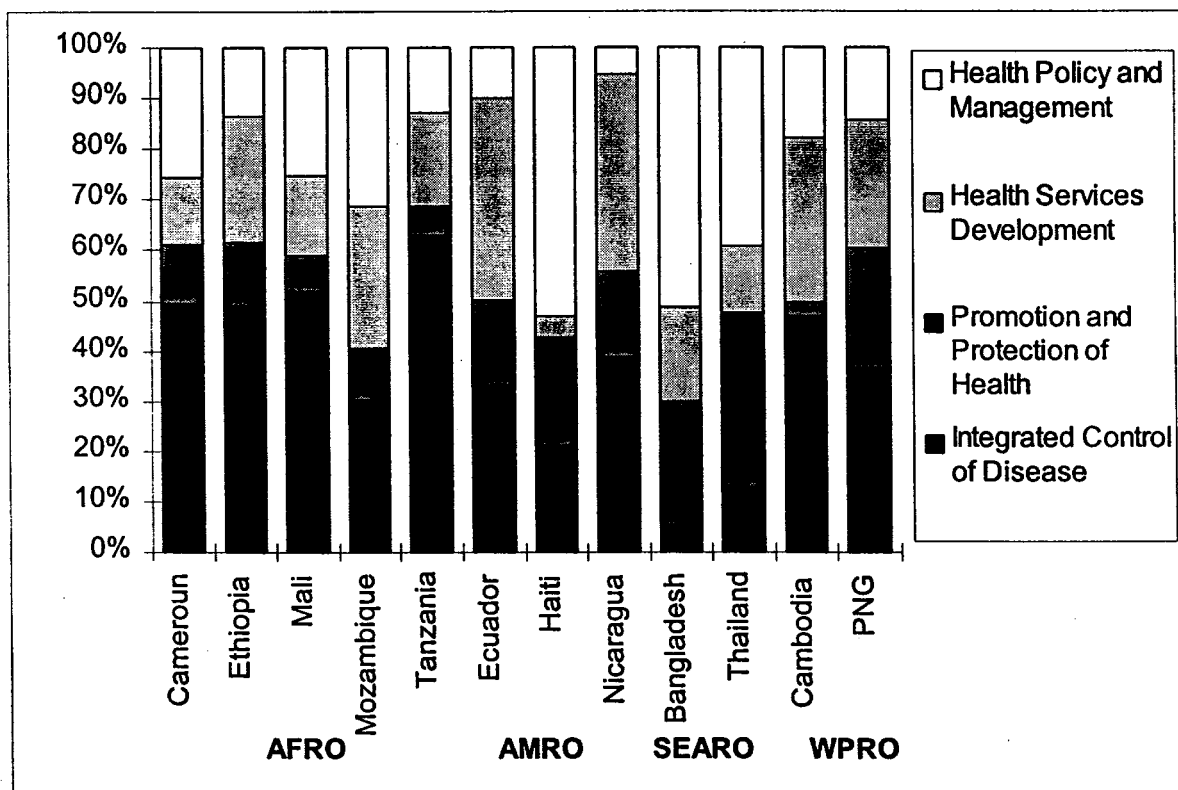
Analysing changes in total expenditure from all 3 levels of the organisation between 1992-93 and 1994-95, there was no particular pattern in which source of funds changed most (Figure 4.6). Five countries experienced a percentage change in RBFs greater than EBFs, and seven with changes in EBFs greater than RBFs. However, in eleven case studies, the change in RBFs reflected an *increase* in expenditure; in contrast, six countries experienced *decreases* in EBFs. This was particularly notable in the AFRO case studies where four of the five case studies saw a decrease in EBFs.

WHO financial support by strategic programme area

The study undertook a detailed analysis of the Financial Activity Profile for each country, (Annex 4, p.A19-21) which provides detailed data on how funds have been distributed across the four strategic programme areas: Health Policy and Management, Health Services Development, Promotion and Protection of Health, and Integrated Control of Disease (see Box 1 in Annex 3, p.A11). Figure 4.7 provides a summary of the findings for 1992 to 95 combined, showing the differences in patterns of expenditure across the case studies.

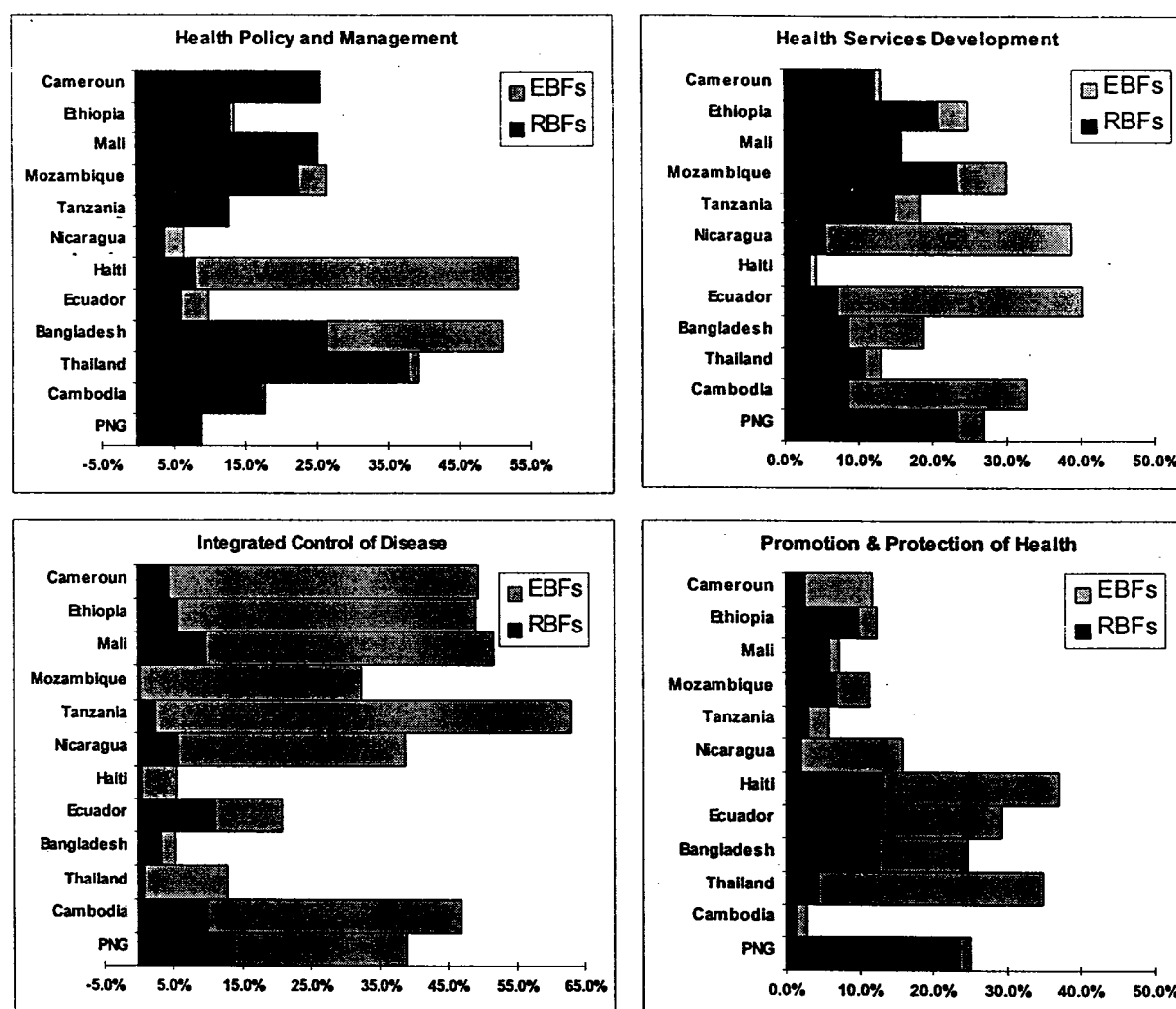
- For Health Policy and Management, Nicaragua (7%) and Ecuador (10%) spent the smallest proportion while most of the remaining case studies spent 11-30%, with the exception of Haiti which spent the largest proportion (50%).
- For Health Services Development, the proportion of total expenditure ranged from 5% in Haiti to 40% in Ecuador and Nicaragua. Eight case studies spent 10-30% on this strategic area, and Cambodia more than 30%.
- Protection and Promotion of Health had the smallest proportion of total expenditure in six of the twelve case studies. Three countries spent less than 10% (Cambodia, Mali and Tanzania), eight countries between 10-30%, and only Haiti spent more than 30%. The proportion of expenditure in this strategic area is highest in PAHO/AMRO and SEARO case studies, and lowest in the AFRO case studies. There is some correlation with capacity clusters, but not consistently.
- Integrated Control of Disease represented the largest proportion of total expenditure in the seven AFRO and WPRO countries and in Nicaragua, all showing 30% to 65% of total expenditure in this strategic area. Bangladesh and Haiti spent less than 10%, and Thailand and Ecuador spent between 10-22% on Integrated Control of Disease.

Figure 4.7 Proportions of Total WHO Expenditure by Strategic Area, 1992-95



Among case studies in the same region, there are broad similarities in expenditure by strategic programme area. This is especially notable between Bangladesh and Thailand which, as described in Chapter 2, have substantially different health needs and capacities, yet have similar overall expenditure patterns. There is also general similarity among the five AFRO case studies, and between the two WPRO case studies. Ecuador and Nicaragua have similar expenditure patterns, but the pattern in Haiti (a 'post' conflict country) is noticeably different from all the other countries (Figure 4.7), though most similar to Bangladesh.

Figure 4.8 Proportions of Total RBF and EBF Expenditure by Strategic Area 1992-95



The percentages from each of the 4 boxes add to 100% for each country.

Examining on what strategic areas RBFs and EBFs were spent, Figure 4.8 shows some clear differences.

- In Health Policy and Management, RBFs were the key source of funding for all the case studies with the exception of Haiti.
- For Health Services Development, RBFs were more important in seven of the case studies (all 5 AFRO countries, Thailand and PNG)
- For Protection and Promotion of Health, EBFs are more prominent in the PAHO/AMRO and SEARO case studies, with a less clear pattern in the other case studies.

- For Integrated Control of Disease, EBFs represent the greatest proportion of expenditure in all the case studies except Bangladesh.

In sum, there are regional variations in how financial resources have been allocated. In all the AFRO case studies, the smallest proportion of total expenditure (less than 12% on average for the two biennia) was for Promotion and Protection of Health. Neither RBFs nor EBFs provided significant funding for this strategic programme in AFRO. In comparison, most of the case studies in the other regions (with the exception of Cambodia) spent between 15-37% for Promotion and Protection of Health. In all the WPRO and AFRO case studies and Nicaragua, Integrated Control of Disease represented the largest proportion of expenditure, followed by Health Services Development or Health Policy and Management. Thus the level of WHO expenditure, and the pattern of that expenditure over the four strategic programme areas, among the case studies, appears to be more related to the regions than to the capacity assessment of countries as presented in Table 2.3, page 15.

Comparing RBFs and EBFs between the two biennia, the Study finds that the countries experiencing the largest increases were Cambodia and Bangladesh ('post' conflict and low capacity countries, and in regions other than AFRO). There is some evidence that change in either RBFs or EBFs may be balanced by corresponding change in EBFs or RBFs. In Papua New Guinea, for example, the proportion of total expenditure on Integrated Control of Disease remained relatively stable between 1992-93 and 1994-95. However, RBFs for Integrated Control of Disease was increased by US\$1.1 million, and EBFs declined by about US\$480,000 during this period. In Haiti, EBFs to Integrated Control of Disease decreased by about US\$120,000 while RBFs increased by US\$215,000. Both examples suggest that RBFs may respond to changes in EBFs, or vice versa, in order to maintain a given level of activity.

4.3 WHOCO Country Collaborative Programme by functional category and by tools used for implementation

4.3.1 WHO activities in terms of functional categories according to intended purpose

As described in Annex 3, the Study analysed each case study by functional category and by tools used to carry out WHO activities. A function in this study is defined in terms of intended purpose or a strategic approach of a specific activity or programme. Five functional categories are examined:

- advocacy,
- support to establishing norms, policies and national planning,
- research and research promotion support,
- information dissemination and
- technical operations support.

For each case study, the WR was requested to estimate the relative importance of each function and tool by budget line item. This assessment of importance or emphasis does not necessarily reflect either time or financial input, but a combination of "efforts" related to the implementation of the activities, as estimated retrospectively by the WHOCO staff. It is also important to note that the assessments and percentages may reflect a combination of *actual* "effort" and what the WHOCO staff perceived as appropriate or *desirable*.

The percentages in Box 4.1 indicate the proportion of total weightings in each of the functional categories, added from the budget line items and combining information from all activities in all countries. The lowest overall “effort” is on research and the highest on technical operations support. Between these two extremes, more or less similar “effort” is made in advocacy, support to establishing norms, policies and national planning and information dissemination.

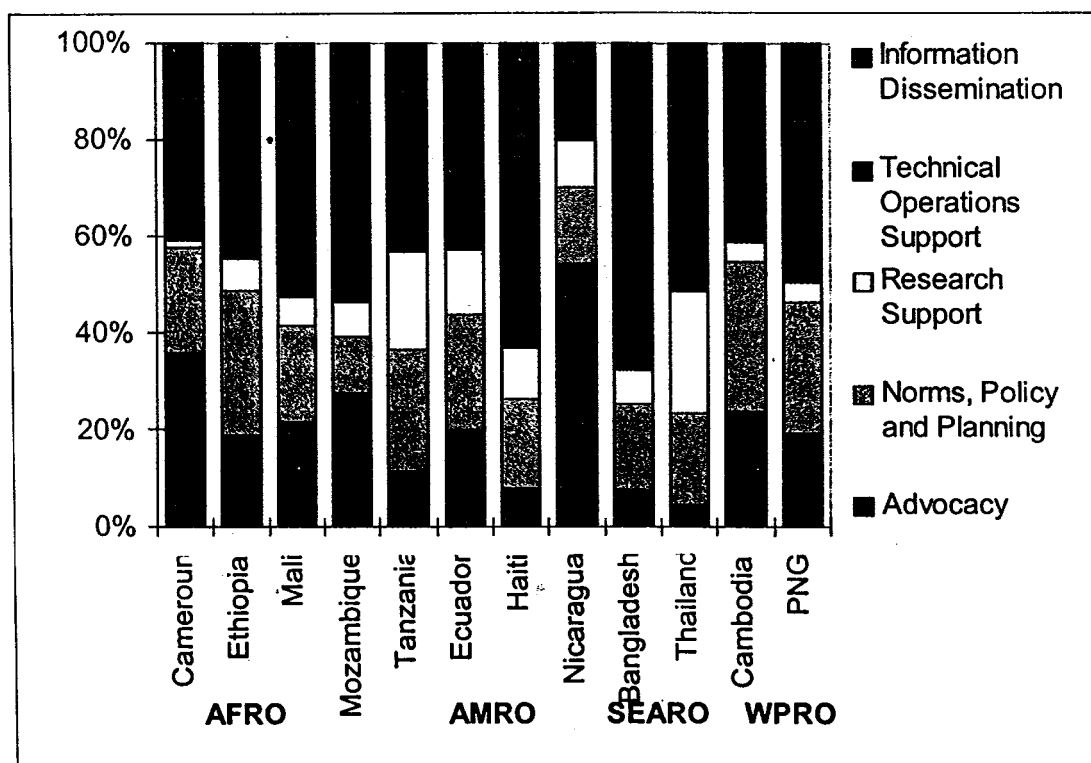
Box 4.1 Percentage of “effort” to functions in the twelve case studies

Function	% of “effort”
Health advocacy	21
Support for establishing norms, policies and national planning	22
Research and research promotion support	10
Technical operations support	29
Information dissemination support	18

Source: Derived from Activity Profile, WHOCO Use of Functions, 1992-93 and 1994-95

The profile of activities in each country by functional category is shown in Figure 4.9. The variation in profile between the countries is notable. There are no striking regional similarities in profile, except for between the two countries in WPRO, and to a lesser extent the two SEARO countries. The low involvement in research is common to most countries, yet more prominent in Tanzania and Thailand than in any of the other countries. Equally striking is the finding that technical operations support, representing the function where WHO actually supports implementation of health programmes, is not more prominent in countries with low capacity compared with to with higher capacity.

Figure 4.9 WHO country collaborative programme: Functional Categories, 1992-95



Health Advocacy

Health advocacy can be defined as *an activity undertaken for the purpose of supporting or recommending a particular health practice or policy*. The Constitution of WHO states that the Organisation should "assist in developing an informed public opinion among all peoples on matters of health."² Such a function would entail, for example, drawing the attention of national policy makers to specific health issues (e.g. mental health, reproductive health, aging, smoking) relevant to needs and priorities at country level. As such, health advocacy is both a common global and country specific function.

Across all the case studies, the emphasis on advocacy is 21% of the total effort as assessed by the WHOCOs (Box 4.1). Advocacy was indicated as most important in Nicaragua (54%) and Cameroon (36%)³ compared with other functions during the two biennia. These countries also have relatively small budgets. Six other countries estimated 18-30% of their effort in advocacy. Thailand (5%), Bangladesh (8%) and Haiti (8%)⁴ indicated the least emphasis on this function (Figure 4.9).

Analysing activities concerned with this function by strategic area (Annex 4, p.19-21), most advocacy effort is directed towards Integrated Control of Disease, and least to Health Policy and Management. However, the differences are generally not great, and advocacy was used across all four strategic areas.⁵ In Nicaragua and Cameroon advocacy was focused on programmes in the strategic areas for Health Services Development and Protection and Promotion of Health and in Mali and Ecuador in the area of Integrated Control of Diseases.

Support for establishing Norms, Policies and National Planning

This function can be defined as *developing norms, in the form of agreed guidelines, standards, conventions, agreements, regulations, and supporting the use of these norms in the development and implementation of national health policies and planning*. As discussed in Chapter 1, this can be seen as both a common global and country specific function. The agreement of norms at the global level is often based on information and knowledge obtained at country level. Global norms, in turn, can be used at country level to strengthen national health policies and planning. It is through this process of interaction that WHO can support the use of strong national policy and planning in health development.

While most countries have a formal national health document (Box 4.2), each varies in the extent to which it forms the basis of a nationally agreed policy, plan or strategy⁶ for health development. In Mozambique, for example, the MoH has taken a strong leadership role among national and external health actors in the development and application of the National Health Policy and Strategy for Cooperation (Mozambique p. 12). In contrast, a multiplicity of national health actors has led to fragmentation and lack of "any consensus...within the Government of Ecuador on what should be the actual direction and content of health sector reform", despite the existence of a national health plan (Ecuador p. 5). Of particular note is Bangladesh where a multiplicity of external actors, led by the World Bank consortium, and relative weakness of the government in directing their activities, has led to a "fragmented approach to health planning...[and] absence of a national health policy" (Bangladesh p. 5).

Across all the case studies, *Support for establishing Norms, Policy and Planning* accounted for 22% of WHOCO effort, and was indicated as the second most important function. For the two biennia, the greatest emphasis was in Cambodia (31%) and Ethiopia (30%) closely

followed by PNG and Tanzania. Five countries indicated 20-30%, and three countries 10-20% of their effort, for this functional category. The countries giving the smallest amount of emphasis to Norms were Mozambique (12%), Bangladesh (18%) and Thailand (19%) (Figure 4.9). As with advocacy, most effort is directed towards Integrated Control of Disease and least to Health Management and Policy.

Box 4.2 National health policies or plans of the case studies

Cameroon	Statement of Cameroon's Sectoral Health Policy, Basic Document (1992)
Ethiopia	National Health Policy (1993); National Health Strategy (1995)
Mali	Declaration de Politique Sectorielle de Sante et de Population (1990)
Mozambique	Mozambique Health Sector Profile (1996); Health Sector Cooperation Strategy (1996)
Tanzania	National Health Policy (1990)
Ecuador	Reforma por la Salud de Todos para Todos, 1995
Haiti	Politique de Sante (1996)
Nicaragua	Health Master Plan (1991-96)
Bangladesh	A national health plan but not policy
Thailand	Eighth National Health Development Plan (1997-2001)
Cambodia	National Health Development Plan (1996-2000)
Papua New Guinea	National Health Plan (1996-2000)

Source: Compiled from the twelve Case Study Reports.

It is not possible to attribute the situation in the countries directly to WHO input. Nevertheless, it is interesting to note that in Cameroon which has only a statement from 1992 as Health Sector Policy, WHO "effort" directed towards norms, policies and planning in Health Policy and Management has been very low compared to other strategic programme areas. In Haiti the Study findings reflect the recent effort to develop a Health Policy (1996): half of the WHOCO "efforts" in this functional category was directed to Health Policy and Management. Bangladesh is characterised as having a fragmented approach to health planning and an absence of a national health policy. This is one of the countries with least activities in this functional category and puts limited "efforts" towards Health Policy and Management.

Research and Research Promotion Support

This function is related to WHO's constitutional responsibility "to promote and conduct research in the field of health",⁷ and can be defined *as identifying research needs, encouraging research workers to conduct research in a particular area, and providing advice about the preparation of research protocols.*

The emphasis given to *Research and Research Promotion Support* across all the case studies was only about 10%, and lower relative to other functional categories in most countries. For the two biennia, emphasis was greatest in Thailand (25%), followed by Tanzania (20%), Ecuador (13%) and Haiti (11%) (Figure 4.9). The remaining eight countries indicated 10% or less of their effort to research support. This limited amount of effort was generally distributed evenly across the four strategic areas. The exceptions are Thailand and Haiti where research in Promotion and Protection of Health is given the highest priority and in Tanzania where Integrated Control of Diseases receives highest priority for research (Annex 4, p.A20).

Technical Operations Support

Technical operations support for the purpose of this study was defined as *the function where WHO goes beyond country specific support to the development of health policies, strategies and systems, into actual operational support or implementation of health programmes.*

Technical operations support was indicated as the most important function (29%) for activity implementation across the twelve case studies (Box 4.1). Bangladesh (44%) indicated a heavy emphasis, followed by six countries which assessed 30-40% of their effort for this function. Nicaragua and Cameroon indicated least effort (10-20%) for technical operations support (Figure 4.9). Technical operations support was indicated as important across the four strategic areas in all the countries though more emphasis can be seen for Integrated Control of Disease and Promotion and Protection of Health. Support to technical operations was surprisingly low in some low capacity countries (Mozambique and Cameroon) and surprisingly high in some high capacity countries (Thailand and Ecuador). Thus, there is no clear pattern indicating use of technical operations in relation to country capacity.

Information Dissemination Support

This function is reflected in WHO's constitutional responsibility to "provide information, counsel and assistance in the field of health".⁸ The function of *Information Dissemination Support* can be defined as *the generation and transmission of information to the Member Countries* and is concerned with distributing material that will be useful in program delivery (e.g. manuals, guides, the results of bibliographic searches, etc.), planning information needs, establishing transmission formats, targeting information to appropriate users, and monitoring the information's use.

The case studies indicated about 18% or the second least amount of effort for *Information Dissemination Support*. Five countries indicated 20-30%, five countries 10-20%, and two countries 10% or less to information dissemination during the two biennia. Mozambique (29%) gave the most and Ethiopia (6%) the least effort to this function (Figure 4.9). *Information Dissemination Support* is most frequently directed towards the strategic area Promotion and Protection of Health. In general, *Information Dissemination Support* accounts for a relatively small amount of "effort" in activity implementation across the four strategic programme areas.

4.3.2 WHO activities in terms of the use of tools for implementing the activities

A tool is defined as the means or instrument by which an activity or programme is carried out. Eight tools are examined: financial assistance, supplies and equipment, consultancies, courses and seminars, travel and visits, fellowships, linkages to other health actors and WR advice and facilitation. The WHOCO in each case study was requested to estimate the relative importance of each tool for the implementation of programme activities. Importance was indicated for each budget line item, and then summarised for the four strategic areas. Again, the emphasis represents an estimate of overall "effort" in the implementation of activities. Thus the percentages used in this section, and presented in Box 4.3 and Figure 4.10 indicate the proportion of total effort considered across all the tools for all the activities in the budget plan for the twelve case studies.

In general, supplies and equipment with financial assistance represented 31% of effort on tools, while courses and seminars together with fellowships comprised 26%. The most striking finding is the low level of effort afforded to linkages with other agencies.

Box 4.3 Percentage of “effort” to tools in the twelve case studies

<u>Tools</u>	<u>% of “effort”</u>
Courses and seminars	18
Supplies and equipment	17
Financial assistance	14
WR advice and facilitation	13
Consultancies	12
Travel visits	10
Fellowships	8
Linkages with other health actors	8

Source: Derived from Activity Profile, WHOCO Use of Tools, 1992-95.

The profile of WHOCO use of tools for each country, is presented in Figure 4.10. The variation in profile between the countries is notable, but no striking regional similarities, except, again, for the two WPRO case studies. The low involvement in establishing linkages to other partners is a common feature, with no involvement at all in some countries.

Fellowships, Courses and seminars

Courses and seminars are indicated to be the most important tool for implementation of programmes and activities (18%) across all the case studies. Including the effort for fellowships, the two account for 26% of total “effort” on all the tools. There is some difference in how the regions rate the importance of fellowships: highest by the case studies in SEARO, moderate by those in WPRO, lowest by those in PAHO/AMRO, and from high (Mozambique) to low (Cameroon, Mali and Ethiopia) in the AFRO case studies. Fellowships are most frequently awarded in the area of Health Service Development and Health Promotion and Protection. Courses and seminars are more frequent in Integrated Control of Disease in WPRO case studies, and in Health Promotion and Protection in Haiti, Nicaragua and Thailand.

Supplies and equipment

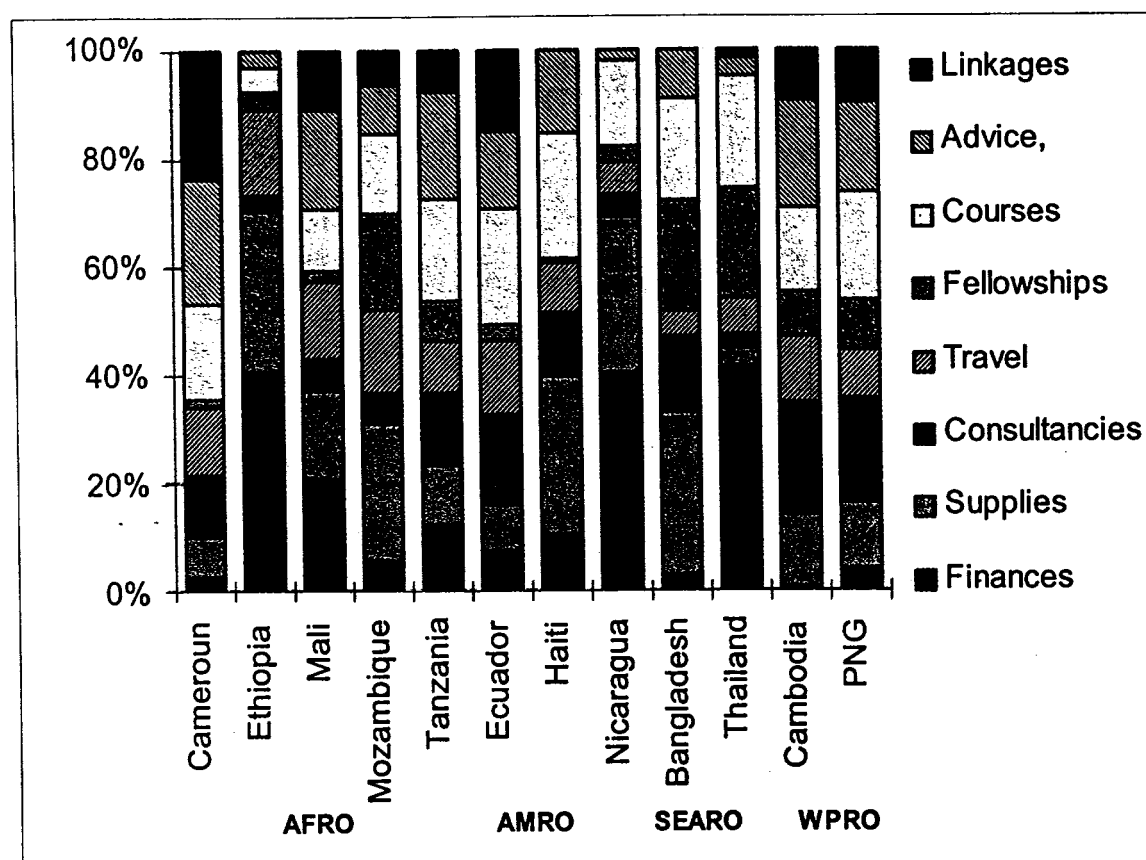
For all the case studies, supporting provision of supplies and equipment in different ways was one of the most frequently used tools (17%), with most importance given to Integrated Control of Diseases. Nicaragua, Haiti, Bangladesh and Mozambique are countries that consistently both in total and across the strategic areas indicate this tool as important while Thailand, Cameroon and Ecuador give this tool low importance.

Financial Assistance

Across the case studies, financial assistance is given moderate importance (14%). The WHOCO in Bangladesh reported financial assistance as the least used as a tool for carrying out its activities. This may reflect the relatively low WHO funding compared with that of the World Bank. Financial assistance was also little used in Cambodia and Papua New Guinea where there are prominent external donors (i.e. UNICEF, bilateral agencies). In contrast, financial assistance was cited as a frequently used tool in Ethiopia, Thailand and

Nicaragua. One could question the relevance of WHO using financial assistance as a tool in a high income country like Thailand.

Figure 4.10 WHO country collaborative programme profile: Use of Tools 1992-95



WR Advice and Consultancies

For all the case studies, moderate importance is given to these tools. Countries putting more emphasis on using WR advice (Cameroon, Cambodia, Tanzania and PNG) tend to use consultancies more frequently as well. Similarly, countries putting little effort on WR advice (Nicaragua, Ethiopia and Thailand) also give least importance to the use of consultancies. There is no clear regional pattern in use of consultancies, although the AFRO countries rate it generally lower than the countries in the other regions. Except for the WPRO countries which used consultancies more frequently in Integrated Control of Disease, there is no other general pattern in how consultancies are used across the strategic areas.

Linkages

In general, making linkages with other actors in the health sector, is given least importance (8%) of all tools. Some WHOCOs indicate no use of linkages at all (Ethiopia, Nicaragua, Haiti, Bangladesh). Conversely, Cameroon and Ecuador, give considerable priority to making use of linkages with other actors in the health sector (Figure 4.10) especially within the strategic area Promotion and Protection for Health.

Generally, there does not appear to be any discernible similarity in the WHOCO profile on use of tools among countries by capacity cluster, or in the same region, with the exception of Cambodia and Papua New Guinea where tools were used in similar proportions.

4.4 WHO activities contributing to health policy development and research,

In relation to directing and coordinating function in international health work, the 9th GPW outlines WHO's role in advocating for health as a human right and greater equity in health and access to health services, defending the rights of vulnerable groups and countries in need. Rather than viewing the directing and coordinating function as distinct from the technical cooperation function, in this Study we have distinguished between common global and country specific functions. The tasks for this global function include support for health research, and strengthening the collection, assessment and dissemination of information on cost-effective methods for health development.

The activities explored in this section include WHO's involvement in:

- (i) activities related to Health Policy Development as reflected in the country programme budgets for the strategic area Health Policy and Management;
- (ii) health related research activities; and
- (iii) inter-country activities related to advocacy, technical programmes and cross-learning.

WHO's financial input to Health Policy

In terms of funding that can be traced for common global functions at the country level in the strategic area for Health Policy and Management, the findings show that involvement is very scattered (Table 4.2). The only two regions where case studies record use of financial resources for the purpose of health in socio-economic development are PAHO/AMRO and WPRO. PAHO/AMRO is also the only region where there has been an effort to document implications of macro-economic conditions for health through mapping the mobilisation of political support (section 4.5). In eight of the case studies, there is WHO country level funding for the specific programme area of information systems, either as planning and management support to information systems or support for trends assessment and country health information.

Table 4.2 Funding available at country level for common global functions, Strategic Area Health Policy and Management⁹

COUNTRY	REGION	Health in Socio-economic Development		Coordination and Resource Mobilisation		Research policy and strategy coordination		Information systems, health status, trends	
		RO funds	CO funds	RO funds	CO funds	RO funds	CO funds	RO funds	CO funds
Cameroon	AFRO	NO	NO	YES	NO	YES	NO	YES	NONE
Tanzania	AFRO	NO	NO	NO	NO	NO	NO	NO	MED
Mozambique	AFRO	NO	NO	NO	NO	NO	YES	NO	NONE
Ethiopia	AFRO	NO	NO	NO	NO	NO	NO	NO	LOW
Mali	AFRO	NO	NO	NO	NO	YES	YES	NO	NONE
Ecuador	PAHO	NO	YES	NO	NO	NO	NO	NO	MED
Haiti	PAHO	NO	NO	NO	NO	NO	NO	NO	HIGH
Nicaragua	PAHO	NO	YES	NO	NO	NO	NO	NO	NONE
Thailand	SEARO	NO	NO	NO	NO	NO	YES	NO	HIGH
Bangladesh	SEARO	NO	NO	NO	NO	NO	NO	NO	HIGH
Cambodia	WPRO	YES	NO	YES	NO	NO	NO	NO	NONE
PNG	WPRO	NO	NO	YES	YES	YES	YES	NO	MED

Advocacy related to programme activity under the strategic area Health Policy and Management is not rated as very significant in any of the case studies, apart from Tanzania where this strategic area demonstrates the highest engagement in advocacy. No commonalities can be found that meaningfully relate to the clustering of case studies according to capacity and service access (Table 2.3 page 15).

WHO research related activities

This section describes the study findings on WHO's role in research at country level. It includes research activities in public health and health systems as well as special programmes in Tropical Disease (TDR) and Human Reproduction (HRP). As noted in Chapter 3, the HQ special programmes are not part of the WR portfolio and function rather independently from regional and country level WHO structures and systems.

The emphasis on the functional category of research and research promotion support is lower relative to all other functions in most countries (see Figure 4.9, page 57). Generally, this is supported by the findings from the country visits which are summarised here.

WHO operates its research programmes through the Advisory Committee on Health Research (AHCR) and through various HQ and RO divisions. At regional level the research programmes are co-ordinated through the Regional AHCR which sets regional priorities for health research, based on country needs, and promotes initiatives in strengthening research capacity in member states, including the award of fellowships, institutional grants and the use of visiting experts.

WHO's global research agenda covers problems of high public health priority, such as disease control in developing countries, which are otherwise relatively neglected by the research establishment and the pharmaceutical industry. Examples include new anti-malarial drugs and ivermectin for onchocerciasis. WHO regional programmes have also addressed problems of regional interest such as dengue haemorrhagic fever in South East Asia and *schistosoma japonicum* infection in the Western Pacific region. Through the years, considerable support to research training has been given to countries such as Ethiopia, Bangladesh and Thailand. The capacity in Thailand for research is now high, but in the two other countries research capacity remains weak. PAHO/AMRO together with IDRC has set a programme offering public health research training grants with focus on strengthening research institutions as well as individuals in applied research.

In many countries, health systems research was relatively poorly developed and in particular research that would inform health sector reform. However, the subregional network on health systems research in Southern Africa was noted for relevant contribution to capacity building, both in Tanzania and Mozambique where Health Systems Research Units have been established and many health staff have been trained. PAHO/AMRO has established a research programme on health systems and services as a complementary effort to the public health programme. A particular focus has been on health sector reform and consequences for equity. However, none of the case studies are as yet included in the programme.

In many of the case studies, national institutions have received support from WHO for research purposes. Examples include university related institutions such as the Centre for Research and Studies in Health (CIES) in Nicaragua, and a network of health training institutions in Ecuador. In nine of the case studies ENHR Committees (or similar research committees) have been established. Only Thailand, Cambodia and Haiti do not have such committees. WPRO countries have least activities related to research.

Several of the case studies had received inputs from the special programmes of research, HRP and TDR. Table 4.3 shows TDR activities in the twelve case studies since the inception of the programme in 1975. The variation in activity between the countries is notable. Given an approach where grants are increasingly given on the basis of competitive bidding, the resulting investment, number of projects and publications represent an indication of research capacity in the country, with Thailand clearly ahead of the other countries. Also notable is the relatively high level of TDR funding to the AFRO case studies, which forms a substantial proportion of total WHO funds at country level.

Table 4.3 TDR support to countries 1975-1995

Countries	Capacity Cluster	Total Amount US\$	No. of Projects	Publications from TDR funded projects	Trainees hosted	Membership of TDR Committees
Thailand	HIGH	14,374,661	257	230	46	37
Ecuador	HIGH	590,258	11	1	0	0
Nicaragua	HIGH	383,470	7	1	0	0
Tanzania	MEDIUM	4,277,342	91	43	9	6
PNG	MEDIUM	1,576,621	27	20	0	1
Cameroon	MEDIUM	5,307,934	83	31	3	7
Haiti	LOW	135,500	1	0	0	0
Bangladesh	LOW	307,693	13	18	0	3
Cambodia	LOW	95,280	5	0	0	1
Mozambique	LOW	837,507	11	10	0	1
Ethiopia	LOW	4,316,524	92	41	7	8
Mali	LOW	2,944,230	53	16	6	12

HRP has also had a strong programme geared towards strengthening the capacity of institutions to carry out research in reproductive health. Successful research groups have been established in Mozambique, Cameroon and Thailand. PNG requests for support to build research capacity had not been met, due to financial constraints. Thailand plays a role in supporting research training in the less developed countries in the neighbourhood. Table 4.4 shows that the level of funding from HRP during the period 1992-95, has been declining in all the case studies.

The special programmes operate differently in the different regions. The case studies in AFRO have received more support from the TDR than any other regions, although Thailand has received the largest amount of funding. HRP has also supported more case studies in AFRO than in the other regions, but only Thailand and Cameroon have participated to any extent in the global research effort.

Generally, communication between research institutions and Ministries of Health would benefit from greater attention from the WHOCO. Several case studies reported excellent collaboration between programme managers, academic institutions and the MoH, such as for malaria in Mali. In other countries there was more distance, such as noted in PNG. Individual scientists who receive WHO research grants are gathered into an international network of researchers, and a dynamic relationship between researchers is fostered. The push to make research findings relevant and useful to national systems may weaken, unless it is actively encouraged and facilitated by all parties.

Table 4.4 HRP support to countries, 1992-95

COUNTRIES	Capacity Cluster	HRP support	1992	1993	1994	1995
Thailand	HIGH	High, declining	831,766	638,430	277,921	114,638
Ecuador	HIGH	None				
Nicaragua	HIGH	None				
Tanzania	MEDIUM	None				
PNG	MEDIUM	None				
Cameroon	MEDIUM	Medium, declining	145,100	110,370	67,000	63,050
Haiti	LOW	None				
Bangladesh	LOW	Low, steady			27,000	26,500
Cambodia	LOW	None				
Ethiopia	LOW	Low, declining	84,000	67,940	25,000	15,000
Mozambique	LOW	Low, declining	53,000	86,000	20,000	30,000
Mali	LOW	None				

Inter-country activities

One of the special advantages of WHO is its ability to enable countries to work together in circumstances that would normally be difficult or impossible. WHO provides a neutral platform for discussion, advocacy, joint planning and mutual support. The Study encountered several examples of WHO facilitating inter-country collaboration through:

- Consultation, advocacy;
- Review and planning of technical programmes;
- Cross-learning and training; and
- Mutual support.

Consultation and advocacy

From the global forum of the WHA to regional committee and sub-regional meetings, WHO provides many opportunities for health officials of member states to exchange experiences and to learn from each other, e.g. SEARO has an annual meeting of Ministers of Health, at which the minister of the host country presides as the chair of a forum that encourages consultations and exchange of visits among within the region. WPRO countries have had a number of exchange visits of high ranking officials between countries in the region, for example to deal with the special challenges in health policy facing the Pacific in (Healthy Islands). Comparable fora are found in all the sub-regions in PAHO/AMRO; e.g. Health initiative for Peace and Healthy Borders in the Andean subregion and Health and Peace towards Democracy and Development in Central America. An Inter-American Network on

Health Economics and Financing (REDEFS) has been established by PAHO/AMRO to strengthen national capacities and promote regional co-operation on reform.

Technical programmes

The control of communicable diseases illustrates the value of WHO's coordinating role in its work with member states. For example, based on the experience gained in the poliomyelitis campaigns in the Americas, SEARO and WPRO coordinated National Immunisation Days in neighbouring states to achieve maximal epidemiological impact. Inter-country and inter-regional collaboration is also evident in the control of malaria in the Indochina peninsula. Gains achieved by the more advanced countries are threatened by cross-border immigration of infected persons. SEARO, WPRO and AFRO have therefore organised various policy and technical meetings to stimulate and promote technical co-operation among neighbouring states in malaria control. Mechanisms for consultation and collaboration between countries in Asia (both WPRO and SEARO) have also been developed in other areas, such as on the question of drugs, both through ASEAN and Technical Cooperation among Developing Countries. Several technical programmes in PAHO/AMRO have a cross country approach, for example, the immunisation programmes with strong sub-regional and regional activities through the inter-agency committees, the Central American project on Intrafamily Violence against Women and the programme on Environment and Health in Central American Isthmus (MASICA).

Cross-learning and Training

Experiences gained in some countries and capacities developed are often shared through WHO initiatives. For example, a WHO organised workshop in Thailand, on the disposal of hospital wastes enabled other countries to share knowledge and experience gained by the host country. In 1995, about 500 WHO fellows were placed in Thailand to undertake a variety of training programmes. PAHO/AMRO has held regular consultations to share experiences. Examples include Health Reform, local health systems and decentralisation at regional and subregional levels. WHO has also supported institutions in less developed countries to gain capacity to meet national needs and to share with other countries. For example, a Malaria Research Centre in Mali, strengthened by TDR, has trained a number of national scientists as well as students from other countries.

Mutual support

In previous decades, much of the flow of knowledge and external aid was from developed to developing countries. WHO and other development agencies adopted the policy of stimulating collaboration among developing countries. As developing countries gain increasing capacity, they are participating in mutual exchange of knowledge and services. Thai institutions provide technical services for neighbouring countries through WHO, such as, laboratory services including diagnostic virology, and quality assurance of drugs. WHO recruits consultants and advisers from developing countries to serve in other developing countries.

Research

Many of the countries in the Study have been involved in collaborative research that was coordinated by Headquarters programmes (HRP, TDR), and by the Regional Offices. In the Americas, collaborative research on Chagas' disease set standards for epidemiological survey, compared various types of interventions and resulted in a regional strategy designed

to eliminate the disease. A recent research initiative on Health Reform and Equity is currently being implemented in some Caribbean countries. Much of the knowledge about the application of mosquito bed nets was derived from collaborative studies coordinated by WHO undertaken in countries.

Overall the study finds that the perceived neutrality and technical expertise of WHO means that it can provide a platform for collaboration between neighbouring states, to work on health issues where individual country effort would be insufficient. WHO seems to be able to play this role in a way that other donors cannot.

4.5 WHO support for mobilisation of financial and other resources for health development at country level.

The Ninth GPW¹⁰ lists the mobilisation of resources as a major task necessary to ensure that the GPW has greatest impact. The Study has taken a broad approach to identifying WHO's role in resource mobilisation covering financial, physical, human, information management, institutional resources and political resources (see Annex 5, p.A31). In each of these resource areas the WHOCOs were asked to list their activities related to mobilisation of national and external resources.

The regions show some differences in whether they have specific regional policies and resolutions that stress the WHOCO role in mobilising various kinds of resources. PAHO/AMRO, has documentation covering resource mobilisation policies and approaches for both the Eighth and Ninth GPWs.¹¹ In PAHO/AMRO mobilising national resources is emphasised in terms of political will in favour of health and modernisation of the sector and institutional resources such as universities, institutes and collaborating centres. In AFRO¹² the recent policy framework for technical co-operation gives most attention to financial resource mobilisation and the role of WHO in preparation of project documents to submit to donors, while not neglecting the advocacy role for health. The WPRO policies¹³ are more concerned with directing resources to priority health needs in the most productive way within countries. The initiative for eradication of poliomyelitis seeks to actively mobilise all sectors, both government and non-government for collaboration in the effort.

WHO Country Office resource mobilisation activities

The WHOCOs listed many and varied activities in national and international resource mobilisation. The strongest feature demonstrated by the findings presented in Table 4.5 is the regional pattern. However, stated regional priorities in resource mobilisation are not consistently reflected in the examples given for this study. In the AFRO case studies, financial resource mobilisation is not more prominent than other types of resources, while PAHO/AMRO and WPRO case studies have as much activity in financial resource mobilisation as in other areas. The WHOCOs have a similar level of activity across all areas of resource mobilisation (whether high, medium or low), although there is less richness in the activities recorded for mobilisation of physical, human or institutional resources. Least effort is directed to mobilising political support. The levels of resource mobilisation activity presented in Table 4.5 may also reflect WHOCO size and capacity (See Figure 3.1 page 22). PAHO/AMRO and WPRO case studies, which listed more and a wider range of resource mobilisation activities, also have more staff.

Table 4.5 A summary of WHOCO activities related to resource mobilisation

Country	Region	Capacity Cluster *	Financial Resources	Human Resources	Institutional Resources	Information Management	Physical Resources	Political Support
Cameroon	AFRO	Medium	Low	Low	Low	Low	Low	Low
Ethiopia	AFRO	Low	Low	Low	Low	Low/Medium	Low	Low
Mali	AFRO	Low	Medium	Medium	Medium	Low/Medium	Low	Medium
Mozambique	AFRO	Low	Low	Low	Low	Low	None	Low
Tanzania	AFRO	Medium	Low	Medium	Medium	Medium	Low	Medium
Ecuador	AMRO	High	High	Low	High	High	Medium	High
Haiti	AMRO	Low	Medium	Low	High	Low	Medium	Medium
Nicaragua	AMRO	High	High	High	High	High	High	Medium
Bangladesh	SEARO	Low	Medium	Medium	Low	High	High	Low
Thailand	SEARO	High	Low	Low	Low	Low	None	Low
Cambodia	WPRO	Low	High	High	Medium	High	High	Medium
PNG	WPRO	Medium	High	High	High	High	High	High

* see Table 2.3 page 15

Source: Compiled from the WHO Country Office data collection instrument

Financial resources

The WHOCOs gave examples of activities in assisting governments to; (i) attract more national resources for health; (ii) use national health and non-health resources more efficiently; (iii) attract more EBFs through WHO channels; (iv) plan and negotiate for additional external health resources; (v) make more efficient use of external resources. (Annex 5, p.A31)

The WHOCO's listed many activities related to mobilisation of both national and external funds. However, more effort is put into raising external finances. This is particularly so for the AFRO and WPRO case studies. There seems to be no marked difference in the use of EBFs, whether mobilised through WHO or other channels (infectious diseases, drugs, water and sanitation). Efforts to mobilise resources for infectious diseases are more frequent than for other purposes (7 countries).

The WHOCOs listed frequent support to develop health sector policy and plans in order to assist the MoHs in their negotiation for external funds with multilateral and bilateral donors. Assisting the MoHs to justify increased national funding to the health sector is achieved by supporting annual budget preparation, making key information available and by general advocacy. Success stories are reported from Cambodia, where there has been a remarkable increase in the national health budget, and in Nicaragua and Ecuador where more national funds have been allocated to cover EPI programme costs. Main activities for mobilising non-health resources for health purposes are directed towards broadening partnerships (6 countries) and developing new financing mechanisms (3 countries). Cameroon recorded very few activities in mobilising financial resources.

Along with efforts to attract more financial resources, countries in PAHO/AMRO and WPRO give examples of assisting governments to make more efficient use of national and external resources, through establishing improved management systems, staff training and strengthening co-ordination mechanisms.

Human resources

The WHOCOs gave examples of assisting the governments to; (i) mobilise the potential of young professionals for national health development; (ii) stimulate more health orientation of education system and adult learning; (iii) make better use of health professionals in the health system; (iv) make more appropriate use of technical assistance personnel. (Annex 5, p.A31)

The WHOCOs put more emphasis is put on mobilising national rather than external human resources by supporting training and systems development. The emphasis is on human resource development in contrast to human resource management.

The award of fellowships is the single most used activity for mobilising young professionals for national health development. Courses, seminars and continuing education are frequently used to mobilise the potential of health professionals and to assist the government in making better use of them in health service delivery. In some countries, such as Ecuador and Cambodia, WHO has supported curriculum development for training under- and post-graduate health workers. Courses and seminars for non-health workers are also used. Half the case studies are supporting initiatives related to human resource development planning. In terms of making better use of health professionals, little appears to be done in the area of incentives, working conditions, or career development.

The activities related to external human resources are mostly concerned with development of Terms of Reference for consultancies, selection and recruitment of technical assistance (TA), and participating in co-ordination committees for national use of TA (3 countries). Recruitment of lecturers from abroad is mentioned by Tanzania and participation on subregional technical meetings by Nicaragua.

Institutional resources

The WHOCOs listed activities in assisting governments to mobilise, nationally and internationally, the potential of (i) universities and teaching institutions for national health development (ii) private sector (iii) NGOs, and (iv) stimulating formation of networks. (Annex 5, p.A31)

The WHOCOs in PAHO/AMRO listed more activities related to mobilising institutional resources than case studies in the other regions. The WPRO case studies also give considerable attention to institutional resources, whereas the African WHOCOs and those in SEARO, listed fewer. More emphasis is put on national than external institutions. However, little is done to assist governments to mobilise the potential of private sector institutions. Where such initiatives are found they are mostly in connection with activities regarding AIDS and EPI. Less attention is given to stimulating formation of networks between institutions involved in health development, except in PAHO/AMRO and WPRO. Nearly all the case studies have some activity to assist the government to mobilise the potential of universities and teaching institutions. Some case studies mobilise lecturers from abroad (4 countries) and use institutions abroad for advanced degrees (4 countries). Nearly half of the case studies stated that they have established links to institutions abroad, but only three stated that they use WHO collaborating centres (two PAHO/WHO, the other in WPRO).

Information management resources

The WHOCOs listed activities in assisting governments to: (i) make better use of available data, (ii) make national information systems more efficient, (iii) achieve more appropriate data generation for health policy analysis and planning, (iv) improve access to relevant international data, (v) establish better match between national data needs and data collected by external support agencies. (Annex 5, p.A31)

Resource mobilisation related to information management is mostly in terms of development of national health information systems (HIS) and building national capacity. Disease surveillance is an area of focus, and activities in relation to drugs and tobacco were listed in Cambodia. The PAHO/AMRO case studies listed a wider range of activities in relation to development of information management systems including norms and standards, and disease surveillance systems, than the other regions. Nicaragua has developed a world-wide WEB page on the Internet to which all actors may link, and the Inter-Agency Co-ordinating Committee (ICC) has made a policy for communication in health. Ecuador has a variety of activities in this area and not only in collaboration with the MoH but also in other sectors related to environmental health and animal health. The WPRO case studies also listed many and varied activities. Fewer activities are listed by the AFRO and SEARO case studies, but, they identified more activities related to information management than in most of the other resource areas. All the case studies use and disseminate WHO documentation and make available regional data on diseases for the countries to use. Cameroon and Mozambique are the case studies with the lowest profile regarding the mobilisation of national information resources, and Cameroon, Thailand and Haiti regarding international information resources.

Physical resources

In this resource area, WHOCOs listed activities for assisting governments in: (i) health facility maintenance, (ii) health equipment maintenance, (iii) use of unused infrastructure, (iv) external ODA procurement, (v) sustainable ODA investment in new infrastructure. (Annex 5, p.A31)

WHOCOs in the AFRO case studies indicated a lower role in regard to all these aspects of mobilising physical resources than case studies in the other regions. Across the regions there is more involvement in activities related to mobilising national rather than external physical resources. Three case studies are assisted in procuring equipment externally and three others are involved in standardisation and development of procurement guidelines.

When mobilising national physical resources, equal weight seems to be given to health facilities and equipment. The activities include development of systems for standardisation, quality assurance (5 countries) and maintenance systems for equipment (4 countries). There are few activities dealing with facility coverage plans, inventories etc., or with capacity building of national staff in these areas. More frequently the WHOCOs are found to be involved in direct implementation of maintenance (4 countries). Only in WPRO (Papua New Guinea) and PAHO/AMRO (Nicaragua and Ecuador) were there activities to mobilise existing, unused infrastructure for health purposes, typically in connection with EPI activities.

Political support

The Study asked WHOCOs to list activities related to assisting governments to: (i) mobilise national political support for health, (ii) development of health legislation and regulations, (iii) make social sector reform more conducive to health, (iv) create better justification for external support, (v) enhance negotiating powers for external health resources; (vi) document implications of macro-economic conditions on health. (Annex 5, p.A31)

Mobilising political support should be an important WHOCO task related to its common global function. However the WHOCOs listed few activities in this area. Again, there are regional differences, and WHOCOs in PAHO/AMRO and WPRO listed more activities than WHOCOs in the other regions.

Generally, there is more emphasis on mobilisation of national then international political resources. The WHOCOs identified different ways of mobilising political support such as encounters with parliamentarians, using and even training the press corps. These are used to mobilise general support, but also to pursue specific critical issues such as equity for indigenous people, AIDS and women's health. In some case studies WHO played a role in the development of legislation and regulations related to health, including on drugs and tobacco. Some WHOCOs listed many activities related to mobilising national political support (Ecuador and Papua New Guinea), while others did not (Ethiopia, Mozambique and Cameroon). Few case studies have assisted the governments to document the implications of macro-economic conditions for health, although the 3 case studies in PAHO/AMRO have made some efforts in these terms. In terms of assisting governments to make social sector reforms more conducive to health, some of the WHOCOs mention contribution to health sector reforms and policies. However, activities directly relevant for social sector reform in broader terms, are rare. One example is the participation of the WR in Tanzania in the Social Services Commission.

In terms of mobilisation of international political support, the WHOCOs concentrate on activities to create confidence in the international donor community. They support development of sector policies, project proposals and ensure that interagency committees are functioning.

In sum, the WHOCOs list a wide range of activities across all the areas of resource mobilisation to provide incremental increases in national health services development. The analysis shows a regional variation which in part corresponds to stated regional policies on resource mobilisation, and in part to the size and capacity of the WHOCO. The WHOCOs put a similar level of effort to all areas of resource mobilisation (whether high, medium or low), although there is less richness in the activities recorded for mobilisation of physical, human or institutional resources. Least effort is directed to mobilising political support. There is low overall resource mobilisation in Thailand where the country need is less.

4.6 Summary of main issues: WHO's Current Activities at Country Level

1. Total WHO (and PAHO) funding globally across all regions for the 1994-95 biennium was almost US\$2 billion, with 40% spent by Headquarters and 60% by the regions and countries. The Americas Region, with WHO and PAHO funding, has by far the highest level of expenditure of any of the regions, at 21% of global funds in 1994-95. EBFs constitute about 50% of funds, being a higher proportion in SEARO and a lower proportion in WPRO.
2. WHO funds flow into countries from Headquarters, Regional Offices and as part of the country programme budget. Most go through the WHOCO. However in some countries substantial amounts, up to 40% of country level spending, come from HQ and RO, and do not go through the WHOCO, making it difficult to manage the totality of WHO resources as a unified whole.
3. Comparing the case studies for 1994-95, the countries with the smallest total country programme expenditure (RBFs and EBFs) were in AFRO (\$1.8 to \$5.3 million) and those with the largest were in PAHO/AMRO (\$6.0 to \$22.5 million), and SEARO (\$8.3 to \$23.7 million). Highest levels of total expenditure were in Nicaragua (high capacity cluster) Haiti and Bangladesh (low capacity cluster), with lowest levels of expenditure in Ethiopia, Mali, Mozambique and Cameroon (most in the low capacity cluster). The conclusion is that at present, levels of funding are more related to the region than to country capacity or need.
4. Funds from the Regional Office budgets (as distinct from the country allocation) may be for country specific or inter-country activities. Over both biennia, RO funds as a proportion of total expenditure at country level range from 2% to 10 % for the AFRO countries, 6% to 18% for the PAHO/AMRO countries and 6% to 14% in WPRO. SEARO was not able to give amounts for country specific funding from the regional budget.
5. HQ funds are mostly from the special programmes such as TDR and HRP, and usually go directly to national institutions, without going through the WHOCO. HQ funds can be for common global or country specific functions. Largest amounts of HQ funding were to Thailand (\$2.6 million) and Bangladesh (\$1.7 million). In all countries except Ecuador, Nicaragua and Cambodia, HQ funding is greater than that from the RO budgets (as described in point 4.).
6. EBFs were a major source of funding to the case studies. For the two biennia, in nine countries more than 40% of expenditure was from EBFs. The great majority of EBFs were spent on activities for Integrated Control of Diseases. EBFs appear to fill gaps in RBF allocations, but are less in the control of the WHOCO and MoH than RBFs. EBFs to AFRO declined across the region over the period 1992-1995, while the PAHO/AMRO countries receive the largest amount of EBFs of all the regions.
7. Among case studies in the same region, there are broad similarities in expenditure by strategic programme area. This is also the case with Bangladesh and Thailand even though they have substantially different health needs and capacities. Integrated Control of Disease represented the largest proportion of total expenditure in the seven AFRO

and WPRO countries and in Nicaragua, all showing 30% to 65% of total expenditure in this strategic area. In all the AFRO case studies, the smallest proportion of total expenditure was for Promotion and Protection of Health. Generally, the level and pattern of WHO expenditure appears to be more related to regional similarities than to the capacity assessment of countries.

8. There was wide variation in which of the five functional categories WHOCOs concentrated their effort: advocacy, support for establishing norms, policy and planning; research; information dissemination and technical operations support. The most important function for implementing activities was judged by the WHOCOs to be technical operations support (29% of effort expended), but its importance varied from 44% in Bangladesh to between 10-20% in other countries. An important focus of technical operations support is Integrated Control of Diseases. Advocacy accounted for 21% of total effort across the 12 countries, with the greatest focus on Promotion and Protection of Health. A similar level of effort was assessed for Establishing Norms, Policy and Planning (varying from 31% in Cambodia to 12% in Mozambique) and Information dissemination. Research was one of the most neglected functional categories with only 10% of total effort across all case studies. In Thailand and Tanzania more emphasis was given to research (> 20%).
9. WHOCOs used a range of different tools to carry out the country programmes. Courses and seminars are indicated to be the most important tool for implementation of programmes and activities (18%) across all the case studies. Including the effort for fellowships, the two account for 26% of "effort" on all the tools. The most striking finding is the low level of effort afforded to linkages with other agencies, only 8% of effort across all the tools. Some WHOCOs indicate no use of linkages at all (Ethiopia, Nicaragua, Haiti, Bangladesh). Conversely, Cameroon and Ecuador, give considerable priority to making use of linkages, especially within the strategic area Promotion and Protection for Health. However, overall there is no clear pattern in the use of tools across strategic areas by need and capacity or by region, except for the two WPRO case studies.
10. In looking at the WHOCOs' involvement support for health policy development and research, there was evidence of some interaction in all regions, although there was great variation. Few WHOCOs and MoH planned financial resources for specific programmes in health policy and management. For activities related to Health in Socio-economic development, only some countries in PAHO/AMRO and WPRO used funds for this purpose. Highest activity level across all regions was in information systems planning and management supporting the findings elsewhere in the study that WHOCOs have significant activities in relation to information in different ways. Advocacy is not rated as very significant. WHO is facilitating inter-country collaboration. Activities for; (i) consultation and advocacy; (ii) review and planning of technical programmes; (iii) cross-learning and training and; (iv) mutual support were found in all regions, although most evident in PAHO/AMRO. Fewer activities were found in SEARO and WPRO and least evidence of such activities were found in AFRO.
11. The study explored WHO's role in mobilisation of resources in broad terms: financial, human, institutional, physical, information management resources and political support. In all the case studies the WHOCOs list a range of activities across all the areas of

resource mobilisation to provide incremental increases in national health services development. The main findings can be summarised as follows:

- There are regional differences in stated policies on resource mobilisation
- There is regional variation in levels of resource mobilisation activities which in part correspond to stated regional policies on resource mobilisation, and in part to the size and capacity of the WHOCO. The PAHO/AMRO and WPRO case studies reported higher levels of resource mobilisation activities. The smaller AFRO offices reported lower levels of resource mobilisation activities.
- Most emphasis across countries and regions is put on mobilising information management resources. Least emphasis is put on mobilising political support and thereafter on human resources.
- Low priority is given to issues related to consequences of macro-economic adjustments and social sector reforms on health.
- There is limited contribution to Human Resource Management which is identified as critical in all the case studies. In terms of making effective use of health professionals, little appears to be done in the area of incentives, working conditions, or career development.

Endnotes: Chapter 4.

- ¹ These three areas of focus, collaboration in policy formulation and implementation, mobilisation and rationalisation of the use of available resources, and provision of technical support have been identified in the Executive Board (Document EB97/5) as specific functions of the WHOCO. While the key role of the WHOCO is recognised, this chapter also examines the contributions of WHOHQ and the WHOROs.
- ² Constitution of the World Health Organisation, 1946, Chapter II, Article 2(r).
- ³ Percentage of effort used for advocacy in Cameroon is for the 1994-95 biennium only.
- ⁴ Percentage of effort used for advocacy by Haiti is for the 1994-95 biennium only.
- ⁵ Detailed graphs on each WHOCO use of functions and tools are presented in the country case study reports. Two samples are provided in annex 3 of this report.
- ⁶ It is important to distinguish between the terms health policy, plan and strategy. The three terms are often used interchangeably and variably in different countries. A **policy** sets out the overall goals and objectives for the health sector of a particular country. A **plan** specifies the various means, in terms of activities and resources, to achieve an agreed policy. A **strategy** describes how these means will be used to achieve the agreed policy.
- ⁷ Constitution of the World Health Organisation, 1946, Chapter II, Article 2(n).
- ⁸ Constitution of the World Health Organisation, 1946, Chapter II, Article 2(q).
- ⁹ Specific programme 2.1.3./2.1.5./2.2.1./2.2.2
- ¹⁰ WHO Ninth GPW page 52
- ¹¹ PAHO/ Regional Office of the World Health Organisation: Strategic Orientations and Program Priorities 1991 - 1994 and PAHO/Regional Office of the World Health Organisation: Strategic and Programme Orientations 1995 - 1998 "Health for All and by All"
- ¹² WHO Regional Office for Africa August 1995: Policy Framework for Technical Cooperation with member countries in the African region.
- ¹³ Partnership in Health in a Region of Rapid Change, WPRO Manila 1996

Chapter 5. TRACER PROGRAMMES

5.1 Introduction

Three specific programme areas were chosen as tracer programmes in order to study WHO support to countries in greater detail (Annex 3, p.A12) and to ensure a framework where some comparison could be made across countries. They were: national drugs programme (DAP), national immunisation programme (EPI), and malaria control. All three programmes are well defined and structured in terms of WHO policies, guidelines and approaches. They are programmes that commonly have support from a number of different partners at the country level. All three are in various ways health system dependent, and could therefore be used by the Study Team to further explore appropriateness and responsiveness to national health capacity issues.

Two of the tracer programmes (DAP and EPI) are set up with a meeting for interested parties at the global level, providing an arena for following progress, sharing views and making recommendations on programme development. It is commonly believed that these advisory mechanisms, the more rigorous programme reporting and the greater flexibility provided through generous EBF allocations lead to better management and more efficient use of resources compared to WHO regular programmes.

This Chapter describes and discusses the way the three national programmes were found operating at the country level, how WHO relates to these programmes and finally whether the WHO support given is responsive, adequate and effective in strengthening national capacity in these areas. A special set of field instruments were used for data collection to check country achievement against programme defined policy indicators and to identify the role and contribution of each of the partners, including WHO.

5.2 WHO related drug programme activities at country level

Resolution WHA 28.66 (1975) underscores the importance of drug policies for linking drug research, production and distribution with real health needs. It was agreed that WHO should be of greater direct assistance to Member States in the formulation of national drug policies and the implementation of national programmes in advising on procurement and quality of essential drugs in training scientific and technical manpower in these areas. In 1977 WHO published the first model list of essential drugs, which has subsequently been revised. Technical discussions during the World Health Assembly in 1978 took the agreed mandate forward, and access to essential drugs was included as an element of PHC at the Alma Ata Conference.

The WHO Action Programme on Essential Drugs (DAP) was started in 1981. Rational use of drugs received particular attention from 1985, and the WHO guidelines for developing national drug policies were published in 1988 (updated by an expert committee in 1995). In 1994 and 1996 the WHA reaffirmed the crucial importance of WHO's leadership and coordination in the development, support and evaluation of national drug policies (WHA 47.13 and WHA 49.14). Concern was however expressed in the 1996 resolution that "access to drugs is still inequitable, that promotion of

commercially produced drugs still outweighs independent, comparative and scientifically validated and up to date information on drugs and that problems persist in ensuring quality of medicines both on the open market and for donation as international aid".

DAP engaged in a review of objectives, priorities for action and approaches during the latter half of 1996, and has produced a new strategy document, restating objectives and approaches in the current context of health reform and broadening partnerships in health development. In the recent document, published in February 1997¹ the new direction given for country level support is to strengthen coordination with WHO Regional Offices and increase support to inter-country and subregional activities and to increase impact at the country level through: focus on specific programme development objectives; careful selection of countries and activities; flexibility and responsiveness to local needs; enhanced country level coordination with all parties and more emphasis on guidelines and technical advice.

In the period under study (1992 to 1996), country support has been the highest priority area of DAP. The framework used for country support distinguishes between Type 1 countries (long term policy and strategy development), Type 2 countries (intensified support) and Type 3 countries (support to implementation of specific technical activities). Of the twelve countries included in the Study, Ethiopia and Cameroon are labelled as Type 1, Ecuador as Type 2 and the remaining 9 countries as Type 3. The study sample is therefore not appropriate for making any observations of what DAP can do at country level, given its full potential. It does however give a reasonable background for discussing features of Type 3 collaboration, with countries represented in all the 4 regions visited. It is also important to note that the Type refers to DAP input rather than country need, and DAP input is adjusted depending on the role of other donors.

DAP noted in its 1994 Progress Report² the concern about a shift by donors from unspecified to specified funding, limiting the ability of the Organisation to use the criteria for prioritisation set out in the Future Strategy paper (WHO/DAP/94.4) and that this might curtail WHO's core global functions of leadership, advocacy, development work and research - and at a time of great demand for such work. Following an intensive effort by DAP, the balance between specified and unspecified funds has improved in 1996-97. Donor earmarking of funds for activities in specific countries has influenced the choice of countries for more intensified support (Type 2 countries) during the period covered by this study.

In the mapping of the policy context and drug programme support at country level, the Study sought to use the tools provided by DAP itself, including its indicators for policy development and regulatory capacity, and the distinction between areas for technical intervention. In addition, WHO reports and the role of other partners in the drug area were studied to get an overall understanding of current status and significant gaps in the sector and the role of WHO as an actor within this context.

The drug policy context and drug regulatory capacity

A map of indicators for the drug policy context and the drug regulatory capacity was filled in for each country, and is appended to each country case study report.

A national drug policy exists in all the twelve case studies, but only 4 of the countries had updated the policy within the last 10 years. Of these 4 countries, three were in the group of countries with highest health systems capacity and highest access to care (Thailand, Ecuador and Nicaragua). In general, compared with the status of the national drug policy, countries are more updated on drug legislation and regulations, essential drug lists, rational drug use and standard treatment (see Table 5.1) It is worth noting that all the case studies with assessed capacity higher than "low" have almost a complete set of updated policy instruments aside from the drug policy.

Table 5.1 Drug Programme: Policy Context

Country	Capacity cluster	DAP Type	Drug Policy updated	Legislation updated	EDL updated	Rational Drug Use updated	Treatment protocol updated
Thailand	HIGH	3	YES	YES	YES	YES	YES
Ecuador	HIGH	2	YES	YES	YES	YES	YES
Nicaragua	HIGH	3	YES	YES	YES	YES	YES
PNG	MEDIUM	3	NO	NO	YES	YES	YES
Cameroon	MEDIUM	1	NO	YES	YES	NO	YES
Tanzania	MEDIUM	3	NO	YES	YES	YES	YES
Haiti	LOW	3	-	-	-	-	-
Bangladesh	LOW	3	NO	NO	NO	NO	NO
Cambodia	LOW	3	NO	YES	YES	YES	NO
Mozambique	LOW	3	YES	YES	NO	YES	NO
Ethiopia	LOW	1	YES(?)	NO	YES	NO	NO
Mali	LOW	3	NO	YES	YES	YES	YES

Note: This assessment was made in October 1996. More recent updates may affect the drug score.

In spite of its earlier achievements in the drug sector, Bangladesh lags remarkably behind in terms of general updating. On the other hand, Mali shows higher achievement in the policy area than one might have expected from national health system capacity/access rating. The achievements of Mozambique and Tanzania is also worth noting.

WHO has developed a self-assessment instrument for drug regulatory capacity in a country. The rating includes legislation (if not in place and up to date, capacity is rated as limited) licensing, inspection (if in place in addition to legislation, rated as basic), product registration, quality control and reporting of adverse reactions (if in place in addition to the above, rated as moderately developed) and finally post marketing surveillance and full range of quality control (if in place in addition to all above, rated as comprehensive). When applying this instrument, a rating is obtained, as presented in Table 5.2 for the twelve case studies.

There is wide variation among countries and no striking common feature that explains the difference, neither by region nor by general capacity criteria. The DAP type 1 and 2 countries (Ethiopia, Cameroon and Ecuador) as a group are not different from type 3 countries. And countries with the lowest regulatory capacity (limited and basic) are not showing a different level of WHO funding for drug programmes than countries with better capacity (Table 5.3). Among the five countries with the lowest regulatory capacity, only Tanzania has substantial inputs in the area of planning and management (Figure 5.2). Mali in this context scores much better than could be expected from the low general health capacity. An explanation is the substantial support from other donors (EU/WB) (Table 5.5).

Table 5.2 Drug Programme: Regulatory Capacity

Country	Capacity cluster	DAP Type	Comments	Drug Regulatory Capacity*
Thailand	HIGH	3	All elements in place	Comprehensive
Ecuador	HIGH	2	No operational ADR	Basic to moderate
Nicaragua	HIGH	3	No operational ADR	Basic to moderate
Tanzania	MEDIUM	3	Some in-country QC	Basic
PNG	MEDIUM	3	No achievement recorded	Limited
Cameroon	MEDIUM	1	No operational ADR	Basic to moderate
Haiti	LOW	3	-	-
Bangladesh	LOW	3	All elements in place, legislation not updated	Limited
Cambodia	LOW	3	No operational ADR	Basic to moderate
Mozambique	LOW	3	Some in-country QC	Basic
Ethiopia	LOW	1	Some elements in place, legislation not updated	Limited
Mali	LOW	3	No operational ADR	Basic to moderate

* According to DAP self-assessment instrument

Quality assurance and rational drug use

Three of the countries which historically were early on the scene in establishing and implementing essential drug policies, Tanzania, Papua New Guinea and Bangladesh, stand out as the countries that today have less engagement in the more recent policy areas of quality assurance and rational drug use. Whereas Tanzania and Papua New Guinea lag behind in quality assurance, Bangladesh has not engaged in operational research activities within the last five years and has not established a satisfactory framework for rational drug use, in spite of the support it receives for drug programmes from WB and UNICEF (mostly focused on supply and logistics and quality assurance). Neither Papua New Guinea nor Tanzania have had much formal collaboration with WHO in these areas of technical interventions, but largely relied on bilateral support through AusAID (Papua New Guinea) and DANIDA (Tanzania). In Tanzania, the limited WHO support given has been through workshops, brief consultancies and some operations research.

Essential drugs, procurement and financing

All countries have essential drug lists which are in use, and for most countries, drugs in the public sector have been limited to the essential drug list (not in Ethiopia, and only partly true for Thailand). There are still gaps in terms of proper procedures for tendering in some of the countries: both the countries in WPRO and two of the five AFRO countries. The three countries in the medium health capacity group are among these. All countries have some WHO input to the supplies and logistics area, apart from Cameroon and Cambodia, where there are other partners involved. Three of the twelve countries, all within the AFRO group, use less than US\$1 per capita of public spending on drugs: Tanzania, Ethiopia and Cameroon. (*The total Cambodia health budget is not a lot more than \$1/head*) The information from Mali is incomplete on this point. While the two WPRO countries, Thailand, Tanzania and Cameroon cover more than 20% of the total public drug budget by public funds, it is notable that the public share is lower in the PAHO/AMRO countries, and in the three AFRO countries within the low health capacity cluster (Mali, Ethiopia and Mozambique).

Country “drug score”

The findings presented in Table 5.1 and 5.2 have been combined to form a country “drug score” by giving each confirmed element in the policy framework one point, and rating the drug regulatory capacity so that 4 = comprehensive, 3 = basic to moderate, 2 = basic and 1 = limited (4th column, Table 5.3). The higher the drug score, the stronger capacity in formulating drug policy and regulation. When scoring country capacity for drug policies this way, the “drug score” appears to follow general health capacity in the country, but with some notable exceptions: Papua New Guinea scores much lower and Mali much higher than would have been expected. Bangladesh and Ethiopia have a generally weak institutional setting for pursuing effective drug policies. Even so, these three countries have access to strong and supportive donors such as the WB and UNICEF, and bilaterals that are either actively engaged in or are ready to be engaged in the drug sector. The four countries with the lowest “drug scores”, Bangladesh, Ethiopia, PNG and Mozambique, are all countries where DAP has had very little involvement over the last 4 to 6 years. In Ethiopia a programme was planned but not implemented.

WHO related drug programme funding

The pattern of funding made available through the WHO for drug programme support at the country level also shows considerable variation. There is no match between funding levels and “country drug score” (note for instance Nicaragua and Ecuador, Table 5.3.) The exceptionally high investment in Ecuador, reflects a country specific partnership established with the Netherlands. The low funding level for the drug programme in Papua New Guinea reflects a situation where a bilateral has taken responsibility for funding and support over a period of years, and therefore WHO has taken a more marginal role.

Table 5.3 DAP Funding to Country Level and capacity (CO, RO and HQ funding)

Programme name: Action Programme on Essential Drugs							
Country	Capacity Cluster	DAP Type	“Drug score”	1992-93 Total		1994-95 Total	
					%EBF		%EBF
Thailand	HIGH	3	9	135,978	91	213,870	67
Ecuador	HIGH	2	8	1,422,301	100	1,101,313	100
Nicaragua	HIGH	3	8	180,891	100	0	0
Tanzania	MEDIUM	3	6	146,895	100	289,613	31
PNG	MEDIUM	3	4	0	0	15,831	0
Cameroon	MEDIUM	1	6	22,751	100	40,689	100
Haiti	LOW	3		0	0	221,799	100
Bangladesh	LOW	3	1	188,643	1	159,226	12
Cambodia	LOW	3	6	74,776	100	262,330	17
Mozambique	LOW	3	5	27,319	100	217,805	8
Ethiopia	LOW	1	3	148,153	59	284,823	17
Mali	LOW	3	7	29,055	10	242,541	0

A commonly found level of total drug programme funding through WHO for a biennium is in the range of US\$150,000-\$280,000 (Table 5.3). Drug programme funding shows fluctuation in the EBF/RBF mix available to any given country from one biennium to the next, such as in this case for Ethiopia, Tanzania, Mozambique and Cambodia. In some countries WHO appears to be able to respond with RBFs if EBFs do not materialise (Ethiopia, Mali, Tanzania and Cambodia). None of the PAHO/AMRO countries or

Cameroon received RBFs for drugs during 1992 to 95. Eight of the countries received a higher level of funding in 1994/95 compared to 1992/93.

WHO support to National Drug Actions programmes by functional categories and by use of tools

As referred to in section 4.3, the Study analysed each case study by functional category and by tools used to carry out WHO activities. This was also done for the budget line activity for DAP. For detailed description of how the data were collected and overview of the various functional categories and tools, the reader is referred to Annex 3.

WHO support by functional categories

Figure 5.1 shows WHOCO staff assessment on how the five main functions contribute to WHO drug programme activities. 'Information dissemination' is not listed as a strong area in any of the case studies, and not at all part of the activities in four countries (Papua New Guinea and Cambodia, Tanzania and Ethiopia). The relative significance of advocacy and normative work differs considerably between the countries. In Nicaragua, along with the other Central American countries, there have been efforts to establish a more concerted drug programme, however encountering difficulties. This may explain the perceived high activity in advocacy in this country. It is also worth noting that a country such as Thailand, has a considerable part of its collaborative programme with WHO in the area of technical operations support. The Tanzania profile reflects a situation with another dominant donor to the area, as does the Cambodia profile. Papua New Guinea represents a country with insignificant activity in the Study period, again with another dominant donor. There are no other obvious connections between the drug policy context and regulatory capacity previously presented and the profile which is emerging from assessing relative significance of functional categories within the collaborative programme. Neither is there any clear pattern for type 3 countries.

WHO support by tools

When examining the tools used for WHO support to drug programmes (Figure 5.2), and seeing them in relation to the areas of technical interventions (Figure 5.3) one of the striking features is how the mix of interventions and tools appears to be largely ad hoc, with little focus or selectivity. This also applies to the type 3 countries (most of the countries represented), in contrast to the direction of the most recent WHO Essential Drugs Strategy³ which states that "WHO will provide only very selective support for type 3 activities." As the documentation of the Study relates to 1992-95, performance should not be assessed in relation to new policies of 1997. On the other hand, the observation made in the Study underlines the need for the shift in policies which now has been made by the DAP programme.

Ecuador, as the only type 2 country in the sample, has the full spectrum of tools applied, apart from financial support which is likely to come via other partners with whom WHO has a close working relationship. Ethiopia (a type 1 country where the policy framework is not updated and there is limited drug regulatory capacity) has largely financial support (to supplies and logistics), which appears as a clear mismatch with country needs. This particular example underlines that WHO, even in alliance with a committed donor partner (Netherlands), cannot do much if the country itself is not responsive.

Figure 5.1 WHO Drug Programme: WHOCO profile of Functional Categories

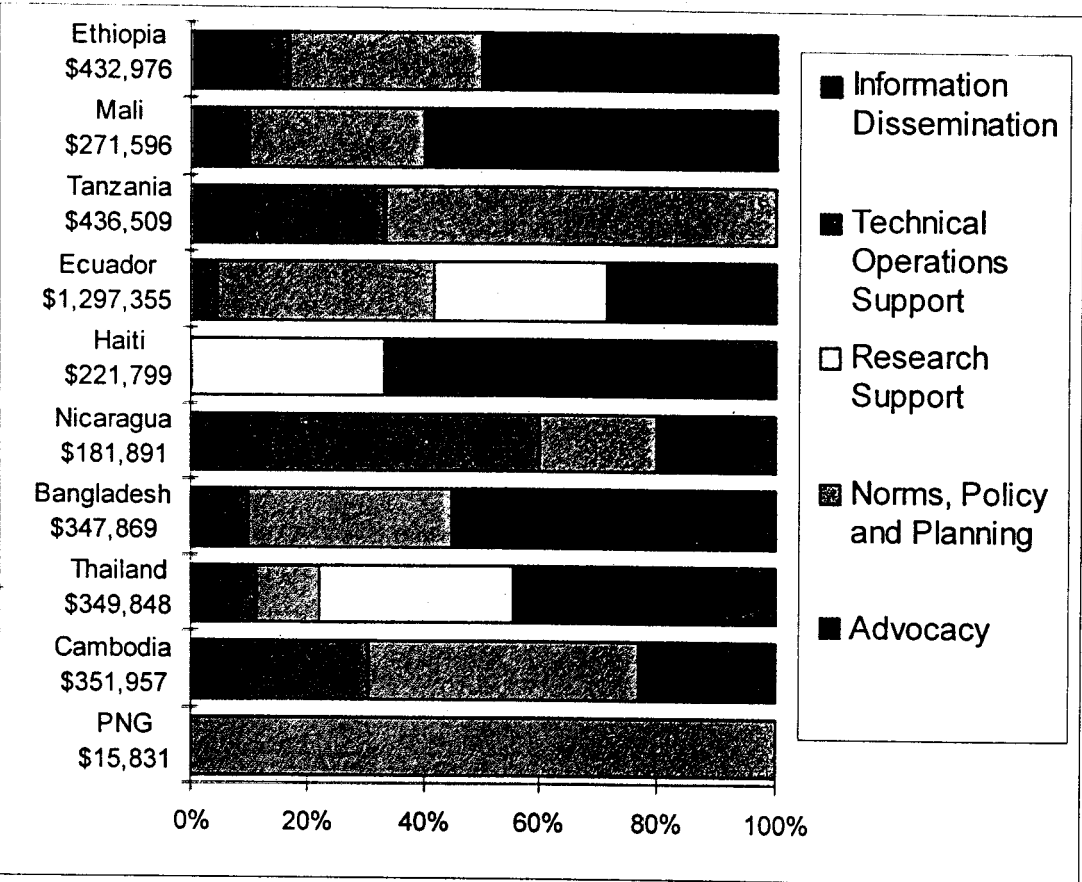
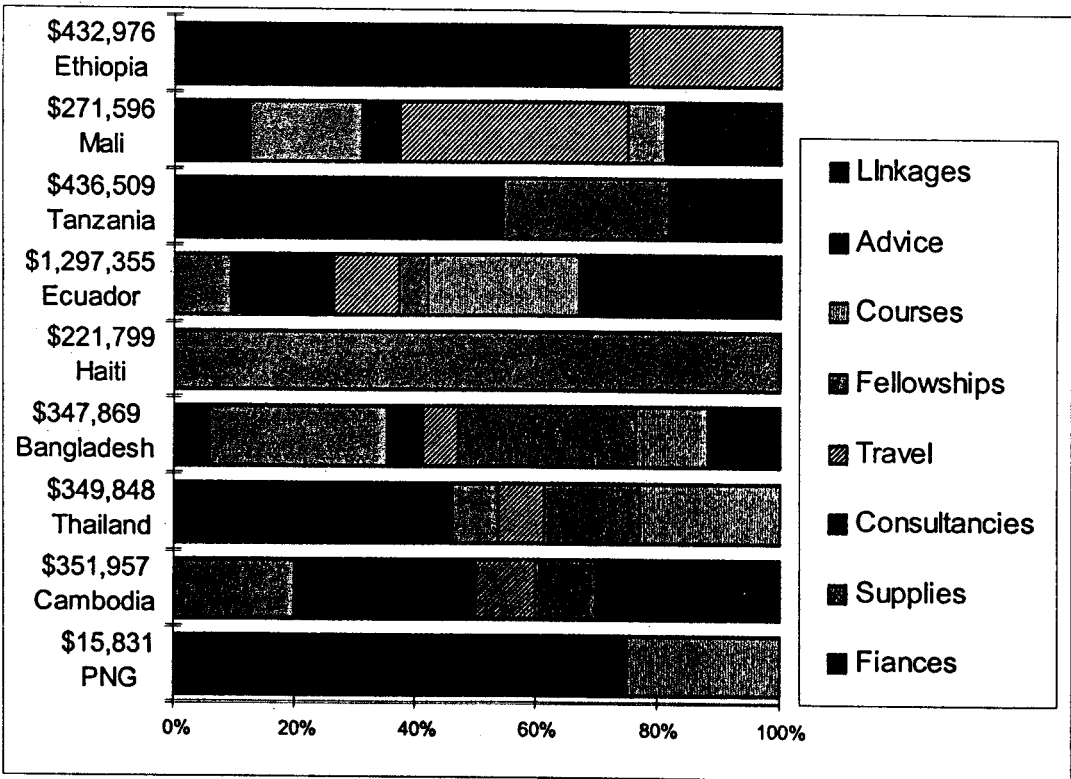


Figure 5.2 WHO Drug Programme: WHOCO profile of use of Tools



Data not available for Cameroon, Mozambique and Nicaragua

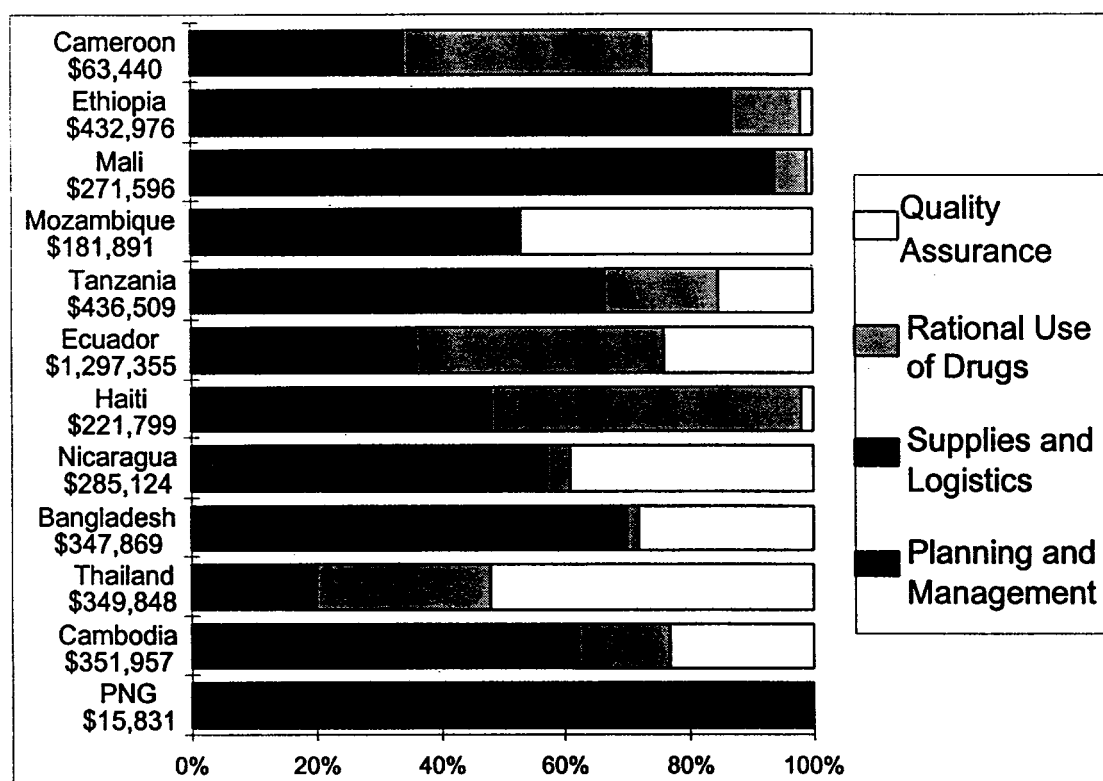
The set of tools used in Thailand, which are appropriately focused on quality assurance and rational drug use, raises questions as to how this level of financial support and support for supplies can be justified, given the high health capacity and the high “drug score” for this country.

Finally, the tool mix in Bangladesh raises questions of relevance and appropriateness in the context of the large donor consortium which also includes major support to the national drug programme. Here the WHO inputs are focused in the technical area of supplies and logistics, but with a little bit of everything in terms of tools.

WHO support by areas of technical interventions

The WHO DAP classification defines four main areas of technical interventions: Quality Assurance, Rational Use of Drugs, Supplies and Logistics and Planning and Management. The WHOCO instruments asked for information about actual expenditure within the two biennia for each of the technical interventions. The findings are presented in Figure 5.3.

Figure 5.3 Drug Programme: Resource allocations by areas of technical intervention



Supplies and logistics stand out as an important component in almost all case studies. Exceptions are countries with high national capacity (Ecuador, Thailand) or where there are other donors specifically involved in supplies (Cameroon, Cambodia). In the latter two countries, policy and management, rational drug use and quality assurance are the significant components, indicating that WHO demonstrates some specialisation in relation to other donors. In Haiti, the emphasis is more on rational drug use than on quality assurance, which may also be very appropriate to the particular context of that country. Mali and Ethiopia have a fairly similar profile, with hardly any emphasis on

quality assurance and rational drug use. This could be questioned, given the country context. For Mali, however, this is explained by the presence of other donors in this area (Table 5.5). In Ethiopia, DAP is providing only policy advice rather than a drug programme as such, and so components other than policy and a one-time donation of drugs, have low profile.

Human resource inputs

The human resource inputs (all technical staff paid by WHO, including also staff from HQ, RO and national technical staff) to drug programmes in the twelve countries show great variation (Table 5.4). While the highest input is in Ecuador, reflecting the type 2 programme status with high level of funding, there is little match between the level of funding and the level of human resource inputs in the other countries. Specifically, it is hard to see any significance of being labelled a type 1 programme in terms of allocation of human resources.

Table 5.4 Drug programme: funding and human resource inputs 1992-95

Country	Capacity Cluster	Total funding, 1992-95		Human Resource Inputs (in workdays) 1992-95
		US\$	%EBFs	
Thailand	HIGH	349,848	76	30
Ecuador	HIGH	2,523,614	100	6,204
Nicaragua	HIGH	180,891	100	946
Tanzania	MEDIUM	436,509	54	117
PNG	MEDIUM	15,831	0	30
Cameroon	MEDIUM	63,440	100	65
Haiti	LOW	221,799	100	1,232
Bangladesh	LOW	347,869	6	770
Cambodia	LOW	337,106	35	617
Mozambique	LOW	245,124	18	35
Ethiopia	LOW	432,976	31	240
Mali	LOW	271,596	1	None

Drug programme activities and other partners

WHO is not the only actor in the drug field in the case studies (Table 5.5). Most countries have several partners. In some countries the coordination between actors is good with clearly complementary activities. Among the approaches taken are special donor coordination meetings for the drug sector. In other countries donors appear to pull in different directions. Several case studies demonstrate competition among agencies. Some donors in some countries have engaged themselves heavily in the sector, without establishing policy dialogue with WHO. Other donors have deliberately chosen WHO as a strategic partner for their support to drug programmes (such as the Netherlands in Ecuador and Ethiopia), thereby providing an opportunity for WHO to respond to requests from countries that have the ability and political will to develop their drug sector.

In none of the case studies does it appear that WHO is functioning as the lead agency in the drug sector. The only exception would be Thailand where no other donors are involved and the country has sufficient capacity to develop its drug sector without funding support from WHO.

Table 5.5 Drug Programme: Actors in the field

Country	Capacity cluster	DAP Type	Other partners	Donor contributions other than WHO
Thailand	HIGH	3	None	None
Ecuador	HIGH	2	Netherlands, WB, USAid, Belgium MSF	Popular pharmacies
Nicaragua	HIGH	3	WB, DANIDA, SIDA	Supplies, Rational Drug Use, DANIDA more than twice the WHO input
Tanzania	MEDIUM	3	DANIDA, UNICEF	Central Medical Stores by DANIDA. No formal collaboration with WHO
PNG	MEDIUM	3	AusAID, WB	Supplies and logistics. Privatisation
Cameroon	MEDIUM	1	GTZ, UNICEF, USAID, Belgium, CARE, EU	Procurement, revolving funds, National centre for essential drugs
Haiti	LOW	3		Drug supply centre/drug supply warehouse
Bangladesh	LOW	3	WB, UNICEF	Supplies and logistics, Rational drug use, Quality Assurance. NB Private sector pressure
Cambodia	LOW	3	UNICEF, WB, Japan	Supplies and logistics, planning and management, Rational drug use, Quality
Mozambique	LOW	3	UNICEF, Netherlands, USAID, SDC, NORAD	Supplies and logistics
Ethiopia	LOW	1	Netherlands, WB, ADB, USAID, UNICEF, SIDA	Supplies and logistics, Needs assessments
Mali	LOW	3	WB, UNICEF, EU	Policy advice, Quality assurance, Rational drug use

Overall assessment of WHO's role in the Drug Policy Area in the case studies

Drugs and politics. Policy watch.

In the period being studied, a main challenge for the drug programme in most of the countries has been to develop and/or maintain basic public systems and at the same time cope with privatisation, diversification and decentralisation. Countries are struggling simultaneously with availability of essential drugs for public service delivery, irrational use of drugs is widespread, unacceptable prescribing patterns, unethical drug promotion and unlicensed drug sellers.

Several of the countries/regions illustrate how the drug sector continues to be politicised, with strong competing interests from drug industries and drug sales enterprises. Free market policies are a component of Health Sector Reform in many countries, causing pressure on established essential drugs policies. The regions experience this situation differently. In PAHO/AMRO, political constraints have made it difficult to establish effective inter-country initiatives for the Central-American sub-region in the drug sector. The response from the RO has been one of active advocacy. In contrast, WPRO has chosen a generally low advocacy profile in the drug area.

While there are instruments available for monitoring the drug policy context, the regulatory capacity and access to drugs in countries, DAP is dependent on an active response from countries and regions for engaging in collaboration at the country level. So far, in the global context, there are more demands than resources. DAP does not see its role as actively watching developments in the drug sector in countries. It could be seen as a task of WHO Regions to do so, and a task of the WR in the countries. In practice the findings from the twelve countries gave little evidence of systematic monitoring of overall status and identification of imbalances and gaps. In a sector that is so politically sensitive, and so directly affected by the ongoing reforms, more attention to

this area ought to be considered, whether WHO is actively involved in any programmatic way or not.

The criteria established for monitoring the policy framework in countries do not adequately catch the difference between *formulating* policies and *implementing* policies. In countries such as Cambodia and Nicaragua, where most of the policy elements are in place, the capacity to implement is low. Yet, on paper, things appear to be well established. Indeed, where there are clear gaps in the policy framework, such as for Papua New Guinea, WHO does not respond by even noting this in the regular WR reports to the RO.

WPRO and SEARO are engaged in a bi-regional initiative on essential drugs under the auspices of ASEAN,⁴ mainly to further technical cooperation among ASEAN member countries in the two regions. The objectives of the initiative, established as early as 1984, are "to strengthen the pharmaceutical sector so as to meet the objectives of the WHO Action Programme on Essential Drugs, and to achieve self-reliance in the training of human resources in the regions". The WHO Certification Scheme has been stressed in the recent meetings, and Centres of Excellence have been developed in good manufacturing practices, drug evaluation and registration and reference substances. This initiative provides WHO with an important arena for policy dialogue and technical advice in a rather complex context.

WHO role

In all the case studies, WHO has directly or indirectly, through well formulated and widely accepted policies, standards and guidelines supported the development of a public pharmaceutical system over many years. The WHO role in the countries varies from having "taken on" the management of the drug sector (Haiti - as part of the emergency programme) to being a marginal observer as in Papua New Guinea.

The Study has not found evidence that the WHO role and activities in the countries is the result of strategic planning at WHOHQ or ROs, neither that there is an obvious match between country needs and DAP type category or WHO level and profile of collaborative activities. In the case studies, the WHO role was largely constituted by capitalising on windows of opportunity as they arose within the country context. A balance is needed between strategic planning and flexibility to respond to unforeseen opportunities. Important factors were identified to be:

- MoH commitment, interest and ability to use WHO as a technical resource in this area
- Country specific strategic alliances/partnerships between WHO and donors, where WHO is either funded to implement an enlarged WHO programme, asked to act as an executing agency for a programme identified by a donor, or used for technical advice in programmes operated by others.

A DAP HQ staff member, commenting critical areas affecting programme implementation in Tanzania, noted: "Good performance in the past due to good collaboration between DAP and the main bilateral donor involved in the pharmaceutical sector, i.e. DANIDA. DAP was able to contribute to the support programme through involvement in major project evaluations and policy meetings, and through support to some technical areas not taken care of by other donors. A facilitating factor was a team of motivated staff in the MoH. In recent years, problems arose from the lack of funds in DAP, the lack of planning processes in the Ministry of Health, a low capacity to manage the pharmaceutical sector and the lack of donor coordination".

The new DAP strategies highlight the importance of strategic partnerships, by stating that type 2 programmes normally should be supported by specified bilateral and multilateral EBFs. The limitation in this approach is that there may not be such specified funding available for some countries with great need and few partners, or countries which are not seen as priority countries for partners that are most open to support DAP programmes. It is for instance much harder to create such partnerships for West Africa than for East and Southern Africa. It is also very difficult to obtain donor support for activities in Viet Nam, the former USSR and countries in the Middle East and Latin America.

Relevance and appropriateness

As has been acknowledged for WHO technical documents on policies, standards and norms generally, there has been a strong indirect influence through HQ/DAP technical tools and policy guidelines in most aspects of member states' national drug policies and supply systems. However, the case studies show that WHO involvement in drug programmes have varying degrees of relevance and appropriateness to the context. One of the countries where the WHO response was considered to be of poor relevance was Mali, where limited WHO resources was spent on drug supply. "...there appears to have been an opportunity for more far reaching support in the policy development process which was not exploited. Instead WHO supplied drugs to the value of some US\$ 200000, an insignificant amount in the total drug provision of the country (in the order of 0.5%) The same amount of money would have been highly significant if used to assist in policy development and training. There are still large areas of little or no activity, e.g. policy and regulations for effective control of the private sector and in rationalising drug use in general".⁵

In general, the case studies did not demonstrate a well formulated overall strategy for ensuring appropriate and relevant inputs to the drug sector, apart from the three countries in PAHO/AMRO and in Ethiopia (a programme concept developed but not implemented). Most of the WHO support represented largely ad hoc initiatives on request from countries, and handled within the regional allocations, with little influence from HQ/DAP. It must however again be noted that the countries in the Study are not very representative of DAP supported programmes on a fuller scale.

Priorities

The drug sector has been identified as a WHO priority to the extent that the Executive Board requested a 5% shift in global budgets for this area. Given that countries set their own priorities for the use of their country allocation, and RBFs form less than 10% of funds managed by DAP centrally, then this financial shift can only be achieved through EBFs at the global level. There is a need to accept the difference between funding a global programme, which then can establish cost-effective strategies based on a management system they can control, and supporting selected countries in their own effort to implement effective health programmes. The EB can more easily influence the use of funds managed by DAP centrally than the way RBFs are allocated to drug programmes in countries. In the case studies, HQ/DAP in general had little influence on what was actually being done in terms of drug programme support to the countries. There is an indirect influence as countries and regions rely on DAP tools, training materials and policy guidelines.

It appears that where there is a strong global programme, such as DAP, more attention should be given to how countries are actually selected for inputs from HQ. Though there are criteria, there is a need to be more transparent in how these criteria are being applied by the programme. This is even more important as resources are becoming increasingly scarce and there is uneven distribution of potential partners to enable WHO to engage in type 2 programmes. The recent decision by DAP to stress the development of an RO-DAP plan of action will be a step in the right direction.

With the stated global priority on drugs, a way to match this with the countries autonomy could be to have countries report on what they have done to safeguard the drug sector in their own national programme in the process of negotiating country budgets, and why they give, or do not give, priority to WHO support in this area.

Effectiveness

The effectiveness and relevance of global norms and instruments for country level policy and strategy formulation was affirmed in all the case studies.

The ability of the WHO system to recruit qualified consultants for specialised tasks within a reasonable timeframe was not found satisfactory in several countries. In some instances, consultants seem to have spent a long time in country with little tangible results, and there is reason to raise questions about quality control of consultants.

Observing the managerial processes in the case studies, there was no difference in the management of resources or evaluation of results between the drug programme and the rest of the collaborative activities. It had the same strengths and weaknesses, and the same type of monitoring systems and audits as discussed in Chapter 3.

5.6 WHO related immunisation activities at country level

The Expanded Programme on Immunisation (EPI) was established in 1974 with the World Health Assembly Resolution WHA 25.57, as the success of world wide smallpox eradication seemed increasingly assured. Although the coverage for EPI target diseases climbed steadily in all regions throughout the 1980s, a decrease in the incidence of disease did not always result. In the mid 1980s more effort was therefore placed on developing surveillance systems. In 1988 the WHA⁶ selected Poliomyelitis to be eradicated globally, in 1989 declared its commitment to global elimination of neonatal tetanus⁷ by 1995 and in 1990 to reduction of measles by 95% by 1995. In 1994, EPI became one of three components of the Global Programme for Vaccines and Immunisation (GPV). The other components are Vaccine Research and Development and Vaccine Supply and Quality. This study focuses on the EPI component. The main objectives for EPI are stated as:⁸

- to promote country self-sufficiency in immunising target populations
- to raise vaccine coverage to 90%
- to increase quality of immunisation services
- to control selected target diseases
- to promote the introduction of new vaccines

GPV offers guidance and support to governments on

- immunisation policy and global standards
- meeting global targets for eradication, elimination, or control of diseases

- disease surveillance
- maintenance of a cold chain for the safe transport and storage of vaccines
- training of health workers and managers

Sustainable immunisation services implies not only increased and sustained levels of immunisation coverage but also more self-sufficiency in vaccine buying and commitment of national budget towards covering operational costs of the programme. The Global Programme for Vaccination⁹ has proposed criteria for grouping countries according to technical/ managerial (high, medium and low coverage) and financial capabilities (weak, moderate and strong). Strategies for support are developed according to the band the countries belong to. WHO and the World Bank have identified some countries as highest priority.¹⁰

Many organisations have become partners in the programme. The main partners are UNICEF, Rotary International, Governments of OECD countries and others, CPHA, JICA and scientific research institutions and Foundations. The programme interacts with partners in different ways at different levels of the organisation; at HQ an annual meeting of interested parties is held to assure funding. At regional and country levels, Interagency Co-ordination Committees (ICC) are established for the purpose of mobilising funds and to assure complementary use of funds and of activities.

Preparation of a Plan of action for a national immunisation programme is seen as an essential element to ensure its success and sustainability. The plan of action provides an opportunity for monitoring the key elements related to implementation of the EPI; the use of resources from various donors and actors, assessment of proportion of funds channelled to districts, indication of level of national funding.¹¹

According to WHA resolution (41.28), poliomyelitis eradication should be pursued by strengthening the development of the EPI as a whole fostering its contribution in turn to the development of the health infrastructure and of primary health care. In parallel with the dramatic and rapid progress in polio eradication particularly in some regions (e.g. Americas), which has its own justification, there has been considerable unease about whether single-intervention focused programmes interfere with general development of primary health care¹². Disease control is the central EPI priority. The success to control the three targeted diseases depends on other aspects of the health services (clean delivery and post delivery services) and requires strengthening of the primary health care infrastructure, improvement of laboratory services and disease surveillance.

Taking these elements into consideration, the Study developed a set of indicators based on those used by GPV to map the policy context, national capacity and WHO support to national immunisation programmes. The map of policy content and national capacity was completed for each country and attached to each country report. The capacity cluster column in the following tables refers to the overall assessment of health capacity as presented in Table 2.3, page 15. In addition, the role and contribution of other partners was studied to provide a more comprehensive understanding of the status of National Immunisation Programmes, identify possible gaps and to assess the role of WHO as an actor within the particular country context as well as the relationship between WHO and the various partners included the Health Ministries. The following presentation seeks to present the results in relation to the goals set for the programme.

Policy context and programme strategy capacity

Ten of the case studies have updated policy on Immunisation, a strategic plan in place and have specific targets and strategies for control of the targeted diseases in place. Nearly half of the countries have not undertaken a needs assessment during the last 5 years. Ethiopia, Haiti and Mali stand out as countries with very vulnerable capacity in these terms. These countries are also assessed to have low health systems capacity and access to services. Only Ecuador and Mozambique have not identified specific strategies and targets for control of all of the targeted diseases (Table 5.6).

Table 5.6 EPI Programme: Policy Context

Country	Capacity cluster	Policy updated	EPI Strategic plan updated	Needs assessment	Specific strategies and targets
Thailand	HIGH	YES	YES	YES	YES
Ecuador	HIGH	YES	YES	YES	only for N-T
Nicaragua	HIGH	YES	YES	YES	YES
PNG	MEDIUM	YES	YES	NO	YES
Cameroon	MEDIUM	YES	YES	YES	YES
Tanzania	MEDIUM	YES	?	NO	YES
Haiti	LOW	NO	-	-	-
Bangladesh	LOW	YES	YES	YES	YES
Cambodia	LOW	YES	YES	?	YES
Mozambique	LOW	YES	YES	NO	Not for measles
Ethiopia	LOW	NO	NO	NO	YES
Mali	LOW	NO	?	?	YES

Sustainable immunisation services

A group of countries have achieved a high coverage:^{13,14} Tanzania, Nicaragua, Ecuador, Bangladesh and Thailand. However, other countries in the sample have medium or low coverage; Haiti, Papua New Guinea, Cameroon and Ethiopia and Mozambique. All the countries with highest systems capacity and highest access to services have high immunisation coverage (Table 5.7). These are the only countries able to cover most or all EPI expenses with national funds. In programme terms, these countries have achieved sustainable immunisation services. Cameroon and Papua New Guinea, in the medium capacity group, used to have more satisfactory coverage, but due to economic recession and in Papua New Guinea poor management, coverage decreased and the countries financial contribution to EPI is limited. Bangladesh has satisfactory coverage and pays for two types of vaccines in spite of the low health systems capacity and low access. Papua New Guinea, Cambodia and Mozambique are currently improving coverage. The others show signs of progress although not as readily.

Quality of immunisation services

All of the countries apparently have most of the quality assurance elements to quality in place. However, only Thailand and Papua New Guinea, two very different countries, do not have strategies in place to monitor missed opportunities for immunisation.

Table 5.7 EPI programme: Financing and Health Systems Factors

Country	Capacity cluster	EPI Coverage	Financial Capability ¹⁵	Current level of national financing	Integration	Supply and logistics
Thailand	HIGH	High	Strong	COMPLETE	YES	Written procedures not existing
Ecuador	HIGH	High	Moderate	HIGH	-	-
Nicaragua	HIGH	High	Weak	HIGH	YES	All elements in place
PNG	MEDIUM	Low	Moderate	ONLY for some vaccines	NO	Few elements in place
Cameroon	MEDIUM	Low	Moderate	Limited	NO	All elements in place
Tanzania	MEDIUM	High	Weak	Limited	PARTLY	Procurement is not planned and undertaken by National Immunisation
Haiti	LOW	Low	Weak	None	NO	-
Bangladesh	LOW	High	Moderate	ONLY for some vaccines	YES	All elements in place
Cambodia	LOW	High	Weak	Limited	-	-
Mozambique	LOW	Medium	Weak	Very limited	YES	Guidelines for procurement not existing, not planned and undertaken by National immunisation
Ethiopia	LOW	Medium	Weak	Limited	YES	All elements in place
Mali	LOW	Low	Weak	?	PARTLY	All elements in place

Integration of EPI and development of health systems

Many countries are struggling for decentralised integration of EPI activities into general PHC services. Mali and Papua New Guinea have no policies for integrated management in place, Cameroon is presently adopting such policies. Other countries have written policies, but struggle to implement according to intention (Tanzania and Bangladesh). Nicaragua and Mozambique are examples of countries where there have been efforts to integrate MCH services in general, contributing to integration of EPI activities. The High capacity countries have succeeded in integrating and have all elements related to supplies and logistics in place (Table 5.7).

In Cameroon, integration of service delivery and supervision at district level has only been achieved in districts that have been reoriented to the new PHC policy. Ethiopia reports that sustainability of the EPI programme depends on further development of basic health services. Bangladesh is struggling to achieve integration in a fragmented health system. The Study provides examples of EPI activities contributing to health sector development in various ways: Nicaragua has developed a well functioning epidemiological surveillance system and in Papua New Guinea, the immunisation programme has contributed to instituting a systems based approach to management linking all levels of the health system.

Summary of National Programme Implementation Capacity

Table 5.8 has summarised the national immunisation programme capacity as assessed in this study. The national programme implementation capacity profiles and the capacity clusters identified in Chapter 2, coincide for the high capacity counties, but in the medium and low capacity countries the coincidence is less distinct. There are also counties with EPI coverage higher than national implementation capacity would permit, which may be the result of external operational support. The programme implementation

capacity in Papua New Guinea, Cameroon and Haiti is particularly low, even though two are assessed at medium general systems capacity. Thailand, the only country covering all costs with national resources and in general terms described to have good capacity, still has some outstanding critical areas. In terms of sustainability, the African countries show less progress than the other countries.

Table 5.8 EPI programme: National Programme Implementation Capacity

Country	Capacity cluster	EPI Coverage	Immunisation programme capacity	Critical areas
Thailand	HIGH	High	High	Still some critical outstanding issues
Ecuador	HIGH	High	High	Refunding --- vaccine shortages, no counterpart in IPD surveillance
Nicaragua	HIGH	High	High	Still in need of operational support
PNG	MEDIUM	Low	Low	Many critical areas in the system unmet
Cameroon	MEDIUM	Low	Low	Management, vaccine supply, reporting, financial
Tanzania	MEDIUM	High	Medium	Financial, integration
Haiti	LOW	Low	Low	No Counterpart in MoH
Bangladesh	LOW	High	Medium	Financial, integration
Cambodia	LOW	High	Medium	Financial, Quality Assurance
Mozambique	LOW	Medium	Low	Financial, Needs assessment, Procurement guidelines
Ethiopia	LOW	Medium	Low	Policies, monitoring, needs assessment, financial
Mali	LOW	Low	Low	Policies, integration, financial

Table 5.9 EPI programme: WHO Financial and Human Resource Support

Country	Capacity cluster	EPI Coverage	Group according to Vaccine Independence Initiative ¹⁶	Total financial support 1992 - 95	%EBF	%RBF	Human Resources Support 1992 -1995 Days
Thailand	HIGH	High	3	28,800	0	100	0
Ecuador	HIGH	High	2	258,118	83	17	4,800
Nicaragua	HIGH	High	1	2,930,425	100	0	2,880
PNG	MEDIUM	Low	8	203,981	0	100	420
Cameroon	MEDIUM	Low	8	67,564	0	100	44
Tanzania	MEDIUM	High	1	0	0	0	86
Haiti	LOW	Low	7	3,764,629	100	0	720
Bangladesh	LOW	High	2	1,279,433	0	100	2,640
Cambodia	LOW	High	1	627,678	81	19	680
Mozambique	LOW	Medium	4	0	0	0	35
Ethiopia	LOW	Medium	4	91,707	30	70	100
Mali	LOW	Low	7	832,956	61	39	660

Source: WHO Study data collected from the WHO COs

WHO resource input in relation to national immunisation programmes

WHO resource input in terms of funds and human resources is summarised in Table 5.9. The financial support varied from US\$4,600 in Mozambique to \$4.5 million in Nicaragua. Five countries received considerable financial support, six countries very limited support and Papua New Guinea, medium financial support. The share of EBFs was highest in the countries receiving the largest total financial support Nicaragua: Haiti, Cambodia and Mali

with exception of Bangladesh which received a large support all from RBFs. The WHO immunisation programme is supported heavily by EBFs (79%). In PAHO/AMRO the major part of funds for EPI are EBFs, in SEARO there are only RBF. The two other regions do not show any specific pattern in terms of budget source. In WPRO one of the countries use mostly EBF (Cambodia) and the other RBFs. Nicaragua, Haiti and Mali have given EPI special priority within the country support programme in terms of budget share (11%, 15%, 17% of CO budget).

The number of days of technical support (all categories) varies in a similar way. Most of the AFRO case studies received limited technical support. Cameroon, Tanzania and Mozambique (Polio NID) had very sporadic STC support and Ethiopia limited FTC support. Regional and subregional EPI advisors have provided some support to a few countries. The PAHO/AMRO case studies received the largest amount of technical support mainly through national professionals. In Ecuador the support has been at central and provincial level. WPRO technical assistance is directed from Regional Office with EPI advisors making frequent visits and providing other technical people for specific tasks. The support is characterised by a process of problem identification and selected support to the problems identified. The two case studies in SEARO show no common features. Thailand received a little support from the SEARO Advisory Committee on Health Research in development of new vaccines, while Bangladesh received strong technical support through seven National Programme Officers in addition to some support through STCs. Generally, the level of financial and human support corresponds. The only exception is Ecuador where there is limited financial support, but very heavy technical support. This may be because Ecuador is a middle income country and receives considerable financial support from other agencies such as Rotary and the World Bank.

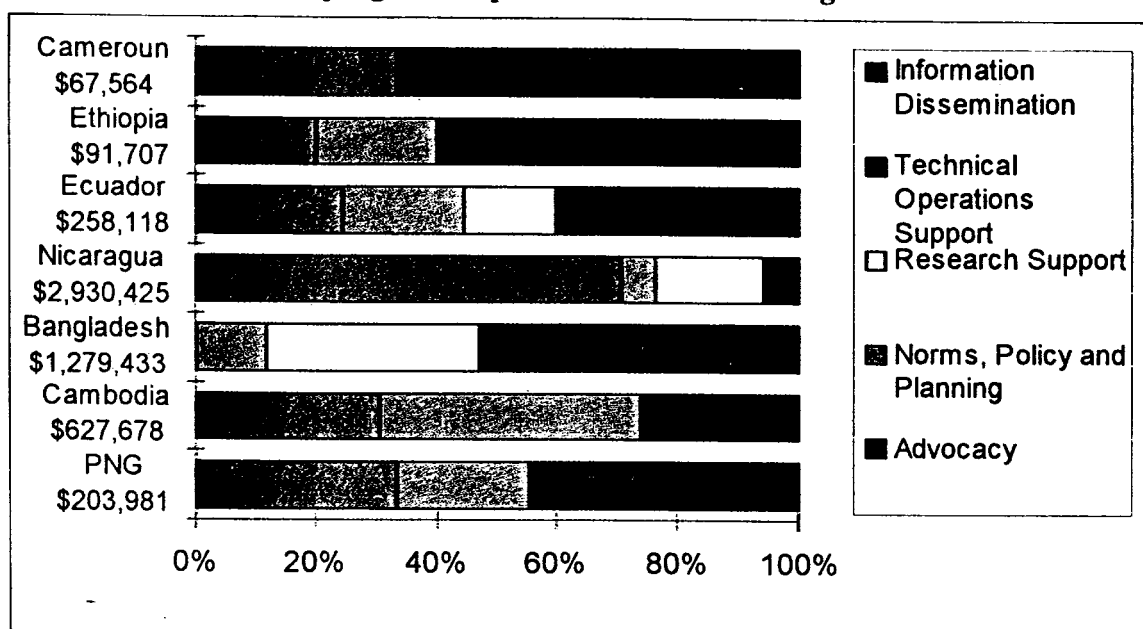
WHO support to national immunisation programmes by functional categories and by use of tools

As referred to in section 4.3, the Study analysed each case study by functional category and by tools used to carry out WHO activities. This was also done for the budget line activity for vaccine preventable diseases. For detailed description of how the data were collected and overview of the various functional categories and tools, the reader is referred to section 4.3.

WHO activities by functional categories:

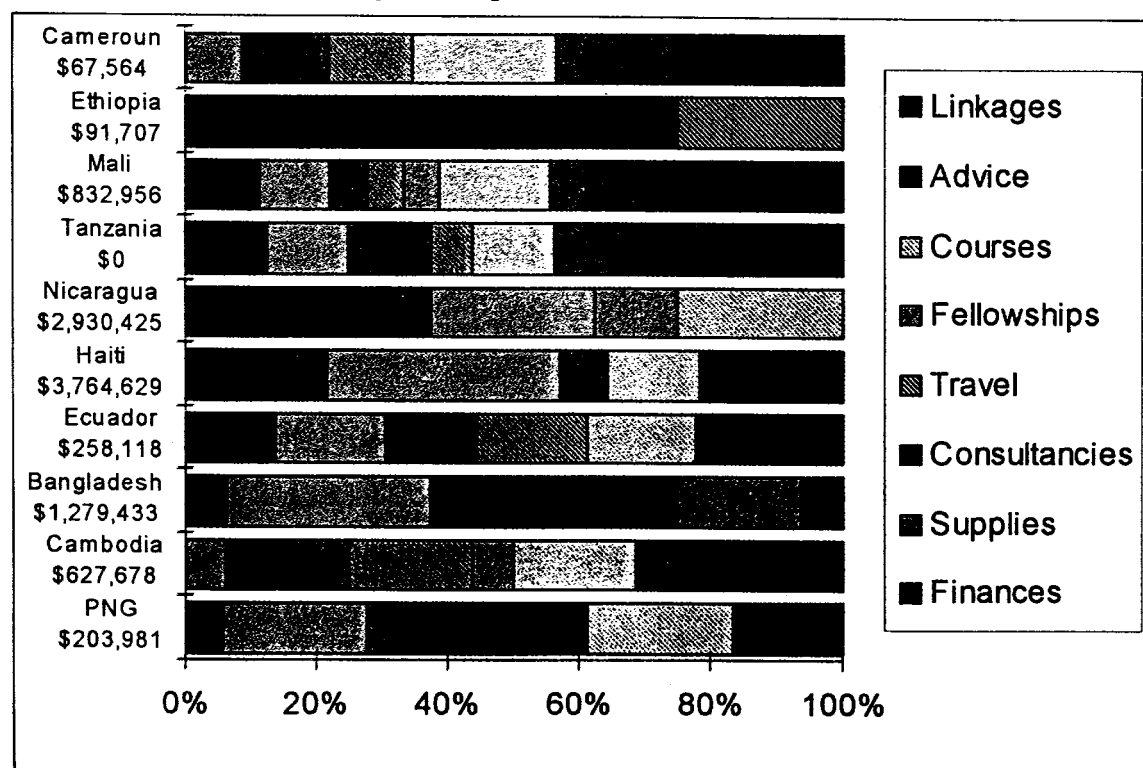
Figure 5.4. shows how WHO staff judge the importance of different functions in WHO EPI country activities; (i) Research is judged as important by very few WHOCOs: Bangladesh, Ecuador and Nicaragua. (ii) Support for establishing norms, policies and national planning is given some importance in nearly all the countries and together with advocacy it is given highest weight in the WPRO and the PAHO/AMRO countries. (iii) Technical operations support is dominant in Ethiopia, but is given considerable importance in almost all countries.

Figure 5.4 WHO EPI programme profile: Functional Categories



Data not available for Mali, Mozambique, Tanzania, Haiti and Thailand

Figure 5.5 WHO EPI programme profile: Use of Tools



WHO support to national immunisation programme by tools

The profile of use of tools (Figure 5.5) shows that *courses and seminars* are used in nearly all the countries and given more or less the same weight. *Consultancies* given most emphasis by Papua New Guinea and Bangladesh, and not used at all by Nicaragua and Ethiopia. Again, Ethiopia stands out with very different profile from the other countries. WHO supports the country mostly in terms of funds and through travel and

visits within country. The use of *financial support* as a tool to enhance national capacity does not generally seem in line with country needs. Ecuador and Nicaragua use financial support as a tool despite the countries covering 80 and 90% of EPI recurrent cost by national budgets.¹⁷ Some African WHOCOs, do not indicate use of financial support as a tool, even though these countries cover very little of the EPI recurrent costs by national budgets. This corresponds with the low overall WHO funding to EPI in these countries. WHOCO *advice* is given considerable weight in African countries, but less so in the PAHO/AMRO country offices with the exception of Haiti.

Haiti, Mali and Papua New Guinea, countries identified as weak in terms of national programme capacity, show a balanced pattern in tools used. However, there is no clear pattern related to countries' systems capacity and access to services.

WHO support to national immunisation programme by technical interventions

Five areas of technical interventions are defined for EPI; Quality Assurance, Integration, Infrastructure including support for cold chain, Supplies and Logistics, and Planning and Management. The WHOCO instruments asked for information about actual expenditure within the two biennia for each of the technical interventions. The findings are presented in Figure 5.6.

There is no apparent pattern e.g. related to health systems capacity or between regions, regarding WHO support in terms of resource allocation to technical interventions. Those countries receiving the largest financial support, also receive the largest support for supplies and logistics. These countries are also those receiving the highest proportion of EBF to the programme. Bangladesh uses 3/4 of the support for supplies and logistics in a context of multi-donor investment in the health sector whereas in Cameroon 3/4 of the support is invested in policy and management functions.

Figure 5.6 EPI : Resource Allocation by areas of technical interventions

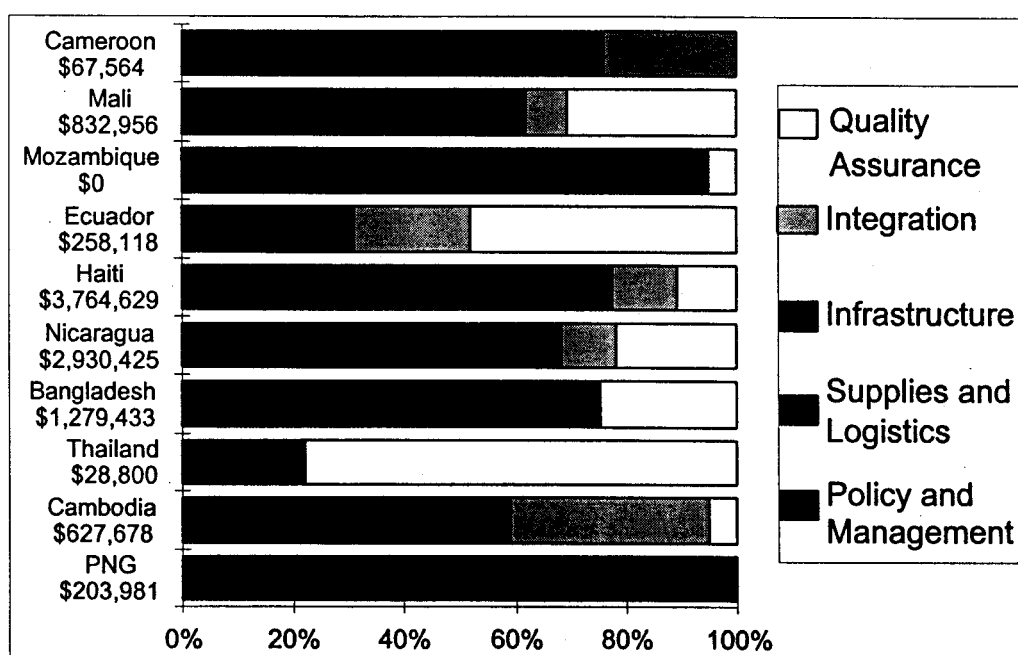


Table 5.10 EPI programme: Actors in the field

Country	Capacity cluster	Actors	Role
Thailand	HIGH	UNICEF, Rotary Int., JICA	Support to NID
Ecuador	HIGH	UNICEF Rotary Int. World Bank USAID/UNFPA	Social Mobilisation and QA Funds Support to supplies and logistics ?
Nicaragua	HIGH	UNICEF Rotary International USAID 20 NGOs	Social Mobilisation Funds Support TA in WHO Operation
PNG	MEDIUM	UNICEF Rotary Int./AusAID	Social Mobilisation Funds
Cameroon	MEDIUM	UNICEF EU CARE int. Business community NGOs	Lead agent, S&L, Infrastructure Vaccine Transport support Operational support to NIDs Operation support to NIDs
Tanzania	MEDIUM	UNICEF Rotary Int. DANIDA JICA	Heavy operational support, S&L, Infra. + TA Funding Heavy operational support, S&L, Infra + TA Funding
Haiti	LOW	UNICEF Rotary Int. French Co-op. NGOs	Supplies and logistics (vaccine + cold chain) Funds Operational support
Bangladesh	LOW	UNICEF Rotary International USAID, SIDA 20 NGOs, CDC Atlanta	
Cambodia	LOW	UNICEF Rotary Int./Japan AusAid JICA	Operational support, social mobilisation Funds Funds to WHO Funds for vaccines
Mozambique	LOW	UNICEF Rotary Int. DANIDA SDC	Operational cost for mobile teams, S&L Funds for Polio NIDs (through WHO office) Vaccine supply, Infra + TA Vaccine supply and operation cost Vaccine supply and operation cost
Ethiopia	LOW	UNICEF JICA	Support to S&L and QA Funds for S&L
Mali	LOW	UNICEF UNDP CIDA/CHA	Support to S&L, Infra Capacity building Funds

EPI activities and other partners

The main partners and actors in the national immunisation programme in the case studies generally correspond to the ones that GPV state as partners of GPV (See Table 5.10). UNICEF is operating in all countries supporting mainly vaccines, logistics and infrastructure as well social mobilisation activities. In some countries they also provide considerable technical assistance. In this sample we find the following governments supporting national immunisation programmes: DANIDA in AFRO countries, AusAid in WPRO countries, USAID in PAHO/AMRO countries as well as Bangladesh. JICA provides financial support to countries in all the regions except for PAHO/AMRO. All the governments provide financial support, some (DANIDA and USAID provide strong technical and operational support as well. Rotary International plays a significant role in national immunisation programmes primarily in terms of funds. In some regions

(SEARO) it is, however, also chairing the regional ICC. The global interest is demonstrated through a presence in nearly all the case studies. In some countries other NGOs support implementation of national immunisation programmes mainly through operations. Bangladesh, Nicaragua and Cameroon enjoy considerable participation from the NGO community. NGOs have been an important partner for programme implementation in Haiti. Table 5.10 provides an overview of the main actors and their role in each of the case studies.

The information collected in this study does not reflect multi-bilateral donor funds for EPI, such as through UNICEF. The bilateral organisations included here are only those that provide support directly at country level.

Overall assessment of WHO EPI at country level

The period studied has been characterised by ambitious goals for eradication and elimination of vaccine preventable diseases. In many countries and regions, these goals are either achieved or will be achieved within foreseeable future. However, some countries are still facing a situation where the EPI coverage is low or even decreased. In some cases this is due to unrest (Haiti, Cambodia and Mozambique). However, in other cases the situation is less easily explained (Mali, Cameroon and Papua New Guinea).

WHO role

As in the drug programme, WHO has directly or indirectly supported the development of the vaccination programme in all of the case studies. WHO policies, standards and guidelines are widely acknowledged and used by all agencies involved in the national immunisation programmes, and whether or not WHO is involved in other ways. The WHOCO role varies from heavy operational support in situations of long-standing emergency (Haiti), to extensive support for National Immunisation Days (Cambodia) to limited support for research on new vaccines (Thailand).

Relevance, appropriateness and responsiveness

A rationale for the WHO operational profile may be found for the extreme examples mentioned above. Across all case studies there is, however, no obvious relationship between goals and strategies set at global level, country needs and WHO profile for immunisation programme collaboration. Countries identified in need of technical and financial support by the Global Programme for Vaccination and according to the findings in this study, having low national programme implementation capacity have received little support compared to other countries which are technically and financially stronger. In some countries, this may be a result of other actors taking the lead and providing the necessary support (Table 5.10). In other countries, technical gaps remain which WHO has not been able to respond to.

Rather than providing support tailored to needs, there seems to be a regional pattern in WHO support to national immunisation programme implementation. The PAHO/AMRO countries have all received considerable amount of financial and technical support. The AFRO countries have in general received very modest financial and technical support with the exception of Mali. This country has, however, experienced declining support in a situation of increased need. The two countries in WPRO receive medium to high level support closely tailored to specific problems identified. Some cases demonstrate the fact

that WHO has not responded effectively to changing conditions; immunisation coverage in Cameroon decreased during economic decline without any apparent WHO response, Mali received decreased support in a situation of increased needs and WHO remained inactive in a critical period in Mozambique as civil war ceased and health systems and service rehabilitation started.

WHO support for vaccine research and development at country level was given to one country (Thailand). Vaccine research and development activities are, none-the-less, widespread in regional terms such as in PAHO/AMRO, but this is not reflected in the WHOCO collaborative programme in the countries included in this study.

Effectiveness

In contrast to the drug programme, WHO has been instrumental in establishing links between partners in the immunisation programme (Table 5.10) enhancing complementarity of use of funds from various sources and use of comparative advantages offered by the different partners. In all regions and nearly all the case studies, an ICC is functioning. Although the case studies provide examples where there are competing interests between actors, they also demonstrate situations where these mechanisms have facilitated effective division of roles and relationships.

The managerial process of the immunisation programme support has some particular features which differs from other programmes. WHO has strongly recommended that annual operational plans be developed combining all efforts. In most of the case studies such procedures have been followed. Linked to disease surveillance systems which have been developed very efficiently in some countries (e.g. Nicaragua) this provides a good basis for measuring programme effectiveness.

The effectiveness and relevance of global norms and instruments for country level policy and strategy formulation was affirmed in most of the case studies.

Several recent evaluations of the GPV, have, on the one hand, discussed issues relating to the effect of the EPI programme on health systems and, on the other hand, NIDs impact on the routine immunisation programmes. In Papua New Guinea and Cambodia, concerns were initially raised to the effect on EPI of running separate campaigns for Polio and measles eradication. In Cambodia a trend analysis¹⁸ looking at the impact of NIDs on EPI suggested that the routine EPI actually benefited from the supplementary immunisation activities. Findings from Papua New Guinea indicate a similar experience. These findings do not consider the cost-efficiency of separate NIDs. Examples of contribution to health systems development (development of epidemiological surveillance systems, annual planning procedures, decentralisation, resource pooling) support the findings in the Tailor Commission's work¹⁹ which indicate that there are several areas in which EPI has developed operational systems which had contributed to other programmes either by sharing them or by setting examples from which to learn. Case countries in this study also provide examples which show that, on the one hand, progress in integration of EPI services depends on having a Integrated Primary Health Care system in place (e.g. Cameroon and Bangladesh) and, on the other hand, when existing, it is tempting to maintain separate systems to ensure specific programme efficiency (e.g. Tanzania).

5.4 WHO related Malaria control activities at country level

Malaria is widely recognised as a major cause of morbidity and mortality in many parts of the tropics. It is estimated that 300-500 million clinical cases and 1.5 to 2.7 million deaths occur each year. Estimates of the effect of malaria morbidity on productivity show that the disease causes enormous economic losses. Not only is it a serious problem but the global situation has deteriorated in recent years, with malaria recurring in areas that had been cleared of the infection. Technical difficulties, notably the spread of drug resistant parasites and insecticide resistant vectors are rendering the control of malaria more difficult and more expensive.

WHO's programme for the control of malaria is coordinated at headquarters by the Division for the Control of Tropical Diseases (CTD) and at the regional level by units that deal with tropical and parasitic diseases. WHO has intensified its malaria action programme in response to the persistent challenge of the disease. A Ministerial Conference in Amsterdam in 1992 reviewed the situation of malaria in the world and strongly recommended a new global strategy for tackling the problem, focusing on four major approaches:

- Early diagnosis and prompt treatment of clinical cases;
- Selective and sustainable preventive measures including vector control;
- Prevention, early detection and control of epidemics;
- strengthening of local capacities in basic and applied research.

This new strategy was adopted by the World Health Assembly and endorsed by ECOSOC and the UN general Assembly. In May 1996, the 49th WHA passed a resolution²⁰ requesting the Director General to explore the possibility of establishing a special programme on malaria. The DG set up a Task Force to advise him. The Task Force was requested to review the malaria situation, to assess the progress made towards the control of the disease and to recommend means by which WHO could best support member states in tackling malaria. At its first meeting in October 1996, the Task Force recommended that WHO should create a strengthened programme for the control of malaria, with strong leadership, adequate human and financial resources, with an autonomous and flexible administrative capable of launching and sustaining unified action against malaria.

As an interim measure, the DG has made available a special fund of US\$10 million to support intensified action in Africa. US\$9 million was assigned to countries in AFRO and US\$1 million for countries in EMRO. This special fund is providing intensified support for 21 countries three of which are included in the present study: Ethiopia, US\$977,000; Mozambique, US\$367,000; and Tanzania, US\$606,000. Resources from the regular budget are also supporting 14 country programmes including two countries in the study: Cameroon, US\$50,000 and Mali US\$25,000. These funds support a variety of activities including:

- Management of severe malaria;
- Vector control, including the use of impregnated bed nets;
- Community based case management;
- Epidemic prevention and control; and
- Information and communication system.

Table 5.11 Malaria Control: WHO Financial and Human Resource Support

Country	Capacity cluster	Total financial support 1992 - 95	%EBF	%RBF	Human Resources Support 1992 -1995 Days
Thailand	HIGH	0			23
Ecuador	HIGH	151,998	100.0%		51
Nicaragua	HIGH	1,717,130	1.4%	98.6%	22
PNG	MEDIUM	318,964	87.2%	12.8%	350
Cameroon	MEDIUM	22,054	100.0%		32
Tanzania	MEDIUM	207,705	100.0%		0
Haiti	LOW	305,348		100.0%	730
Bangladesh	LOW	1,120,785	100.0%		27
Cambodia	LOW	1,532,083	14.8%	85.2%	1,157
Mozambique	LOW	0			0
Ethiopia	LOW	166,544	100.0%		87
Mali	LOW	49,771	100.0%		246

Source: WHO Study data collected from the WHO COs

WHO is working with various partners, especially multilateral and bilateral agencies, in implementing this initiative. Prominent partners include UNICEF, the World Bank, European Union and various bilateral donors: Belgium, Germany, Italy, Japan, the Netherlands, Sweden, UK, and USAID.

This global effort is also being reinforced by regional initiatives. Malaria has its most severe effect in the region for African and AFRO has developed a regional malaria control strategy, a refinement of the global strategy specifically adapted to the African situation. AFRO has produced technical manuals in English, French and Portuguese to make the information available in the three major technical languages in the region. It has sponsored training activities, sponsored and guided operational research and promoted the use of impregnated bed nets.

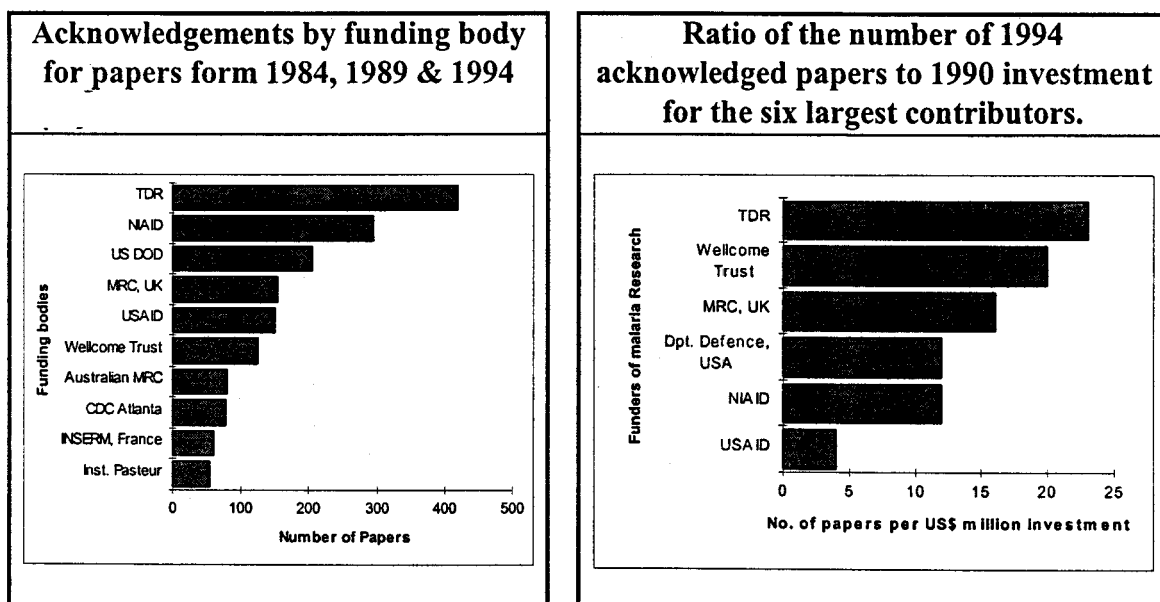
Table 5.12 WHO products being used in national malaria control programmes

Type of Product	Products	In use for disease control	Comments
Anti-malarial drugs	Mefloquine & combinations	1984	Discovered by Walter Reed; developed in collaboration with Hoffmann la Roche.
	Artemisinin & derivatives	1994	Discovered by Chinese scientists from traditional herbal remedy; formulations developed & tested by TDR.
Diagnostics	Microtest Kit	1985	Extensively used in surveys of drug resistance.
	Portable incubator	1986	For in vitro-drug sensitivity test in the field.
Vector Control	Zavala test	1989	Developed by Chilean scientist, Dr Zavala for species specific identification of sporozoites in mosquitoes.
	Impregnated bed nets	1994	Evaluated in various epidemiological situations

TDR coordinates WHO's research programme on malaria at the global level supplemented by the support from Regional Offices. TDR's research programme spans a wide range from basic biomedical studies on the biology of the parasite and host-parasite relationships, to the research and development for new and improved tools for the control of malaria as well as applied field research. Table 5.12 lists some TDR contributions to the development of new technologies for malaria control.

It is not easy to assess the effectiveness and cost-effectiveness of large research programmes. A recent study published by the Unit for Policy Research in Science and Medicine (PRISM) of the Wellcome Trust gives an insight into the performance of TDR's research programme. The relevant findings from the independent audit of global malarial research are briefly summarised in Box 5.1.

Box 5.1 TDR funding and scientific papers



TDR is also involved in training scientists and in strengthening national institutions. In this study the TDR's capacity strengthening for malaria research showed up prominently in Mali and Thailand.

The country studies

Malaria is endemic in all twelve countries in this study. It was thus possible to examine the translation of the policies adopted and promulgated by WHO into support for national malaria programmes.

The policy context

It is clear from the Study that WHO policies on malaria and the new global strategy adopted in Amsterdam have penetrated and influenced national policies and strategies. As shown in Tables 5.13 and 5.14, most of the case studies have recently updated their national policy, have devised national control strategies and have adopted specific strategies in renewed effort against malaria. Both the national health authorities and their other external partners fully endorse the WHO strategy as being appropriate and realistic.

Only Bangladesh, Mozambique and Ethiopia have gaps in their policy documentation (Table 5.13).

Table 5.13 Malaria Control: Policy Context

COUNTRIES	Capacity Cluster	POLICY CONTEXT			
		Policy updated in past 10 years	National malaria strategy exists	Needs assessment in last 5 years	Included in Sick Child Initiative
Thailand	HIGH	YES	YES	YES	YES
Ecuador	HIGH	YES	YES	YES	YES
Nicaragua	HIGH	YES	YES	YES	YES
PNG	MEDIUM	YES	YES	YES	YES
Cameroon	MEDIUM	YES	YES	YES	YES
Tanzania	MEDIUM	YES	YES	YES	YES
Haiti	LOW				
Bangladesh	LOW	NO	YES	YES	NO
Cambodia	LOW	YES	YES	YES	NO
Mozambique	LOW	YES	YES	NO	NO
Ethiopia	LOW	YES	YES	YES	NO
Mali	LOW	YES	YES	YES	YES

Table 5.14 Malaria Control: Strategies

COUNTRIES	Capacity Cluster	SPECIFIC STRATEGIES			
		Malaria control plan exists	Therapeutic protocols exist	Vector control strategy exists	Local research results influence control
Thailand	HIGH	YES	YES	YES	YES
Ecuador	HIGH	YES	YES	YES	YES
Nicaragua	HIGH	YES	YES	YES	NO
PNG	MEDIUM	YES	YES	YES	YES
Cameroon	MEDIUM	YES	YES	YES	YES
Tanzania	MEDIUM	YES	YES	YES	YES
Haiti	LOW				
Bangladesh	LOW	YES	NO	NO	YES
Cambodia	LOW	YES	YES	YES	YES*
Mozambique	LOW	YES	YES	YES	YES
Ethiopia	LOW	YES	YES	YES	YES
Mali	LOW	YES	YES	YES	YES

* New programme will emphasise operational research

Country context is important to note, as Mozambique has just emerged from protracted civil war. Conversely, Ethiopia has enjoyed a well-organised malaria control programme since 1956, but at present it is decentralised with more than 27 programme managers responsible for malaria control at various levels of the health system. Half of these are biologists/malariologists, with the other half being medical doctors. Malaria control programmes are also dependent on policies and actions outside the health sector. Development programmes especially agro-engineering projects, dams, irrigation schemes, mining and other activities that alter the breeding sites of mosquitoes affect the pattern of transmission and the likelihood of epidemic malaria. In one country, an intensified control programme based on the use of impregnated bed nets was frustrated

for over a year when another ministry of the same government banned the importation of insecticides that were required by the national malaria programme.

Implementation of national malaria programmes and WHO support

All the case studies have had a long experience in dealing with malaria with variable results. Most of the countries have established or are in the process of establishing the managerial processes for running their revitalised malaria programmes.

With the exception of Thailand the public sector is not able to cover the cost of the national malaria programmes fully and are therefore dependent on external aid for implementing their programmes. Economic crises have adversely affected malaria control programmes in some of the countries.

The case of Thailand illustrates a number of important features of the malaria control problem. In spite of technical difficulties, notably the prevalence of multi-resistant parasites, the Thai national malaria programme is steadily bringing the disease under control. In discussion, the Thai authorities acknowledged WHO's contributions to the development of their national capacity; they drew attention to the fact that most of the current leaders of the National Malaria Programme had received significant part of their training through WHO fellowships and other mechanisms.

The most important challenge to the Thai malaria programme is the introduction of new cases from neighbouring states where the control measures have been demonstrably less successful. In 1995, 40 to 50% of newly diagnosed malaria cases were in persons who came across the border from one of the neighbouring states.²¹ The success of the Thai programme shows that, given national commitment and adequate resources, the strategy proposed by WHO can effectively bring the disease under control. But it also illustrates the need for inter-country collaboration in dealing with an infectious disease that does not respect national boundaries. Thailand is supporting collaborative programmes financially through its bilateral donor programme.

The Study observed the role that WHO is playing in facilitating cross-border collaboration in Africa and Indochina. Not only is its technical input appreciated, but more importantly, WHO provides a neutral platform that facilitates inter-country cooperation which could have been stalled by political differences among neighbouring states. Border meetings on malaria, inter-country workshops on the management of severe and complicated malaria, epidemic prevention and control, and monitoring efficiency of antimalarial drugs are common activities, especially in Africa.

In promoting inter-country collaboration on the Indochina Peninsula, WHO had to overcome its own bureaucratic complexities in dealing with countries that belong to two WHO regions, SEARO and WPRO. The regional directors have dealt with this problem by permitting direct contacts among WHO technical staff across regional borders. They have also jointly sponsored inter-regional meetings on malaria, bringing together public health practitioners and scientists for the exchange of ideas and for developing joint projects. A recent example on drug resistant malaria took place in Manila in October 1996; the participants were drawn from Cambodia, India, Indonesia, Laos, Malaysia, Myanmar, Papua New Guinea, Philippines, Solomon Islands, Thailand, Vanuatu and Vietnam.

WHO is also playing an active role in the malaria programme in Cambodia. Here the challenge is to rebuild capacity in a 'post' conflict era. The national programme has received support from the British DfID (ex ODA), the World Bank and other partners, and is now also involved in a new major initiative sponsored by the European Union (EU) with technical guidance from WHO. This EU sponsored inter-country programme includes Laos, Cambodia and Vietnam.

Malaria in Africa remains a daunting problem. There is a wide gap between the needs of national malaria programmes and the resources available to them. WHO's regular funds for malaria control in Africa are minuscule, attempting to cover training, advocacy, needs assessment and some technical assistance. The bulk of funds required for implementation of programmes must come from additional resources that the country can mobilise with the support of WHO. The DG's special fund of US\$9million can temporarily enhance WHO's ability to respond to the requests from malaria programmes in African countries, but much larger sums secured over time are required to tackle the problem meaningfully.

The malaria programme in Mali illustrates some important issues. Although the country is economically one of the least developed countries in the Study, its university has developed a remarkable degree of expertise in malaria research. Funded by TDR and supported by other agencies, the Malaria Research Unit of the medical school has trained many malaria scientists and practitioners, not only Malians but also students from other African countries. The group has participated with the bilaterally funded demonstration malaria control programme in partnership with the Ministry of Health and GTZ. And yet the national malaria programme is still relatively underdeveloped and lacks effective capacity or funding.

Table 5.15 Malaria Control: Other Actors in the field

COUNTRIES	Capacity Cluster	OTHER ACTORS
Thailand	HIGH	Technical cooperation with US based institutions - AFRIMS and Walter Reed on mosquito identification
Ecuador	HIGH	China and the Instituto Juan Cesar Garcia
Nicaragua	HIGH	Nordic countries until 1995; Grant from Sweden in 1996 for control of epidemic
Papua New Guinea	MEDIUM	a) AUSAID funds include support for the Institute of Medical Research; b) UNICEF funding of bed nets. Linkage with Japanese Voluntary Contribution; Rotary and UNICEF for bed nets.
Cameroon	MEDIUM	UNICEF, Belgian Cooperation, GTZ, EU, CARE have provided inputs at meetings and workshops.
Tanzania	MEDIUM	a) JICA \$13.8 million for equipment and supplies, technical assistance b) UNICEF c) Swiss Cooperation d) African Child Survival Initiative
Haiti	LOW	UNDP funds programme managed by WHO
Bangladesh	LOW	World Bank led consortium
Cambodia	LOW	WHO/DFID (ex ODA) main actors until 1996; World Bank and EU are now making major contributions
Mozambique	LOW	UNICEF, USAID and Italian Cooperation; supplies for hose spraying, procurement of antimalarial drugs, training including safe handling of insecticides
Ethiopia	LOW	Netherlands \$250,000 for training in 1994; USAID and Italian Cooperation
Mali	LOW	GTZ and others

Note: this is not an exhaustive list.

Other Actors

UNICEF has worked closely with WHO on malaria control. The World Bank and the European Union have recently increased their involvement. Various bilateral donors, DfID (ex ODA), JICA, AusAid, GTZ, etc. have supported malaria control programmes in the case studies (Table 5.15). There is however, a massive gap between the needs of national malaria programmes especially in Africa and the available resources.

Overall assessment of the Malaria Programme in the twelve case studies

WHO's contributions to malaria control include:

- Policy and strategy development: WHO has worked with countries to adapt the global strategy enunciated in Amsterdam to national programmes.
- Guidelines, protocols, manuals and other technical documents: WHO has produced a variety of technical documents that provide guidance for national malaria programmes both in the design and operation of the interventions. Some of the materials are used in training programmes and others deal with special problems such as "Malaria Control among refugees and displaced population".
- Research Mainly through the TDR programme: WHO has been involved in the development and evaluation of new and improved tools for the control of malaria. TDR has been involved in the development and evaluation of new antimalaria drugs, mefloquine, and artemisine derivatives. It has also developed and standardised techniques for testing sensitivity of parasites to drugs. It has co-ordinated trials to assess the efficacy and acceptability of impregnated bed nets in various epidemiological situations. It is also involved in immunological studies aimed at the development of malaria vaccines. Of related interest to malaria control is WHO's Pesticide Evaluation Scheme that is aimed at promoting the development and evaluation of new pesticides. This programme is managed by the Division for the Control of tropical Diseases and is linked with WHO's network on the Promotion of Chemical Safety.
- Support for Country Programmes: All the case studies indicated WHO's close involvement in the design and evaluation of their national malaria strategy and programmes. WHO has also supported the training national malaria programme managers, both within country, and internationally. WHO has aimed to strengthen programme capacity on epidemic prevention and control, monitoring and efficiency of antimalarial drugs and management of severe and complicated malaria.
- Resource mobilisation: WHO has been supporting countries in their quest for additional resources for their malaria control programmes. The relatively small sums available from WHO has enabled some countries to prepare credible national malaria programmes and thereby leveraged more substantial funds from donors.

Malaria remains a major cause of disease death and disability in many countries. Existing technologies, vigorously applied according to the new global strategy can ameliorate the situation. The problem remains very severe in Africa where WHO is spearheading a new initiative aimed at reducing the heavy toll from malaria. The situation calls for strong national commitment from the governments of the endemic countries and more generous, sustained support from external donors.

5.5 Summary of main issues: The three tracer programmes

1. The three tracer programmes, national drug programme (DAP), national immunisation programme (EPI) and malaria control (Malaria) are used to analyse in greater depth, the role, effectiveness, appropriateness and relevance of WHO Collaborative Programme at country level. These programmes are well defined and structured in terms of WHO policy and approaches, and have special structures for policy dialogue and reporting, such as the meeting of interested parties for EPI and DAP. All the tracers are in various ways systems dependent, but are also sufficiently diverse (EPI strong technical, DAP strong political, malaria control strong multi-sectoral aspects) to provide a broad view of WHO operations at country level. The choice of the three tracer programmes was thereby affirmed through the Study process as relevant for the purpose.

National programme implementation capacity

2. In terms of policy context, five countries had a complete set of updated policy instruments on EPI and four countries had two or fewer items in place. For DAP, three countries (all high capacity) had a complete set of updated policy instruments and another six had 3 of the 5 items in place. Bangladesh did not have any, and Ethiopia had only two. Policies on malaria control have recently been updated following the renewed effort towards control of Malaria.
3. *National funding* for the programmes varies between countries and the programmes. Three countries cover more than 80% of the EPI costs from the national health budget, contrasting with other countries particularly in Africa, which cover hardly any. Public spending on drugs is very low for some countries, while other countries cover more than 20% of the total public drug budget. With the exception of Thailand, the public sector is not able to contribute significantly to the national malaria control programmes in the case studies.
4. The Study findings show that in general *the national programme capacity* for the drug programme follows the national health systems capacity as defined in this study, with two exceptions: Mali showing higher capacity and PNG lower capacity than expected. Countries in the high capacity cluster also have high capacity in the EPI programme, while some low capacity countries (Bangladesh and Cambodia), have higher EPI coverage than would be expected.

The role of WHO

5. WHO has had a long-standing commitment to EPI and DAP in case studies. Malaria has, after years of less attention, recently received renewed emphasis. Many of the case studies have enjoyed considerable financial and human support from WHO in the study period, others negligible. Across the twelve countries for 1992-95, EPI funding was \$10 million, nearly twice as much as DAP (\$5.5 million) or Malaria (\$5.6 million). However, the DAP funds have been somewhat more evenly spread between the countries. The differences in human resource input are less. The three tracer programmes have been highly dependent on EBFs (79% for EPI, 70% for DAP and 60% for Malaria). A special fund for intensified action for malaria control in Africa was established in 1996, but the US\$10 million available is very little compared to the size of the problem over all of Africa and Europe.

6. WHO has directly or indirectly supported the development of all these programmes, through well formulated and widely accepted policies, standards and guidelines.
7. The role of WHO has varied from heavy operational support (e.g. Haiti for EPI and DAP), to a marginal observer role (PNG in DAP) or contributing to very specific components (such as vaccine research and development in Thailand). WHO has been heavily involved in malaria control as part of the overall disease control thrust in the PAHO/AMRO countries. In AFRO there are examples of significant involvement in malaria research (Mali) as well as in Thailand. The role of WHO in malaria control is now changing in AFRO following the special fund and intensification of the programme.

Relevance and appropriateness of WHO support

8. For all three tracer programmes, the findings show that WHO involvement has varying degrees of relevance and appropriateness. There is no obvious match between the country needs as defined by national capacity for programme implementation and WHO level and profile of collaborative activities.
9. The Study constructed a "drug score" reflecting drug regulatory capacity and policy framework. There is no match between country "drug score" or DAP category and WHO funding level, nor between country "drug score"/DAP category and the functional emphasis described by the WHOCOs in the collaborative programme. The mix of interventions and tools appears to be largely ad hoc with little focus or selectivity.
10. Among the case studies, highest WHO funding for DAP went to Ecuador (a high capacity country), receiving \$2.5 million EBFs over the 2 biennia. Least funding for DAP went to PNG and Cameroon, both medium capacity countries. Thailand received more funds for DAP than four of the low capacity countries.
11. Countries with high national programme capacity as assessed in this study and according to the Global Programme for Vaccination, in general receive more technical and financial support for EPI than those with low capacity. The findings indicate regional commonalties, but no obvious and overall match between needs, capacity and level of support.
12. Among the case studies, 1992-95, most WHO funding for EPI went to Haiti (\$3.7 million), Nicaragua (nearly \$3 million) and Bangladesh (1.3 million). No funding for EPI went to Mozambique or Tanzania, and less than \$100,000 went to Thailand, Cameroon and Ethiopia.
13. The WHOCOs have, had close involvement in the recent review of national malaria strategy which is highly acknowledged. However this has created expectations for funding which is not forthcoming. The facilitation of inter-country focus and networks in malaria control appears appropriate and effective.
14. Among the case studies, 1992-95, most WHO funding for malaria went to a high capacity country, Nicaragua (\$1.7 million, EBFs) and two low capacity countries, Cambodia (\$1.5 million, 85% EBFs) and Bangladesh (\$1.1 million RBFs). No WHO funding for malaria went to Thailand or Tanzania, and less than \$100,000 went to Cameroon and Mali.

15. For both EPI and DAP, the level and nature of WHO involvement (or lack of involvement) in the countries may be explained by the presence of other donors and actors supporting critical capacity gaps. In some cases, the situation has arisen as a strategic choice, or as a result of WHO having let itself become marginalised, or by being slow in responding.
16. In all the three tracers, HQ established criteria for involvement in countries did not appear to influence WHO's actual presence and profile. The level of involvement depended more on the availability of donor partners wanting to work through WHO in that particular country. In relation to DAP, donor earmarking of funds for activities in specific countries has clearly influenced the choice of countries for more intensified WHO support. MoH commitment and ability to use WHO in policy and as a technical resource, also stands out as an important factor determining WHO role and activities in the case studies.

Effectiveness

17. The effectiveness and relevance of WHO established global norms and instruments for country level policies and strategy formulation was affirmed for all the tracers in all the case studies. The policies developed and agreed through the work of WHO at the global level were accepted and used as basic to both national and donor policies.
18. The effectiveness of WHO programme operation at the country level is harder to judge, because of the complex pattern of multiple partners for both EPI and DAP, and the dependency on national system factors for all three tracer programmes. The NID strategy, where implemented, has served as an instrument for raising general immunisation coverage and for re-establishing infrastructure and motivation for EPI, and thereby demonstrated results, at least in the short-term. In several countries one could question the effectiveness of WHO consultancies as measured against low level of advice and recommendations actually implemented.
19. Effective linkages and partnerships stand out as a critical element in overall effectiveness. WHO has been instrumental to establish links between partners in EPI, as the ICCs at country and regional level have provided an effective instrument for co-ordination of resources and for drawing on the comparative advantage of various partners. However, in the case studies, this has been much less the case for DAP.

Endnotes: Chapter 5.

- ¹ DAP/MAC(9)/97.4 WHO Essential Drugs Strategy; Objectives, priorities for action, approaches, Geneva February 1997
- ² DAP/MAC(7)/95.4 Interim Report of the Biennium 1994 - 1995, Geneva Feb. 1995
- ³ DAP/MAC (9))7.4, page 25
- ⁴ WHO Bi-regional TCAC Meeting on Essential Drugs, Malaysia December 1994, WHO/MOH Malaysia and Report of the first meeting of the Working Group, Biregional TCAC November 1995, WHO/SEARO
- ⁵ Country Case Study Report, Mali
- ⁶ WHA41.28
- ⁷ WHA42.32
- ⁸ The new GVP Strategic Plan 1996 - 2000 (WHO/GPV/96.02: «... country self-sufficiency, coverage and quality»
- ⁹ Expanded Programme on immunisation. 1995 Immunisation Coverage. Achievements and Future Strategies. Draft 09.05.96
- ¹⁰ WHO/GPV/96.06 Report of the Meeting of Scientific Group Experts (SAGE) of the CVI and the GPV&I.
- ¹¹ 24th March: Guide for the Preparation of a national EPI plan of action
- ¹² PAHO/WHO March 1995: The impact of the Expanded Program on Immunization and the Polio Eradication Initiative on Health Systems in the Americas. Final report of the «Taylor Commission».
- ¹³ In the 1996 Meeting of SAGE it was agreed that coverage should be regarded as a process indicator, an indicator for service access and availability and that disease reduction should be the main impact indicator.
- ¹⁴ Using the cut-off points high > 70% coverage, medium 50 - 70% and low < 50% (Vaccine Independence Initiative). WHO/GPV/96.06 Report of the Meeting of Scientific Group Experts (SAGE) of the CVI and the GPV&I.
- ¹⁵ According to VII WHO/GPV/96.06
- ¹⁶ Group characteristics; Group 7 technically and financially weak, Group 4 managerially and financially weak, Groups 5,6,8,9, technically weak, financially moderate to strong, Groups 1,2 technically strong, financially weak.
- ¹⁷ PAHO/WHO Washington D.C. November 1996: Special Program for Vaccines and Immunisation (SVI) Program Evaluation
- ¹⁸ 1995 TAG meeting
- ¹⁹ The impact of the Expanded Programme on Immunisation and the Polio Eradication Initiative on Health systems in the Americas. Final Report of the «Taylor Commission» March 1995.
- ²⁰ WHA49.11
- ²¹ J. Anderson, M. MacLean and C. Davies (1996) PRISM Report No. 7. Malaria Research: An Audit of international activity". Unit for Policy Research in Science and Medicine. The Wellcome Trust, London.

Chapter 6. WHO LINKS AND PARTNERS

6.1 Introduction

This Chapter focuses on how WHO fulfils the intentions expressed to establish new partnerships relevant to the country context in such a way that it may make any significant contribution to strengthening the country's own capacity for health sector development. While the focus of this study is on the health sector, it does not assume that interventions within this sector have the strongest impact on health in a population. The health sector is a complex policy environment where WHO's contribution to a country's health system is mediated through, and influenced by, the actions of many other players: the government institutions responsible for health policy and health service delivery, the bilateral and multilateral donors and a range of different for profit and not-for profit actors within civil society. The interactions between the different players are affected by factors such as their capacity and competence (both real and perceived), their interests and their value systems as well as the political and economic structures of the country.

The Chapter describes the links and relationships WHO has established with other actors and how other actors approach and relate to WHO. It also analyses the strength of the country itself in directing and coordinating national health development.

6.2 WHO policies for partnership in health

WHO has long recognised its need to make links with other organisations involved in health. The concept of partnership was strongly on the agenda of WHO in the early 1980s. The 33rd WHA discussed the Organisation's cooperative activities within the UN systems through joint efforts to support health as part of development and to influence the channelling of all available resources, including those of other relevant sectors and nongovernmental organisations (NGOs), into support for national, regional and global strategies for health¹. The 34th WHA² considers that technical cooperation in international health work must be characterised by equal partnership among cooperating parties, developing and developed countries alike, WHO and other intergovernmental, bilateral, multilateral and NGOs participating in technical cooperation. Since these early resolutions, the scene has changed considerably, largely because WHO is no longer the obvious strong partner that can set the agenda for cooperation in health development.

In the 1990's as part of its efforts to renew the Health for All strategy, WHO has taken a series of steps to establish "Global Partnership Initiatives for Health Development",³ where special attention is given to the relationship with other United Nations bodies and Bretton Woods institutions, at the same time as identifying new collaboration with academic institutions, foundations and private enterprises. The UN Resident Coordinator System has been established to provide a framework for collaboration within the UN system at country level.⁴

WHA 49/19 sets out a policy on collaboration with partners for health development with the following objectives: (i) to place and maintain health at the centre of national development and regional and global cooperation (ii) to ensure complementarity and cost-effectiveness in the allocation and use of resources for health (iii) to promote the

continued development of strategic alliances with intergovernmental organisations and other important institutions to meet the health needs of member states.

Collaboration with NGOs is guided by the Principles Governing Relations between the WHO and NGOs.⁵ Current policies give emphasis to relations with NGOs which are international in membership or scope of activities. Regional Offices may also establish working relationships with regional and national NGOs confined to the regional level. WHO/INA97.2 notes that the time has come to take into more account national and regional NGOs in the health development process. The Study found evidence that this is being done in some regions more than others.

In the case of national organisations, WHO is required to consult with the government concerned before working relations are established. PAHO/AMRO states⁶ that as the Regional Office of WHO, the Bureau has a constitutional mandate to direct and coordinate international health work in the region and in this regard will assert its leadership in health matters. AFRO states in its policy framework of 1995 that WHO will invite all its partners for active collaboration at the regional and country level, finding expression in concerted action directed by the Organisation, strengthening its technical capacities and using the coordination mechanisms established by Headquarters. Capacity building partnerships is one of the policy objective in the WHO policy orientation for African Recovery and Development.

The Director General has reported progress at global level:⁷ (i) links with the World Bank are strengthened, guided by procedural strategies for implementation of recommendations for health development, (ii) significant contribution to UN Special Initiative for Africa is made by developing an implementation strategy for health sector reform through series of interagency and technical consultation (iii) a "new level of commitment and activity in the area of regional health sector policy formulation and country-specific support" is reached with the five regional development banks.

The Study examined the links and partnerships in the case studies in the light of these policies and reports. An overview of the relationships established in the case countries is presented in Annexe 6.

6.3 WHO and the Ministry of Health

In all twelve countries, the essential partner for WHO is the Ministry of Health. Some WRs were closely involved in national health planning and development of policy, others were more marginalised. The findings from the case studies underscore that the functionality of the relationship depends on the one hand on the capacity of the WR and the WHO systems' ability to respond, and on the other hand on MoH ability and interest in using WHO as a close ally and privileged partner in health development. Ecuador has a large CO which, in the context of national fragmentation and discontinuity of leadership in the MoH, represents a strong "corporate memory". Although, to some extent this is highly regarded by the MoH, there is a mismatch between the intentions and utilisation of the competence and capacity represented by the WHOCO. The MoH in Cambodia and PNG demonstrated strong and consistent interest in safeguarding WHO's role as a neutral broker and privileged policy adviser. Conversely, the MoH in Ethiopia,

refers to WHO as a key partner in health development, even “as an arm of the Ministry”, but gives the WR no particular role or opportunity in supporting the MoH in sector policy development and discussion, currently being undertaken with support from the World Bank.

In all twelve case studies the MoH is the main institution responsible for health policy and service delivery. Ecuador and Nicaragua provide examples where service delivery or purchase is by a third party (the social security system {ISS}). In Nicaragua there is no doubt that the MoH is the ultimate policy maker in health sector development, in Ecuador the division of roles between the MoH and the ISS is disputed. In both these countries, PAHO/AMRO has relations with the social security institutions, although not on a large scale. It has been instrumental in the organisation of the Central American network of social security institutions through the ISCA programme.⁸

Several of the case studies demonstrate that with weak government leadership for health and a fragmented health sector, the WR is left with a difficult situation. Even so, the credibility of WHO as an institution, which still remains high in many of the countries, gives the WR a strategic position.

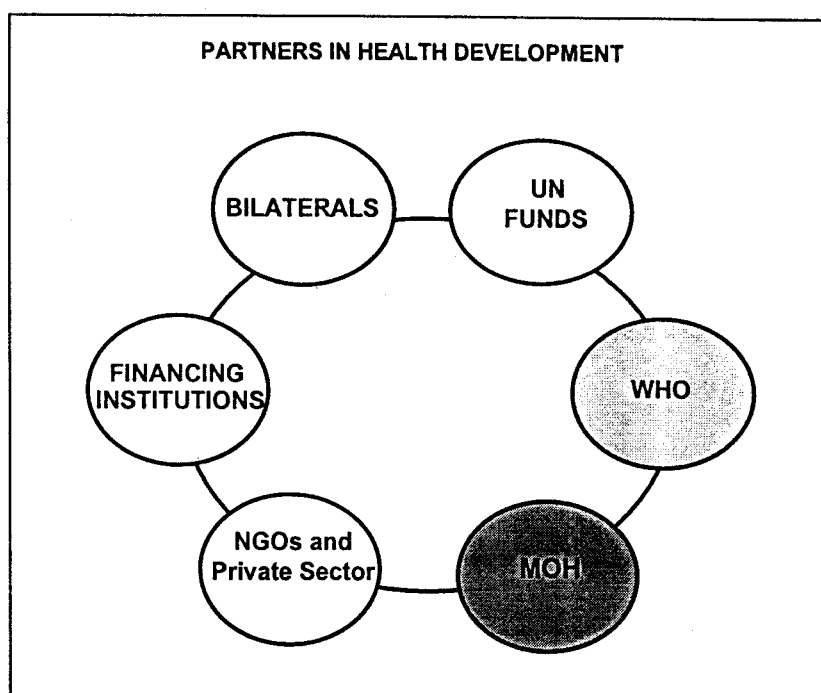
The WHO relationship with the MoH is generally valued by the other partners and actors. WHO is seen to have a position that could be used strategically by partners in terms of communication and influence with the MoH. In many of the case studies the WR has relatively easy access to high level officials including the Minister (e.g. in Mozambique, Ecuador and PNG). The bilateral agencies in Ecuador felt that, in a difficult political scene, WHO's position in relation to the MoH provided a platform for collaboration. On the other hand, the NGO community saw WHO as too closely identified with MoH which was interested in “controlling” NGOs.

6.4 WHO and other main actors in the health sector

Based on the premise that the relationship between the MoH and WHO in a country serves as the reference point for WHO's relationship with other partnerships, this section firstly presents some general observations and then examines findings relevant to each main group of partners, the UN organisations, the Development Banks, the bilateral agencies and the NGOs. Figure 6.1 provides a map of the main groups of actors in health development at the country level. The term NGO in this context should be understood in a broad sense, as all actors in civil society, non-profit and profit, and including academic institutions, interest groups and peoples movements.

Within this framework, WHO has some unique features. Compared to donor agencies, it is by design weak in terms of ability to mobilise financial support, but is intended to have its strength as a technical resource and authority. It is also, through its specific relationship to the MoH, distinctly different from actors in civil society. Its challenge is to maximise its strengths and enter into partnerships that compensate for its weaknesses without undermining the strengths. It should be noted that when this study discusses whether WHO is perceived as a leading partner among external actors in health development, the purpose is to explore relationships, not to state what ought to be.

Figure 6.1 WHO in the context of other partners



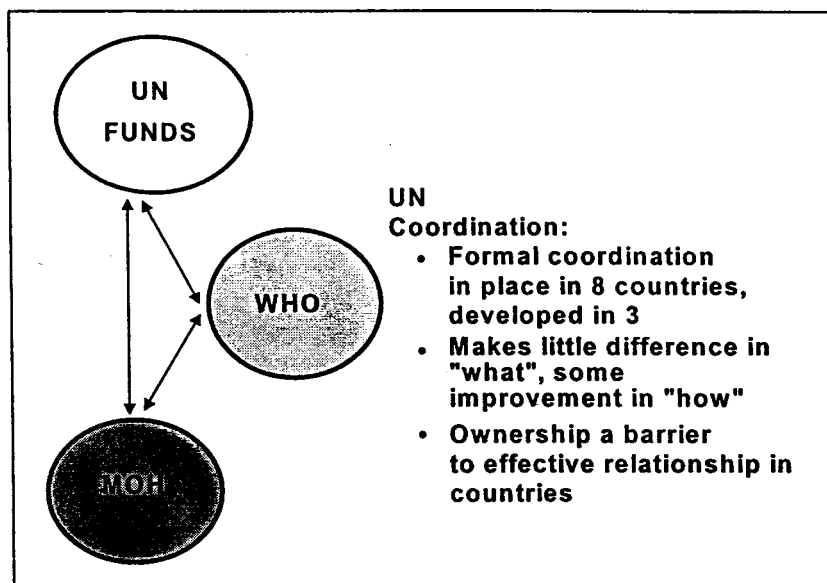
WHO and other UN organisations

A number of formal and informal mechanisms for collaboration and coordination between WHO and other UN organisations have been in operation at the country level. The Country Strategy Note (CSN) is the most recent effort to establish an overall development cooperation framework for the UN inputs to countries. In the twelve study less than half (5) had developed a Country Strategy Note. Most of the other countries are, however, in a process of developing such notes. In some of the countries the process has involved the government and in others not. In Mali the Government itself has taken a lead, and in Tanzania the CSN is now being transformed into a Government Paper. Some Governments have not seen the value of the exercise and have until recently delayed the process. In Haiti the WHOCO expressed some scepticism about its usefulness, and concern at the resources expended developing it (p. 32) and in Thailand it was seen to "carry little weight". In Mozambique it had been developed, but had not served as an instrument to operationalise joint action. Therefore in some countries it has served to bring the UN agencies together with the national government. In others the process has been less useful. In several of the countries with a CSN, it was expressed that the exercise served to create more transparency and greater awareness of the different roles and activities of the agencies, but did not as such cause UN agencies to change what they were currently doing (Figure 6.2).

The case studies demonstrate that ultimately it is a government's position on their partnerships with the UN agencies and the way they use these partnerships which provide the platform for them to act at the country level. In this, the specialised agencies, such as WHO, UNESCO and FAO, are in positions which are distinctly different from the UN funds, because their primary link is with a sector ministry rather than with a ministry of planning, finance or external aid coordination. Governments commonly express a different type of ownership when they speak of the specialised agencies, as compared to

the funds. These differences give these agencies both their advantages and their limitations, which need to be taken into account in the ongoing efforts to streamline UN development cooperation functions at the country level.

Figure 6.2 WHO and the UN system



There are a number of examples in the case studies, of other attempts by agencies within the UN system to coordinate activities. The countries which have been through major emergency situations, such as Cambodia, Haiti and Mozambique, all give examples of concerted action and willingness to give up the usual "territorial" thinking in these situations. In Haiti and Mozambique, WHO had a distinct leading role during the emergency. The experience with coordinated action under a UN umbrella in preparation for the 1993 elections in Cambodia has carried over into the style of collaboration in the rehabilitation phase.

In most of the case studies there are also examples of coordinated action among the UN agencies on particular health issues. In many of these, WHO plays a key role, such as in chairing theme groups. For example, it was commonly found that the WRs chair the UN theme group on AIDS. However, only two of the five African countries (Mozambique and Ethiopia) had taken any country specific steps in regard to the "UN Special Initiative on Africa". In Bangladesh, WHO's close collaboration with the MoH is considered to be hindering more significant UN collaboration, as UNDP, UNFPA and UNICEF operate in a more decentralised manner. Eight of the twelve countries report that there are regular meetings between the country representatives of the UN organisations.

Many MoH officials still complain that the different UN organisations operate with separate and sometimes conflicting strategies for health sector support. The extent of duplication of activities between agencies depends very much on the context of each country. In some countries, UNICEF and WHO seem to draw on each others strengths and financial abilities. In Tanzania a series of seminars and workshops were planned together, using WHO guidelines and materials, but implemented and paid for by UNICEF. In Nicaragua, the collaboration between UNICEF and PAHO/AMRO as joint executing agencies for SIDA funded project has built on the strengths of the two parties.

Experience to date indicates that this operation has functioned well. The same refers to the role of the two agencies in the ICC for Immunisation programme. However, in other countries the "operational culture" of UNICEF and the "technical culture" of WHO has not always been compatible. In Haiti while both UNICEF and WHO have developed mutually acceptable arrangements for avoiding duplication, they are both still operating in the same areas - immunisation and nutrition for example - which does not appear to build on their comparative advantages. The arrangements established in Cambodia to the drug sector and immunisation activities still reflect some tension, in spite of formal joint meetings to agree on the divisions of tasks and roles.

This Study did not examine UNAIDS in depth. However, through interviews with a wide range of organisations it became clear that, in all the case studies, there were gaps and problems in relation to the transition phase from GPA to UNAIDS. UNAIDS was established in January 1996, to coordinate and facilitate the HIV/AIDS activities of six cosponsoring organisations. While theme groups have been established, during the country visits they were commonly referred to as places of words rather than action. Donors are seen to be waiting for each other before country funds are allocated through their regular agency procedures.

UNAIDS' new operational style of facilitating, coordinating, monitoring and guiding rather than funding is generally respected. However, the apparent lack of attention to the transition phase has caused concern among government officials, health care providers and other partners at the country level. A broad range of interviewees in the case studies noted critical set backs and discontinuity in the national strategies for prevention and care of AIDS, and that motivation was low and energy drained from the system. Responsibility to ensure action, is delegated to the chair of the them group. This is often the WR, who needs to depend on other partners for resources and feels limited without authority over finances. This theme group mechanism and delegated authority, is operating within a complex policy environment. In the early operational phase, as observed during this study, it was found to be vulnerable in terms of mobilising resources, initiating action and ensuring progress. However, since the visits for this study (late 1996), progress has been reported by the UNAIDS' Executive Director to the Programme Coordinating Board (April 1997). Then it was noted that harmonised and coordinated UN action on AIDS through the Theme Groups was resulting in more effective support to countries.⁹ The report of the Executive Director also highlights that effective functioning requires not only commitment from sponsors, but also resources.

The situation found at the time of the case studies can partly be explained by some sense of loss over the GPA instruments and close ties to WHO and National Aids Programmes/MoH, and partly by the time factor. The greater concern is, however, that in the largely donor driven reform from GPA to UNAIDS, not enough attention was given to operational issues and realities at the country level, and not enough commitment was given in terms of country level financial allocations from the agencies concerned

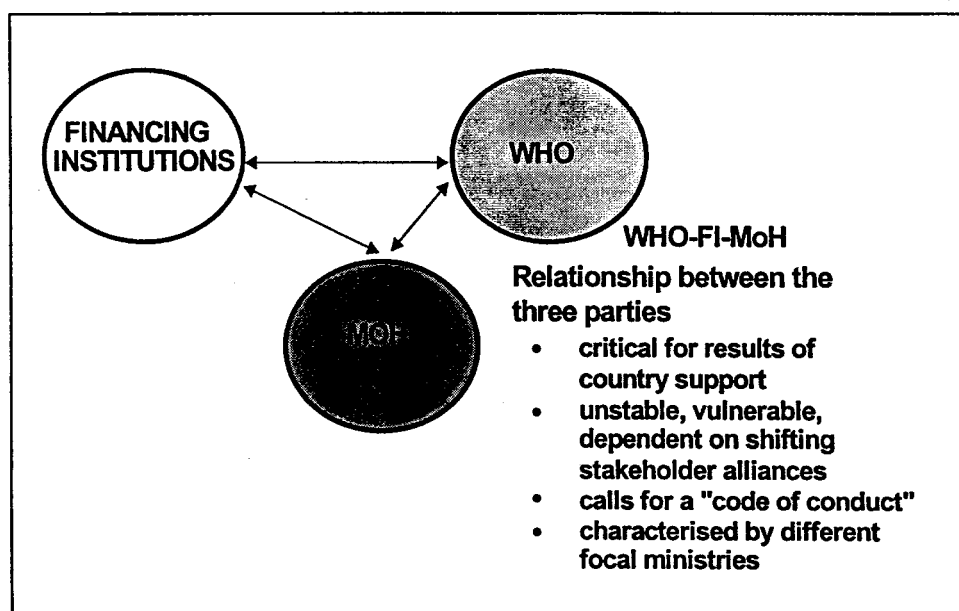
WHO and the Development Banks

Far the most significant of all the development banks in terms of both funding and policy influence is the World Bank. The World Bank has increased its loans to social sector

substantially during recent years (around US\$2.3 billion of new commitments in 1996). The leadership of WHO (HQ level) and the WB has developed a specific collaborative framework for support of each country's health development. The conceptual thrust of such collaboration is to combine the Bank's resources, particularly financial, with WHO's policy guidance and technical expertise and its privileged entry point for interaction with the MoHs in member states. While these consultations have led to a situation where increasingly WB financed development projects in countries are said to come in line with member states' priority needs and the policy directions set out by WHA,¹⁰ the results from the field visits in the case studies indicate that in many of these countries, much is left to be translated from intention to practice.

In the case studies, the World Bank has either been engaged for some time or is in the negotiating phase (Ethiopia) for sector lending. Loans are usually of considerable size and in most countries the WB becomes the major contributor to the health sector (Thailand is an exception). This puts the WB in a situation where it can influence policy through funding, regardless of advice from WHO, pending the interest of the government. The fact that the WB loan negotiations are conducted with ministries other than the MoH, may increase conflicting views and policy directions for the country concerned.

Figure 6.3 WHO and the Multilateral Financing Institutions



The case studies provide examples of where WB and WHO have a established good working relationship at a technical/planning level (Cambodia, PNG, Mali, Ecuador; and Nicaragua; especially in the drug sector). In other cases WHO is being used by the WB as executing agency. However, in terms of policy advice, a number of inhibiting factors were identified. In Nicaragua, a decision to work together in providing support to the new government in policy development, was jeopardised by a WB mission developing its own priorities together with the MoH as basis for future health sector support. In Ecuador a coordinating committee for health sector reform included all major stakeholders including WB, instituted by the previous government with WHO in the lead. However, in the transition to a new government, WB created alliances within the

Ministry separate from this mechanism. Planning for the new Sector Investment Programme (SIP) in Ethiopia has the WB in the lead, but no special role for WHO and the other UN agencies, although they participate in the programming activities along with bilateral donor agencies. Other countries provide examples of WHO participation in annual supervision missions of WB sector programmes, such as in Mozambique and in Tanzania. In Nicaragua the Institute for Water and Aqueducts indicated that they valued PAHO/AMRO's influence with both WB and IDB on policy and investment in the water sector.

As a follow up of the World Development Report, 1993, the World Bank established a new programme for "Better Health in Africa" (BHA). The BHA secretariat, located in Washington, coordinates the work of an expert panel whose activities focus mainly on the mobilisation of the civil society in support of health reform in Africa. At its 45th meeting in September 1995, the WHO Regional Committee for Africa passed a resolution (AFR/RC45/R9) endorsing "Better health in Africa" as a framework for action for health reform at country level. It urged the regional director to continue the active engagement of WHO on health reform and the work of the Better health in Africa Expert Panel. In taking the programme forward, some strains in the relationship between AFRO and the BHA has developed, mainly related to issues of ownership and channels of communication.

In those countries where WHO currently has a lead role in the health sector, the WB was identified as a potential threat. In such a setting, ad hoc relationships depending on personal loyalties and interests do not create a sufficient platform for joint action towards strengthening national capacity. There is a need for establishing more clearly country-specific contracts between the key partners for a given period of time, spelling out mutual commitments to a "code of conduct" including policy dialogue, information sharing and to expect commitment and accountability from each party even though the persons involved may change. Given the complexity and the sensitivity of the policy environment in health, such a "contract" between MoH, WB (along with regional banks if involved) and WHO may be as important as the UN collaboration based on the CSN.

The Regional Banks are also increasingly involved in the social sector and in health sector reform and policy issues. The regional banks were present as actors in the health sector in many of the case studies. An exception was the African Development Bank which hardly had a health presence in the AFRO case studies. In the Americas, it was found that the person responsible for country operations in the Interamerican Development Bank in one of the case studies had limited (if any) knowledge about PAHO/AMRO activities in the country. Several examples were given from SEARO and WPRO of WHO's participation in Asian Development Bank workshops and missions for policy and programme development and project formulation (PNG, Cambodia and Bangladesh).

In the Americas, consultations and negotiations are sometimes held between the WB, IDB and PAHO/AMRO. A joint process on Health Sector Reform was undertaken during 1995 and 1996 in order to agree on a common understanding of the issues involved. While these consultations are held with high level people in the central offices, it seems difficult to translate policy agreements into action at country level.

The Asian Development Bank appears to have less regular contacts with SEARO and WPRO regional staff than was the case for the Americas, and very limited contact was found between AFRO and the African Development Bank. Most of the interaction between the financing institutions and WHO in WPRO and SEARO countries appear to take place at the country level.

WHO and bilateral agencies

As shown in Table 2.1 (page 13) the countries have a wide range of bilateral partners in health development, however different in mix and numbers from country to country. Bilateral donors in the AFRO and WPRO countries appear to engage themselves more heavily in operational activities than may be the case in the PAHO/AMRO countries. In two countries in Africa, Mozambique and Tanzania, a bilateral donor is regarded as the lead agency in the coordination of health sector support.

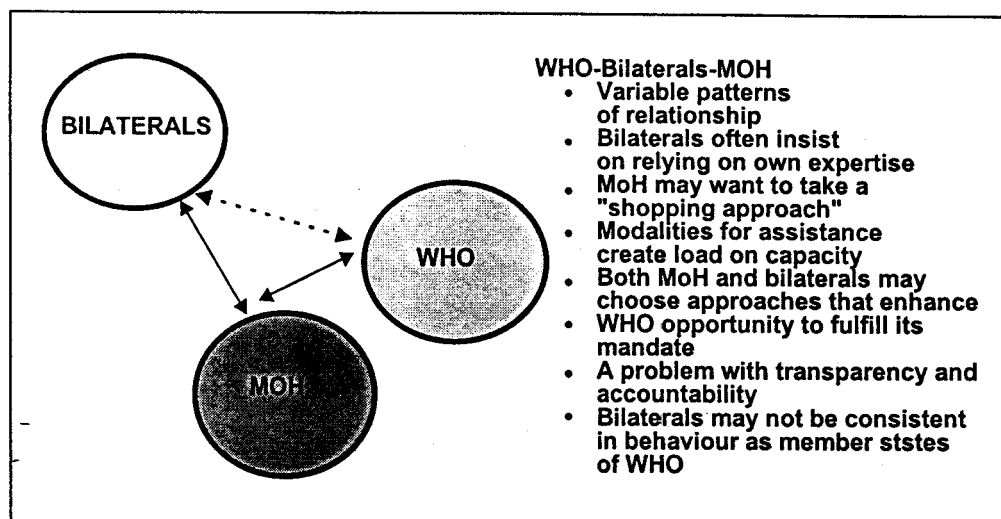
The major external financial contributors of grant money to national health systems are often the bilaterals. How far the WHOCO relates to these players is complex, and is highly influenced by the political and economic context. There are examples in these case studies where the WHOCO clearly has a facilitating role as broker or negotiator. In PNG, MoH is concerned about the feasibility of certain policies promoted by a bilateral donor and makes use of WHO in the dialogue. In Ecuador, WHO is assisting in the negotiations between the MoH and other national health institutions. Much depends on the culture of the bilaterals and other donors, and their historical relationship with the country in question. The relatively independent stance and skills of the WHOCO is paramount in defining its role. In the Bangladeshi situation, with its plethora of donors, strongly led by the World Bank, the CO is highly limited in its relationship with the MoH which has its eyes firmly on the Consortium, and values WHO largely in its executing agency role.

In their development cooperation activities, bilaterals are seen as more unpredictable than the UN agencies in general and WHO in particular (Figure 6.4). They often have their own special interests, which shift according to prevailing trends and political/economic circumstances. A UK agency such as DfID (ex ODA) will often be found engaged in reform issues, USAid largely interested in family welfare, nutrition, population and the private sector, the Dutch and DANIDA in drugs and immunisation, and the Scandinavian agencies interested in gender and reproductive health. It is also often the case that bilateral donors have their special countries to concentrate assistance, leading to a situation where, for instance, it is more difficult to generate support for drug programmes in West Africa than in East Africa.

Bilateral donors who are 'like minded' often establish mechanisms for collaboration, and this together with their financial strength, gives them special influence on sector policies and the balance of sector development. Often the difficulty of overlapping activities and interests stand out as more difficult to deal with for health authorities than the issue of overlap among UN agencies. Some areas with heavy donor interest, such as reproductive health, may be over-subscribed. Planning and reporting procedures, planning cycles and information requirements are different and often demand separate actions from the

country concerned, causing a heavy load on systems with strained capacity. Eagerness in producing results in a defined area may lead to a high degree of donor-implementation, sometimes without the necessary attention to building sustainable national capacity.

Figure 6.4 WHO and Bilaterals



Bilaterals may or may not use WHOCO for advice in their programming and monitoring of country level activities. They tend to shop around and use their own consultants, both for project preparation and implementation. Several of the bilaterals visited during the country studies noted that they did not see WHO as a resource of excellence, and that they were more likely to call on their own expertise than to call on the WHOCO. In situations of conflicting views between the "WHO global advice" and the bilateral expert, donor agencies tended to put more trust in their own experts views and perceptions. However, there were clear exceptions from this general description. Some agencies were particularly sensitive that in some areas WHO would be in a better position for specific advice and development, and had been in contact with WHO in order to negotiate collaborative arrangements.

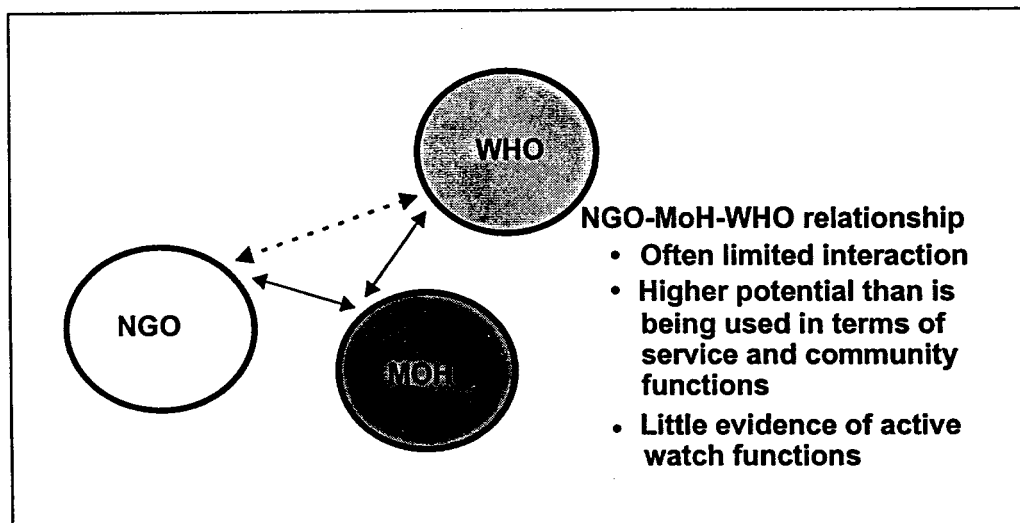
Most of the bilateral agencies with their own in-Country Offices related to health sector development and policy dialogue through generalist aid bureaucrats, which on the one hand made them dependent on the expert advice they received, and on the other hand put them in a position where their ability to engage in health sector policy dialogue did not match the financial investment in the sector. It appears obvious that in some of the countries with heavy external bilateral support, it would be in everybody's interest to have access to a credible, neutral technical resource of expertise at the country level, such as WHO. As it now is, WHO is being watched and assessed by the bilaterals, but not appropriately used by them, either for core support, nor for strategic partnerships or advice. This, together with deficiencies within the WHO system itself creates a vicious circle, which is most evident in the AFRO countries, in none of which was WHO taking a lead role.

WHO and the NGO's

In most countries, the links between the WHOCO and NGOs are relatively thin (although NGOs provide few financial resources to most countries, they are many and often provide a significant part of services, often in rural areas). Given the increasingly plural environment, WHOCOs may, at the very least, be missing opportunities for advocacy. The countries included in this study, show a difference between the regions. In PAHO/AMRO and WPRO, links towards both NGOs and academic institutions are more widely established than in AFRO and SEARO. Using the Immunisation Programme as an example, there has been an increase of NGOs as partners from 4 to 20 in the last few years in Nicaragua. Ecuador on the other hand, has few partners. As noted this is explained by a reluctance from the part of the NGOs to join hands with WHO as the organisation is considered to be too close to the government. There is very little evidence of forming partnerships with the private sector, although some small initiatives have been identified (Haiti, PNG, Thailand, Ecuador, Nicaragua). In Cambodia, there has been quite active collaboration between VSO and the WHOCO, and a number of other NGOs (including Medicine Sans Frontier, Pasteur Institute, ICRC, Health Unlimited). There is also a fairly active coordinating body of NGOs, Medicam, which does encourage a culture of collaboration with NGOs.

NGO's themselves indicated that WHO is largely interested in governmental activities, and do not reach out to interact with them in the way they would want (Figure 6.5). In most countries they did however confirm that guidelines, information and advice from the country office was available to them on request.

Figure 6.5 WHO and the NGOs



This low profile in nurturing relationships between WHO and the NGO community is of particular interest in a context where WHO makes a strong point of the need for closer collaboration in its policy statements. One of the situations given by WHO is to watch equity indicators and represent a corrective voice on issues pertaining to justice in health and human rights. At the international level the NGO community has stated its intention to participate constructively in this process. Little evidence was found that such collaboration had penetrated down to the country level, either by WHO or by the NGO community.

6.4 Country capacity for coordination of external support and WHO role in donor coordination

It is primarily the country itself that is responsible for coordinating and directing the external support to the health sector. WHO has therefore a role in contributing to countries' own capacities in terms of coordination. Table 6.1 summarises the country coordinating mechanisms in place in the various countries for donor coordination and the contribution of WHO. There are a few countries which may be characterised as having strong capacity for coordination of donors (Thailand, Cambodia, Mozambique, Nicaragua), although less for coordination and regulation of NGOs. In few cases could the Study Team establish some effect from WHOCO in terms of enhancing the MoH's own capacity for coordination (Cambodia being the exception).

Table 6.1 Country capacity for coordination of external assistance to the health sector, WHO's role and contributions.

Country	Country coordinating mechanisms	UN coordination	Theme/ Programme Coordination	NGO coordination	WHO role
Thailand SEARO <i>High Capacity Cluster</i>	Good MoH; WHO (co-chaired by Dep. PS Div. Int. Health) other donors through Dept. Tech. Cooperation	CSN developed but bears little weight, UNCEP developed by GOT/UNDP, WHO reluctant to endorse the plan.	UN Theme group on AIDS established.	?	WHO reluctant partner in UN initiatives.
Ecuador AMRO <i>High Capacity Cluster</i>	Weak. Fragmented health system. Difficult to establish locus of leadership. (IESS/MSP etc.). Difficult to establish effective coordination mechanisms. Division for External relations?	CSN internal draft developed. Several coordinated actions UN theme group on Aids. Wide collaboration in different programmes, Women's health, vaccination, micronutrients. However, indication of disjointed actions.	UNAIDS Theme group chaired by WHO Inter-agency committee on health sector reform (CIAR).	Weak coordination: 15 % has permanent relationship with MSP. NGOs very resistant to «control».	WHO chair CIAR. WHO has suggested possible mechanisms for improved coordination between state and non-state actors.
Nicaragua AMRO <i>High Capacity Cluster</i>	Relatively Good. Min. of External Cooperation and MoH directorate for External Cooperation. Need for more coordination in policy issues (Decentralisation)	Rather a UN position paper to present to new government. UN theme group on Aids.	UNAIDS Theme group	Through Dir. external cooperation. Weak (?)	UNAIDS Theme group chaired by WHO.
Tanzania AFRO <i>Medium Capacity Cluster</i>	Medium. Core donor group + MoH chaired by host. All donors meet 1-2/year. Chaired by MoH Health and Population Sector meet, not chaired by government, but by WHO.	Monthly meetings Country strategy note in process of being transformed into a GoT paper	Health an Population Sector Group Theme group on UNIDS SMI HSR Initiative		Chair of H&P group Coordinates and Chairs theme group on AIDS. Chair of negotiating group with government.
PNG WPRO <i>Medium Capacity Cluster</i>	Functional. Donors need approval from MoH/National Planning Office. but little formal coordination	UN heads meet monthly. CSN prepared. Various UN theme groups meet regularly Formal coll. meetings, UN organisation and AusAid	Coordination of AIDS activities in collaboration with AusAid.	Churches as strong partners, coordinated in umbrella organisation	Many meetings chaired by WHO between UN, bi- and multilateral organisation WHO influential in informal and formal donor coordination
Cameroon AFRO <i>Medium Capacity Cluster</i>	Weak. Min. of Ec. & Fin. Consultative Coordinating Group Health sector - none	Good. Twice monthly. Informal Coordinating UNICEF/WHO			Informal monthly donor coordination meetings initiated by WHO.
Haiti AMRO <i>Low Capacity Cluster</i>	Relatively weak, but in progress after the unrest. Recent established Forum of Donor agencies coordinated by MSPP. Transformation of coordination unit of donor agencies to a central division in MSPP reporting to DG.	Level of coordination good. Regular meetings, CSN in progress. WHO not enthusiastic.	UNAIDS chaired on rotation between UN organisation	Planning and External Cooperation currently developing norms to regulate NGO activity.	Previous Interagency committee chaired by WHO. The technical subcommittees of current FAS chaired by PAHO/AMRO, & is also supporting the establishment of the central coordination division.

Country	Country coordinating mechanisms	UN coordination	Theme/ Programme Coordination	NGO coordination	WHO role
Bangladesh SEARO Low Capacity Cluster	GOB external Relations Division in Min. WB used as a mechanism to coordinate.	UN have until recently operated separately. Now in the process of developing CSN.		Registered in NGO bureau. Relatively free to operate. New GOB-NGO coordinating committee established.	UNDP/UNICEF operate more on decentralised basis. WHO close tie to MoHFW considered to be hindering greater UN collaborations
Cambodia WPRO Low Capacity Cluster	Good, mechanisms for donor coordination, directed by MoH. WB did not want to join SHS steering committee	CSN pending UNDP: SHS project UNICEF: Drugs, EPI, Polio, Provincial advisors	UN technical Working group on AIDS	MEDICAM chaired by MoH	Influential in donor coordination as lead external support agency for health.
Ethiopia AFRO Low Capacity Cluster	Weak (no political will) Annual meeting on Family Health	Initiated work on CSN, Heads meet regularly. Cooperation on UN specific Initiative for Africa UNFPA/UNICEF on adolescent health	UN theme group on AIDS Theme group on RH HPN group	?	Theme groups chaired by WHO
Mali AFRO Low Capacity Cluster	Weak in health sector in general. Donor Round Tables Min. of Foreign Affairs. New framework in Min. for International Cooperation. Better coordination at project level.	GoM taken lead in developing CSN Head meet regular Well coordinated actions UNICEF/WHO	UN thematic group. WB supported PSPHR and investment programme well coordinated. Leprosy programme well coordinated with NGO/MoH	NGO coordination Unit in Min. of Territorial Adm. Umbrella Ass. for NGOs in health - meets regularly.	WHO not played a significant role (donor or NGO) Unresponsive to specific requests from NGOs. Contributed to development of new framework (MIC). Chair UN thematic group.
Mozambique AFRO Low Capacity Cluster	Good. MoH drafted strategy for cooperation. FORUM for donors in health sector, chaired by MoH: Donors General meeting Donor Focal point established Pooling agreements. Still lack of capacity in MoH for implementation.	CSN developed, but not followed-up. Regular meetings Discussions with MoH about priorities in relation to UN Special Initiative on Africa UNICEF/WHO has various working links.	UN theme group on AIDS Community Health Group Joint auditing of donor supported programmes	Weak Efforts to coordinate NGOs, but difficult after mushrooming during the emergency.	WHO starting to take part in collaboration - now chairing Com. Health group. No significant contribution during study period.

One of the ways in which the WHOCO can support the MoH is through helping to coordinate all the different inputs into the health system to provide a coherent and comprehensive health policy: collect, synthesise and analyse information on all donors: their financial and HR inputs, locations, project objectives and timeframes. This information can assist MoH in planning to identify gaps and avoid overlaps.

All twelve countries have experimented with formal ways of coordinating the activities of the various actors in the health sector. The WHOCO seldom takes the lead in formal coordination mechanisms. The most prominent coordination mechanism is the consortium of donors in Bangladesh, which evolved out of project co-financing. Chaired by the World Bank, it includes almost all the health sector donors (not USAid or the Asian Development Bank), has a Secretariat and meets regularly both with the MoH as well as with all the donors. WHO, along with other multilaterals, plays a minimal role in the Consortium. In many countries (Tanzania, Mali, Cameroon, Ethiopia, Papua New Guinea) it is the donors who initiate coordination meetings. In some of these countries, the WHOCO has brought the donors together, where efforts to get the MoH to take the lead have failed. In others, the WHOCO has failed to capitalise on a leadership vacuum (Mali). In Thailand's growing economy, external agencies play a minimal part in the health sector, so the need for coordination is less. The WHOCO interacts only with the

MoH, other agencies being coordinated through the Department of Technical and Economic Cooperation

The political context influences coordination measures. In Haiti, during the emergency, the WHOCO coordinated all efforts in the health sector, including the delivery of services. Once the emergency was over, the MoH gradually began to take over, but the frequency of inter-agency coordination meetings decreased. In Cambodia, as donors started to arrive in the country when peace was being established, the WHOCO played a key role in supporting the MoH to coordinate the influx. The consensus of collaboration and coordination of the early post-conflict years is, however, now on the decline and WHO's lead role in the health sector is being challenged by other partners.

Coordination efforts are not confined to the national health sector level. There is evidence in the case studies that the WHOCO may play an active role in project coordination (Mali, Tanzania, Mozambique, Ethiopia, Papua New Guinea) or in coordination at decentralised, sub-national level (Ecuador, Nicaragua, Cambodia).

Inter-agency Coordination Committees (ICC) for National Immunisation Programmes have been established at regional (AFRO/WPRO), subregional and country level (seven out of twelve countries). WHO plays a key role in these, in some countries as secretariat in others as coordinator or member. The ICC have been instrumental to the coordination of resource mobilisation, planning and implementation. In some countries, NGOs also participate and in Nicaragua, the IDB does.

More recently there has been a growing international attention to coordinated, sector wide approaches in national health development. A main concern in the debate has been the need for stronger national ownership and commitment, the need for more concerted external support efforts and improved results of investments in health development. To this end, the WB has developed its concept for Sectoral Investment Programmes (SIP), while a number of country initiatives taking a similar direction have emerged with initial support from bilaterals, such as in Mozambique. Ethiopia has engaged in developing a SIP with the WB as the lead external agency.

The approach have many promising elements which will make donor coordination to a necessity and not an option. It also poses new challenges for WHO and the need for new interpretation of what it means to be in the role of technical expert, neutral broker and enabler in this new policy environment, without the clout of the money and with many competing interests. Rather than make general statements and assumptions on the basis of a mandate to direct and coordinate international health, WHO has to actively construct its role within each country in dialogue with the MoH and the other partners. If it is seen as irrelevant to the MoH and the other donors, this will have consequences for the nature of presence of WHO in the country which should be taken seriously. It is hard to perceive an effective WHOCO in a country with a SIP that covers most of the external investment into the health sector, if WHO is marginalised in the policy dialogue relating to the SIP.

6.5 WHO as an executing agency

WHO frequently takes on the role as an executing agency. As it has not been possible for the Study team to find references to a WHO-specific definition of an executing agency role, it is for the purpose of this study used for two types of collaboration:

- where WHO is asked to have executing responsibilities for a project developed, negotiated and «owned» by another external agency
- where WHO together with one or several other agencies undertake joint planning and negotiations for a project, with joint ownership, and WHO is asked to carry executing responsibilities on behalf of the parties.

This is to make a distinction from situations where a project initiative is developed by WHO in response to a need established by MoH, and where WHO is able to secure funding partnerships for the project while the ownership and overall responsibility remains with WHO.

The WR in each of the countries was asked to list all projects where they themselves defined their role as an executing agent. The role they have taken on ranges from administering projects on behalf of other donors, for the MoH, or actually implementing projects with resources from other donors. In Bangladesh it seems that the WHOCO's *raison d'être* is largely as executing agency for World Bank projects, which it administers for the MoH. Grouped under the four WHO case studies, Table 6.2 shows that most of the projects fall into Health Services Development and Integrated Control of Disease.

Not all projects where the two-pronged study definition is applicable, were listed by the WR's as projects where WHO has an executing role. For example, the major project for strengthening health service development in Cambodia was not mentioned, probably because it was seen as a WHO operation with EBF support. This project is the most visible component of the whole WHO collaborative programme in Cambodia. Formally it is a joint project owned by DfID/UNDP and WHO in partnership, and with WHO in the executing role. The DfID (ex ODA) recruited team leader has a WHO contract. The project gives WHO a strong entry point to the whole arena of reform and policy development, which is respected by all parties. Yet there is some confusion in the donor community as to its identity, whether it is DfID that uses WHO as a platform, or it is WHO that makes optimal use of DfID collaboration.

Whatever this may be, it illustrates some of the issues involved in the role of being an executing agency. It needs to be very clear to all the parties what the role implies, who the stakeholders are and who holds the overall control. WHO should only be involved in such projects where the benefit of its specificity is obvious to all partners in health development. And it should be projects where WHO's neutrality and technical integrity as a policy adviser are used, not jeopardised. WHO should avoid taking on project execution just to expand the project portfolio, to fill gaps in MoH administrative capacity or to work on behalf of bilateral donors where it is seen convenient.

Table 6.2 Projects for which WHO was an executing agency on behalf of other donors, 1992 - 1995

Country	Donor	Type of project ¹¹	Project budget ¹²
Bangladesh	IDA (6)	ICD, PPH, ICD, ICD, HSD,	8,000,000
	IDA/Australia	ICD	335,000
	IDA/UK (2)	Hpol	1,100,000
	Canada (2)	ICD, HSD	3,500,000
	UK	HSD, HSD	272,000
	Norway (2)	HSD	13,400,000
	Sweden/Norway (2)	HSD, HSD, HSD, HSD	559,000
Cambodia	UK (2)	ICD	490,000
	France	HSD	140,000
Cameroon	UNFPA	HSD	457,000
	WB	PPH	2,000,000
Ecuador	ECHO	HSD	420,000
	OFDA/UK	HSD	n/a
	Netherlands (3)	HSD, HSD, PPH	1,000,000
	Canada	HSD	60,000
	DMT	HSD	n/a
	Spain	HSD	1,500,000
	UNICEF/WB/USAID	PPH	4,000,000
	WB (2)	HSD, HSD	8,000,000
	BIRF	HSD	102,000,000
Ethiopia	UNDP (2)	HSD, HSD	237,000
	Netherlands (4)	ICD, ICD, ICD, HSD	3,000,000
	Italy (2)	ICD, ICD	653,000
	Canada	ICD	423,000
	Norway,	ICD	344,000
	Sweden	Hpol	199,000
	USA	HSD	1,000,000
Haiti	Canada	ICD	575,000
	UNFPA	HSD	203,000
	USAID/UNFPA/UNDP	HSD	n/a
	UNDP	ICD	1,000,000
Mali	UNDP (3)	HSD	10,000,000
	UNFPA	HSD	118,000
Mozambique	None		
Nicaragua	USA	ICD	2,800,000
	Canada	HSD	327,000
	Swiss/France/UNICEF	PPH	96,000
	Denmark	HSD, HSD, HSD, HSD	1,700,000
	UK	HSD (emergency)	106,000
	Sweden/Switzerland/France/	PPH	30,000
	UNICEF	HSD, PPH, HPM	4,500,000
	Sweden (3)	ICD	215,000
	Sweden/Finland	PPH	106,000
	Sweden/Norway		
Papua New Guinea	UNFPA	HSD/PPH	twelve3,000
	JSIF	ICD	153,000
Tanzania	Canada (IDRC)	HSD	170,000
	Denmark	HSD	n/a
Thailand	None		

Source: Tables A.4.3. Collaborative Programme Outputs: Project execution for other agencies, 1992-1995, WHO Country Office Collection Instrument

If each project actually being executed by WHO is assessed as to whether it is an appropriate role for WHO, according to the criteria just discussed, the findings of the study are mixed. There are a number of the projects where there is no other substantial

argument for WHO as an executing agency than a shortage of capacity in the MoH. The range of activities as well as relatively large financial resources available make heavy demands on administrative capacity. If the MoH lacks capacity for projects administration and implementation, the WHOCO can offer managerial and administrative support as well as technical and knowledge-based skills to support implementation. Yet this may not be the best use of WHO's presence in the country.

Table 6.3 gives an overview of WHO's role and relationships as an executing agency in the case studies. Although WHO has high activity as executing agency in some low capacity countries (Mali and Bangladesh), there are more countries with a higher capacity in which the WHOCO still executes projects (Nicaragua, Ecuador). PAHO/AMRO countries are more active as executors than the other regions. One of the contrasts between the countries in AFRO and PAHO/AMRO is that the former have smaller WHOCOs with fewer staff, and one could argue that that AFRO's possibility in taking an active role in execution is therefore limited.

Table 6.3 WHO as an executing agency

Country and Region	Executing Agency	Main collaborative partner	Areas of support	Comments
Thailand SEARO	None			Did have a role as executing agency in the past.
Ecuador AMRO	High	World Bank, Netherlands (3) ECHO, OFDA/USAID	Key administrative role, Essential drugs. Capacity in Disaster Management, Gender, quality of services and Violence, Drinking water, Cholera control, strengthening basic services, micro-nutrients.	Hamper effectiveness in supporting policy coordination and reform, having key staff in ministry on WHO pay role.
Nicaragua AMRO	High	Sweden, USAid, Denmark, Canada, UK, Finland, Norway, Swiss, France	Decentralisation (SILAIS), planning and implementation of EPI, Strengthening Prenatal health services, Human resource development, Information dissemination, Disaster Management, Nutrition, Water, Infectious disease control, Women/Violence.	Donors value highly the WHO implementation capacity. Taking the responsibility of the government which may already have the capacity to implement. Loss of «neutral» strategic position or give grater credence to expertise for support to national policy development.
PNG WPRO	Low	UNFPA, JSIH	DHS, staff support, fellowship, drugs, supervision.	Will continue and link into PNG P&FPP jointly funded by WB, ADH, AusAid
Tanzania AFRO	Low	Canada	Coordination of pilot project on Health policy	
Cameroon AFRO	Medium	UNFPA, World Bank	Commodity supply, training	Execution functions for WB under planning
Haiti AMRO	High	UNDP, UNFPA, USAid, Canada (?)	Training in RII	Highly efficient
Cambodia WPRO	Low	UK (2), France		The joint UNDP/DfID/WHO SHS project not included
Bangladesh SEARO	High	World Bank Consortium projects under FHP2 funded by Australia, Canada, UK, Norway, Sweden	Fellowships and training. Commodity supplies	21 out of 66 separate projects of FHP2 executed by WHO. Perhaps too much reliance on intermediary organisations for implementation which could have been placed on the GOB. Slowness of administrative procedures...
Ethiopia AFRO	Medium	Netherlands, USAid, Italy, Canada, Norway	In term of numbers of collaborators/projects Disease Control dominating. In terms of funds: repair of health facilities.	UNFPA has found the administrative processes unsatisfactory.
Mali AFRO	High	UNDP (3), UNFPA		Low level of project implementation. slowness of admin. procedures, difficulty. obtaining financial information
Mozambique AFRO	Low	Norway	Ministry of Health Donor coordination capacity	Has not been able to implement the project.

The experience with WHO as an executing agency in terms of efficiency and effectiveness has been mixed. In Nicaragua, Ecuador and Haiti the WHOCO have had long and reasonably successful histories of project execution, which are highly valued by the donors funding the projects and by the MoH. In some other countries (Mali, Cameroon, Mozambique) donors were critical of their experience in using WHO as an executing agency because of slow or inadequate procedures and low level of project implementation. The reason for low performance in Africa was as much related to problems in AFRO as in the individual countries.

Arguments that were raised from other partners questioning the relevance of WHO's role as an executing agency included:

- It might potentially undermine MoH capacity, especially where higher salaries are paid by the WHOCO
- It might make the organisation an interestholder rather than a neutral player limiting the organisation from being able to play the role of supporting the MoH in developing norms, guidelines and models. This was especially pointed out in relation to the SILAIS project in Nicaragua

On the other hand:

- Involvement in operational support through executing (and implementing) projects might provide experience and opportunity for WHO to provide more appropriate and relevant support to MoH in developing norms etc.
- If the role as an executing agency was successfully implemented, WHOCO staff contend that it gives greater credence to their expertise.

The special situation of the donor consortium in Bangladesh raises additional questions, such as whether there ought to be a limit on the overall volume and number of activities executed by WHO in any given situation, and how such a limit should be established. It is important that WHO keeps to its specificity within such a collaboration, and that the other partners respect and support the role of WHO as a technical expert and policy adviser and not a funder or a development agency. It is the opinion of the Study Team that in the current context of Bangladesh, WHO has lost its potential to represent a corrective voice in policy dialogue and be a neutral broker in a rather complex stakeholder interaction.

A definite criterium for taking on executing functions, should in all situations, be a clearly established need for the particular expertise of WHO, which is recognised and supported by all parties involved. In addition, WHO should only be an executing agency for projects which are in line with WHO global policies and best practice, and where WHO has participated fully and independently in policy dialogue related to the project design and implementation.

6.6 Summary of main issues: WHO Linkages and Partners

1. The concept of partnership has been on the WHO agenda since the mid 1980s, and there are a number of policy statements at global and regional levels that underpin WHO's work with government ministries other than health, other UN organisations, NGOs, academic institutions and private enterprise.
2. The functionality of WHO relationships depends on the one hand, on the capacity of the WR and the WHO systems' ability to respond, and on the other hand, on MoH ability and interest in using WHO as a close ally and privileged partner in health development.
3. In all twelve case studies the MoH is the main public institution responsible for health policy and service delivery, though there were also WHO contacts with other ministries, third party payers and the private. WHO is seen to be in a strategic position in terms of communication and influence with the MoH, which is generally valued by other partners in the health sector. There needs to be a change in collaborative relationships at all levels, moving from the exclusivity with MoH to including partnerships with other actors, and guaranteeing greater accountability between such actors, perhaps through the use of codes of conduct or contracts of partnership.
4. The Country Strategy Note (CSN) as an effort to establish an overall development cooperation framework for the UN inputs to countries was found to have limited usefulness. Five of the case studies had developed a CSN and others were in the process of developing them. In some countries the process has involved the government and in others not. Several countries complained that the different UN organisations operate with separate and sometimes conflicting strategies for health sector support, but did not see the CSN as a valuable tool.
5. There are a number of examples in the case studies, of other attempts by agencies within the UN system to coordinate activities such as: in major emergency situations (Haiti and Mozambique), on particular health issues (AIDS) and for particular regions (The Special Initiative on Africa). In some countries, UNICEF and WHO seem to draw on each others strengths and financial abilities, but in other countries the "operational culture" of UNICEF and the "technical culture" of WHO has not always been compatible. All the case studies reported gaps and problems in relation to the transition from GPA to UNAIDS, particularly with regard to the lack of mechanism to identify who should accept responsibility.
6. The World Bank is the most significant of the development banks, having increased its loans to the social sector to US\$2.3 billion of new commitments in 1996. WHOHQ and the WB have developed a collaborative framework to support country health development, combining the Bank's financial resources, with WHO's policy guidance, technical expertise and privileged interaction with MoHs. However, translation of these high level intentions into practice at country level was not evident in many of the case studies. WB loans form major contributions to the health sector placing the Bank in a position to influence policy through what is funded, regardless of advice from WHO. The case studies provide examples of where WB and WHO

have a established good working relationships, but also where the Bank works without any reference to WHO. In countries where WHO currently has a lead role in the health sector, the WB was identified as a potential threat to that position.

7. Bilaterals are often major external financial contributors to national health systems. There are examples in these case studies where the WHOCO plays a facilitating role as broker or negotiator between MoH and bilateral donors. However, several of the bilaterals stated that they did not see WHOCO as a resource of excellence, and that they were more likely to call on their own expertise. WHO is being watched and assessed by the bilaterals, but not always used by them for core support, strategic partnerships or advice.
8. WHOCOs have a low profile in nurturing relationships between WHO and the NGO community, but links are more widely established in PAHO/AMRO and WPRO case studies than in AFRO and SEARO. NGO's commonly perceive WHO as associated with government and not interested in developing relationships with nongovernment sectors. However NGOs do use and appreciate WHO guidelines, information and advice from the WHOCO. One area where WHO may want to nurture a stronger relationship with NGOs in the future is with regard to monitoring equity indicators and providing a corrective voice on justice and human rights in health. However, little evidence of such engagement and interaction at the country level was found at the time of the country case studies.
9. All twelve countries have experimented with formal ways of coordinating the activities of the various actors in the health sector. The WHOCO seldom takes the lead in these formal coordination mechanisms.
10. WHO frequently takes on the role as an executing agency ranging from administering to actually implementing projects with resources from other donors. As would be expected, WHO has high activity as executing agency in some low capacity countries (Mali and Bangladesh). However there are more countries of higher capacity in which the WHOCO still executes projects (Nicaragua, Ecuador). This would appear to be beyond the needs of those countries, and contrary to WHO's stated policies of capacity building and focusing effort to countries in greatest need. The dilemma is that the experience with WHO as an executing agency, in terms of efficiency and effectiveness, has been positive in higher capacity countries and certain regions (Nicaragua, Ecuador, Haiti and Cambodia), but less positive in lower capacity countries and other regions: (Mali, Cameroon, Mozambique) where donors were critical of WHO procedures and low level of project implementation.

Endnotes: Chapter 6.

- ¹ GPC/twelve.2 Rev.1 Review of WHO's Mission and functions.3. July 1996
- ² WHA34.24 The meaning of WHO's international health work through coordination and technical cooperation.
- ³ WHO Global Partnerships Initiatives for Health Development, WHO, Geneva 1997
- ⁴ The fundamental concepts and principles governing the Resident Coordinator system are extracted from UNGA resolutions 44/211, 47/199 and 50/120, United Nations (1997) A Guidelines for the UN Resident Coordinator System. Primary Health Care within the Basic Social Services. Draft. 13 January 1997.
- ⁵ WHO EB99/35: Collaboration with nongovernmental organisations: Review of overall policy in collaboration with nongovernmental organisations (1994 -96) Report by D-G 2. December 1996
- ⁶ PAHO/Regional Office of the WHO: Strategic and Programmatic orientations 1995 - 1998. "Health for All and by All"
- ⁷ A 50/16 Collaboration within the United Nations System and with other intergovernmental organisation. General matters. Report by the D-G
- ⁸ Iniciativa de la Salud de America Central (ISCA - Central American Health Initiative
- ⁹ Speech of the Executive Director to the UNAIDS Programme Coordinating Board, 7 April 1997
- ¹⁰ A 50/16 Collaboration within the United Nations System and with other intergovernmental organisation. General matters. Report by the DG
- ¹¹ - Project types are grouped in WHO's case studies: Health Policy and Management (HPM); Health Services Development (HSD); Promotion and Protection of Health (PPH); Integrated Control of Disease (ICD). Since these often overlap, the above groupings may be subject to correction. Project budgets are rounded up or down to give approximate totals, and cover all projects funded by the external donor over the period 1992-1995
- ¹² Project budgets are rounded up or down to give approximate totals, and cover all projects funded by the external donor over the period 1992-1995

Chapter 7: ACHIEVEMENTS AND CONSTRAINTS

7.1 Introduction

This chapter assesses the performance of WHO in its support to countries, on the basis of findings described in the preceding chapters. In exploring achievements and constraints, the Study Team used a series of questions to guide their assessment, as shown in Box 7.1.

Box 7.1 Assessing WHO

1. Is there a discrepancy between WHO's mandate and its ability to direct and coordinate international health work at the country level?
2. Does WHO carry sufficient weight to promote common global goals such as equity at the country level?
3. Is the relationship between the national government and its role as a member state well understood and facilitated by the WHO Country Office?
4. Are there tensions between support for health systems development and technical disease interventions at country level?
5. Have the WHOCOs been able to adapt to contextual changes in country?
6. Are skills that were once unique to WHO now more widely available at the country level?
7. Are there barriers to effective collaboration where there are many actors in a country's health system?
8. Is WHOCO effectiveness largely determined by support from the Regional Office?
9. Is WHO well enough structured and equipped for dealing with inter-country activities in a proactive way?

After examining these questions, broad conclusions are drawn in relation to the issues presented in the Terms of Reference, categorised into the four key areas as put forth in the Inception Report:

- i) WHO's mandate and role
- ii) WHO structures and processes
- iii) WHO programmes and activities
- iv) WHO and other partners in health development

7.2. WHO's leadership in international health work

The concept of WHO as a lead agency in international health work is basic to the constitutional mandate of the Organisation. The constitutional function of acting as the directing and coordinating authority on international health work has repeatedly been interpreted by the WHO Governing Bodies to extend also to technical cooperation with its member states at the national level, and to include facilitating collaboration among them. In May 1981 the Health Assembly¹ "Reiterates that WHO's unique constitutional role in international health work *comprises in essence the inseparable and mutually supportive functions* of acting as the directing and coordinating authority on international health work and ensuring technical cooperation between WHO and its Member States...making *no distinction between these integral functions* carried out at country, regional and global levels."

As noted in section 6.4 (page 113), this Study discusses whether WHO is perceived as a leading partner among external actors in health development. By raising this question the purpose is not to state that WHO ought to be the leader, but rather to record how the situation is perceived at the country level in the case studies. Asking the question has in itself revealed lack of clarity and diverging opinions among partners as to whether or not WHO should have a role as a privileged partner or lead among external actors at the country level. To take this discussion further is a challenge which ought to be picked up by the appropriate global bodies, in order to reach some agreement on how WHO's constitutional mandate should be interpreted and implemented in the current health development context.

The findings of this Study, as presented in the country case studies and synthesised in previous chapters of this report, highlight that there is no uniform understanding of what such a "lead agency" role entails. It is open to different interpretations by WHO itself, national institutions and other external partners and is often left vague and ambiguous. The Study Team therefore focused on two questions regarding WHO's overall role: its ability to carry out directing and coordinating functions in international health work at the country level and its ability to promote common global goals such as equity.

As is clear from Table 7.1, the Study Team found a major difference between AFRO and the other regions. In none of the five case studies in AFRO was WHO perceived as the lead agency. In contrast, the three PAHO/AMRO case studies and the two WPRO case studies all showed WHO in a lead position. The two SEARO case studies were both special cases, Bangladesh being a country with a large and dominant donor consortium, and Thailand a country where no external partner is competing for the lead role.

Table 7.1 WHO's leadership role

Country	Region	<i>Is there a discrepancy between WHO's mandate and its ability to direct and coordinate international health work at the country level?</i>
Thailand	SEARO	Confirmed. Also in terms of resources
Bangladesh	SEARO	Confirmed. WHO is marginalised
Ecuador	PAHO	Not confirmed. Depends heavily on the MoH ability and willingness to use WHOCO for these purposes. Seems to have a stronger leadership/coordination role than any other UN organisation.
Nicaragua	PAHO	Not confirmed. Depends heavily on the MoH ability and willingness to use WHOCO for these purposes. Seems to have a stronger leadership/coordination role than any other UN organisation.
Haiti	PAHO	Not confirmed. WHO high profile during embargo period.
Cambodia	WPRO	Not confirmed. Fairly well placed in ability to perform according to mandate. Trusted by MoH.
PNG	WPRO	Not confirmed. Fairly well placed in ability to perform according to mandate. Trusted by MoH.
Cameroon	AFRO	Confirmed
Tanzania	AFRO	Confirmed. Has been a huge gap. Effort to reduce gap. Effort to close gap. Reorient/re-establish WHO.
Mozambique	AFRO	Confirmed
Ethiopia	AFRO	Confirmed. WHO is not given the opportunity and there is a lack of capacity to perform this role.
Mali	AFRO	Confirmed

The history of having had a dysfunctional WHOCO was noted as an important reason for a perceived low key and sometimes marginal presence of WHO, particularly in the AFRO case studies. Even though most of these countries currently had WRs who were seen to be performing well, they had all had to re-establish confidence with the MoH and other partner agencies and institutions. Unlike the other case studies, it was also noted that the MoH in the AFRO case studies (and in Bangladesh), did not consider that WHO ought to be seen as different from other donors to the health sector.

In some of the other case studies, even where WHO presently does not have a strong lead position, the Organisation is generally invited to participate in committees and working groups related to policy and planning, which provides a platform and overview for potential influence and engagement. Where the MoH does not even give WHO this opportunity to contribute in a regular and predictable way as a trusted partner in policy dialogue, or where WHO is not able to respond to such dialogue in a way that is recognised and valued by the MoH and other partners, it is doubtful whether keeping a presence through a WHOCO can be justified.

In most AFRO case studies, authorities were largely concerned with the need to expand WHO's role as a funding partner and less concerned with the skill mix of the WHOCO or with better access to WHO's global body of technical knowledge and expertise. In case studies in other regions, where WHO was perceived to be in a lead position, it generally did not have this position due to financial strength. The lead role had developed because the MoH saw WHO as a neutral broker and ally in directing, coordinating and negotiation with other partners. There were examples where other dominant donors challenged the MoH in taking this position, and did not easily accept being subjected to the policy advice given by MoH/WHO.

Across the regions (including AFRO) there were several examples of themes and programme areas where WHO clearly acted as the lead agency, such as efforts in poliomyelitis control (National Immunisation Day strategy) and malaria control. In contrast, none of the case studies had WHO in the lead for drug policies and systems. Other programme areas, such as those related to health policy and systems reform, showed marked regional differences. PAHO/AMRO and WPRO case studies had a high profile in health reform, with WHO in a lead partner role for support in this area.

In all the case studies WHO guidelines, technical norms and standards were acknowledged as being unrivalled, high quality resources, especially in the more technical areas such as disease control and drugs policy. In Tanzania, the WHOCO acknowledged that its value in collaboration lay largely in its ability to supply materials, guidelines and checklists for workshops or courses initiated and funded by others.

The Study finds that WHO's actual opportunity to function as a lead agency in a country is not primarily created by statements of the WHO Governing Bodies, but is constructed through formal and informal mechanisms for interaction and contest among stakeholders in health development within each country in a complex interplay of:

- WHO system related factors,
- the way MoH uses WHO

- the country specific mix of other external partners and their perception of what WHO's role is and ought to be.

The number of external partners may also itself be important, as well as their relative financial and political influence in the country concerned (whether there is an obvious "dominant donor" or not). Technical competence and capacity, responsiveness to perceived needs and financial leverage represent very significant factors. A basic condition for a lead function is that WHO must be able to recruit WRs with skills that provide the potential for the role as "neutral brokers", serving as respected communicators, facilitators and mediators, with access to a global body of technical knowledge.

According to the Study findings, an equally important clue to the role of WHO is the position of the MoH. In cases where the MoH insists on having WHO as a lead partner and acts accordingly, WHO is allowed a platform that helps to overcome limitations in WHO's own system, such as the lack of financial leverage and cumbersome bureaucratic procedures. On the other hand, in countries where MoH regards WHO as just one among a number of donors to the health sector, and does not perceive the Organisation to be a partner or policy adviser, WHO is not able to contest the influence of other dominant partners regardless of the skills and abilities of the WR.

To sum up, the Study findings underscore that WHO cannot take for granted that there is common acceptance for its role as lead agency with directing and coordinating functions in technical health cooperation at the country level. It is being challenged by the member states themselves, both in their role as countries receiving technical and financial inputs and in their role as countries providing technical and financial inputs. The same member states who are the key actors in WHO Governing Bodies are also the internal and external stakeholders in cooperation for health development at the country level. A Member State may insist on WHO improving its performance at the country level, while simultaneously effectively undermining WHO's position to do so through its actions as a bilateral donor, as a MoH hosting a WHOCO or as a voter on the Board of the multilateral funds and banks.

7.3 Common global functions expressed at the country level

Common goals

The findings of the Study generally point to a large gap between intentions and practice in the area of common global functions. In spite of deliberate efforts by the Study Team to assess how far the WHOCO promoted the notion of equity (through policy dialogue, reform efforts, work on information systems, service delivery) very little hard evidence could be traced. As can be seen from Table 7.2 below, there was a major gap - with only three COs clearly advocating equity issues. In the PAHO/AMRO region, initiative had been taken by the RO to strengthen the advocacy on equity through a particular focus on indigenous people.

Whereas Health For All (HFA) policies are nominally supported by all countries, policy development is largely driven by other forces and values. It is not apparent from the Study findings that the WHOCO keeps a "watch function" for HFA high on their agenda.

Present country contexts are characterised by market-oriented reform efforts. Generally in these contexts, the energy for pursuing HFA goals is low, even though the countries have committed themselves to the HFA strategies and values. This situation is a challenge to WHO in its current process of renewal of the HFA strategy.

Table 7.2 WHO's ability to promote common global goals

Country	Region	<i>Does WHO carry sufficient weight to promote common global goals such as equity at the country level?</i>
Thailand	SEARO	Not confirmed. Need to address human rights and equity issues, e.g. child prostitution.
Bangladesh	SEARO	Not confirmed. Poverty relief is a major issue. Absence of a national policy framework makes it difficult to address such issues.
Ecuador	PAHO	Confirmed. Regional level taken a strong equity advocacy stand so that IDB/WB find PAHO/AMRO difficult to deal with. WHOCO flags equity highly, however, the inequities are still very large and the national capacity for change is limited.
Nicaragua	PAHO	Confirmed. PAHO/AMRO regional level has taken a strong equity advocacy stand so that IDB/WB find PAHO/AMRO difficult to deal with. However, WHOCO does not flag equity very highly may be because equity has been a national agenda (since Sandinista government).
Haiti -	PAHO	Not confirmed. Still turbulent situation. Difficult to assess.
Cambodia	WPRO	Confirmed to some extent. Regional policies and advocacy statements recognised, but little in terms of proactive engagement in vigilance.
PNG	WPRO	Confirmed to some extent. Regional policies and advocacy statements recognised, but little in terms of proactive engagement in vigilance.
Cameroon	AFRO	Not confirmed
Tanzania	AFRO	Not confirmed. Yet has some willingness. Some advocacy efforts are recorded
Mozambique	AFRO	Confirmed in terms of WHO indirect involvement. The MoH has a strong policy towards more equitable distribution of health services.
Ethiopia	AFRO	Not confirmed. Low external/public profile.
Mali	AFRO	Not confirmed. Equity issues are not much recognised/acknowledged; although efforts to improve access

According to the Study observations, regional policies related to health and socio-economic development are most actively pursued in PAHO/AMRO and WPRO. The emphasis on health promotion as developed in WPRO through the *"New Horizons in Health"* policy and the *"Healthy Islands"* concept seems to carry more significance in the countries concerned than the HFA policy as such. Similar initiatives were observed in PAHO/AMRO on a sub-regional level, such as *"Healthy Borders"*, *"Health and Development for Peace"*. WHOCO advocacy appears to be more focused on these regional initiatives than on the global, and they are more frequently referred to by national governments.

A lot more could be done at the country level for stimulating, facilitating and supporting engagement in global common activities. In the case studies there is some evidence that the political nature of the Organization encourages avoidance of conflict at the expense of the advocacy role, and that the Organisation is reactive rather than proactive in policy initiatives. A stronger focus on countries performance in these areas, and a way of monitoring performance within and between regions may be the way to go, although the current use of indicators for Health for All does not serve the purpose.

In a similar way, monitoring the impact of current health development assistance policies and strategies, on countries' ability to achieve better, in terms of capacity building and equitable service delivery would also be appropriate. A global watch on how the current

reform efforts that are being strongly advocated by dominant actors in health development impacts on systems in terms of equity and access to care, is of growing importance.

Through its research programmes, WHO has made significant contributions to the development and evaluation of new and improved technologies for disease control. WHO's mechanisms for capacity strengthening in research include the award of fellowships, institutional grants and the use of visiting experts as consultants to the institutions. The Study Team found a number of achievements in individual countries:

- National research priorities: with support from WHO and other agencies, some of the countries in the Study had developed mechanisms for defining national priorities for and coordination of health research.
- National Research Capacity: WHO has made a contribution to the development of national research capacity in most countries in the Study. The degree of success has largely been determined by the absorptive capacity of the country and the degree of interest within the Ministry of Health. Predictably, the most advanced developed countries like Thailand have developed substantial research capacity. However, the highly effective malaria research capacity in Mali shows what can be achieved even in countries with limited resources and general capacity.
- International Collaboration: an important feature of WHO's contribution is its strategy of promoting cross national research collaboration, promoting research networks and stimulating interaction among scientists across national boundaries, for example with multi-drug therapy in leprosy control, control of Chagas disease in the Americas. Furthermore, WHO has used these ongoing programmes for strengthening research capacity. Some of the training programmes have taken place in the traditional academic centres in developed countries but increasingly, WHO is making use of institutions in developing countries that have been strengthened to the level of providing training programmes of excellent quality and relevance. For example, in 1995, about 1000 candidates applied through WHO to Study in Thailand and about 500 of them were placed.

In sum, the Study Team found that, while WHO was supporting research in a variety of ways in all the case studies, the actual engagement in research by the WHOCO was limited. Indeed, research represents the functional area which almost in all case studies is given the lowest significance of all the activities within the collaborative programme, with the exception of Thailand and Tanzania. WHOCO staff were not usually well equipped to guide national authorities in developing research. In many case studies, health systems research was relatively poorly developed and the type of research that would inform the reform of the health sector has been relatively neglected.

7.4 Country specific functions

The Study has through all the case studies observed that central to the function of WHO in a country, and particularly in the case of country specific functions, is a clear understanding in the MoH of the nature of presence of the Organisation, its abilities and its limitations.

In Table 7.3 it is suggested that there is considerable difference in the way countries perceive, interact with, and utilise the WHOCO. In some of the case studies opportunities are being missed because neither WHO nor the MoH and the other partners have been able to unfold the potential in the relationship. This is not always because of weaknesses in the WHOCO, but may also be because of the particular constellation of donors and other actors in the health system, and the way interactions take place. Some case studies are not fully using their opportunities as members of the Organisation in relation to the broader regional and global context.

Table 7.3 WHOCO's role in facilitation and briefing of the MoH

Country	Region	<i>Is the relationship between the National government and its role as a member state well understood and facilitated by the WHO Country Office?</i>
Thailand	SEARO	Confirmed. Deep appreciation of WHO's role and functions
Bangladesh	SEARO	Not confirmed. Activities of WB and other donors overshadow WHO's relationship with MoH
Ecuador	PAHO	Confirmed. Relationship and loyalties strongest towards regional level, but also to organisation as a whole
Nicaragua	PAHO	Confirmed. Relationship and loyalties strongest towards regional level, but also to organisation as a whole
Haiti	PAHO	Not confirmed. Regional activities better understood and facilitated
Cambodia	WPRO	Confirmed. Role well understood in senior MoH, but not throughout system. Well briefed by WHOCO. Main interest in RC/regional activities
PNG	WPRO	Confirmed. Role well understood throughout MoH, but not by all partners. Well briefed by WHOCO. Main interest in RC/regional activities
Cameroon	AFRO	Not confirmed. Frequent change of ministers. Minimal briefing for WHA and RC. WHO seen as donor
Tanzania	AFRO	Not confirmed. Some initiatives to improve the situation by current WR
Mozambique	AFRO	Not confirmed. A limited tradition of utilising WHOCO in an effective way in the various preparatory processes
Ethiopia	AFRO	Not confirmed. Rapid turn over of ministers has been a strong constraining factor. National authorities keeps UN specialised agencies at a "distance"
Mali	AFRO	Not confirmed. Minimal briefing for WHA and RC. WB starting to dominate in policy discussions

It will be noted that the case studies where the Study Team concludes that the role and relationship is not well understood, largely are the same countries where WHO does not serve as a lead agency in the health sector. This indicates a close link between the understanding of WHO's mandate by the MoH as the key partner, and the actual role that WHO is able to perform.

It is therefore imperative that WHOCO actively seeks ways to communicate and facilitate such an understanding. Even so, WHOCO's across the regions demonstrate remarkable weakness in communicating its own profile and specificity as an actor in health development in each country.

While the CO assists the MoH in developing its overall plan, or in presenting a structured overview of national health status and health needs to other partners who might have an interest in collaboration, CO's do not make the same effort to present their own profile, style of operations and activities within the country. WHO information on its presence in the country is usually activity specific, so that WHOCO staff themselves, as well as other actors in health development, have only fragmented information on what WHO is actually doing. Few of those interviewed in the 12 case studies felt able to describe

WHO's role in the country in broad terms, and tended to fall back on examples of specific individual activities.

Overall balance and complementarity of functions

In most of the case studies, the implementation rate of planned activities is generally high. RBFs are largely absorbed at the level they are allocated (see Annex 4, Country Office Expenditure against Budget, p.A23). However, reallocations were often required. The Study did not review the reasons for, or appropriateness of these reallocations, as the justification was not easily available in most countries' monitoring systems. Monitoring systems serve to follow each planned activity in terms of inputs and outputs, and reflect whether there is capacity and opportunity to implement what is planned, but are built on the *assumption that what is planned is relevant and appropriate*.

The findings from the twelve country case studies highlight three main observations on WHO's activities: where WHO is generally strong, where WHO is largely invisible and where WHO does not have particular advantages.

- WHO is most typically seen to be *strong* in the technical areas of preventing and controlling specific health problems (integrated disease control). This is a finding across the regions - regardless of estimated country capacity and the presence of other partners, and regardless of whether WHO is contributing substantial finance or not. In some case studies there was some tension between support for technical disease interventions, and health systems support, but this was by no means felt in all countries, as Table 7.4 shows.
- There is *lowest overall involvement* in the area of promoting and protecting health, particularly in the AFRO region. This strategic programme area represents a cluster of very different programmes, ranging from reproductive health, mental and occupational health via nutrition to media and physical environment. In many of the case studies these programmes are seen as "bits and pieces" and not given strong recognition and visibility. Yet in some case studies they actually represent a very significant part of WHO's work, particularly in the area of environmental health. Only Thailand and PNG have a strong emphasis on promotive activities, which is still an area with very little "competition" from other partners in health development.
- In dealing with actual implementation of health programmes WHO becomes more *similar to other partners* in health, and does not present any clear and specific advantages. A relevant question here is whether WHO is involved in the right things. There may be activities that develop new or modified approaches to implementation where WHO has a specific role to play. And there may be aspects of monitoring implementation, focusing on access and quality of care, where WHO could assist the MoH in a particular way. In countries where WHO has a heavy involvement in implementation, there is little evidence of this as a strategic choice.

WHO Governing Bodies have repeatedly emphasised the importance of a strong focus on Primary Health Care, recently also discussed in the Executive Board and the Health Assembly.² While the framework for PHC elements at regional and global level provided by the Director General may make it possible to pursue a discussion of future PHC priorities, the Study was not able to identify retrospectively which of the activities at the

country level reflected a PHC approach. The appropriateness in emphasis on PHC can therefore not be analysed. Unless such activities are clearly defined and coded as part of a unified monitoring system, global priority setting and reporting is likely to carry a lot of uncertainties.

An important aspect of the PHC concept is the emphasis on integrated approaches. In pursuing this question, it again becomes clear that there are no blueprint solutions to the balance between disease-specific interventions and more integrated systems development. What is clear, however, is that WHO in many countries still gains recognition by its activities in disease control.

Table 7.4 Integrated approaches to health development

Country	Region	<i>Are there tensions between support for health systems development and technical disease interventions at country level?</i>
Thailand	SEARO	Confirmed to some extent. WHO's capacity to support health systems development not perceived as strong as in disease control and health promotion.
Bangladesh	SEARO	Hard to interpret. WHO's limitations are aggravated by contextual problems. Fragmented WHO approach
Ecuador	PAHO	Not confirmed. More emphasis is currently been given to systems development leading to organisational changes. However, limited human capacity in the areas of system development.
Nicaragua	PAHO	Not confirmed. More emphasis is currently been given to systems development leading to organisational changes. However, limited human capacity in the areas of systems development.
Haiti	PAHO	Confirmed to some extent. Commitment to new balance - but lack of expertise (critical mass) within the Organisation.
PNG	WPRO	Not confirmed. New Horizon and Healthy Islands accepted as lead policies. Resources are still more geared towards disease intervention. Involvement in systems development gives credit.
Cambodia	WPRO	Not confirmed. The two sides have not embraced each other, but both present with strength. Involvement in policy and systems development important for lead role.
Cameroon	AFRO	Confirmed. WHO ability in health systems development is weak at both WHOCO and RO levels, with very limited involvement
Tanzania	AFRO	Not confirmed. Low "medical" profile. Strong support of health systems approach.
Mozambique	AFRO	Not confirmed. There is an evident attention to systems development issues, however, limited capacity.
Ethiopia	AFRO	Confirmed to some extent. De facto "tension" in programme priorities, while little attention/awareness re such tensions. WHO given limited opportunity
Mali	AFRO	Confirmed. WHO ability in health systems development weak. Some involvement in health systems, but largely other actors. Fragmented WHO approach

For making further assessment to examine the relevance and appropriateness of the WHO supported activities, the collaborative programme activities are grouped in two main clusters:

- i) support for *development of country health policies, strategies and systems* (including application to country level of the larger global programmes and policies on organisation, management and infrastructure) and
- ii) support for *country implementation of health programmes* (including executive agency functions, resources for fellowships, courses, procurement, national applied research etc.)

Support for development of country health policies, strategies and systems

As discussed in Chapter 2, health systems capacity, including monitoring, quality-assurance and information systems are weak areas in all the case studies apart from the country with highest overall capacity (Thailand), regardless of whether the country has a developed health system but which has been disrupted or strained (e.g. medium capacity cluster), or a system that has not functioned well in the recent past (low capacity cluster). Given the pressure for reform and the multiple actors, capacity gaps in this area makes countries vulnerable and thereby represents an area where the role and contribution of WHO as a “neutral broker” and adviser in policy dialogue is of particular interest.

The Study findings suggest that WHO to some extent is able to make relevant and appropriate contributions to health policy/systems development in two of the regions studied, namely PAHO/AMRO and WPRO, whereas the response is inadequate in AFRO. The case study selection in SEARO makes it difficult to make any assessments. However, even in the PAHO/AMRO and WPRO case studies there are notable gaps in the “normative area” of specific programmes (i.e. drugs, reproductive health), and certainly in the area of human resource management.

Only in the PAHO/AMRO case studies and Cambodia does WHO engage actively in the issues of financing and privatisation, however with limited capacity and influence. While it may be appropriate to say that this has never represented WHO’s area of expertise, it is equally clear that unless WHO can carry a meaningful policy dialogue on health sector reform issues with the strong actors from the bilateral and financing agencies, the Organisation is likely to miss out in its efforts to assist countries to implement the health for all policy in its renewed form. The current response from the two regions that are involved in a visible way at the country level, is also somewhat detached from the WHOHQ base, and there is a strong need for the Organisation to start building up a global body of knowledge about policy choice, conditions for and implications of various health reform policy choices in different country contexts. There needs to be a stronger interaction from HQ with the regions and not only with individual countries on this policy topic in order to construct a better platform for concerted efforts.

The policy area of *drugs* stands out as the most politically sensitive among the three programmes studied in depth, where gaps noted are not filled, either because WHO does not have EBFs earmarked for that particular country, or because WHO has opted out. because of conflicting interests, either in the country itself or in the region/sub-region. When bilateral donors are engaged in the drug policy area they may or may not want to relate their work to WHO, thereby creating a somewhat difficult policy arena. There are also case study examples where assistance has been requested and WHO has not been able to find the appropriate expertise within an acceptable time frame

In the area of *reproductive health policy*, the findings from the case studies give a rather mixed picture. None of the case studies have WHO in any lead role in this policy area. There are several examples of joint programming and executing relationships between WHO and UNFPA. Global guidelines for Mother and baby packages, or safe motherhood approaches are available in the MoH in most case studies, but without much engagement in terms of adapting policies. In many of the case studies the maternal mortality figures demonstrate how this area still lags seriously behind other priority areas. The case studies

in WPRO had a particularly low profile in reproductive health, and upon further exploration it was evident that the WPRO has been very slow in responding to actual requests for assistance, and even potential strategic partnerships with bilaterals. The low level of involvement in the AFRO case studies may indicate that there is a crowding of donors in this area. Even in such a situation one would expect WHO to have a clear role in terms of policy advice and advocacy, since reproductive health continues to be a sensitive area in many countries. The inability of WHO to respond to this challenge gives reason for concern. It should be noted, however, that there are recent initiatives taken at the regional level, both in SEARO and AFRO, and regional policy and strategy documents developed, which may enable improved action at country level.

Table 7.5 WHO's responsiveness to change

Country	Region	<i>Have the WHOCOs been able to adapt to contextual changes in country?</i>	<i>Are skills that were once unique to WHO now more widely available at the country level?</i>
Thailand	SEARO	Not confirmed. A major review of WHO's role is required.	Confirmed
Bangladesh	SEARO	Confirmed to some extent. The urgent need is however for changes in the MoH and among donors.	Not confirmed
Ecuador	PAHO	Confirmed to some extent. Continuous political changes constrains action. WHOCO represents continuity in an environment without memory	Not confirmed. Frequent changes in MoH staff drains capacity.
Nicaragua	PAHO	Confirmed. WHOCO has been able to position itself in changing governments with considerable influence.	Confirmed. Current staff policies take these changes into consideration. Need to reconsider staff mix.
Haiti	PAHO	Confirmed. Process of ongoing change - but several barriers. Lack of direction/vision in transition from emergency to development.	Not confirmed. WHO has a high profile - also technically. Particularly during the emergency period.
Cambodia	WPRO	Confirmed. To a very large extent been able to be responsive to change.	Not confirmed. Only a thin crust of skilled manpower. Overload of technical advisers, pushed by donors. Still WHO TA in demand
PNG	WPRO	Confirmed. To a very large extent been able to be responsive to change.	Not confirmed. Only a thin crust of skilled manpower. WHO traditional expertise in demand for selected areas.
Cameroon	AFRO	Not confirmed. The deteriorating country and health services situation has only been met by corresponding weakness of WHO.	Confirmed
Tanzania	AFRO	Confirmed to some extent. Moving in right direction. Adjusting gradually.	Confirmed to some extent. No obvious role for WHO - due to weak past? Not commonly available in other organisations.
Mozambique	AFRO	Confirmed to some extent. WHO has played a modest role in the rehabilitative phase after a more significant role during the emergency period.	Confirmed to some extent. The MoH has significant capacity at senior level, but gaps. WHO needs to find its role and approach together with other donors providing TA.
Ethiopia	AFRO	Not confirmed. Considerable programme inertia. Lack of response to political changes (federalisation). Marginalised by authorities.	Confirmed to some extent. Other agencies building traditional WHO expertise, e.g. World Bank
Mali	AFRO	Confirmed to some extent, but evidence of adaptation within a framework dominated by other donors	Confirmed

In the policy and systems area of *human resources*, gaps in national capacity were also noted in all case studies and across all regions, regardless of generally assessed capacity, particularly regarding the working conditions of the health manpower, skill mix, distribution, deployment, remuneration and incentives. Whereas WHO has made major contributions to human resource development through support to manpower planning, training, curriculum development, ongoing education and fellowships, the questions of how to make the best possible use of these manpower resources, personnel management structures and systems, have received little attention in the case studies. In contrast to the other policy areas mentioned, this is an area with minimal competition from other donors and actors, which desperately needs attention and where WHO has been slow to respond to need. WHOHQ have recently identified this as a priority area for further development, and is currently building a body of knowledge and expertise in the regions and HQ, and developing approaches for enhancing country competence. None of these very recent initiatives were, however, apparent in the case studies.

As is clear from Table 7.5, most WHOCOs have tried to respond to the changing policy environments they have found themselves in, although with varying success. There are few countries in our sample where MoH or other agencies have skills available which would make redundant the technical skills that WHO has traditionally provided. However, there are skills or professional knowledge which are needed at the country level, which WHO has not been able to provide, especially in the area of health systems reform.

Support for country implementation of health programmes

It is the national capacity for health service delivery and access to care which largely makes the distinction between the three clusters of countries in the Study, as presented in Table 2.3 (page 15). The low capacity cluster has a situation where infrastructure is not functional in the periphery, unevenly distributed and with poor continuity in actual service provided. The medium capacity cluster has a problem with breakdown of previously established services, is often assisted by a large NGO sector in service provision and struggles with quality of care issues. The high capacity cluster faces problems with appropriate service packages, the public/private mix and the implied equity issues.

Apart from being proportionately more involved in support for service implementation (technical operations support) in some low capacity countries, what is striking is the lack of a pattern in what WHO is doing at the country level. Among the tools applied by WHO, the Study Team expected that *financing* service implementation would have been concentrated to the low capacity countries. This is not the case. Similarly, the Team expected that if WHO is involved in supplies, it would be more prominent in the low capacity countries. This is also not the case. And finally, the Team expected that fellowships would be concentrated to the low capacity countries. This is also not the case. Support to technical operations was surprisingly high in Thailand and Ecuador (much more prominent than in Nicaragua) and surprisingly low in Mozambique and Cameroon.

Service implementation is likely to be an area where much more could be done to focus resources and attention on the countries in greatest need, and where there are few other donors. It is also the area where there is most to gain without losing identity in coordinating the development assistance functions of the UN agencies. WHO is already seeking to avoid being involved in large investments in physical infrastructure. Among the case studies, Ethiopia was the only country where WHO was involved, and then in a role of an executing agency. Only in a few case studies did WHO actually engage in the periphery in support of a province or a district. Where that took place, the appropriateness was hard to assess. In principle this is clearly not a role where WHO has, or should have, particular expertise over other partners in health development. The only rationale for such involvement would be to have sufficient contact with the realities in the field that appropriate advice can be given at the policy level.

The fellowships programme has been criticised for lack of appropriate evaluation. In the regions visited, PAHO/AMRO, SEARO and WPRO had undertaken evaluations recently, and claimed that policies had been sharpened to improve effectiveness. However, the evaluations focused on numbers rather than strategic impact. There is little doubt that in spite of poor scrutiny of fellowship candidates, the investment in fellowships is perceived to have made a difference in the availability of skilled manpower. There is, however, little evidence in the case studies that WHO has had a conscious long-term approach to different levels of capacity building through the fellowships scheme. Nevertheless fellowships and other mechanisms of capacity building are seen by the countries to be valuable.

Quality-assurance, service management (including information systems for management) and appropriate service models are technical areas where one would have expected WHO, with its technical expert profile, to have a strong role if at all involved in service implementation. These are, however, areas where WHO in most of the case studies seemed to be less involved. Efforts to strengthen district management, and for operationalising CDR/ARI and integrated management of childhood disease were examples noted in some case studies, however without any strong prominence.

The most critical gap found in this area, with many actors but quite confusing and inappropriate outcomes, is the area of health information systems for management purposes. A lot of current attention to management systems is invested in areas where agencies are particularly interested, the need for reporting to donor agencies or creating data for national and global aggregate information. The data inputs into the systems are often of poor quality, one collects too much data, and it is not used by the managers and service providers that collect it. It is of vital importance that an agency with concern for appropriate and user oriented systems engage more in support to development and implementation of these systems, and that WHO ensures that it has the capacity and ability to come forward as a lead in this area in countries that need such guidance. While ad hoc type of support could now be recorded in the case studies, WHO was nowhere in the lead and had no clear idea of where it was going, in spite of tremendous gaps in the national systems.

In some case studies, where WHO is playing a major role in project execution on behalf of other donors, either taking an accounting, administrative role (as in Bangladesh), or as

a more active implementer (in the PAHO/AMRO case studies) the WHOCO is doing what the MoH should be doing, but due to lack of capacity, cannot. The role of executing agency is most appropriate when paralleled with capacity building and leading to a transfer of responsibility to the MoH or other national health institutions. The stability of the WHOCO in comparison to MoH staff puts WHO in danger of substituting for rather than building capacity, as expressed in Ecuador and Nicaragua.

Many WHOCOs are failing to take advantage of all its good material for active information dissemination in support of service implementation. Often the extent of availability and use depends on MoH interest and capacity. These are opportunities missed by the whole Organization, as this is how one can get value for the investments in the large global programmes. Thus there is an unmet need for the Organization to strengthen WHOCO role and funding for information dissemination and/or to build MoH interest and capacity in this function. Ensuring that documents are available in appropriate languages increases the relevance of the Organization to the country.

Constraints in linkages and partnerships at the country level

The Study has shown that there are many different actors in the health sector at country level, both national and external. A recurring theme was to assess how far this has affected activities in health, and inter-relationships between actors, leading to duplication or competition in implementation. Table 7.6 gives an overview of the assessment of findings from each country.

Table 7.6 Project ownership as a barrier

Country	Region	<i>Are there barriers to effective collaboration where there are many actors in a country's health system?</i>
Thailand	SEARO	Not confirmed
Bangladesh	SEARO	Not confirmed
Ecuador	PAHO	Confirmed to some extent i.e. WB's new project on health reform. IDB's plans for support to health sector reform.
Nicaragua	PAHO	Confirmed to some extent i.e. various organisations involved at SILAIS level with considerable ownership and lack of coordination.
Haiti	PAHO	Confirmed to some extent. No clear evidence within. Between agencies, e.g. UNICEF
Cambodia	WPRO	Confirmed between actors at country level, but less so HQ/RO/CO
PNG	WPRO	Confirmed between actors at country level, but less so HQ/RO/CO. Hardly from HQ.
Tanzania	AFRO	Confirmed to some extent. There are formal mechanisms for coordination - but coordination only acceptable within certain limits.
Cameroon	AFRO	Confirmed within WHO, especially with regard to HQ programmes. Less so between WHO and other organisations at country level.
Mozambique	AFRO	Not confirmed. Considerable openness to coordination and cooperation between donors. The challenge for WHO is to regain its credibility in the "health community" and to prove itself as a resource in areas strategically important for WHO as organisation.
Ethiopia	AFRO	Confirmed. Within WHO - e.g. TDR and between, e.g. WB, and UNICEF
Mali	AFRO	Not confirmed. WHO involved in many collaboration meetings, but as a member rather than a leader.

In most case studies, significant barriers are recognised. In Bangladesh and Mozambique there are donor mechanisms which probably have served to reduce such barriers. In countries where barriers are recognised, there may be coordinating mechanisms in place

(Chapter 6), such as in Cambodia and Tanzania. Even so, these mechanisms may only serve the purpose of mutual information. It is important to note that the issue of project ownership and pursuing "own" results is as important in relation to bilateral as multilateral partners. For the health related UN funds (UNICEF and UNFPA) it means that they do not see themselves as partners that have a role in providing financial support to a WHO/MoH programme. For bilateral agencies it may mean that they bring in their own technical assistance separately, rather than seek to make optimal use of a strategic partnership with for instance WHO. In such situations, it is not just a question of the capacity of a country to coordinate donors, but also barriers between donors which donors themselves need to address.

Contradictory expectations

During the field visits, the various partners in health development were asked to indicate the strength of WHO's current involvement in the country, and what they would like to see as the desired future direction for WHO involvement in that particular country over the next 5-10 years.³

The use of terms differ greatly, with a lack of common vocabulary. Distinctions such as "normative" and "operational" are not understood in the same way. The strategic areas of WHO programme involvement, such as presented in the 9th GPW were also not self-evident and needed explanation. There is a lack of clarity in what activities are placed in the category "Health Policy and Management" or "Health Services Development", and, for instance, there is no obvious reason why all activities related to reproductive health appears under "Promotion and Protection of Health". In addition, there is no specific strategic programme area that reflects or covers Primary Health Care related activities. Rather, the budget structure scatters the elements of PHC throughout the different strategic programme areas.

This lack of common vocabulary and the complexity in relating the currently used vocabulary meaningfully to the budget structure is an evident problem in discussions of priorities for WHO, at country, regional and global levels. Statements of opinion such as "WHO should limit itself to a normative role" or "WHO should put more stress on strengthening health system capacity for disease control" are therefore likely to have limited value.

Even if a common vocabulary were agreed, the stated positions on the future desired strength of WHO indicate that it will be difficult for WHO to respond to contradictory expectations. For instance, some bilaterals, think that WHO should not have any operational support functions at the country level, while others regard the operational support functions as highly desirable. NGO's on the other hand, have overall the highest expectations of WHO's operational role or support for the implementation of health programmes.

Bilaterals and WHO representatives are generally in close agreement, and fairly consistently emphasise advocacy, particularly in the area of health policy and management. However, UN agencies have the lowest expectations of all when it comes to the desired involvement of WHO in advocacy.

WHO representatives have consistently higher expectations for their involvement in support to norms and policy development at the national level than any of the other groups interviewed. These same high expectations are not matched by the bilaterals when it comes to service development and promotion and protection of health. UN agencies have the lowest expectations of WHO's future involvement in promotion and protection of health, but put much higher emphasis on support to national norms and policies in service development.

The only clear message is that the expectations are contradictory and terminology needs to be clarified. More constructive discussions regarding future priorities for the Organization, be it locally, regionally or globally will be dependent on recognising and responding to these issues.

Regional interactions

The four regions visited demonstrate wide variations. While SEARO serves a relatively small number of countries with close historic ties, situated in close vicinity of each other, it serves a huge and rapidly growing population. PAHO/AMRO and WPRO have all types of countries represented, scattered over wide areas and with very large countries (Brazil, China) along with tiny islands, advanced industrial economies alongside impoverished nations, some of them emerging from long standing civil unrest. PAHO/AMRO has the additional characteristics of combining wide socio-economic inequalities with relatively high cultural homogeneity. This is not the case for WPRO. AFRO is largely made up of countries in one continent, many suffering from unsettled conflicts, wars and disasters, with weakened nation states, and a constant economic marginalisation. Overall the AFRO region faces very complex external and internal conditions for human and economic development.

While both PAHO/AMRO and WPRO have among their membership countries that participate as donors in health sector development, this is much less the case in SEARO and AFRO. This situation gives considerable advantage, particularly to PAHO/AMRO, in that the Regional Office is able to serve member states with noticeably more resources of all sorts, than is possible in the other regions. This also explains the very large operations in the case studies in the PAHO/AMRO, in terms of technical staff and financial throughput. WPRO also has possibilities for generating additional external resources and making strategic partnerships among the rapidly growing economies in this region, which may also serve as an engine for energising the system and stimulating creativity and joint action.

Many SEARO countries continue to struggle with large bureaucratic public structures, some of them highly dependent on external aid. With the much weaker nation states often found in AFRO, and the ongoing democratisation processes, the ability to utilise membership in an organisation such as WHO is much more difficult. In these two regions, the efforts to establish better coordinated sector investment (or sector wide) approaches stand out as crucial, and offer a different challenge to WHO.

The organisational culture, the management style and the efficiency of administrative procedures vary between the four regions, in ways which cannot only be explained by the need for relevance to different regional contexts. While difficult to characterise the WHO

operations in the regions from studying only a few countries, a picture emerges which at least raises some issues for further discussion.

Table 7.7 Influence of the Regions on functioning of the WHOCOs

Country	Region	<i>Is WHOCO effectiveness largely determined by support from the Regional Office?</i>
Thailand	SEARO	Hard to assess importance of RO support ; strong WHOCO relates well to RO.
Bangladesh	SEARO	Confirmed to some extent. RO and HQ need to help build WHO's image, no way for WHOCO in isolation
Ecuador	PAHO	Confirmed to some extent. WHOCO has strong and independent leadership, able to act on the autonomy PAHO/HQ gives them Effectively supported by PAHO/HQ
Nicaragua	PAHO	Confirmed. PAHO/HQ hold brokering deals with policy makers in the WB, IDB, USAid, but this seems to break down at country level.
Haiti	PAHO	Confirmed. Strong PAHO/AMRO support. Agreed FCO autonomy. Balanced division of labour.
Cambodia	WPRO	Confirmed. RO support essential, but also seen as delaying procedures. WHOCO strength largely determined by role assigned after war, cooperative "force" + bilateral agreements.
PNG	WPRO	Confirmed. Very clearly dependent on RO for effectiveness, yet with strong WHOCO presence and delegated authority
Tanzania	AFRO	Confirmed to some extent. Support from RO has been variable, but mostly administrative. Signs of improvements after WHOCO has been regarded weak. Combination RO and WHOCO efforts
Cameroon	AFRO	Not confirmed. Support from RO has been variable, but mostly administrative. WHOCO is very small and weak.
Mozambique	AFRO	Confirmed to some extent. Effectiveness depends not only leadership and support from RO, but also on how WHOCO exercises its powers and functions and utilises RO. Signs of improvement RO+CO
Ethiopia	AFRO	Confirmed. Lack of political support in-country, requires RO intervention and technical/strategic support. Administrative/financial constraints.
Mali	AFRO	Confirmed to some extent. Support from RO has been variable. Strength of WHOCO is improving, as is support from RO, though still mainly admin.

According to the observations made in the case studies, including the visits to the regions, PAHO/AMRO and WPRO have managerial systems that are able to produce relevant information, keep information updated, serve the Country Offices and manage their resources in a fairly effective way. In spite of this, there are still complaints of undue delays, although not to an extent which seriously undermines the responsiveness and credibility of the organisation. There is a marked difference between the two regions in terms of the autonomy of the WR's, which might be worth looking into in order to be able to assess weaknesses and strengths. The greater autonomy of COs in PAHO/AMRO is probably largely due to the fact that available resources are above a certain critical minimum. An obvious strength with the rather centralised WPRO system is the ability to stretch resources by making optimal use of pooling resources among countries, so that money can be redirected.

AFRO was the region with the most complaints regarding the WHO regional operations, related to delays in approval and response and inefficient procedures. In the countries visited, however, there were signs of a new managerial style being introduced, and the effects of new communications systems were beginning to be visible. AFRO and SEARO

were both regions with less evidence of being proactive, and where there were gaps in national health systems' basic ability to deliver, as evidenced in regional discussions and initiatives. SEARO is a region with a reputation of being relatively passive, bureaucratic and slow.

The Study Team was particularly interested to assess how far the Regional Offices supported the WHOCOs: one of the expectations was that they could have a significant effect on the effectiveness of the CO. Table 7.7 shows that the country findings to a large extent confirm the need for support from the regional level, with the present structure.

Another way Regional Offices (and HQ) may support countries is through encouraging and coordinating *inter-country collaboration and exchange*. Many examples were found from the country case studies, of valued cross-fertilisation of ideas, good practice and information exchange. In Table 7.8 the Study Team's assessment is again mixed, depending on a number of different factors, with the level of inter-country facilitation lowest in the AFRO case studies. Previous sub-Regional Office arrangements have not served the countries well, and were seen to have limited usefulness for the countries visited.

Table 7.8 WHO and inter-country issues

Country	Region	<i>Is WHO well enough structured and equipped for dealing with inter-country activities in a proactive way?</i>
Thailand	SEARO	Confirmed within region. Structural constraints exists across regional boundaries
Bangladesh	SEARO	Confirmed within region. Intercountry activities exist
Ecuador	PAHO	Confirmed within region. Many Andean inter-country (subregional) initiative. Active inter-American frameworks in health policy (meetings of ministers)
Nicaragua	PAHO	Confirmed within region. Central American subregional Initiatives such as ISCA. Active inter-American frameworks in health policy (meetings of ministers)
Haiti	PAHO	Not confirmed.. Language barrier - French in a Spanish speaking region.
Cambodia	WPRO	Confirmed within region. Many examples of inter-country activities. Structural constraints exists across regional boundaries
PNG	WPRO	Confirmed within region. Many examples of inter-country activities. Structural constraints exists across regional boundaries
Tanzania	AFRO	Not confirmed. Some emergency examples.
Cameroon	AFRO	Not confirmed- e.g. could help more with trypanosomiasis which spreads to Cameroon from Equatorial Guinea.
Mozambique	AFRO	Not confirmed. Few inter-country initiatives in place. Sub-regional abolished. ? Established focal points for various initiatives?
Ethiopia	AFRO	Not confirmed. No evidence of regional interaction.
Mali	AFRO	Confirmed to some extent. Not raised as a problem. The WHOCO is the office for two regional staff.

There is a growing interest in and need for exchange of experience and collaboration towards common health goals among countries within regions, as well as between regions. This would indicate that a WHO for the future should engage strategically in making use of this interest and potential. In such efforts, there is a need to address and overcome regional barriers that still exists.

Finally, in relation to HQ the four regions had distinctly different patterns of operation: PAHO/AMRO being almost an entity on its own, and WPRO making deliberate efforts to utilise its own technical resources before requesting HQ resources. WPRO also takes a strong stand against HQ taking initiatives in relation to countries in the region. SEARO

and AFRO had more of an attitude of openness towards HQ initiatives, responding positively to efforts to promote HQ programmes, and in the case of AFRO also letting HQ act in direct relationship to countries in the region. From a HQ perspective, SEARO is often mentioned as a region with a good HQ-RO relationship, because of the ease by which communication takes place and the openness for collaboration.

In sum, the Study Team recognised that there is not one WHO, but many, because of the relative decentralisation to the regional structure. Further, the Team's findings emphasise that because of the context in which WHO is operating, there is a need for many 'different WHO's', if the concern is for relevance to the country context and optimal collaboration among countries. It is however not clear to the Team that geographical proximity is the most relevant regional criterion, or whether a completely different regional pattern should be established for inter-regional linkages among countries with similar problems. The findings from the Study of the countries in the four regions confirm that it is a challenge to find the unifying principle in this complex and diverse Organisation, and that the answer cannot be uniformity in approach.

7.5 Broad conclusions

The basis for conclusions

The preceding chapters described WHO's collaborative programme of activities at country level, and how it is undertaking those activities. In this chapter, the Study Team has evaluated WHO's overall performance at the country level, first by asking a number of key questions, and in this section by summarising the main findings from the preceding chapters, using the analytical framework derived from the terms of reference.

In interpreting the findings, the Study Team underscores the wide variation found in the different countries and regions, which make any attempt to summarise difficult. WHO through many years has made significant contributions to the development of human resources and the overall service delivery framework in most of the countries visited. Major progress has been made in control of a disease such as leprosy, which has taken years of diligent efforts and demonstrates the importance of an Organization that has continuity, persistency and presence over time. A country such as Thailand, acknowledges WHO's contributions to the development of their health system generally and some major programmes specifically. WHO's creditable record in the emergency in Haiti has also been noted.

Yet, very little can be said about WHO that is true in all countries. For the nine broad questions examined regarding WHO's role and performance in countries, the Team found both common features as well as distinct differences. These cannot be explained only by factors internal to WHO, nor by general socio-economic variation in the countries. In each case, the inter-relationship of factors needs to be carefully examined. The conclusions drawn here attempt to identify and summarise such *system-related* factors which appear to have a bearing on WHO's role and function in many of the case studies, which are likely to be of sufficient general importance to demand further attention in efforts to reform the Organization. These conclusions are grouped to match

the four key areas of the Terms of Reference, as interpreted by the Study Team in the Inception Report.

WHO mandate and role

On the relative strengths and comparative advantages of WHO's country presence, the Study concludes that the organisation has made important and unique contributions to health development. WHO common global activities, policies and products are generally seen as *valuable*, and provide the WHOCO with *credibility and authority* at the country level. WHO scientific and technical information is universally acknowledged as being of high quality and value. While the national context, the interest of MoH and the presence and activities of other partners have strong influence on WHO's role in a country, there are also obvious differences in how WHOCOs are able to tailor their activities so that they are optimal and complimentary to other efforts. The study concludes that more could be done to stimulate, facilitate and support engagement in common global activities at the country level and to make country specific activities better tailored to the particular needs in the countries.

WHO has a high international reputation at the country level, and this creates expectations. It means that there is a growing demand for WHOCO staff to have the right skills as enablers and facilitators so they can participate with authority in policy dialogue. There is lack of clarity about the meaning of WHO's formal mandate to coordinate and direct international health work when it is applied to the country level. The Study Team found that, where WHO technical authority and relationship with the MoH is perceived to have legitimacy, then WHO was described by many partners to have a unique character in its presence and a number of different strengths. *However, the overall match between support and need was not found to be sufficiently strategic, and the application of WHO's mandate not optimal* in many of the case studies.

WHO is *not automatically the lead agency* among external partners supporting health activities at the country level, but it did have this role in nearly half of the case studies. The main factors determining WHO's actual role among the partners were related to the interplay between MoH and WHOCO, and to WHO's predictability and responsiveness as a technical resource, rather than to the level of financial resources. Even where it does not have a lead role, WHO has potential comparative advantage because of its reputation for technical skills, expert advice and materials. However, it seems that many WHOCOs are failing to take advantage of this recognised status. Technical materials are not sufficiently accessible, or disseminated throughout the country, libraries are poorly managed and under-utilised, and consultants are sometimes poorly selected. These are of course, opportunities missed by the whole Organisation, not just the CO, which to some extent depends on HQ and ROs for support in these areas.

WHO shows *varying effectiveness in advocacy*, as a neutral adviser or broker, from being at the forefront in countries to being hardly visible. On some politically sensitive issues the Organisation generally was found to avoid conflict at the expense of its advocacy role. One of the ways to become proactive rather than reactive could be to link up with nongovernment organisations which were more distanced from national and international policy interests. At the time of the study, none of the case studies had this kind of NGO involvement in support of the advocacy role.

The case studies show that there *are further opportunities to make use of WHO strengths* in order to contribute to health systems capacity at country level. Furthermore, there is an opportunity for WHO to reinforce its mandate at country level by addressing the need for expertise in health systems development, human resource management and sector reform. These were identified as areas of opportunity for WHO to extend its knowledge-based comparative advantage, and supports recent direction provided by the WHA where the Director-General is requested to “provide an analytical capability to distil the different experiences of health sector reform based on firm evidence; and to promote and support countries in the area of health sector reform bythe systematisation, documentation and dissemination of health sector reform approaches and to enable countries to exchange experiences on a continuing basis”.⁴

The Study concludes that *WHO's mandate and actual presence at country level has not been adequate across all case studies*. The strongest presence, in terms of financial (both RBFs and EBFs) and human resources, has been in the PAHO/AMRO case studies, Bangladesh and Thailand. The weakest has generally been in the AFRO case studies. If presence is judged by the overall significance of WHO as an actor in health development within the country context, WPRO and PAHO/AMRO case studies are the strongest. In general, the pattern of support has not been sufficiently linked to needs and capacity of countries due, in large part, to historically-based rather than strategic allocation of resources. Resource allocation has not been sufficiently targeted to countries in greatest need. This has been a major constraint for WHO's activities at country level which all member states must address. There is a need, therefore, for agreed and explicit criteria for determining actual presence in countries.

While the current mandate, repeatedly interpreted by governing bodies, gives sufficient direction and flexibility for effective country support, in many case studies the mandate and the flexibility is not optimally used, by WHO, the National Ministry of Health or other external partners in health development. There is a need to re-examine and clarify previous statements and resolutions on the relation between WHO's role in directing and coordinating international health work and its role in technical cooperation among countries. It is also necessary *to deal with the contradictory expectations and the unclear terminology used among partners for describing WHO's functions*, in order to be able to communicate better in debates about WHO's future role.

WHO structures and processes

The unique character demonstrated by each of the four Regional Offices covered by this Study demonstrates the difficulty of such a large organisation maintaining a single coherent structure. The Regions have *decentralised control and considerable autonomy, and although they follow uniform procedures*, these have been adapted to their own systems. They also support the activities of groups of very diverse countries, disparate both within and between regions.

The Study found *regional differences in managerial style and efficiency, in the autonomy of the WR, in programme profile and in approaches to programme evaluation, monitoring and documentation*. The regions also differed in the way they related to

WHOHQ. In broad and general terms, SEARO had an "open door policy" with fairly free access for HQ staff and programmes, yet based on a two way communication; AFRO could in some cases be seen as managed and overtaken by HQ programmes and initiatives, whereas WPRO and PAHO/AMRO set their own terms for HQ involvement, being selective and keeping more of a distance. This appeared to be an even stronger feature in WPRO than in PAHO. There are also regional differences in resource mobilisation and reputation as an executing agency.

On the other hand, the Study found no obvious regional differences in relevance and appropriateness of the programme profile, the extent to which programmes showed internal coherence or fragmentation, in the effectiveness of the tracer programmes or in the way WHO at the country level is dependent on strategic alliances with other partners. These questions are therefore likely to be broadly systems-related.

The Study concludes that there is *unnecessary complexity of structures and procedures within WHO regarding the identification, selection and support of health priorities at country level*. In principle, the three levels of the organisation are structured to create complementary top-down and bottom-up mechanisms for defining country specific activities. In practice, the Study found problems with these mechanisms including their variation across regions, lengthy and burdensome requirements, fragmentation of programme support, and difficulties in harmonising global, regional and country priorities.

The current approach, where the whole system is asked to generate more activities in certain areas labeled global priorities, is not sufficiently sensitive to the variation in country needs and status of health development. In the global debate, two aims need to work in tandem: the need for a broad debate on global challenges and emerging concerns in health on the one hand, and the need for concentrating more attention to countries in greatest need on the other.

A possible approach could be to *focus the global priority debate on the global common functions, on critical research and policy/method development needs for meeting agreed gaps, and on criteria for allocations to countries in need of country specific support*. At the country level, the first concern ought to be whether there is capacity to ensure implementation of those basic policies and principles that all member states have agreed on in their own health system development; whether through their own means, with WHO support or through other types of assistance. The key priority question at the country level would then be whether the WHO resources, allocated for country specific functions, are used strategically to fill capacity gaps and imbalances which may prevail in that particular country, rather than seeking to match a globally established percentage allocations for certain activities. Such a system would probably continue to require an intermediate mechanism (such as the current regional level) for assisting communication between the global and country levels, for mobilising and enabling joint inter-country action, and for linking countries to a pool of technical expertise.

The Study concludes *that monitoring and evaluation of WHO country specific activities have been too closely tied to inputs, and insufficiently linked to outcomes or achievements*. While it is agreed that one cannot measure the precise impact of WHO

on health development given the multiplicity of contributing actors and variables in all countries, the Study found that monitoring and evaluation was almost exclusively directed at accounting for, and reporting on, financial resources. There is a need for WHO to use monitoring and evaluation to generate information that can be used more strategically in managing country specific activities. Some examples include monitoring the careers of WHO fellows, measuring the national dissemination and use of WHO technical guidelines, and performance appraisal of WHOCO personnel. Staff within WHOCOs, in turn, must be supported with the capacity to carry out such requirements through appropriate training, resources and feedback mechanisms.

Across the twelve case studies and four regions, *WHO Country Office size and programme budget are not related to country capacity or need*. The 3 low capacity AFRO case studies have the smallest WHOCOs, whereas the 3 low capacity case studies from the other regions, have the largest number of WHO staff. All 3 case studies in the high capacity cluster have WHOCOs larger than those in 3 low capacity and 3 medium capacity countries. The difference is more extreme for the PAHO/AMRO high capacity case studies. *Within* the regions, there is some relationship between capacity and WHOCO size, but this is less so for the 5 AFRO case studies. Similarly, the case studies with the smallest total country programme budgets (RBFs and EBFs) are in AFRO, and those with the largest are in PAHO/AMRO, and SEARO. Thus WHO is not achieving its own objective to direct resources to countries in greatest need.

However, *in areas such as advocacy and policy dialogue, WHO's role cannot be measured through the volume of funding alone*. The level of financing is not sufficient as the main measure of the mix between activities that support policy formulation and activities that support implementation of policies. There is still a lot of work to be done to find a way to assess the effectiveness of WHO's broad inputs to the country level.

WHO regular budget funding is different in nature from that of other donors because the government can have a stronger voice in deciding on their use. Although the amounts of WHO RBFs are relatively small compared to funding from other donors, *they are more dependable over time, and the government retains some flexibility in the way they are used*. For example, RBFs can be used in "non-fashionable" areas. EBFs now form a substantial part of WHO funding at all three levels of the Organisation. The focus and use of EBFs are more reflective of donor interests.

The patterns of expenditure for RBFs and EBFs show that they differ in stability over time and the types of activities and programmes supported by them. RBFs have been generally more stable across the two biennia in the case studies, and more broadly deployed across the four strategic programme areas. In contrast, EBFs fluctuated more, and tended to be concentrated on Integrated Control of Disease. This raises the question as to whether WHO's deployment of RBFs and EBFs is appropriately complementary to support a unified WHO approach from all levels to underpin countries' own national health strategies. The variability of EBFs and decisions about their use raise questions for the capacity of WHO to establish longer-term planning of activities at country level.

It can be difficult to plan for the coordinated use of RBFs and EBFs, as during WHO's long planning process, the anticipated level of EBFs that will actually be available is not accurately known. Increased earmarking of EBFs for use in specific countries, further

complicates overall planning, and requires new steps to accommodate new approaches to country specific, coordinated sector investment. Yet it ought to be possible to establish an improved planning framework, such as has been achieved in some of the other UN-agencies. The implications of a frozen regular budget, and decreasing EBFs in some regions, require WHO to have good financial management information in order to maximise the use of its resources. However, Study findings do not indicate that this is the case. Financial information on total support to individual countries is generally unclear, and there was no one source which was able to give an overall picture. Moreover, information between HQ, ROs and COs often conflicted. Financial information available to WHOCOs and the MoH is not conducive to effective management.

The Study concludes that the *professional and administrative capacity of WHO, and technical and logistical support, at country level has been uneven across the case studies*. In part this has been due to an inadequate match between WHO support and country need. However, the Study finds that there is a general requirement to strengthen personnel management through more transparent recruitment and appointment procedures, strategic assessment of human resource needs (e.g. skills mix), rationalisation of responsibilities, training and development, and performance indicators.

Although they have improved, the procedures for selection and recruitment of WRs, Country Office staff and consultants are inadequate in many case studies, and continue to be influenced by Organisational politics. Among the case studies there are past examples of poorly functioning WRs being left in place, even though MoH and other partners in health have submitted requests or suggestions to WHO for their replacement. In several of the case studies, present WRs were struggling to overcome the loss of the Organization's reputation and role in the country due to poor performance of a previous WR, especially in the AFRO region. This is an area in which changes towards recruitment by competition, qualification, and using transparent procedures are necessary.

In sum, the Study Team recognised that there is not one WHO, but many, because of the relative decentralisation to the regional structure. Further, the Team's findings emphasise that because of the context in which WHO is operating, there is a need for many 'different WHO's', if the concern is for relevance to the country context and optimal collaboration among countries. It is however not clear to the Team that geographical proximity is the most relevant grouping criterion, or whether a completely different regional pattern should be established for inter-regional linkages among countries with similar problems. The findings from the case studies in the four regions confirm that it is a challenge to find the unifying principle in this complex and diverse Organisation, without losing the necessary room for diversity.

WHO programmes and activities

The Collaborative Programme of WHO is more than the activities directly supported by its budgets. The Study concludes that WHO inputs to sustainable health sector development, including national capacity, has been relevant to country needs in some of the case studies. Support for training of nationals and research capacity were two notable examples. There is a need for more of such inputs and their provision more strategically

across countries and regions according to needs and capacity. The Study also concludes that there is *strong evidence of the utility of WHO inputs to the development and implementation of national technical standards and norms*. This is one of the key inputs and most highly valued contribution by WHO to health development at country level.

Its role in advocacy and as an arena for common global functions is summarised under mandate and role above. Another set of activities which are not reflected through the budgeted programmes is the broad area of resource mobilisation. There is no clear pattern in the size of the country programmes in relation to country need or capacity, for example with regard to GNP per capita, government expenditure on health or health capacity. The Study describes collaborative programmes which vary greatly, both in the scale of operations, their strategic orientation, the mix of activities and tools, the balance among functions and the source of funding.

Programmes generally lack a coherence that demonstrate an internal logic between the programme components. On the other hand, the activities are tailored into specific gaps in the health system based on priorities established by the MoH, and are as such unique. Often the activities supported by WHO serve to take new initiatives, or to facilitate development of a programme area until it can be funded through other sources.

There was a great deal of difference in the focus of the WHO country programme budget between the countries, although eight case studies spent a higher proportion of the budget on Integrated Control of Disease compared to the other three strategic programme areas (Health Policy and Management; Health Services Development; or Promotion and Protection of Health). There was also wide variation in which of the five functional categories WHOCOs concentrated their effort in programme implementation: advocacy, establishing norms, policy and planning; research; information dissemination and technical operations support. The most important function for implementing activities was judged by the WHOCOs to be technical operations support, with 29% of total effort across all case studies, but its importance varied from 44% in Bangladesh to between 10-20% in other countries. Technical operations support involves direct implementation of health programmes, and strongest emphasis was on Integrated Control of Diseases and Promotion and Protection of Health. The emphasis on advocacy was on average 21% of total effort, with 40% focused on the Promotion and Protection of Health. About the same level of effort was expended on establishing norms, policy and planning. Research was the most neglected functional categories with only 10% of total effort across all case studies. In Thailand and Tanzania more emphasis was given to research.

WHOCOs used a range of different tools to carry out the country programmes. Courses and seminars are indicated to be the most important tool for implementation of programmes and activities (18%) across all the case studies. Including the effort for fellowships, the two account for 26% of the "effort" on all the tools. The most striking finding is the low level of effort afforded to linkages with other agencies, only 8% of effort across all the tools. Some WHOCOs indicate no use of linkages at all (Ethiopia, Nicaragua, Haiti, Bangladesh). However, overall there is no clear pattern in the use of tools across strategic areas by need and capacity or by region, except for the two WPRO case studies.

No specific strategic focus for WHO support was evident across regions in the case studies with lowest capacity and greatest need, neither in terms of volume and use of resources, collaborative programme profile or in better managed and more effective partnerships.

Acknowledging that assessing the relevance and appropriateness of WHO programmes needs to be in relation to both the country needs and the activities of other donors, the Study was *not able to find any consistent match between critical gaps in national policy and WHO involvement*. Programmes are broadly relevant to some country needs, because of the way they are developed in close partnership with the MoH, and can pick up areas which cannot easily be supported through other sources. The case studies illustrate *wide variation in the types of activities and programmes* undertaken by WHO, the functions and tools receiving emphasis, and linkages with other health actors. In several case studies, the appropriateness of the mix of functions and tools was being questioned. There is some evidence that this variation may be related to the specific needs and capacities of a given country, but the Study noted a number of policy and implementation gaps in national health systems. Several of these were of a nature where WHO's role might have been particularly useful, but where its ability to respond was low, either due to low priority and interest in MoH or WHO, or because WHO systems constraints made it difficult to make an adequate response in time.

In the area of reproductive health, one of the global priority areas of WHO and where many partners compete over turf, the Study found gaps both in terms of policy and partnerships. The WPRO and PAHO/AMRO case study WHOCOs had an active engagement health reform, but this was much less the case in the other regions. Overall, there was also *limited involvement in quality assurance*, service management and service models, which again represent growing challenges in systems with an increasingly diverse mix of public and private providers. A particular concern noted was the lack of a global knowledge base to assist countries as they struggle with reform options and implications of reform. The need to address this area is therefore urgent, as also acknowledged by the WHA (noted above).

In spite of high interest in the area of information and information management, the Study noted a need for more consolidated approaches, where partners pull together, and where the country's own *need for information to inform policy and manage care* is the primary aim, rather than the reporting requirements and interests of agencies. WHO did not have a key role in ensuring that such consolidation take place in any of the case studies.

Similarly, in terms of human resources, WHO has made strong achievements in human resource development, *whereas inadequate attention has been given to issues concerning human resource management* at the country level. This area stands out as one of the most critical gaps in national capacity, regardless of region or country capacity, and is made even more urgent by the current reform and adjustment policies undertaken in many of the case studies.

As WHO inputs take the form of technical advice, provision of tools, and support for courses, seminars or fellowships which do not necessarily cover a full project or

programme activity, it is hard to evaluate effectiveness of the WHO input in isolation. It is *the catalytic function, the initiating and piloting possibilities, the strategic use of limited inputs within a system that is primarily funded through other sources (private and public spending combined with development assistance), which represent the most promising options if the aim is to optimize the use of WHO resources.* However, this requires a strategic rather than an ad hoc approach, as was seen in some case studies.

As WHO commonly does not have the option to provide additional resources to meet the needs of service delivery, a basic question is how these kinds of technical inputs best can be directed to and through the system in order to achieve results. *The MoH is itself a main key to whether WHO potential can be used this way.* Another main cluster of factors relates to WHO processes and structures. Concentrating the small WHO resources in one or two areas in a country, may not serve to make WHO support more effective, as the resources, even when combined, will continue to be very small. The relatively low funding level and the WHO approach to working with national counterparts to build capacity in national systems make WHO programmes small in terms of visibility, but potentially robust in terms of sustainability. However, case studies indicated that capacity building was often not approached strategically, in some cases neglected, and at times even undermined by the activities of the WHOCO.

There is no evidence in this Study that WHO resources to a country would have been spent more efficiently if concentrated in one or two areas, in contrast to current practice. There is however reason to believe that *any effort to create a more standardised "WHO-package" of priority interventions to be pursued in all countries, would not be appropriate in meeting country needs.* The documentation in this report demonstrates that WHO may contribute more towards health goals in a country by what is being done in networking, mobilising non-financial resources, helping in problem solving and creating an arena for policy dialogue in a rather complex environment

WHO Governing Bodies have repeatedly underscored the importance of a strong focus on Primary Health Care, recently also discussed in the Executive Committee and the Health Assembly.⁵ While the framework for PHC elements at regional and global level provided by the Director General may make it possible to pursue a discussion of future PHC priorities, the Study was not able to identify retrospectively which of the activities at the country level reflected a PHC approach. The appropriateness in emphasis on PHC can therefore not be analysed. *Unless such activities are clearly defined and coded as part of a unified monitoring system, global priority setting and reporting will be based on uncertain information.*

An important aspect of the PHC approach is the emphasis on integrated approaches. In pursuing this question, it again becomes clear that there are no blueprint solution to the balance between disease-specific interventions and more integrated systems development. However, what is also clear is, that WHO still gains its recognition by its activities in disease control in many countries.

The Study explored WHO's role in mobilisation of resources in broad terms: financial, human, institutional, physical, information management resources and political support. It is clear that the WHOCO does not play a major role in the mobilisation of financial

resources. However, there are *activities undertaken by the WR and WHOCO staff in other resource mobilisation that suggest ways in which WHOCOs make small, incremental additions to national systems*. The numerous examples of resource mobilisation demonstrate that many COs are creative and active in collaborating with others to promote a variety of activities. However, judging the quality of those interactions or their output is difficult, and they are highly dependent on the capacity, energy and interest of WR and CO staff. There are regional differences in stated policies on the WHOCO's role in mobilising resources. PAHO/AMRO and WPRO had consistently higher level of activities in all of areas of resource mobilisation.

In general, the Study found least examples of mobilising political support and human resources, whereas most emphasis across case studies and regions was put on mobilising information management resources. A seemingly low priority was given to issues related to consequences of macro-economic adjustments and social sector reforms on health. The many examples of resource mobilisation demonstrate that many COs are creative and active in collaborating with others to promote a variety of activities. However, they appear to be highly dependent on the capacity, energy and interest of WR and CO staff, and the expectations and policies of the Regional Office.

While there is strong support from HQ (notably from the research programmes such as TDR and HRP) to countries for developing research capacity, most WHOCOs do not see support to research as their role, and rank research as a low priority compared to other activities. This may be due to a lack of interaction between HQ and countries, or a lack of opportunity to demonstrate how local health research can inform policy. Another important factor is a general lack of research background in the WHOCO staff.

In terms of policy context for the three tracer programmes, many case studies had reasonably updated policies and strategies, but this varied more or less in line with the capacity clusters. *A striking feature is however the gap between policy and implementation*. This is not at least the case in the area of drugs, where the implementation of policies and regulations was noted as problematic in most of the case studies. The area of drugs is the most politically sensitive of the programme areas studied, demonstrating how limited WHO is in promoting policies if there is not sufficient receptivity and interest in the country concerned. The interests of member states as drug producers were evident in inhibiting drug policy and implementation.

In terms of national ability to fund programmes, only three of the case studies cover more than 80% of the EPI costs from the national health budget, contrasting with other countries, particularly in Africa which cover almost none. Public spending on drugs is very low for some case studies, while other countries still only cover somewhat more than 20% of the total public drug budget. With the exception of Thailand, the public sector is not able to contribute significantly to the national malaria control programmes in the case studies.

The WHO role in the three tracers in the case studies has varied from heavy operational support, to a marginal observer role, or contributing to very specific components. The striking finding is that there is no obvious match between the country needs and capacity, and WHO level and profile of collaborative activities in the tracer programmes. *The HQ*

established criteria for involvement in countries did not appear to influence WHO's actual presence and profile. The level of involvement depended more on the availability of donor partners wanting to work through WHO in that particular country. In relation to DAP, donor earmarking of funds for activities in specific countries has clearly influenced the choice of countries for more intensified WHO support. MoH commitment and ability to use WHO in policy development and as a technical resource is manifest as an important factor determining WHO role and activities in the case studies.

The effectiveness and relevance of WHO established global norms and instruments for country level policies and strategy formulation was affirmed for all the tracers in the case studies. The policies developed and agreed through the work of WHO at the global level were taken up and accepted as basic to both national and donor policies.

The effectiveness of WHO programme operation at the country level is harder to judge, because of the complex pattern of multiple partners for both EPI and DAP, and the dependency on national system factors for the three tracers. The NID strategy, where implemented, has served as an instrument for raising general immunisation coverage and for re-establishing infrastructure and motivation for EPI, and thereby demonstrated results, at least in the short-term. In several case studies one could raise doubts about the use and effectiveness of WHO consultancies, as measured against the low rate of advice and recommendations actually implemented. Effective linkages and partnerships are salient as a critical element in overall effectiveness in the tracer programmes. WHO has been instrumental to establish links between partners in EPI, but in the case studies, this has been much less the case for DAP.

Finally, while the CO often assists the MoH in developing its overall plan or in presenting a structured overview of national health status and needs to other partners, COs do not make the same effort to promote their own profile, style of operations and activities in the country. Much more could be done to present what the CO is doing, and could do, to give the WHOCO a more recognised presence at country level.

WHO and other partners in health development

As is clear throughout this report, the health policy environment has become much more pluralistic, with many different stakeholders.

The key linkage for WHO at country level is the MoH. This special relationship, along with its nature as a technical rather than a financing resource agency, gives WHO its specificity. Despite widespread changes in the number and type of institutional actors in the case studies, WHO has maintained and protected its historical relationship. The strength of this linkage has been the potential for WHO as a privileged partner with MoH, to provide policy advice and have close collaboration. The potential disadvantages are a weak MoH vis-à-vis other national health institutions, the risk of compromising WHO's neutrality and the neglect of other key actors within the health sector.

It is necessary, therefore, for WHO to develop flexible mechanisms of working at country level which balance linkages with a wider range of health actors. The Study found that many case studies have experienced a greater pluralism in the health sector⁶

which WHO has not yet responded fully to. *There is room for WHO to broaden its links with other national institutions within member states without sacrificing the advantages of its current linkages with the MoH.*

WHO's main strength for the MoH is its relatively neutral position in comparison with the interests of other agencies, and its technical knowledge, whether in the form of access to individual expertise, through consultants for example, or to guidelines, norms, standards or training materials. These also form WHO's main attraction for other agencies, and in addition, WHO is seen to be in a strategic position for communication and influence with the MoH. However, some feel its independence and neutrality is called into question because of its closeness to the MoH. Occasionally in some case studies WHO strategic partnerships with selected bilateral agencies are questioned in a similar way.

WHO's role as neutral broker, advisor and facilitator is dependent on many factors: the dominance of other actors (who may not want to be part of networks or coordination mechanisms, or may want to take the lead in such mechanisms); the capacity and interest of the MoH; the capacity and interest of the WR; the context in which coordination is happening. However, it is not only WHO's neutrality which gives credence to its role in coordination - it is also its acknowledged expertise and technical knowledge in the health field. In a number of the case studies WHO were actively building strategic alliances to meet country needs through collaborative efforts.

There is a need for WHO to be more aware of the changing political economy of health in member states which directly affects which institutions WHO could and should be working with. Case studies vary in the number, types and relative strengths of national actors, and WHO must understand each country's institutional map, and then build coalitions and alliances with key institutions likely to contribute most appropriately and effectively to health development. This may be around more specific health issues or policies, particularly given the broad scope of health needs.

The Study noted that UN organisations have looked to WHO for technical guidance and expertise, and in some areas have encouraged the Organisation to take the lead role among UN organisations in the health sector. WHO has maintained linkages through a range of mechanisms, both formal and informal, which have led to greater or lesser degrees of interaction. Even so, *project ownership and competition over territory was noted as a barrier in several of the case studies, both in relation to UNICEF and UNFPA.* Similarly, an increasing engagement of the international financing institutions was in some instances perceived as a threat to WHO's established role at the country level.

WHO has maintained *few linkages with nongovernmental organisations, both indigenous and international, in the case studies.* This has been so even in case studies where NGOs have been prominent actors in the health sector. Given the increased importance of NGOs as a channel for external health resources, that there is a need for WHO to establish more systematic links with NGOs at the country level.

The Study concludes that *WHO can be more proactive in raising awareness and improving dissemination of its "niche" products, particularly to counter the lower influence due to limited financial resources.* In general, WHO has maintained a low-key presence in the case studies and more could be done to enable WHOCOs to ensure products developed through common global activities will be available and applied for health development at the country level.

WHO is *generally not functioning as a coordinator of external health resources as a whole.* This responsibility falls upon the MoH or, in some countries, with another external agency. The exception among the case studies has been Haiti where WHO acted as the lead executing agency for humanitarian assistance for the health sector. However, WHO plays a lead role on specific issues and projects such as UNAIDS. The Study concludes that WHO should give more attention to supporting the MoH as the lead coordinating agency at country level wherever possible (i.e. national capacity building).

While WHO should develop stronger linkages with other health actors, assert its organisational strengths more prominently, and support the MoH in strengthening coordination of health development, the Study concludes *that many WHOCOs do not have the capacity at present to achieve these objectives.* As previously discussed, the formal mandate of WHO at country level remains poorly articulated. The Constitution states that WHO should "act as the directing and co-ordinating authority on international health work", and to work "in co-operation with other specialised agencies where necessary" on a range of other functions.⁷ This broad remit is not supported, for example, by the job description of the WR which says little about his/her role in developing linkages with other partners in health development. Furthermore, while the mandate to act as the "directing and co-ordinating authority" is consistent across WHO regions, the Study finds that the capacities of the WHOCOs are not. There is a need to develop and apply more explicit criteria that, inter alia, would enable WHOCOs to play a more prominent role in developing linkages.

WHO frequently takes on the role as an executing agency ranging from administering to actually implementing projects with resources from other donors. As would be expected, WHO has high activity as executing agency in some low capacity countries (Mali and Bangladesh). However, WHOCOs still execute projects in higher capacity countries such as Nicaragua, Ecuador. This would appear to be beyond the needs of those countries, and contrary to WHO's stated policies of focusing effort to countries in greatest need, and capacity building. The quandary is that the experience with WHO as an executing agency, in terms of efficiency and effectiveness, has been positive in higher capacity countries and certain regions (Nicaragua, Ecuador, Haiti and Cambodia), but less positive in lower capacity countries and other regions (Mali, Cameroon, Mozambique) where donors were critical of WHO procedures and low level of project implementation.

The Study Team recognised that WHO technical expertise may lack credibility if it is too distanced from action in the field, but had doubts as to the validity of WHO's role as executing agency, where WHO is merely administering resources on behalf of other agencies, and has been little involved in the planning and development of the health policies it is overseeing. The Study Team felt that the general principle should be

national execution of projects with technical support from WHO, and that much more critical criteria should be utilised in deciding whether WHO becomes an executing agency. An example is given in Table 7.9 (but additional criteria could be added).

In some case studies WHO is missing opportunities for advocacy, and may have compromised its independence by being an executing agency for other organisations. Moreover, through playing a strong implementation role it may be undermining (however inadvertently) MoH or other national capacity. More critical criteria should be developed for deciding the circumstances under which WHO should act as an executing agency, and the Study Team suggested five such situations, with three minimum criteria: specified time limits, strategic capacity building and planned transfer to a national institution or MoH. WHO should not be acting as an executing agency just for the convenience of other aid organisations (especially where there is a strong implementation dimension). The definitive circumstance for taking on executing functions, is a *clearly established need for the particular expertise of WHO, which is recognised and supported by all parties involved. It should only be in projects which are in line with WHO policies and best practice, and where WHO is invited to participate fully and independently in policy dialogue* related to the project design. Minimum criteria for WHO to function as an executing agency should be: a specified time frame, strategic capacity building and planned transfer of responsibility to national institutions.

Table 7.9 Circumstances under which WHO should act as executing agency

CIRCUMSTANCE	CONDITION
No national or other external actor can execute the project.	Contract with other actors to time limit and transfer the project
Project requires coordinated inter-country (cross border) health intervention	Establish and support inter-country coordinating mechanism to take over from WHO
Development and/or testing of innovative approach	Ensure close involvement of nationals , and prepare to eventual transfer
Required expertise is only available from WHO	Establish technical cooperation with national institution to transfer knowledge and skills, build capacity
Emergency situation which requires immediate action, and national government cannot execute the project	Incorporate long term strategy for strengthening national capacity Ensure limited timeframe.

The findings from the case studies suggest that in some instances Regional Office operations are perceived by Country Offices as hierarchical and procedure driven, often not providing the type of support most needed at country level. The Study Team observed that some regions tended to be non-analytical and not very pro-active. Although difficult to generalise, the Study Team felt there is a paucity of self-assessment and evaluation, and monitoring systems tend to be used mechanistically and not for learning or improved implementation. Globally or regionally agreed policies - on equity, on health as a human right could be more proactively pursued, possibly by making alliances

with non government organisations which may be more objective or distanced from national policy. The inter-relationship between common global and country specific functions is not served well by the long and somewhat inflexible process of priority setting at three levels in the Organisation. Common global activities are based, at least in part, on country specific activities, but the reverse is also true. Knowledge gained through global and regional surveillance, research and information exchange should be used to inform WHO activities at country level. The Study Team believes that changing the culture of the Organisation - at all levels - to a more learning orientation will make Country Offices more effective.

Endnotes: Chapter 7.

- ¹ WHA 34.24, "The meaning of WHO's international health work through coordination and technical cooperation"
- ² A 50/4, Report of the Executive Board to the World health Assembly on the proposed programme budget for the financial period 1998-1999 and response by the Director General
- ³ Methodology and findings described in the Regional report for Western Pacific Region
- ⁴ Resolution on Strengthening health systems in developing countries, World Health Assembly 1997
- ⁵ A 50/4, Report of the Executive Board to the World health Assembly on the proposed programme budget for the financial period 1998-1999 and response by the Director General
- ⁶ See for example Walt G. (1996), "International Organizations in Health: The Problem of Leadership" in *Enhancing the Performance of International Health Institutions, Report from the Pocantico Retreat*, Harvard Center for Population and Development Studies, Boston.
- ⁷ *Constitution of the World Health Organisation*, 1946, Chapter II.

CHAPTER 8. ESTABLISHING “ESSENTIAL PRESENCE” AT COUNTRY LEVEL

8.1 Introduction

In this chapter the Study Team suggests options for strengthening WHO's support for health development at the country level, taking account of the current process of WHO reform. While the focus is on activities in countries, it is recognised that this cannot be separated from activities undertaken at headquarters and regional levels. Discussion starts from two premises:

- there is a need and opportunity for WHO to renew and reassert its role in global health cooperation
- the status quo is not an acceptable option, and WHO needs to review and strengthen its role at country level

The chapter is based on the findings for the twelve case studies, consultations with Special Advisers, staff at Regional Offices and Headquarters, and a review of recent literature and documents on WHO reform.¹ It addresses the conceptual framework of mandates, programmes, structures and linkages, but integrates these in a series of crucial questions.

8.2 Establishing WHO essential presence at country level

WHO's “essential presence” is proposed as the mechanism by which the Organisation relates to each member state at the country level. “Essential” is used in the sense of being necessary and sufficient for fulfilling an agreed role. For it to be rational and effective, the essential presence cannot have identical features in all countries. Rather, its shape should be determined in each country, in consultation with the national authorities and other relevant groups, by using the type of analytical process discussed below. The nature of the essential presence, which would range from a physical presence in the form of a WHOCO or a liaison office, to no physical presence, would thus vary from country to country and over time in the same country. Essential presence should be reassessed regularly to ensure that country specific activities and the size of the Country Office are adjusted in response to changes in national capacity and the health policy environment over time. Criteria and strategies are needed for reducing and phasing out Country Offices.

There are many potential mixes of functions which WHO could provide depending on a country's needs and capacities. Table 8.1 suggests five potential models of WHO essential presence, each with a different mixture of common global and country specific functions. They reflect a continuum of support by WHO, from category 1, a maximum physical and functional presence in countries of greatest need, and with few other partners, to no physical presence, but a functional presence, for developed market economies. The involvement of the most developed countries in common global functions is served by established national mechanisms in the Ministries of Health and other relevant institutions: bilateral aid agencies and WHO collaborating centres. WHOCOs would not necessarily be tied to providing only the functions indicated in the

table, but their financial support through WHO would be tied to those functions. Any other functions undertaken would have to use funds mobilised from other sources.

Table 8.1 illustrates how WHO's essential presence should vary with national capacity. From the least developed countries (+) to the most developed (+++++), WHO's physical presence is adjusted to match the needs of each member state.

Table 8.1 Five models for WHO's essential presence at country level

Category	National Capacity	FUNCTIONS			WHO's ESSENTIAL PRESENCE
		Common Global	Country Specific		
			Health Policy	Technical operations support	
1	+	WW	WWW	W	Large WHO physical presence including support for technical operations.
2	++	W	WW	W/N	Smaller WHO physical presence with little or no support for implementation of programmes
3	+++	W/N	W	N	Minimal WHOCO. Increasing reliance on national institutions and personnel
4	++++	N	W/N	N	Liaison office to facilitate contact with WHO. Mostly reliant on national resources. Presence of WHO staff intermittent or in special circumstances
5	+++++	N	N	N	Complete self-reliance on national institutions

Key

National capacity from + = "Low" to +++++ = "High"

W = Small WHO physical presence; WWW = Large WHO physical presence

W/N = Small WHO physical presence complementing national institutions and staff.

N = National institutions and staff

1. The category 1 office would represent the largest presence by WHO, would have highly competent external personnel, and be located in the countries with the highest needs and the lowest national capacity. In these countries, WHO will have agreed to provide support to the implementation of programmes, based on established need (using criteria similar to those suggested in Box 8.1), as well as taking on an appropriate role of neutral broker, facilitator, adviser. This model would be most relevant to countries like Cambodia, Ethiopia, Haiti, Mali, and Mozambique. However, in countries of great need, but where there are many external actors (such as Bangladesh), WHO essential presence may be category 2 or 3 rather than 1. Conversely, in countries of relatively higher capacity, but with little other external support, category 1 may be appropriate.

2. The category 2 office would provide a somewhat smaller WHO presence at country level. The WHOCO would be responsible for supporting all regular common global and country specific functions with the exception of support to the actual implementation of country health programmes. Among the case studies, none of the countries currently fit this category. However, it would be most relevant for Ecuador, Nicaragua and Papua New Guinea, requiring a negotiated scaling down of WHO involvement in implementation of programmes.

3. The category 3 model would provide a limited WHO presence at the country level, primarily involving negotiated support for three country specific functions: health advocacy, norms, policy and planning, and information dissemination. In addition there might be arrangements for intermittent support for policy development. Other functions would be carried out by the national government or national institutions. This model would be most relevant to middle-income countries, such as Thailand or Brazil. There would need to be regular evaluation for anticipated transition from category 3 to category 4 or 5.

4. The next level of WHO essential presence is the category 4 office, which is characterised by existing Liaison Offices. This model would focus largely on information dissemination support, and intermittent support for policy development. Such offices would be located in countries where there is a high level of national capacity, but where there are acute or transitory problems (e.g. East and Central European countries, South Africa). Such offices could be restructured, as category 3 or 5, if required, after completing the sort of analytical process described below. A country might scale down its WHOCO from category 3 to 4, for the final five to ten years before moving towards having no WHO physical presence in country.

5. Finally, WHO essential presence would be at the functional level only (no physical Country Office) in high income countries where common global and country specific functions are carried out by the national government. This would include most of the industrialised countries, where support for WHO is channelled through (and often shared between) the Ministry or Department of Health and/or the country's aid agency. Even in these countries it may be desirable to have a mechanism with some degree of independence from government, particularly for the advocacy and watch functions. These countries would draw on WHO's knowledge and expertise to support national health policies, using products derived from common global functions, and would contribute to the identification, formulation and implementation of those common global functions. They would also continue to support lower-income countries through voluntary contributions to WHO.

WHO's ultimate goal should be to build sufficient national capacity to enable countries to assume responsibility for country specific functions and participation in common global functions. A measure of WHO's success, therefore, would be appropriate movement of countries from a greater to a lesser intensity of presence. In working to achieve this goal, a substantial proportion of the WHOCO's work should be focused on developing national capacity in many of these functions.

At all levels of essential presence, (but especially for levels 1 to 4) there is a requirement for regular analysis of country capacity and the role of WHO, as described in section 8.3. **All WHOCOs should be able to be restructured to higher or lower levels, retained at the same level, or phased out, depending on the results of such reviews.** Transition to a less intense level of essential presence may be phased over a number of years. Conversely, if there is an identified need for more intense WHO essential presence, then transition ought to be reasonably rapid, but continue at that more intense level for a limited period of time.

In sum, the concept of essential presence has some important features which make it attractive as the potential mechanism through which WHO relates to its member states at the country level:

- **Universal** : It is a global concept that is relevant on a global scale to all member states of the Organisation. This study specifically focused on the needs of developing countries but the essential presence concept also applies to developed countries which do not require a WHO physical presence. Developed countries should however, review the mechanisms for performing common global functions such that on the one hand they can make even more effective contributions to the shared public goods and on the other hand, derive maximum benefits from their association with WHO.
- **Logical & Systematic** : It relates WHO's response to the needs of the member state taking note of the existence of other resources both national and foreign.
- **Progressive** : It proposes graduated change in WHO's relationship with member states.
- **Interactive** : Decisions will be based on situation analysis in collaboration with the member state and other relevant parties.
- **Fair** : It will promote allocative equity by linking WHO's input to the needs of the country. This should reduce the anomalies noted in the Study in which countries that were judged to be most in need received the smallest allocations of RBFs.
- **Flexible** : Rather than using stereotyped packages, the model is adaptable. Essential presence is designed to adapt to the local situation and is not based on pre-conceived notions.
- **Forward looking** : The concept sets a forward looking plan in which the relationship of each member state is based on its current status but with strong encouragement to developing countries to move progressively from dependence on WHO's physical presence to increasing self-reliance.

8.3 How to assess WHO's essential presence at country level?

The balance between common global and country specific functions

One of the foremost issues identified in discussion about WHO reform is the need for the Organisation to define more clearly its functions and activities, and to prioritise among them. There have been a number of efforts to classify the varied activities of WHO² but the task has been complicated by vague, undefined or variable use of such terms as normative, technical cooperation and operational activities.

As described in Chapter 1, this Study builds on the distinction used in the Phase 1 Study between common global and country specific functions. **Common global functions** are defined as 'global functions of salience to all member states, regardless of the state of health development in the country. They include consensus building on shared values, cross-learning and transfer of knowledge, production and sharing of international public goods, including research. All member states are concerned with and may be committed to these common global functions, and participate in their identification, formulation and

implementation'. **Country specific functions** are defined as those 'aimed at assisting countries with special needs, responding to their requests for support in order to develop and implement their own health services. Country specific functions may include advocacy, norms, policies and planning, research, information and dissemination and technical operations support, but are dependent on the capacity, needs and interest of a country, and would evolve over time'.

Focusing on country specific functions, the Study concludes that the process of selecting the most appropriate activities for WHO within a country should take account of four factors:

- the specific needs and capacities of the country concerned
- the ability and commitment of the country concerned to make use of WHO's specific contribution
- activities of other external agencies in the health sector
- WHO's ability to respond within a given country

First, it is necessary to define the particular needs and capacities of the country concerned when selecting WHO's country specific activities. The Study Team believes that WHO should agree on a set of criteria for assessing country needs and capacities in a regular and systematic way. Any such criteria developed should be precise and related to potential WHO functions and should replace historical precedents for allocation of WHO resources. The ultimate aim of WHO's support to countries is to improve the health of the population. The Organisation's specific objective should be to build and strengthen national capacity to achieve this goal. In Chapter 2 the Study Team used two sets of criteria (Tables 2.2 and 2.3) for the 12 case studies to assess country needs and capacity, drawing on a variety of sources. Such criteria could be enhanced by the addition of other data (such as number of trained professionals in particular fields) or more time-sensitive qualitative information.

Box 8.1 Possible criteria for assessing country health needs and capacities

Assessing country needs and capacity
Total population
Annual population growth
Infant mortality rate
Maternal mortality rate
Under 5 mortality rate
Life expectancy rate
GNP per capita
Govt health budget as % of GNP
Access to health services
Coverage of immunisation
Literacy rate
Human resources

Second, the country itself would need to examine the kinds of partnerships for health it sees as desirable and realistic, and elucidate its interest, ability and commitment in

relation to collaborating with WHO as a member state. In order to make the most effective use of national and international resources invested in the health services, (including from WHO) national authorities should strive to achieve greater stability within the top management of the Ministries of Health than was evident in the case studies. The rapid turnover of political, professional and administrative leadership in the Ministries of Health is not conducive to developing and maintaining consistent policies nor does it facilitate effective management.

Third, the Study Team believes that, in addition to the above, WHO should tailor its engagement to the presence, capacity and role of other actors in each country (both internal and external). Mapping exercises regarding stakeholders' inputs and interests in the countries' health system should be undertaken systematically. Strong preference should be given to supporting national actors to carry out country specific functions wherever possible. Where national actors are able to carry out such a function, WHO should not. Rather than directly implementing health programmes, WHO should help national authorities to mobilise partners from within the country and from external agencies. And where other external partners can provide technically appropriate support to the implementation of health programmes, that is acceptable to MoH, WHO should support and complement that role, rather than compete.

Fourth, the Study Team believes that if the above exercise is undertaken and well documented, the WHO Country Office will be in a better position to decide how to respond to country needs. Given the increased number of actors within the health sector, an analysis of shaping WHO's essential presence would explore questions such as: what functions can WHO offer that other health sector actors (national and external) cannot provide, or provide as effectively? Are there sensitive issues which can be better supported (or promoted) by WHO because of its perceived neutrality and legitimacy? Is there a 'health watch' role for WHO to play, in relation to equity, to human rights, to violence? In countries where external actors play a prominent role in country specific functions, how can WHO encourage national capacity building? And how can WHO best influence other external actors to maximise appropriate support for the country's health services?

The Study Team believes there should be a more systematic assessment to match WHO's specific functions with country needs and capacities using such questions, or others, in conjunction with a country profile of health actors as described above. This implies that there should be greater openness to diversity in the health system, and that WHO requires improved analytic capacity at all levels of the Organisation in order to support the assessment process. A systematic review should take place every four to six years, as an integral part of the country programming process and provide the basis and direction for the Country Office, and the profile for the collaborative programme between the country and WHO. The countries too, will need to build up analytical skills. The assessment process could be prepared and developed in many different ways: through regular mapping of national capacity as well as of key actors and their relative roles in health development; through active involvement in coordination mechanisms, such as sector wide approaches to programmes or through other forms of collaboration and dialogue. It would include an analysis of data, reports and evaluations from national and external agencies. It should be a joint review process between the national government and WHO,

with the process coordinated by the Regional Office and would lead up to the contract for the following years (see section 8.4). Including external, independent evaluators in such a process should be given serious consideration.

One of the consequences of such an assessment exercise would be that the particular mix of country specific functions offered to a given country would adapt according to changing circumstances, including improvement or deterioration in national health capacity. Clearly such a process should not preclude exceptional circumstances (e.g. health emergencies) where it may be necessary for WHO to carry out a particular function on a temporary basis (e.g. as it did in Haiti).

Tables 8.2 and 8.3 suggest how the conceptual framework, described in Chapter 1, which introduced the notion of common global and country specific functions, could be developed as part of the assessment exercise. Table 8.2 shows how WHO's common global functions might be implemented at the country level, and Table 8.3 illustrates the analytical approach for optimising country specific functions.

Table 8.2 Making the best use of WHO's common global functions at country level

COMMON GLOBAL FUNCTIONS	
NATIONAL ACTION	WHO SUPPORT
Consensus building and advocacy • effective participation in WHO governing bodies • consulting all stakeholders to achieve consensus on national health issues • monitoring and vigilance	• Guide and support national authorities in preparing for WHA and RC meetings • Stimulate and promote interactions between MoH, other ministries, the private sector, other external actors, including NGOs
Cross-learning and transfer of knowledge • Dissemination of WHO publications to relevant institutions - service, research, academic • Utilise WHO manuals, guidelines, standards in design of intervention programmes • Incorporate WHO guidelines, standards and recommended procedures in training programmes for health personnel	• Promote the wide dissemination of WHO documents within the public and private sectors • Advocate the use of WHO standards in the design of health programmes • Promote and facilitate the use of WHO manuals, guidelines and other publications in training programmes • Support to inter-country programmes
Production and sharing of international public goods • Observe international conventions for disease control, undertake surveillance • Use WHO technical standards e.g. vaccines, nomenclature of drugs etc. • Participate in global health research in neglected areas of high priority • Getting research findings into policy and practice	• Advocate WHO and other international conventions relevant to disease control, both communicable and non communicable • Advocate use of WHO standards • Encourage national institutions to engage in global health research on the basis of national capacity

Table 8.3 Making the best use of WHO's country specific functions

COUNTRY SPECIFIC FUNCTIONS	
NATIONAL ACTION	WHO COUNTRY OFFICE SUPPORT
• Define and update national health policy and overall health sector planning framework	• Stimulate and support the development of national health policy and planning framework and its periodic review
• Assess and monitor national capacity and identify gaps in human institutional and financial resources	• Promote and support critical inventory of national resources and policies in both in the public and private sectors
• Identify priority areas needing external support and coordinate such support where necessary	• Support analysis of needs for external input. Assist in mobilisation of resources and enable concerted action.
• Identify specific desired inputs where WHO has specific advantage	• Work with national authorities to identify where WHO's input can be most valuable in the context of other sources of external support
• Develop strategies for capacity building, capacity strengthening, or performance enhancement	• Support national strategies for improving capacity aiming at self-reliance

8.4 Contracting for WHO essential physical presence

The need described above, of a dynamic process of matching WHO support with country needs and capacity, thus leading to more diverse and time-limited types of support, should be accompanied by clear agreement between WHO and member states on the rights and responsibilities that accompany this relationship. Even though governments are members of WHO, this does not confer automatic entitlement to a WHO physical presence in country, or to a given level of support to country specific activities.

The physical presence of a WHOCO should be a negotiated contract, in which both parties, WHO and the MoH agree to the objectives of the WHO presence, the expected contributions and mutual responsibilities of each partner; and the expected outcomes over a particular time period, which can be used to measure the performance of the collaborative effort. This contract would be much more explicit and outcome oriented than the country collaboration plan and budget agreement, signed by MoH and WHORO. The contract for a WHO physical presence could be part of a broader agreement between the country and other agencies, especially other UN agencies. This would have the advantage of enhancing coordinated policy and action among different agencies.

The exercise of assessing country needs, other actors in the health system and WHO's essential presence, as described above, would contribute to the monitoring of the contract. The agreement reached in the contract would be time-limited, say four to six years in the first instance, and would be renewable for a similar period after an appropriate review. The contract does not suggest conditionality as with World Bank loans. Never-the-less, the continuation of a WHOCO would cease to be taken for granted as a routine entitlement, but would be contingent on need and an agreement in which both partners have duties and expectations. If the country does not fulfil its contractual obligation, then details and reasons would be included in the review process prior to

development of the ensuing contract. If WHO does not fulfil its contractual obligation, then the member state should be able to raise this issue through appropriately established procedures for this purpose. Overall, WHO's role should be supportive to countries, but there needs to be a clear understanding of legitimate expectations of both parties.

8.5 Mixing the skills for essential presence

One implication of establishing different models of essential presence is that different skills will be needed in different Country Offices. Thus, the category 1 model will need a mix of generalist skills, with high capacity to manage and mobilise support (from a variety of sources) for all five functions, including some very specific technical expertise for particular problems. Staff will also need to be able to collaborate and coordinate activities with other actors in the health sector. Category 1 offices will be more complex and have more resources than other models, and therefore will need strong administrative and managerial staff of high calibre to underpin and guarantee procedures and processes. There is an argument that such offices should have greater autonomy over decision-making (e.g. on staff recruitment, consultancies, fellowships and expenditure) than Country Offices do at present.

It is clear to the Study Team that WHO Country Representatives need to have public health training and communication skills, but not necessarily medical qualifications. It is not obvious to the Team that they should have worked at the Regional Office before becoming WR (as is current practice in at least one region) although training, de-briefing, and refresher courses should be mandatory. They should be recruited for their leadership and management qualities, and the selection process should be robust and competitive, based on merit.

The proposed periodic assessment of the country's needs and WHO's response to those needs, implies a review of personnel in the WHOCO, ensuring that the profile of WHO staff meet the needs of member states in relation to the Contract mentioned above. Since the requirements of member states will evolve over time, WHO cannot easily adapt to such changes by relying on too many staff with long term contracts. WHO's human resources strategy should be adapted to allow the Organisation to respond flexibly to the needs of its member states. Part of the assessment of country needs and WHO's response should include considering the employment of national experts in WHOCOs. This is a contentious issue, and needs to be decided on a case by case basis rather than by applying a general rule. On the one hand, national experts know and understand local conditions, and may be less costly to employ. On the other hand, WHO should provide expertise not available in the country, and not employ nationals who might otherwise be working in national institutions were it not for poor conditions of service and low salaries.

The main issue is that the composition of each category of office needs to be closely matched to the need of the country, rather than be prescribed by any arbitrary or generic standard.

8.6 How should WHO finance its essential presence at country level?

One of the ways of matching the type of WHO support at country level with national needs and capacities is through WHO financing. At present resources provided by WHO

are not based on country needs. In this Study, the second largest WHO regular budget allocation is to the most affluent country in the group (see Figure 4.4, page 51). There seems no rationale for allocating \$6million (1994/95) to Thailand, and only \$2m to Mozambique (see Annex 4, p.A22). The allocation of WHO's regular budget is made by initial allocation, on an unknown basis to regions. The regional allocations are then subdivided to the regional programme and the individual country programmes on an historical basis, with anomalous results. Small adjustments have been made over the years, but the mechanism does not achieve WHO's own objective of directing funds to countries in greatest need. The Study Team believes that a number of issues around budgets and expenditure should be reviewed at all levels of the Organisation.

- Resources should vary in line with the scale of essential presence, with more RBFs going to countries in greatest need with category 1 offices, and progressively fewer funds to other categories. RBFs are appreciated by countries for their continuity and relative predictability. However, RBF allocations should also be rational, based on specified criteria, and realistic, allowing WHOCOs to adequately undertake the functions for the agreed level of essential presence. Support to countries would thus no longer be dependent on inconsistent allocations to regions, but be built up from the assessed essential presence, depending on country needs.
- Currently countries receive funds from all three levels of the Organisation, with substantial amounts channelled around, but not through, the WHOCO. Funds arriving from HQ and RO are outside the country level planning process and the involvement of the Ministry of Health. Some funds from HQ (and to a lesser extent, ROs) are for common global activities rather than country specific activities. The Study Team believes that, where possible, it would assist the Organisation in analysis of its functions and funding if:
 - i) HQ and RO funding for country specific activities were channelled through the WHOCO, and preferably coordinated with the Country Collaborative planning process, involving the MoH; and
 - ii) funding for common global activities were accounted for, distinct from funding for country specific activities. As noted in Chapter 2, this differentiation between functions is not a headquarters / country division. Therefore, some effort is required to distinguish between common global and country specific activities that are funded from HQ and ROs.
- The use of extrabudgetary funds requires review. WHO should fill its acknowledged gap, and develop a policy framework for managing EBFs to improve integration with RBFs. WHO should also develop, with major donors of EBFs, a policy framework and guidelines on handling EBFs in the context of common global and country specific functions to reach greater clarity on what funds should be used for. As recommended in phase 1 of this study, the WHO EB should more actively exert governance over the use of EBFs received. In order to do this adequately, the EB needs to enunciate WHO's priorities clearly and to receive reliable information on the amount and timing of arrival of EBFs to facilitate planning for their use at global or country level.

- EBFs could be used to pay for intensive phases of global policy development or research and to correct inequities in those countries where few other donor funds are available. EBFs for country specific activities and earmarked for specific countries, should preferably be related to sector wide approaches which aim to support and develop comprehensive plans for the health sector. Such funds should be negotiated to fit the aim and scope of the contracts for WHO essential presence, following criteria agreed on by WHO governing bodies. Within such a framework (which is distinctly different from seeing WHO as an executing agency for other agencies), increased use of country specific partnerships between WHO and bilateral agencies, multilateral agencies or NGOs, may enable WHO to provide support to policy areas which are particularly sensitive and should be encouraged. Such action would need to be country focused, and would depend on how much discretion donors have at the country level. It would have implications for WHO procedures which lay down that all EBFs raised at country level be approved at headquarters.
- WHO country offices should be encouraged to strengthen its support to the MoH in mobilising additional external and internal resources in support of country health development within the framework of agreed national policies. It can be argued that WHOCOs that demonstrate they have proper accounting and auditing procedures should be allowed significant autonomy in mobilising and utilising such resources. However, this also has implications for the type of training of WRs and Liaison Officers receive in order to develop skills in these areas, and for the independence of the CO.

8.7 WHO essential presence and other health sector actors

As described in Chapters 2 and 6, one of the key features of the changing context of international health policy has been the increased number and diversity of actors. In this complex and crowded policy environment, WHO can still play a key role in most of the countries, but is facing an increasingly pluralistic situation with opportunities for greater support through new alliances and partners, but also threats through increased competition and institutional isolation. The Study Team noted three alternative strategies which WHO could pursue in more pluralistic health sectors, each of which will have organisational and programmatic implications:

- WHO could resist the increased involvement of other health sector actors and seek to reassert and re-build its leadership, especially given its clearly admired technical and scientific reputation. This implies that WHO would need more technical and financial support on a broad range of traditional and new programme areas.
- WHO could identify niches left unfilled by other health sector actors, and focus activities correspondingly. This implies a high analytical capacity in the country, clear awareness of other actors' plan, great flexibility to change direction and focus as other actors withdraw from old, or enter new, programme areas.

- WHO could exploit opportunities to build strategic alliances with other health sector actors. This implies that WHO would have to transform its exclusive relationship with the Ministry of Health to a special relationship which assists the MoH to make closer links with other health sector actors, including, possibly, the private sector.

The case studies did not identify any clear discussions of such issues at the country level. In the Americas, PAHO/AMRO is still the unrivalled health agency, but is increasingly challenged by other actors, especially the financial institutions. It is difficult to envisage WHO as the sole leader in international health work, or identifying an exclusive niche for itself, and for that reason, the last alternative seems most likely - and one which WHOCOs are already taking. In other words, in all the case studies, WHO was relying on, and cooperating with a number of other actors in the health sector, whether UN, bilateral or non-governmental. This may become a feature of WHOCOs in the future, undertaken as an explicit and positive move, to forge new alliances.

However, the Study Team felt that the context of each country is unique, and in each, the WHOCO would have to use its own analytical skills, and in dialogue with the Ministry of Health, decide what its role should be vis-à-vis coordination. There are so many different ways of coordinating in countries, and they are so liable to change that WHOCOs need be to flexible but pro-active in deciding their role in coordination. Their ability to build on opportunities will be dependent on their ability to make strategic alliances and partnerships with a wider group of actors than has sometimes been the case. Improved coordination of UN agencies would be very helpful.

8.8 How should WHO Headquarters and WHO Regional Offices support essential presence?

There has been much discussion of the organisational structure of WHO and needed reforms to improve effectiveness and efficiency. Several recent reports recommend abolishing the Regional Offices, in favour of time-limited regional bodies,³ Regional Offices limited to an advisory not policy making role, or regional desks at WHO headquarters.⁴

Using essential presence as the mechanism by which WHO relates to member states at country level requires changes in the role and function of Regional Offices. Country Offices will need to be supported in the processes of collecting and analysing information to assess the level of essential presence, and to establish, monitor and review the contract for essential presence. As discussed earlier, all levels of the Organisation require improved analytical capacity to make comprehensive assessments and to follow through with appropriate staff, financing and functions. The role for the Regional Office in determining the level of funding for each country will be focused more on assessing the level of essential presence, rather than deciding levels of funding directly. However, support for managing the use of that funding, and in additional resource mobilisation, are critical roles for Regional Offices.

Supporting inter-country action is one of WHO's comparative advantages. Its effectiveness in coordinating inter-country activities is well illustrated by the successful control of onchocerciasis in West Africa and the elimination of poliomyelitis from the

Western hemisphere. The Study Team feels that Regional Offices should support WHOCOs to build on past experience, looking for opportunities to promote inter-country collaboration and exchanges. This should cover learning from each other, sharing experiences, expertise and tested good practice, as well as collaboration in tackling common problems. It should include research on regional health problems (whether they are disease oriented such as Chagas or dengue fever, or health system research on social insurance schemes) and getting research findings into policy and practice (GRIPP).

Inter-country collaboration is a potential function for all categories of essential presence. A WHOCO could collaborate with a relevant cluster of neighbouring countries on a number of different components: identifying issues of common concern for which cross-border effort would be more efficient than individual national action; offering training or laboratory or research facilities where they are lacking or could be more effectively done in neighbouring countries; exchanging experience and expertise on particular issues; testing new disease control methods. Since the findings of the Study demonstrate that WHO is valued for its perceived neutrality and technical expertise, it can provide a platform for mutual health collaboration between neighbouring states, helping to overcome political and other obstacles to rational coordination of inter-country effort and enable wider sharing. The Study Team suggests that facilitating such inter-country collaboration should be a regional responsibility (or sub-regional responsibility with one WHOCO serving as a focal point).

Table 8.4 Collaboration through inter-country programmes

NATIONAL ACTION	WHO SUPPORT
Collaborate with WHO and relevant cluster of neighbouring countries in identifying issues of common interest for which collaborative international effort would be more efficient than individual national action	Facilitate inter-country programmes by assisting national authorities in making appropriate contributions to the common effort and obtaining expected benefits
Progressively take over responsibility for aspects of inter-country programmes	Work with national authorities to develop capacity to accept responsibility from international agents.

WHOROs should explore the possibility of purposefully building inter-country activities into the role of some of its Country Offices, especially for strategically placed offices. Thailand is a potential example. The country is strategically placed in the Indo-China peninsula; the neighbouring states share common health problems which spill over their extensive borders. The Study Team found that a variety of WHO services are currently being provided through the WHOCO in Thailand including training, technical services and co-ordinated plans for disease control. Formal recognition of the role of this office's inter-country activities could lead to a more purposeful design of its structure to match its revised functions. Table 8.4 gives examples of what national action WHOCO actions can be taken to support country specific activities on inter-country collaboration.

8.9 Summary: WHO's essential presence

1. WHO's specificity at country level is rooted in its nature as a specialised UN membership organisation, which confers a perception of neutrality and authority. It is further legitimised by its acknowledged scientific and technical expertise, and its development and implementation guidelines for disease prevention and control, and health promotion. This specificity should be protected, but needs clearer projection and differentiation from bilateral aid and development bank assistance.
2. WHO needs to develop a clearer mission statement for what it seeks to achieve at country level. The Study Team believes this should begin with the overall goal of strengthening national capacity for health development, and that the functions of the Country Office should be directed strategically and consciously towards achieving this goal.
3. WHO's "essential presence" is proposed as the mechanism by which the Organisation relates to each member state at the country level. "Essential" is used in the sense of being necessary and sufficient for fulfilling an agreed role. For it to be effective, essential presence cannot have identical features in all countries. The nature of essential presence, would range from a physical presence in the form of a WHOCO or a liaison office, to no physical presence, and would vary from country to country and over time in the same country.
4. Having a physical presence in country is not predicated on entitlement, through being a contributing member of WHO. Rather, having a WHO physical presence should be based on need and a contract between the country and WHO, with agreed rights and responsibilities for both partners. Such a contract would be at a strategic level and for a longer period than the present two year Country Collaborative Plan. The contract for a WHO physical presence could be part of a broader agreement between the country and other agencies, especially other UN agencies. This would have the advantage of enhancing coordinated policy and action among different agencies.
5. The aim of essential presence is for Country Offices to more clearly reflect country needs and capacity. The Study Team has suggested criteria for judging needs and capacity, and has presented one option for differentiating between five levels of essential presence, from no physical office to a full Country Office. Staff and funding would reflect the size and functions of each office in a more equitable way across countries than at present. Additional functions could be undertaken with resources mobilised from other sources.
6. WHO should agree on a set of criteria for assessing country needs and capacities in a regular and systematic way. Criteria should be precise and related to WHO country specific functions and should replace historical precedents for allocation of WHO resources. Essential presence should be reassessed regularly to ensure that country specific activities and the size of the Country Office are adjusted in response to changes in national capacity and the health policy environment over time. Criteria and strategies are needed for reducing and phasing out Country Offices. A measure of WHO's success, therefore, would be increasing country

capacity and the movement of countries from a greater to a lesser intensity of physical presence.

7. In order to establish and effectively use criteria to determine essential presence, changes are needed at all levels of the Organisation: the culture needs to be learning oriented, to encourage more analysis and critical appraisal; and to be less hierarchical and procedural, while retaining good practice and governance. WHO will need to develop its analytical capacity at all levels of the Organisation to evaluate and plan its country approach. There are many ways in which this could be done, from setting up special policy units within the Organisation to using systematic means of mapping actors and their inputs to the health sector, reviewing criteria for needs and capacity, and so on.
8. Having different models for Country Offices has implications for the skill mix in each Country Office, with a full essential presence demanding greater managerial and specialist competencies, and a minimal presence needing more generalist, interpersonal and communication skills. Meeting the recruitment and management requirements to ensure appropriate, well qualified, staff in all Country Offices is a challenge for WHO.
9. Funding for countries should be based on the level of essential presence (determined from country need and capacity) and the finances required to support the concomitant country specific functions. In this way there would be a more rational and equitable distribution of funds to countries across regions, rather than the present anomalies that exist between relatively rich and relatively poor regions. Extrabudgetary funds should be planned within existing SIPs or SWAPs, and where these do not exist, should be negotiated as part of country contracts.
10. WHO should review the use of extrabudgetary funds and develop a policy framework for managing EBFs to improve integration with RBFs. WHO, with major donors of EBFs, could develop guidelines on handling EBFs in the context of common global and country specific functions. The WHO EB should more actively exert governance over the use of EBFs received.
11. WHO Country Offices should be encouraged to mobilise resources from other sources on the country's behalf, and to support the country to do so. This has implications for WHO procedures in financial management and auditing. It also has implications for the autonomy of the CO, as well as for the briefing and training that WRs receive.
12. WHO should maintain its special relationship with the MoH, and building closer alliances and partnerships with other ministries. It is also imperative that WHO exploit opportunities to build strategic alliances with other actors in the health sector in order to maximise the effect of its financial and technical input for the country. Its role within the country will depend on the context, and how many other actors there are in the health sector.
13. Regional Offices should support WHOCOs in collecting and analysing information to assess the level of essential presence and to establish, monitor and review the contract for essential presence. HQ and ROs should also support essential presence through promoting inter-country activities. Inter-country collaborative exchanges

should be common to all WHO Country Offices, and inter-country programmes common to many. They should be coordinated and led by Regional Offices or selected WHOCOs serving as sub-regional focal points. Country Offices should have human and financial resources to allow MoH full participation and gain from such exchange and collaboration.

Endnotes: Chapter 8.

- ¹ Lee K 1997 A meta-analysis of recent literature on WHO reform. (SIDA: Stockholm: LSHTM: London).
- ² For example, see Sterky G, Forss K and Stenson B 1996 *Tomorrow's global health organization: ideas and options* (Ministry of Foreign Affairs: Stockholm); Frenk J, Sepulveda J, Gomez-Dantes O, McGuinness M, Knaul F, 1997 The new world order and international health *The British Medical Journal* 314; 1404-7
- ³ Sterky G, Forss K and Stenson B 1996 *Tomorrow's global health organization: ideas and options* (Ministry of Foreign Affairs: Stockholm) pp 47 -48
- ⁴ Australia 1996 *Modernising the World Health Organization: Australia's agenda for change* (Government of Australia: Canberra) p 17

CHAPTER 9. RECOMMENDATIONS

Introduction

In the Terms of Reference, the Study Team was requested to make recommendations to WHO, Member States, donors and other interested organisations. It is clear that the effectiveness and efficiency of WHO's programmes do not rest solely on the Organisation but are influenced by the actions of others, notably the host country and other external agencies. The Team has therefore, included recommendations on how countries can make more effective use of WHO's services and potential, as well as suggestions to other international agencies that are active in the health sector.

1 Essential Presence

WHO's support for countries is an expression of the relationship with its Member States. As a voluntary association of sovereign nations, every member state has the opportunity of participating in defining the goals, priorities and strategies of the Organisation, contributing to its activities and deriving benefits from its membership. Member states interact with WHO through common global and country specific functions.

The Study Team recommends that WHO should

- 1.1 Establish “**essential presence**” as the mechanism through which WHO interacts with Member States at country level. Essential presence would range from having a physical presence in the form of a fully fledged Country Office (category 1) to a situation in which national institutions perform common global and country specific functions (category 5).
- 1.2 Install physical presence (categories 1 to 4) on a time-limited, renewable, negotiated **contract**, replacing the current open ended relationship. The contract should represent an agreement between the member state and WHO, setting out clearly the objectives of the office, the mutual commitments and responsibilities, and the expected outcomes that can be used to measure the performance of the collaborative effort.
- 1.3 Base criteria for determining essential presence on social, economic and health indicators, including national health system capacity, and on the role of other actors in the health system. Criteria should specify at what stage essential presence moves from one category to another, including indications for phasing out a physical presence.
- 1.4 Institute a regular consultative assessment or review process, to determine the appropriate level of essential presence, and including HQ, RO, CO, national authorities and also external assessors to guarantee independent and objective assessment. It should be structured and adapted to the local situation, and take place every 5 to 7 years.
- 1.5 Improve analytical capacity at all levels from the Country Offices to Headquarters, in order to undertake this consultative review process. WHO should strengthen the capacity of ROs and COs to collate, synthesise, explore and discuss information that can guide the assessment and policy processes. Such analyses should include the activities of other actors in the health sector.

The Study Team recommends that Member States should

- 1.6 Support the concept of essential presence and participate in regular reviews to determine the level of WHO essential presence in their countries, collaborating with WHO to adjust the level of physical presence where indicated, in order for WHO to more equitably direct resources to countries in greatest need.
- 1.7 Review the mechanisms in developed countries for performing common global functions so they can make even more effective contributions to shared public goods, as well as derive maximum benefits from their association with WHO.

2 Financing essential presence

Currently the allocation of WHO's regular budget is made, in the first instance, as a top down allocation to regions, from which planning figures are assigned to individual countries. This approach has resulted in anomalous allocations where some of the largest RBFs are allocated to the most affluent developing countries.

The Study Team recommends that WHO should

- 2.1 Allocate funds according to the assessed level of essential presence in each individual country. This means that once the level of essential presence is decided, sufficient funding should be provided for the WHOCO to perform the associated functions. The budgets to regions would therefore be a bottom-up aggregation of individual country allocations, plus RBFs allocated specifically for regional functions, rather than the present regional system. Allocation according to essential presence would overcome the anomalies in funding that currently exist between regions, and also direct more funds to countries in greatest need.
- 2.2 Exert stronger governance over the use of EBFs and develop a policy framework and guidelines for the use of RBFs and EBFs in relation to WHO and country priorities. There should be a rationalisation of the use of RBFs and EBFs on a global basis. RBFs should be used to maintain essential presence up to level 4, and to assist additional country specific activities relevant to WHO's technical functions where there are critical gaps in national capacity not filled by other donors. EBFs could be used to pay for intensive phases of global policy development and research; and to further support WHO essential presence for countries in greatest need where few other donor funds can be mobilised.
- 2.3 Reconsider and be more proactive about resource mobilisation, facilitation and networking at the country level, and give greater autonomy to COs in raising financial resources locally for particular country-level programmes.

The Study Team recommends that multilateral and bilateral agencies should

- 2.4 Work with WHO to develop a policy framework and guidelines on managing EBFs in the context of common global and country specific functions to ensure that resources are allocated to clearly defined priority activities or needs.
- 2.5 Assist WHO planning and programming by providing the Organisation with reliable information on the amount and timing of arrival of EBFs.
- 2.6 Direct the use of earmarked EBFs to activities in line with the contract for WHO essential presence in the country.

3 Headquarters and Regional support to essential presence

The findings from the case studies confirm that it is a challenge to find the unifying principle in this complex Organisation made up of very diverse Member States, but that the answer cannot be uniformity in approach if relevance and optimal collaboration between countries is an aim. WHO needs to vary its approach in order to achieve relevance and optimal collaboration in each country.

The Study Team recommends that WHO should

- 3.1 Accept the need for decentralisation and diversity in its ongoing reform and streamlining of management procedures, in order to make the Organisation better equipped to respond to the unique situation of each country.
- 3.2 Review the regional structure of the Organisation in light of the concept of essential presence, and consider various options for the future. Such a review would include exploring the size and role of Regional Offices, and whether groupings other than geographical might be more beneficial to the countries concerned.
- 3.3 Ensure that ROs provide proactive and effective support to COs in relation to improving planning, financial, evaluation and administrative procedures in support of essential presence.
- 3.4 Establish for each programme a rationale for what expertise should be located in HQ, in Regions (or sub-regions) in order to serve global policy development and to support countries. For some programmes this may result in concentration of expertise in HQ, for others a shift to one or several regions. All programmes should be more strategic and time-bound in their use of expertise, and integrate efforts especially at country level.
- 3.5 Review the different regional experiences with delegation of authority to WRs, and develop mechanisms for increased delegation that takes into account the level of essential presence in each country.
- 3.6 Promote and facilitate a variety of approaches to inter-country collaboration, including across current regional boundaries.

4 Processes and procedures

Processes and procedures for evaluation and management of financial and human resources are recognised by WHO to be fragmented and inefficient at all levels of the Organisation, but action by WHO to correct the problems have been inadequate.

The Study Team recommends that WHO should

- 4.1 Widen its search and improve recruitment procedures for technical staff and consultants, including a review of consultancy fees, to ensure that the most appropriately qualified and experienced personnel are working at country level.
- 4.2 Strengthen the supervision, management, performance appraisal and in-service education of WHOCO staff, including WRs.

- 4.3 Simplify the planning and financial disbursement procedures to reduce the administrative burden on Ministries of Health, but still retain accountability and transparency.
- 4.4 Revise its financing systems at country and regional levels, to make processes more oriented towards financial management than accountancy, more transparent and accountable, and more useful for monitoring and cross-referencing.
- 4.5 Make monitoring and activity reports, submitted from Country to Regional Offices, problem and solution oriented. Regional Offices must make time to follow-up and give feedback on country reports, independent consultant evaluations and so on. For evaluation at country level, WHO should adopt some of the methods used by the special programmes, including the involvement of external, independent assessors. This should include evaluation of the fellowship programme.

The Study Team recommends that Member States should

- 4.6 Work to reduce delays in approval of staff and consultants proposed by WHO to work in their country, and to collaborate more effectively with WHO regarding staff recruitment, planning, disbursement and evaluation procedures.

5 Participation in the policy process

It is essential that Member States participate actively in WHO's policy process and take steps to reduce existing gaps between policy statements and implementation, which undermine the credibility of both Member States and the Organisation.

The Study Team recommends that WHO should

- 5.1 Give more attention to working with the MoH to review background papers and resolutions both before and after the WHA and RCMs, so Member States participate more actively in the policy-making bodies of the Organisation. This should be achieved through making documents more problem oriented, and by the WHOCO providing timely briefings for senior management, especially where there is rapid turnover of the MoH staff.
- 5.2 Work closely with the MoH and others to promote and incorporate into national health programmes agreed common global goals and standards. Encourage the MoH to set up mechanisms for monitoring national performance on sensitive issues such as equity. One option would be for the MoH to involve national NGOs or development institutes to monitor national performance on such issues.

The Study Team recommends that Member States should

- 5.3 Review and reduce the inconsistencies between resolutions and actions they have supported globally through WHO, and their actual practice as partners in health development, both nationally and internationally.
- 5.4 Strive to achieve greater stability and institutional memory within the top management of the Ministries of Health, in order to enhance their representation and contributions to the WHO governing bodies.

6 Partnerships

Traditionally WHO's closest relationship at the country level has been with the Ministry of Health. However, in the new plural environment of most health systems, where there may be many different external and internal actors, WHO needs to engage more actively in country-specific strategic alliances and partnerships in order to best promote its specific advantages, and to assist the member state to gain most from the different inputs to the health system.

The Study Team recommends that WHO should

- 6.1 Widen its traditional partnership with the MoH to make alliances with other relevant national and international agencies, taking on different roles depending on the constellation of different actors and the MoH capacity and interest.
- 6.2 Assist the MoH to manage its relationships with the different donors to the health system by building capacity in the health sector to manage the coordination of external assistance. One way to do this would be to assist the MoH to negotiate country-specific 'codes of conduct' between key partners that spell out mutual commitments related to policy dialogue, information sharing and reporting on resources and activities.
- 6.3 Be more selective in accepting the role of executing agency, limiting projects to those in line with agreed global policies and best practice, where WHO's specific expertise is needed, where WHO participates fully in policy dialogue and project planning, and where there is no obvious alternative. Minimum criteria for WHO to function as an executing agency should be a specified time frame, strategic capacity building and planned transfer of responsibility to national institutions.

The Study Team recommends that multilateral and bilateral agencies should

- 6.4 Use their contacts at the highest levels to reconcile their health policies so as to facilitate collaboration among their staff at the country level.
- 6.5 Consider developing strategic alliances with WHO at country level, support the role of WHOCOs and use WHO technical information and policy advice in their work at country level.

7 Information and Dissemination

WHO's technical and scientific guidelines and standards are widely appreciated. Technical documents are regarded as being scientifically sound and authoritative. The Organisation has a well established reputation for supporting disease control and health promotion activities such as immunisation. However, it could do more in a number of areas, including a better presentation of its own profile of activities in country, about which many actors, and even WHOCO staff, are surprisingly little aware.

The Study Team recommends that WHO should

- 7.1 Pay more attention to promoting its own in-country profile to show its range of activities, and to presenting a more open and accessible face to others in the health sector.

The Study Team recommends that Member States and WHO should

- 7.2 Do more to promote the dissemination of technical and scientific material, both in countries and between countries to ensure that practitioners, scientists and academics have access to relevant WHO publications and products.

8 Health Sector Reform

WHO has not been able to respond to many countries' needs for advice within the context of ongoing health reforms. The Organisation is not perceived as a credible expert adviser to national government, with requisite technical strengths and capacity in health sector reform. Nor does it have sufficient confidence or support from other partners to develop a global body of evidence based on country experiences in health sector reform.

The Study Team recommends that WHO should

- 8.1 Strengthen capabilities at all levels of the Organisation in order to respond to the challenges of health sector reform, to advise on how agreed global policies on reducing inequities and improving the quality of health can be applied in specific reform contexts, and to provide support to countries as they pursue reform efforts.
- 8.2 Make a greater effort to work with others to synthesise and exchange information on health reforms in different countries, in order to develop a body of global knowledge, accessible to countries.

The Study Team recommends that Member States and other partners in the health sector should

- 8.3 Affirm WHO's specific role in advocacy and promoting globally agreed policies, and, in the context of health reform, commit themselves to policy dialogue and information sharing at all levels.

9 Human Resources

WHO has played a major role in building human resource capacity in a large number of countries. In the current context of reform and adjustment, human resource management is an emerging challenge in many countries, with high attrition rates, poor motivation and distribution of human resources, and a need to deal with contracting and regulatory mechanisms within a mixed public and private delivery system. This is an area to which WHO, as privileged partner of the MoH, ought to pay special attention.

The Study Team recommends that WHO should

- 9.1 Make use of its role as enabler and adviser to assist the MoH in assessing manpower management needs, to build up an adequate and appropriate base of knowledge and technical expertise in order to facilitate health systems development and support.
- 9.2 Assist the MoH in advocating for better working conditions for health service staff, including a living wage and appropriate career development.

10 Research

Research is facilitated, funded and supported through many different levels of the Organisation, both in and between countries, and in collaboration with other institutions and partners. With WHO's support and coordination of international research, several new and improved technologies are being used, particularly in disease control.

The Study Team recommends that WHO should

- 10.1 Make special efforts to keep informed about ongoing, in-country health policy and systems research and assist national institutions to make proper use of research capacity and research findings.
- 10.2 Ensure that, in those countries where one of the defining functions of 'essential presence' includes research support, the WHOCO staff have sufficient skills to coordinate and call on national or external expertise to assist in research activities, and to make available research findings that have relevance to particular issues or problems identified in country.
- 10.3 Ensure WHOCOs promote the involvement of national institutions and scientists in global research by:
 - disseminating information about WHO's research programmes (HRP, TDR, CDR, etc.);
 - identifying and drawing the attention of headquarters and regional programme managers to scientists and institutions that can participate in regional and global research programmes;
 - identifying promising institutions that would benefit from capacity strengthening programmes managed by the RO or at Headquarters;
 - following up research projects funded from RO or Headquarters."

Conclusions

Implementation of the recommendations from this study would have notable impact on all levels of the Organisation but most specifically on its operations at the country level. The proposals presented would radically alter the way in which WHOCOs are designed and managed. Table 9.1 highlights some of the key recommendations as they affect WHO's work at the country level.

Table 9.1 WHO at country level: Summary of Recommendations

ISSUE	RECOMMENDATIONS
Essential Presence	• Determine the size, configuration and functions of the WHO country office on the basis of detailed analysis of each country's needs, capacity, and the role of other actors in the health sector.
Physical presence	• Develop time-limited, renewable, negotiated contracts, and changing levels of essential presence over time. • Develop strategies for adjusting the level of essential presence and, where indicated, closing country offices.
Financing essential presence	• Allocate resources on the basis of essential presence. • Increase resources to countries in greatest need, and reduce to others. • Rationalise use of RBFs and EBFs globally. • Develop policy framework and guidelines for use of EBFs. • WHOCOs to be more proactive in resource mobilisation and use.
WHO staff and consultants, and essential presence	• Match staff skills to essential presence and country needs. Ensure capabilities in research and health sector reform available where needed. • Widen the search and improve recruitment procedures for staff and consultants; Avoid making political appointments. • Improve supervision and performance appraisal of staff, including WRs • Review and update the levels of consultancy fees.
Processes and programmes to support essential presence	• Base WHO's input on the country's needs, capacity, and the role of other actors i.e. on essential presence; integral focus on capacity building. • Develop strategic alliances with other partners to maximise the benefit of input to the health sector. • Coordinate WHO's activities at all levels of the organisation, from Headquarters and Regional Office to the country level. • Assist MoH to coordinate the inputs of all actors in the health sector. • Improve dissemination of WHO technical documents, and promote more extensive use of WHOCO libraries. • Be more selective in taking on a role as executing agency. • Provide better and more timely briefings for WHA and RCMs.
WHO management to support essential presence	• Simplify the planning and financial disbursement procedures. • Improve financial management to provide greater transparency. • Improve analytical capacity at all levels of the organisation. • Make monitoring and evaluation more problem and solution oriented, and periodically involve external assessors.
Headquarters and Regional Support to essential presence	• Establish criteria for essential presence, ensure appropriate financing. • ROs support WHOCOs in analysis of data to assess essential presence. • Improve feedback and support from ROs to WHOCOs on implementation monitoring and evaluation. • Rationalise location of expert staff to support essential presence. • Provide more problem oriented briefing documents in sufficient time prior to the WHA and RCMs to facilitate briefings. • Improve WHO capabilities in health sector reform and assist in building a global body of knowledge. • Develop criteria and strategies for acting most effectively as an executing agency.
Inter-country Programmes	• Strengthen inter-country collaboration. • Facilitate inter-regional cooperation.

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“COOPERATION FOR HEALTH DEVELOPMENT”

WHO’s SUPPORT TO PROGRAMMES AT COUNTRY LEVEL (PHASE II)

Terms of Reference

I POINT OF DEPARTURE

The World Health Organisation (WHO) has a unique position as the specialised UN agency for international health. It has played a distinguished role in raising global levels of health and in assisting member states to establish approaches for health development. Recently, WHO has embarked on a reform programme designed to increase its capacity to respond to the world’s health needs in the context of global change. These reform efforts are not subject for analysis, but their effects should be manifest in the present study.

The first part of the study “Cooperation for Health Development” is a global level assessment of the role, effectiveness and value of WHO activities supported mainly through extrabudgetary funds.

The second part will focus on the role played by WHO’s support to and involvement in programmes at country level. The overall purpose of WHO supported programmes, their achievements (contribution to building essential national capacity for managing sustainable, equitable and effective health policies and systems) and the effectiveness and efficiency with which resources are used, will be examined.

II STUDY OBJECTIVES

The main objective of the study is to review WHO’s achievements at country level concerning its:-

- response to health needs and problems of the most seriously affected populations in developing countries, and
- support to national health policies and other health promotion activities in these countries.

The second study objective is to identify the potential for more effective support programmes.

The aim is to contribute towards the improvements of WHO’s overall performance to the benefit of its target groups and to provide additional information about WHO’s activities to its members and the general public.

III ISSUES AND QUESTIONS

In a selected number of countries the team shall carry out the following tasks:

1. PRIORITIES

- 1.1 Document the various components of WHO country level activities, and analyse the interrelationships between programmes supported by WHO's extrabudgetary and regular funds. Discuss degree of complementarity, overlap, gaps and/or conflict between WHO supported health efforts and other health programmes and activities supported by other partners.
- 1.2 Analyse WHO's role in technical cooperation, as described by the four core functions
 - global health policy formulation and advocacy,
 - health research and standards,
 - development of country health systems policies and strategies,
 - support for country implementation of health programmes and how it is reflected and applied at country level. Assess likely effects of the ongoing reform programme on the application of the mandate. Review potentials for increased synergy between the functions.
- 1.3 Assess the balance between the various types of activities, such as disease prevention and control, health promotion, training and health policy/health systems development, and discuss its appropriateness in relation to needs and priorities defined by the countries concerned.
- 1.4 Study whether the WHO supported programmes and activities at the regional and country levels reflect the major health needs in the region and country, taking into account the scope for improving the health status through effective interventions by countries and other partners.
- 1.5 Determine whether the WHO programme profile is changing over time, whether it responds to new health challenges and whether the profile is improving. (Ref. WHO's ongoing reform programme).
- 1.6 Identify constraints and potentials in WHO's normative and technical cooperation role at national level.
- 1.7 Assess briefly to what extent WHO adequately focuses on the major health problems and gives priority to the most seriously affected population groups in the developing countries of Africa, the Americas, Asia and the Pacific..

2. WHO'S ROLE AT COUNTRY LEVEL

- 2.1 Establish whether the WHO country level efforts are consistent with existing national health policies and priorities, and whether WHO is supporting the development of appropriate national policies i.e. through various types of advocacy work (e.g. on breast feeding and essential drugs). Assess the results of WHO's support to policy formulation and advocacy work.
- 2.2 Assess to what extent WHO has supported countries in developing health status and health care norms which are appropriate to the health situation, as well as to the economic, institutional and other resources or constraints, of the respective country.
- 2.3 Assess whether WHO has contributed adequately to the development of national technical standards and protocols (on e.g. quarantine and vaccination schedules), and whether such schedules have been implemented.

- 2.4 Describe how WHO's global or regional scientific and technical work and expertise are being utilised by WHO itself, the government or other organisations or aid agencies.
- 2.5 Study to what extent and in what areas the overall mandate and role of the organisation gives WHO a comparative advantage at the country level relative to other agencies.

3. INTERACTION AND COORDINATION AT COUNTRY LEVEL

- 3.1 Describe WHO's institutional linkages to Ministries of Health as well as relations to other ministries. Assess the actual and potential advantages, opportunities and constraints that these relations represent for WHO, relative to other donor organisations.
- 3.2 Describe the interaction between WHO and other significant agencies, organisations and groups involved in health development, such as multilateral and bilateral donors and the private sector, including NGOs.
- 3.3 Assess to what extent the complementarity between the government and the donor organisations is in line with mandates, competence and capacities of WHO as well as other major organisations.
- 3.4 Discuss whether there are adequate mechanisms for facilitating coordination between government and the donor organisations and whether WHO country offices play an appropriate role in facilitating coordination.

4. IMPLEMENTATION STRATEGIES

- 4.1 Considering the varieties of country situations and capacities, assess to what extent WHO has developed or is developing adequate strategies appropriate to the level or area of in-country action (e.g. support to policy development, institution strengthening, project implementation).
- 4.2 To what extent does WHO provide sufficient and relevant professional and administrative capacity, as well as logistical and technological support, to fulfil its role and functions.

5. WHO'S SUPPORT AND MANAGEMENT SYSTEM

- 5.1 Assess the adequacy of institutional arrangements and technical and financial support for in country programmes from regional offices, WHO headquarters, as well as donor countries and other organisations involved in health work.
- 5.2 Discuss the effects of WHO's budgeting systems, the recent changes of such systems, as well as the terms and conditions of EBFs, for WHO's in-country activities and supported programmes.
- 5.3 Discuss the role of the WHO country offices, and the adequacy of their mandate for effective and efficient planning and implementation of support programmes and activities as well as for their advisory role. Discuss the division of responsibilities between the country and regional offices.
- 5.4 Assess the adequacy of guidelines and systems for planning, monitoring and evaluation of WHO country level programme activities, including systems for task assessment and indicators or benchmarks for achievements, by WHO and/or the country concerned.

6. EFFECTIVENESS, EFFICIENCY, IMPACT AND SUSTAINABILITY

To the extent that satisfactory data can be gathered, the team shall:

- 6.1 Assess outcomes, results and impacts of WHO's technical cooperation efforts to supporting countries in
 - disease prevention and control health promotion
 - knowledge transfer and capacity building
 - health policy and systems development
 - development of health care norms, technologies, technical standards and protocols appropriate to the national or local situation.
- 6.2 Assess to what extent WHO supported activities have reached their objectives or expected results, and the relation between programme costs and benefits over time.
- 6.3 Assess the impact of programmes' activities, their integration into national systems and the extent to which they have contributed, or are likely to contribute, to capacity building and an overall sustainable health sector development.

7. RECOMMENDATIONS

- 7.1 Prepare recommendations on the above issues to WHO, and for sharing with participating recipient countries, donor countries and other organisations engaged in health work.

IV SELECTION OF COUNTRIES; DELIMITATION OF STUDY

The study shall cover 6 - 12 countries under regional offices in Africa, the Americas, Asia and the Pacific. The countries will be selected on the basis of the following criteria:

- at least two countries in each continent/region
- at least two countries that are receiving emergency health assistance
- GDP/Capita
- health status indicators
- level of coverage by local health authorities
- content and profile of WHO programme support.

The basic unit of analysis will be the totality of WHO's activities (country programme). However, a number of the issues/questions may be restricted to certain regular or co-sponsored programmes. Both the selection of countries and delimitation of issues/questions is dealt with in the Study Design.

STUDY DESIGN AND METHODS

1 Introduction

This chapter gives a brief description of the selection of case studies which was undertaken at an earlier date,¹ and goes on to describe the design, work plan and methods used to undertake the Study. Finally the constraints of undertaking the Study are discussed.

2 Selection of case studies

It was agreed to base the selection of studies on purposive rather than random sampling in order to maximise the range of WHO activities that would be represented in the Study. In selecting countries a number of inclusion criteria were used as defined by the sponsors, among which were:

- 8-12 countries from Latin America, Africa and Asia/Pacific with WHO Country Offices
- countries representative of major parts of WHO's activities
- at least 2 countries from each continent/region
- at least 2 countries receiving emergency aid from WHO

These criteria were applied with the following exclusion criteria agreed:

- countries with a population of less than 2.5 million or more than 150 million
- countries currently in conflict or highly unstable
- countries hosting a regional or subregional WHO office
- countries with a GNP of more than US\$ 8,356
- countries where data on the health sector are limited
- countries located within the European and East Mediterranean Regions (EURO & EMRO).

This method led to the selection of twelve countries which were illustrative of WHO country activities, with different scales of operation, and in varying political and economic contexts.

3 Study design

The Core Team was led by Dr Adetokunbo Lucas, (Harvard University), with Dr Sigrun Møgedal (Diakonhjemmets Internasjonale Senter, deputy team leader) and Dr Gill Walt (London School of Hygiene and Tropical Medicine) as co-directors. The other members of the Core Team were Ms Sissel Hodne Steen, Mr Stein-Erik Kruse (DiS), Dr Kelley Lee and Ms Laura Hawken (LSHTM). Ms Hawken also coordinated the Study from the secretariat established in the London School of Hygiene and Tropical Medicine.

A group of Special Advisers, selected for their wide experience and seniority, assisted the Core Team at various points of the Study: Dr Julio Frenk (Mexico), Professor Samuel Ofosu-Amaah (Ghana), Dr Elizabeth Quamina (Trinidad), Professor Chitr Sitthi-Amorn (Thailand), and Professor Patrick Vaughan (UK). They advised on the instruments developed for the Study, reviewed the country case study reports, and commented on final drafts of the final synthesis report.

Each country case study was undertaken by a team of three, led by an independent International Consultant: Mr Bo Stenson (Sweden), Ms Sheila Faure (Canada), Mr Ted Freeman (Canada), Ms Carolyn Marsh (Australia) and Ms Eleanor Sullivan (Australia). Two of the Special Advisers also served as International Consultants: Professors Ofosu-Amaah and Vaughan. Each

country team included a member of the Core Team, who visited case study countries and the relevant Regional Office with the International Consultant.ⁱⁱ

In addition, a National Consultant in each country organised the field visit, collected data beforehand, and participated as members of the country teams in the field. The National Consultants were:

Dr. Syed Jahangeer Haider, Research Evaluation Associates for Development (READ),
Dhaka, Bangladesh
Dr. Tea Phauly, UNDP, Phnom Penh, Cambodia
Dr. Gladys Martin, Independent Consultant in Public Health, Younde, Cameroon
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University, Bangkok, Thailand

4 Working phases

The Study took place over three phases.ⁱⁱⁱ During the first, in August and September 1996, a number of data instruments were prepared by the Core Team, and finalised at a workshop with the International Consultants and Special Advisers. Interviews were also undertaken by members of the Core Team with programme staff in WHOHQ, and the Team Leader gave briefings about the Study to staff at the World Bank, Washington, and UNICEF and UNDP, New York.

Visits to the case study countries and Regional Offices were made during the second phase of the Study, between October and December 1996. Besides the data collection instruments, the country team conducted in-depth interviews with the WHO Country Representatives and their staff, with Ministry of Health personnel - often the Minister - and with representatives of the leading multi- and bilateral organisations as well as non-governmental organisations. Each visit was concluded with a Round Table discussion,^{iv} to which representatives of interested parties were invited, and where observations and selected findings were shared and further explored.

The International Consultant was responsible for writing the country case study report, consulting with both the Core Team member and National Consultant. All three members of the team agreed the final report on the country. The Core Team member was responsible for a short report on the visit to the Regional Office. The reports and all the data instruments collected were submitted to the Secretariat by the end of February 1997.

The third phase of the Study began in February 1997, with a workshop attended by the Special Advisers and the Core Team, to explore the main issues emerging from the twelve country case studies and regional reports. A meeting with the Steering Group was held just before the

workshop. The results of this workshop and the following analysis are given in this final synthesis report. The country case studies are bound separately, according to region. There are thus four accompanying volumes: AFRO, including Cameroon, Ethiopia, Mali, Mozambique and Tanzania; PAHO/AMRO, including Ecuador, Haiti, and Nicaragua; SEARO, including Bangladesh and Thailand; and WPRO, including Cambodia and Papua New Guinea.

5 Data Collection Instruments

Five instruments were prepared by the Study Team. These were

- i) A Country background instrument completed by the National Consultant.
- ii) A WHOCO instrument completed by the WHO Country Office
- iii) A regional instrument completed by four WHO Regional Offices
- iv) An instrument completed by WHO division directors at Headquarters
- v) An instrument for the field visit, to guide the team in country

i) *The instrument completed by the National Consultant* contained information on the structure and staffing of the Ministry of Health, the national health budget and external resources for health, the health system, Ministry of Health capacity for planning, research, information and communication; on coordination of aid, and basic information on three tracer policies: essential drugs, malaria and expanded immunisation programmes. It also contained relevant background data on the economic and political factors, and national and international actors participating in health.

ii) *The WHO Country Office data collection instrument* asked for information on WHO's activities in country. In order to document activities, it was necessary to use the standardised classification system utilised by WHO itself. Until the Eighth General Programme of Work (1989 - 1995), WHO activities and programmes were grouped according to a Classified List of Programmes which included 15 divisions with about 53 programmes. For the Ninth General Programme of Work (1996 - 2001) a new Classified List of Programmes (CLP) was introduced which regrouped activities into 6 Appropriation Sections, consisting of 19 major programmes and 59 specific programmes. This new CLP is currently being used at Headquarters, and is being extended to regional and country levels. During this period of transition, the Study Team was required to take account of both classification systems in operation at different levels of the Organisation.

The 6 Appropriations of the new CLP are: Governing Bodies, Health Policy and Management, Health Services Development, Promotion and Protection of Health, Integrated Control of Disease and Administrative Services. The first and last appropriations are only used at Headquarters and Regional Office levels. Costs of operating the WHO Country Office (WHOCO) are included under the Health Policy and Management appropriation. The remaining four appropriations are referred to as strategic programme areas and the Study used these to describe what WHO was doing at country level (making necessary adjustments for PAHO/AMRO which uses slightly different categories):

- Health Policy and Management
- Health Services Development
- Promotion and Protection of Health
- Integrated Disease Control

In order to analyse in greater detail the intended purposes and means through which WHO carried out country activities and programmes, the Study examined each strategic area in relation to what functions and tools perceived as important by the WHOCO staff to carry out activities. A *function* is defined in terms of the intended purpose of a specific activity or

programme. A *tool* is the means or instrument by which the activity or programme is carried out to achieve the agreed purpose.

The classification of functions and tools used in the study (Box 1) is developed from a taxonomy of technical cooperation.^v

Box 1 Strategic areas, Major Programmes, Functions and Tools

Strategic Areas	Major Programmes	Functions	Tools
Health policy and management	General programme development and management Health Science and Policy National Health Policies and Programme development Biomedical and Health Information and trends	Advocacy Support for establishing norms, policies, national planning	Financial assistance Supplies and equipment Consultancies
Health services development	Organisation and management of health systems based on PHC Human resources for health Essential Drugs Quality of care and health technology	Research and research promotion support Information dissemination support	Courses and seminars Travel visits Fellowships
Promotion and protection of health	Reproductive, family, community and population health issues Health behaviour and mental health Nutrition, food security and safety Environmental Health	Technical operations support	Linkages to other health actors WR advice and facilitation
Integrated control of disease	Eradication / elimination of specific communicable diseases Control of other communicable diseases Control of noncommunicable diseases		

In addition, WHOCOs were asked to list examples of collaborative programme outputs, involvement with other agencies, and contributions made to mobilise a wide range of national and external resources, in support of health development at the country level, both within and outside the regular programme of work.

The Core Team thus had an overall picture of the different activities undertaken by each WHOCO, but also an overview of where it was perceived that most effort was expended. This was then compared with the Eighth and Ninth General Programme of Work (GPW) documents, which give the priorities and objectives for WHO's work over a six year period.^{vi}

iii) *The Regional Office data collection instrument* was completed by the four Regional Offices, using similar categories as above, giving financial and programme data, showing Regional Office support to the countries.

iv) *The Headquarters data collection instrument* was completed by Divisional Directors, and described the extent of support of all programmes to each of the twelve countries.

v) *The fieldwork instrument* was used by the three-member team in each country, to ensure that the main questions under each of the four key areas - mandates, programmes, structures and linkages, were covered and to facilitate a common approach and framework.

6 Financial data

For this Study, financial and other data from two biennia were scrutinised: 1992-93 and 1994-95. Proposed budgets for countries and regions, prepared and published about 18 months prior to the start of the relevant biennium, are often changed during the process of approval through the EB and WHA. Each Regional budget proposal document presents both approved figures for the current biennium and proposed figures for the next biennium. Therefore, budget figures used for this study were those presented in the approved column for the relevant biennium in the document subsequent to the initial budget proposal. However, following preferred practice, most of the information used for this Study is expenditure rather than budget data. The limitations of identifying and using expenditure information are discussed under section 8.

7 Tracer programmes

In order to obtain in-depth information on WHO activities, three specific programmes were selected which illustrated WHO's involvement in advocacy, policy formulation and implementation, and research. The three selected tracer programmes were health system dependent, each addressing important and common health problems. They were: national drugs programme, national programme on immunisation, and control of malaria. Detailed data on these three *tracer* programmes was collected in all the study countries, and used for intense analysis and comparison.

8 Limitations

It must be acknowledged that this Study took place during a period of review and reform within WHO. Many of the issues raised in this report were recognised and discussed within the Organisation itself, not only for the period of the Study but in thinking ahead to the 10th General Programme of Work, which takes the Organisation into the next millennium. Thus there was significant openness in discussion about the issues raised by the Study.

Measuring Effectiveness

In measuring the effectiveness of WHO at the country level, there were four main difficulties facing the Study Team:

- 1) how to assess the effectiveness of WHO's activities given their diversity at country level, and the way they are interwoven with activities of the national health system
- 2) how to judge the extent to which each country's particular context influenced the effectiveness of WHO's activities;
- 3) how to take into account the positions and actions of the Ministry of Health (MoH) itself as well as other organisations involved in health systems support, and their influence on the role and significance of WHO's support to countries;
- 4) how to generalise lessons from reviewing twelve selected countries (out of a potential of 165 with WHO Country Offices or Liaison Offices).^{vii}

1) Judging the effectiveness of WHO's activities depends on the level of specificity of expected outputs and outcomes.^{viii} Evaluating the effectiveness of activities such as immunisation programmes or research on particular diseases, where inputs and outputs are clear, measurable, and visible, is relatively easy. It is more difficult to evaluate low-specificity activities where outputs may be delayed, diffuse, and less identifiable, for example, in policy development or advocacy or where the input is a small component within a broader national programme. The WHO Country Office (WHOCO) may play a central role in assisting the Ministry of Health to

develop a health policy or plan, but the effectiveness of that input is not easily separated by inputs from other sources (e.g. from the Ministry itself) and there is no clear measure that can judge its value. The Study Team therefore used a mix of methods to assess WHO's support to countries, where possible quantifying output, but also using qualitative measures such as interviews and Round Tables held with interested parties and actors in the health system, to solicit perceptions and understanding of WHO's effectiveness in achieving programme objectives. Detailed information collected on the tracer programmes was useful to inform on effectiveness of WHO activities.

2) Since WHO's overall purpose is to support and strengthen national capacity, the important issue, from the recipient country perspective, is whether such assistance contributes to a total allocation of resources consistent with the country's political and institutional development. Hence, an evaluation of WHO assistance should assess national capacity, in order to explore how far, and to what extent, WHO has contributed to the current situation. In order to judge country capacity, the Study Team drew on a number of indicators. In chapter 3 two overlapping typologies are suggested. One breaks the twelve countries into four groupings, using a number of basic economic and health status indicators (for example, population, GNP per capita, adult female literacy rates). The other breaks the twelve countries into three clusters, using health system indicators (for example, access to health services, immunisation coverage, human resources). The Study Team also used other data to judge the capacity of the MoH (for example, numbers of external advisers in the MoH, turnover of Ministers and top civil servants). This information was added to basic historical and situational data available from a number of sources, including visits to the countries.

3) For each country a map of other actors was also drawn up, indicating the ten most important and influential organisations in health (in terms of financial input and presence). Through interviews it was possible to identify the extent to which WHO had links with other organisations (including the MoH) involved in the health sector, and to judge the intensity of these links and how they were perceived. The Study Team also looked at formal coordination mechanisms, and how far WHO played a role in them.

4) Finally, to overcome the limitations of a relatively small, and selected sample of countries, the Core Team designed a common analytical and methodological framework to be applied in each country. This was reinforced by assuring that a Core Team member visited each country, and using group meetings to establish consensus in making comparisons. This synthesis report thus draws some general themes and lessons from the country visits, but is cautious about making statements that are generalisable to all twelve countries or to all WHO Country Offices.

In spite of constraints, the Core Team found that it was possible to evaluate WHO's role in providing leadership, support and stimulus to national governments, and in mobilising resources from other agencies. Few would deny WHO's central role, among other things, in the eradication of smallpox, the elimination of poliomyelitis from the Western Hemisphere, the global control of leprosy or the focus on primary health care. What this study can do is demonstrate what WHO is currently doing in these twelve countries (which is likely to be mirrored in others), and how well it is undertaking those activities, adapting to change, and anticipating future change. Nevertheless, it is worth reiterating, that precise measurement of the impact of WHO's activities on improving health status in the case study countries does not lie within the scope of this study. Given the many different and inseparable factors which influence health status within any country, it is not easy to separate the specific impact of WHO's operations from the policies and resources of the national government or the inputs of other external donor agencies.

Reliability and validity of data

The Core Team and the Country Teams were assisted by many others, who completed the data instruments. It was not possible to verify all the information provided in this way, although checks were made by collecting the same information from different points, and through interviews. While this clearly increased the reliability of the information collected, it became clear through looking at the financial data in particular that it was not always possible to reconcile different pieces of information. This was judged to be a failure of the information systems, admittedly extremely complex, and variations in definitions, rather than any attempt to obfuscate or hide data.

In addition to quantitative data, the Core Team used various sources of qualitative data including various assessments and individual perceptions on a number of questions. For example, significant actors in the health sector were asked how they perceived WHO and the Country Office; WRs were asked to judge the balance of their programme activity, and where they thought most effort was expended. This was, where possible, measured against expenditure, but the breakdown of strategic areas made this calculation difficult, and sometimes impossible.

There were also limitations to the financial information. First, the Study asked for information according to the new Classified List of Programmes, which required COs and ROs to re-code the information for the biennia 1992-93 and 1994-95 which were originally managed under the previous CLP. This led to difficulties in reconciling sets of information obtained from different sources. It is possible that this was caused in part by different interpretations in re-coding to the new CLP. However, there were also discrepancies in expenditure data from other sources too. For individual countries there was generally little correlation between expenditure listed for the tracer programmes and amounts against the same line items in the full list of expenditure. This may be because the former did not include salary costs or included funds other than from WHO, but reasons for discrepancies were not pursued in the same way in all the country studies and could not always be explained.

Discrepancies in information were not limited to financial data. One RO forwarded two sets of information for the same periods, on numbers of fellowships awarded and associated financial expenditure, neither of which matched.

Finally, the Study Team did not distinguish between funds used at country level for Common Global Functions and Country Specific Activities. This may be most significant in Thailand, where some of the research funding is for global projects rather than for the country. The lack of this distinction influences analysis regarding levels of funding in relation to country need.

Endnotes: Annex 3.

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- i Møgedal S, Walt G, Hodne-Steen S, and Lee K (1996) *Selection of Countries and Contribution to Study Framework*. (Oslo: DiS; London: LSHTM).
 - ii The independent consultant was unable to visit SEARO, so this visit was undertaken by the Core Team member alone
 - iii These are fully described in Lucas A, Møgedal S, Walt G, Kruse SE, Lee K (1996) *Inception Report: A study of WHO's Support to Programmes at Country Level* (London: Oslo: LSHTM, DiS). See pages 15 - 17.
 - iv There was no round table in Thailand, and that in Cameroun was attended by few people as the new Minister of Health had called an unexpected meeting.
 - v Alleyne G (1991). In PAHO/AMRO an analysis and grouping of activities was carried out to develop a system of classification that would facilitate execution of technical cooperation. This led to six broad categories known as strategic approaches to technical cooperation. These approaches, in turn, provided a framework for planning, programming and evaluation as required by the American Region Programming and Evaluation System (AMPES) discussed in Chapter 4.
 - vi WHO, *Eighth General Programme of Work covering the period 1990 - 1995*,. *Ninth General Programme of Work covering the period 1996 - 2001*, Geneva
 - vii As reported to the Executive Board in January 1997, there were 108 Country Offices in the 6 WHO regions, 57 liaison offices, served either by international or national staff or the relevant Regional Office, and 25 member countries with no office.
 - viii Israel A (1987) *Institutional Development: Incentives to Performance* Johns Hopkins Press, Baltimore.

QUANTITATIVE DATA

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1. Scale of Operations

Biennium: 1992/93

Total Financial Expenditure at Country Level: Country Programme, Regional Programme and WHO Head Quarters (in US\$ 000)

Country	All sources 1992-93				Country Programme 1992/93				Regional Programme 1992/93				WHO Head Quarters 1992/93						
	Total expend	% RBFs	% EBFs		Total expend	RBFs	EBFs	% RBFs (% of total CO expend)	% EBFs	Total expend	RBFs	EBFs	RBFs% EBFs (% of RO countryexpend)	Total expend	RBFs	EBFs	RBFs% EBFs (% of HQ country expend)		
AFRO																			
Cameroun	4,586,770	40.6%	59.4%		2,951,583	1,622,783	1,328,800	55.0%	45.0%	376,771	136,010	240,761	36.1%	63.9%	1,258,416	102,917	1,155,499	8.2%	91.8%
Ethiopia	5,743,108	41.8%	58.2%		4,738,762	2,178,022	2,560,740	46.0%	54.0%	85,676	10,873	74,803	12.7%	87.3%	918,670	209,084	709,606	22.8%	77.2%
Mali	5,091,375	54.0%	46.0%		3,224,702	2,063,449	1,161,253	64.0%	36.0%	418,606	293,156	125,450	70.0%	30.0%	1,448,067	392,321	1,055,746	27.1%	72.9%
Mozambique	4,002,603	42.3%	57.7%		3,726,252	1,674,477	2,051,775	44.9%	55.1%	78,724	20,326	58,398	25.8%	74.2%	197,627	0	197,627	0.0%	100.0%
Tanzania	5,987,630	30.6%	69.4%		4,976,896	1,656,550	3,320,346	33.3%	66.7%	210,070	52,951	157,119	25.2%	74.8%	800,664	121,631	679,033	15.2%	84.8%
AMRO/PAHO																			
Ecuador	6,272,598	40.4%	59.6%		3,652,664	1,472,209	2,180,455	40.3%	59.7%	1,383,135	808,600	574,535	58.5%	41.5%	1,236,799	256,330	980,469	20.7%	79.3%
Haiti	12,279,309	33.4%	66.6%		10,385,197	3,183,240	7,201,957	30.7%	69.3%	902,912	0	902,912	0.0%	100.0%	991,200	917,965	73,235	92.6%	7.4%
Nicaragua	16,533,388	12.9%	87.1%		13,922,537	1,707,676	12,214,861	12.3%	87.7%	2,503,032	411,900	2,091,132	16.5%	83.5%	107,818	7,213	100,605	6.7%	93.3%
SEARO																			
Bangladesh	14,430,676	65.7%	34.3%		13,169,774	8,693,681	4,476,093	66.0%	34.0%	261,557	0	261,557	0.0%	100.0%	999,345	793,748	205,597	79.4%	20.6%
Thailand	11,091,710	47.2%	52.8%		7,856,075	5,128,051	2,728,024	65.3%	34.7%	0	0	0	#DIV/0!	#DIV/0!	3,235,635	104,468	3,131,167	3.2%	96.8%
WPRO																			
Cambodia	3,554,420	38.6%	61.4%		3,277,565	1,274,141	2,003,424	38.9%	61.1%	239,467	96,737	142,730	40.4%	59.6%	37,388	0	37,388	0.0%	100.0%
Papua New Guinea	5,184,824	68.1%	31.9%		4,180,276	3,021,479	1,158,797	72.3%	27.7%	281,918	7,622	274,296	2.7%	97.3%	722,630	499,994	222,636	69.2%	30.8%
TOTAL	94,758,411	41.1%	58.9%		76,062,283	33,675,758	42,386,525	44.3%	55.7%	6,741,869	1,838,175	4,903,694	27.3%	72.7%	11,954,259	3,405,651	8,548,608	28.5%	71.5%

SEARO Regional funds incomplete

Appropriation 1 subtracted from Bangladesh and included in Regional Support

Double check 0

2. Scale of Operations

Biennium: 1994/95

Total Financial Expenditure at Country Level: Country Programme, Regional Programme and WHO Head Quarters (in US\$ 000)

Country	All sources 1994-95			Country Programme 1994/95				Regional Programme 1994/95				WHO Head Quarters 1994/95			
	Total expend	RBFs	% EBFs	Total expend	RBFs	EBFs (% of total CO expend)	EBFs	RBFs	Total expend	RBFs	EBFs (% of RO country expend)	Total expend	RBFs	EBFs (% of HQ country expend)	EBFs
AFRO															
Cameroun	3,166,146	51.7%	48.3%	1,806,733	1,333,695	473,038	73.8%	26.2%	315,788	197,496	118,292	62.5%	104,184	939,441	90.0%
Ethiopia	6,105,046	56.7%	43.3%	4,995,963	3,046,468	1,949,495	61.0%	39.0%	171,277	123,706	47,571	72.2%	292,423	645,383	68.8%
Mali	4,920,726	59.2%	40.8%	3,117,325	2,306,272	811,053	74.0%	26.0%	491,457	373,826	117,631	76.1%	230,627	1,081,317	82.4%
Mozambique	4,527,924	62.4%	37.6%	3,462,198	2,273,028	1,189,170	65.7%	34.3%	544,781	448,944	95,837	82.4%	103,200	417,745	80.2%
Tanzania	6,872,923	35.5%	64.5%	5,808,412	2,188,322	3,620,090	37.7%	62.3%	216,073	120,762	95,311	55.9%	130,012	718,426	84.7%
AMRO/PAHO															
Ecuador	8,244,854	35.4%	64.6%	6,006,013	1,845,707	4,160,306	30.7%	69.3%	1,166,433	780,100	386,333	66.9%	291,719	780,689	72.8%
Haiti	24,604,323	21.1%	78.9%	22,503,923	3,950,506	18,553,417	17.6%	82.4%	1,014,100	213,100	801,000	21.0%	1,028,700	57,600	5.3%
Nicaragua	13,158,430	22.5%	77.5%	11,673,594	2,586,064	9,087,530	22.2%	77.8%	1,405,471	373,300	1,032,171	26.6%	894	78,470	98.9%
SEARO															
Bangladesh	26,822,487	42.9%	57.1%	23,728,792	9,707,721	14,021,071	40.9%	59.1%	495,908	0	495,908		1,807,709	790,078	30.4%
Thailand	10,014,567	61.8%	38.2%	8,268,126	6,066,555	2,201,571	73.4%	26.6%	0	0	0		125,801	1,620,640	92.8%
WPRO															
Cambodia	9,680,878	36.4%	63.6%	7,792,694	3,095,714	4,696,980	39.7%	60.3%	1,002,754	310,886	691,868	31.0%	120,109	765,321	86.4%
Papua New Gui	5,425,741	74.1%	25.9%	4,263,233	3,222,425	1,040,808	75.6%	24.4%	607,812	404,144	203,668	66.5%	394,208	160,488	28.9%
TOTAL	123,544,045	40.1%	59.9%	103,427,006	41,622,477	61,804,529	40.2%	59.8%	7,431,855	3,346,264	4,085,591	45.0%	4,629,586	8,055,598	63.5%

SEARO Regional funds incomplete

Double check 0

Financial Activity Profile Biennium: 1992-93
Country Programme Expenditure

WHO Collaborative profile according to Specific Programme Areas or Strategic Orientations

1992-93	Region/Country	Total	SPA/SPO 2			SPA/SPO 3			SPA 4 /SPO (4+5)			SPA 5 /SPO 6		
			Health Policy and Management			Health Services Development			Promotion and Protection of Health			Integrated Control of Disease		
			% of Total	RBFs	EBFs	% of Total	RBFs	EBFs	% of Total	RBFs	EBFs	% of Total	RBFs	EBFs
AFRO														
	Tanzania	4,976,896	12.3%	614,280	0	20.54%	859,207	162,963	5.1%	61,452	194,849	62.0%	121,611	2,962,534
	Ethiopia	4,738,762	15.2%	688,179	30,101	22.25%	817,039	237,424	9.0%	422,212	3,471	53.6%	250,592	2,289,744
	Mozambique	3,726,252	26.1%	951,738	22,421	22.60%	499,846	342,238	11.2%	222,893	194,093	40.1%	0	1,493,023
	Mali	3,224,702	32.4%	1,043,240	0	17.24%	555,980	0	5.6%	135,189	44,646	44.8%	329,040	1,116,607
	Cameroon	2,951,583	38.1%	1,125,819	0	11.51%	339,861	0	7.4%	34,641	184,419	42.9%	122,462	1,144,381
WPRO														
	Papua New Guinea	4,180,276	15.3%	641,308	0	32.09%	1,191,104	150,323	19.0%	752,232	43,146	33.5%	436,835	965,328
	Cambodia	3,277,565	32.3%	1,057,405	0	30.20%	48,743	941,113	0.2%	0	6,110	37.4%	167,993	1,056,201
SEARO														
	Bangladesh	13,169,774	56.9%	5,555,397	1,939,584	23.06%	1,841,664	1,194,845	19.5%	1,232,442	1,341,664	0.5%	64,178	0
	Thailand	7,856,075	48.6%	3,723,058	98,414	12.95%	934,941	82,252	37.8%	418,734	2,547,358	0.7%	51,318	0
AMRO/PAHO														
	Ecuador	3,652,664	15.6%	407,950	161,198	43.28%	432,937	1,147,922	15.4%	313,971	248,357	25.7%	317,351	622,978
	Nicaragua	13,922,537	5.1%	460,534	247,672	41.49%	738,964	5,038,175	19.8%	173,560	2,585,760	33.6%	334,618	4,343,254
	Haiti	10,385,197	48.3%	1,553,771	3,462,036	6.83%	626,512	82,705	23.3%	1,002,957	1,419,243	21.5%	0	2,237,973
	TOTAL	76,062,283		17,822,679	5,961,426		8,886,798	9,379,960		4,770,283	8,813,116		2,195,998	18,232,023
Percentage			31.3%	23.4%	7.8%	24.0%	11.7%	12.3%	17.9%	6.3%	11.6%	26.9%	2.9%	24.0%

Country Programme Expenditure SEARO funds incomplete

1992-93

Double Check 0

Financial Activity Profile **Biennium: 1994/95**
Country Programme Expenditure

WHO Collaborative profile according to Specific Programme Areas or Strategic Orientations

1994/95		SPA/SPO 2 Health Policy and Management				SPA/SPO 3 Health Services Development				SPA 4/SPO (4+5) Promotion and Protection of Health				SPA 5/SPO 6 Integrated Control of Disease			
Region/Country	Total	% of Total	RBFs	EBFs	% of Total	RBFs	EBFs	% of Total	RBFs	EBFs	% of Total	RBFs	EBFs	% of Total	RBFs	EBFs	
AFRO																	
Tanzania	5.6%	17.3%	1,003,882	0	18.2%	1,024,217	33,839	1.3%	74,129	0	63.2%	86,094	3,586,251				
Ethiopia	4.8%	17.0%	850,466	0	34.3%	1,630,529	83,972	7.7%	352,391	29,906	41.0%	213,082	1,835,617				
Mozambique	3.3%	33.4%	962,020	194,510	35.0%	1,108,152	104,462	7.9%	202,856	72,324	23.6%	0	817,874				
Mali	3.0%	31.4%	974,141	5,826	32.2%	1,003,686	0	6.8%	146,943	64,517	29.6%	181,502	740,710				
Cameroon	1.7%	40.2%	726,348	0	28.9%	522,531	0	8.0%	38,214	105,460	22.9%	46,602	367,578				
WPRO																	
Papua New Guinea	4.1%	20.1%	856,226	0	30.2%	1,116,004	172,516	21.9%	849,477	82,527	27.8%	400,718	785,765				
Cambodia	7.5%	15.2%	1,183,551	0	40.1%	1,028,610	2,097,667	2.3%	56,324	126,243	42.4%	827,229	2,473,070				
SEARO																	
Bangladesh	22.9%	54.0%	5,311,341	7,509,249	19.8%	1,733,753	2,975,757	25.8%	2,594,823	3,536,065	0.3%	67,804	0				
Thailand	8.0%	53.9%	4,275,232	177,478	15.6%	1,214,238	79,678	29.5%	497,463	1,944,415	1.0%	79,622	0				
AMRO/PAHO																	
Ecuador	5.8%	14.3%	470,890	385,866	49.1%	618,110	2,330,314	22.7%	528,083	834,620	14.0%	228,624	609,506				
Nicaragua	11.3%	7.6%	712,795	177,334	49.2%	916,045	4,823,833	19.1%	407,181	1,826,991	24.1%	550,044	2,259,372				
Haiti	21.8%	64.8%	1,370,552	13,211,283	3.9%	657,960	222,732	15.9%	1,695,600	1,872,829	15.4%	226,394	3,246,573				
TOTAL			18,697,444	21,661,546		12,573,835	12,924,770		7,443,484	10,495,897		2,907,715	16,722,316				
Percentage		39.0%	18.1%	20.9%	24.7%	12.2%	12.5%	17.3%	7.2%	10.1%	19.0%	2.8%	16.2%				

Country Programme Expenditure	SEARO funds incomplete
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1994/95

Double check

C

**Financial Activity Profile Combined Biennia: 1992-93 and 1994-95
Combined WHO Support to Programmes at country level (HQ + RO + CO)**

WHO Collaborative profile according to Specific Programme Areas or Strategic Orientations

1992-93 and 1994-95		SPA/SPO 2			SPA/SPO 3			SPA 4/SPO (4+5)			SPA 5/SPO 6		
Region/ Country	%	Health Policy and Management			Health Services Development			Promotion and Protection of Health			Integrated Control of Disease		
		% of Total	RBFs	EBFs	% of Total	RBFs	EBFs	% of Total	RBFs	EBFs	% of Total	RBFs	EBFs
AFRO													
Cameroun	3.6%	7,752,916	1,989,506	0	13.0%	944,955	64,149	11.7%	207,519	699,644	49.6%	355,105	3,492,038
Ethiopia	5.4%	11,848,154	1,541,114	70,101	24.9%	2,477,402	470,102	12.4%	1,159,823	307,524	49.1%	682,217	5,139,871
Mali	4.6%	10,012,101	2,516,683	5,826	15.8%	1,574,607	11,845	7.2%	601,212	117,549	51.8%	967,149	4,217,230
Mozambique	3.9%	8,530,527	1,920,885	329,931	30.0%	1,989,716	571,763	11.3%	575,346	392,013	32.2%	34,028	2,716,845
Tanzania	5.9%	12,860,553	1,641,130	9,000	18.3%	1,908,007	450,888	5.7%	396,290	341,175	63.1%	324,801	7,789,262
AMRO/PAHO													
Ecuador	6.7%	14,517,453	878,840	547,064	40.1%	1,051,047	4,777,591	16.9%	1,376,854	1,082,977	33.1%	2,147,924	2,655,156
Haiti	16.9%	36,883,632	2,924,323	16,673,319	4.3%	1,284,472	305,437	21.5%	4,640,557	3,292,072	21.0%	444,159	7,319,293
Nicaragua	13.6%	29,691,817	1,173,329	425,005	38.8%	1,655,009	9,871,509	17.0%	585,398	4,452,751	38.8%	1,673,311	9,855,505
SEARO													
Bangladesh	18.9%	41,253,163	10,866,738	10,230,298	18.8%	3,575,417	4,190,505	24.6%	5,148,865	5,010,486	5.4%	1,411,839	819,015
Thailand	9.7%	21,106,277	7,998,290	275,892	13.0%	2,296,521	449,207	34.9%	926,197	6,437,716	12.9%	203,867	2,518,587
WPRO													
Cambodia	6.1%	13,235,298	2,252,556	88,000	32.6%	1,132,918	3,179,271	2.8%	201,734	175,453	46.9%	1,310,379	4,894,987
Papua New Guine	4.9%	10,610,565	1,512,296	0	25.4%	2,322,939	370,349	23.6%	2,339,793	167,305	36.7%	1,374,844	2,523,039
TOTAL		218,302,456	37,215,690	28,654,436		22,213,010	24,712,616		18,159,588	22,476,665		10,929,623	53,940,827
Percentage			30.2%	17.0%	13.1%	10.2%	11.3%	18.6%	8.3%	10.3%	29.7%	5.0%	24.7%
Double Check		SEARO funds incomplete											
		0											

WHO Country Programme Budgets (in US\$ 000)

Source: Regional Budget Proposals

Region/Country	Country Programme Budget 1992-93					Country Programme Budget 1994-95				
	Total expend	RBFs	EBFs	% RBFs (% of total CO budget)	% EBFs (% of total CO budget)	Total expend	RBFs	EBFs	% RBFs (% of total CO budget)	% EBFs (% of total CO budget)
AFRO										
Cameroun	2,347,000	1,507,000	840,000	64.2%	35.8%	3,020,000	1,820,000	1,200,000	60.3%	39.7%
Ethiopia	5,302,500	3,494,000	1,808,500	65.9%	34.1%	5,415,900	3,615,900	1,800,000	66.8%	33.2%
Mali	3,024,000	2,124,000	900,000	70.2%	29.8%	3,431,700	2,460,700	971,000	71.7%	28.3%
Mozambique	3,167,000	1,967,000	1,200,000	62.1%	37.9%	3,291,400	2,191,400	1,100,000	66.6%	33.4%
Tanzania	3,545,000	1,745,000	1,800,000	49.2%	50.8%	3,665,400	2,065,400	1,600,000	56.3%	43.7%
AMRO/PAHO										
Ecuador	4,619,900	2,756,200	1,863,700	59.7%	40.3%	9,404,200	3,186,800	6,217,400	33.9%	66.1%
Haiti	13,759,200	4,356,800	9,402,400	31.7%	68.3%	23,589,900	4,680,400	18,909,500	19.8%	80.2%
Nicaragua	11,492,000	2,377,600	9,114,400	20.7%	79.3%	9,007,900	2,748,400	6,259,500	30.5%	69.5%
SEARO										
Bangladesh	11,780,400	9,913,500	1,866,900	84.2%	15.8%	85,631,700	10,694,300	74,937,400	12.5%	87.5%
Thailand	8,162,200	5,864,000	2,298,200	71.8%	28.2%	8,814,300	6,406,300	2,408,000	72.7%	27.3%
WPRO										
Papua New Guinea	4,783,400	3,272,700	1,510,700	68.4%	31.6%	4,938,500	3,719,400	1,219,100	75.3%	24.7%
Cambodia	2,703,400	700,000	2,003,400	25.9%	74.1%	3,551,700	1,630,000	1,921,700	45.9%	54.1%
TOTAL	67,199,200	36,105,100	31,094,100	53.7%	46.3%	155,272,400	39,869,600	115,402,800	25.7%	74.3%

WHO Country Programme Expenditure against Budget (in US\$ 000)

Source: Regional Budget Proposals and WHOCO or WHORO data collection

Region/Country	Country Programme Budget 1992-93					Country Programme Budget 1994-95				
	Total difference	RBFs difference	EBFs difference	% RBFs (% expenditure)	% EBFs (% expenditure)	Total difference	RBFs difference	EBFs difference	% RBFs (% expenditure)	% EBFs (% expenditure)
AFRO										
Cameroun	-1,431,896	88,450	-1,520,346	94.9%	184.5%	-2,143,012	-122,922	-2,020,090	106.0%	226.3%
Ethiopia	563,738	1,315,978	-752,240	62.3%	141.6%	419,937	569,432	-149,495	84.3%	108.3%
Mali	-559,252	292,523	-851,775	85.1%	171.0%	-170,798	-81,628	-89,170	103.7%	108.1%
Mozambique	-200,702	60,551	-261,253	97.1%	129.0%	314,375	154,428	159,947	93.7%	83.5%
Tanzania	-604,583	-115,783	-488,800	107.7%	158.2%	1,213,267	486,305	726,962	73.3%	39.4%
AMRO/PAHO										
Ecuador	967,236	1,283,991	-316,755	53.4%	117.0%	3,398,187	1,341,093	2,057,094	57.9%	66.9%
Haiti	-2,430,537	669,924	-3,100,461	71.8%	134.0%	-2,665,694	162,336	-2,828,030	94.1%	145.2%
Nicaragua	3,374,003	1,173,560	2,200,443	73.1%	76.6%	1,085,977	729,894	356,083	84.4%	98.1%
SEARO										
Bangladesh	-1,389,374	1,219,819	-2,609,193	87.7%	239.8%	61,902,908	986,579	60,916,329	90.8%	18.7%
Thailand	306,125	735,949	-429,824	87.4%	118.7%	546,174	339,745	206,429	94.7%	91.4%
WPRO										
Papua New Guinea	603,124	251,221	351,903	92.3%	76.7%	-2,854,194	623,686	-3,477,880	83.2%	385.3%
Cambodia	-574,165	-574,141	-24	182.0%	100.0%	-711,533	-1,592,425	880,892	197.7%	54.2%
TOTAL	-1,405,242	6,724,962	-8,130,204	-478.6%	578.6%	63,901,321	4,565,262	59,336,059	7.1%	92.9%

Table 1 Proportions of WHO total expenditure from HQ, RO and CO 1992 to 1995

Country	1992-93 (RBFs and EBFs)			1994-95 (RBFs and EBFs)			1992-95 (RBFs and EBFs)		
	%HQ	%RO	%CO	%HQ	%RO	%CO	%HQ	%RO	%CO
Cameroun	13.4%	3.5%	83.1%	33.0%	10.0%	57.1%	14.3%	4.1%	52.7%
Ethiopia	16.0%	1.5%	82.5%	15.4%	2.8%	81.8%	15.7%	2.2%	82.2%
Mali	4.9%	2.0%	93.1%	26.7%	10.0%	63.4%	17.7%	6.7%	80.2%
Mozambique	28.4%	8.2%	63.3%	11.5%	12.0%	76.5%	19.7%	9.6%	66.8%
Tanzania	27.4%	8.2%	64.3%	12.3%	3.1%	84.5%	27.2%	7.6%	113.0%
Ecuador	19.7%	22.1%	58.2%	13.0%	14.1%	72.8%	15.9%	17.6%	66.5%
Haiti	0.7%	15.1%	84.2%	4.4%	4.1%	91.5%	4.0%	11.9%	122.8%
Nicaragua	8.1%	7.4%	84.6%	0.6%	10.7%	88.7%	2.9%	6.3%	59.7%
Bangladesh	6.9%	1.8%	91.3%	9.7%	1.8%	88.5%	8.7%	1.8%	89.4%
Thailand	29.2%	0.0%	70.8%	17.5%	0.0%	82.5%	23.6%	0.0%	76.4%
Cambodia	1.1%	6.7%	92.2%	9.1%	10.4%	80.5%	10.3%	13.8%	123.3%
Papua New Guinea	13.9%	5.4%	80.6%	10.2%	11.2%	78.6%	8.6%	6.0%	56.8%
TOTAL	12.6%	7.1%	80.3%	10.3%	6.0%	83.7%	11.3%	6.5%	82.2%

Table 2 WHO Country Programme expenditure, 1992-93 and 1994-95 (million US\$)

Country	Country Programme 1992-93					Country Programme 1994-95				
	Total expenditure	RBFs	EBFs	% RBFs	% EBFs	Total expenditure	RBFs	EBFs	% RBFs	% EBFs
Cameroon	2.9	1.6	1.3	55%	45%	1.8	1.3	0.5	74%	26%
Ethiopia	4.7	2.2	2.5	46%	54%	5.0	3.0	2.0	61%	39%
Mali	3.2	2.0	1.2	64%	36%	3.1	2.3	0.8	74%	26%
Mozambique	3.7	1.7	2.0	45%	55%	3.5	2.3	1.2	66%	34%
Tanzania	4.9	1.6	3.3	33%	67%	5.8	2.2	3.6	38%	62%
Ecuador	3.7	1.5	2.2	40%	60%	6.0	1.8	4.2	31%	69%
Haiti	10.4	3.2	7.2	31%	69%	22.5	3.9	18.6	18%	82%
Nicaragua	13.9	1.7	12.2	12%	88%	11.6	2.6	9.0	22%	78%
Bangladesh	13.2	8.7	4.5	66%	34%	23.7	9.7	14.0	41%	59%
Thailand	7.8	5.1	2.7	65%	35%	8.3	6.1	2.2	74%	26%
Cambodia	3.3	1.3	2.0	39%	61%	7.8	3.1	4.7	40%	60%
PNG	4.2	3.0	1.2	72%	28%	4.2	3.2	1.0	76%	24%

Table 3 Total WHO financial expenditure at country level by RBFs and EBFs
(million US\$)

Country	All Sources 1992-93			All sources 1994-95			All Sources 1992-95		
	Total	% RBFs	% EBFs	Total	% RBFs	% EBFs	Total	% RBFs	% EBFs
Cameroun	4.6	41%	59%	3.1	52%	48%	7.7	45%	55%
Ethiopia	5.7	42%	58%	6.1	57%	43%	11.8	50%	51%
Mali	5.0	54%	46%	4.9	59%	41%	10.0	57%	43%
Mozambique	4.0	42%	58%	4.5	62%	38%	8.5	53%	47%
Tanzania	6.0	31%	69%	6.9	36%	64%	12.9	33%	67%
Ecuador	6.2	40%	60%	8.2	35%	65%	14.5	38%	62%
Haiti	12.3	33%	67%	24.6	21%	79%	36.9	25%	75%
Nicaragua	16.5	13%	87%	13.1	22%	78%	30.0	17%	83%
Bangladesh	14.4	66%	34%	26.8	43%	57%	41.2	51%	49%
Thailand	11.1	47%	53%	10.0	62%	38%	21.1	54%	46%
Cambodia	3.5	39%	61%	5.4	74%	26%	8.9	60%	40%
Papua New Guinea	5.2	68%	32%	9.7	36%	64%	14.9	48%	52%
TOTAL	94.7	41%	59%	123.5	40%	60%	218.3	41%	59%

Table 4 WHO total expenditure from HQ, RO and CO: changes between biennia 1992-93 and 1994-95

Country	1992-93		1994-95		RBFs Change	% Change	EBFs Change	% Change	Total change	% change over 1992/93
	RBFs (million US\$)	EBFs (million US\$)	RBFs (million US\$)	EBFs (million US\$)						
Cameroon	1.8	2.7	1.6	1.5	-0.2	-12%	-1.2	-73%	-1.4	-31.0%
Ethiopia	2.4	3.3	3.5	2.6	1.1	44%	-0.7	-20%	0.4	6.3%
Mali	2.7	2.3	2.9	2.0	0.2	6%	-0.3	-11%	-0.1	-3.4%
Mozambique	1.7	2.3	2.8	1.7	1.1	67%	-0.6	-21%	0.5	13.1%
Tanzania	1.8	4.1	2.4	4.4	0.6	33%	0.3	11%	0.9	14.8%
Ecuador	2.5	3.7	2.9	5.3	0.4	15%	1.6	55%	2.0	31.4%
Haiti	4.1	8.1	5.2	19.4	1.1	27%	11.2	216%	12.3	100.4%
Nicaragua	2.1	14.4	2.9	10.2	0.8	39%	-4.2	-143%	-3.4	-20.6%
Cambodia	1.3	2.2	3.5	6.1	2.1	157%	4.0	113%	6.1	172.4%
PNG	3.5	1.7	4.0	1.4	0.5	14%	-0.3	-6%	0.2	4.6%
Bangladesh	9.5	4.9	11.5	15.3	2.0	21%	10.4	90%	12.4	85.9%
Thailand	5.2	5.8	6.2	3.8	1.0	18%	-2.0	-33%	-1.0	-9.8%

Human Resources: Staff available at WHO Country office 1995

Source: WHOCO Data Collection: Table A.7

Region/Country	Total no. of staff	Support staff % of Total Staff	Support staff	Professional staff % of Total Staff	Professional staff	FTS % of Professional Staff	FTS % of NPOs of Professional staff	NPO	Non-FTS as % of Professional staff	STP	STC	TA / APO	paid from other sources	No. of WRs in last 10 years
AFRO average	16	64.6%	51	35.4%	28	35.7%	10	35.7%	10	28.6%	5	1	2	0
Cameroun	15	86.7%	13	13.3%	2	50.0%	1	0.0%		50.0%		1		5
Ethiopia	16	75.0%	12	25.0%	4	25.0%	1	75.0%	3	0.0%		21		4
Mali	20	55.0%	11	45.0%	9	22.2%	2	66.7%	6	11.1%	1			6
Mozambique	9	77.8%	7	22.2%	2	50.0%	1	0.0%		50.0%		1		3
Tanzania	19	42.1%	8	57.9%	11	45.5%	5	9.1%	1	45.5%	4	1		2
AMRO/PAHO averag	68	71.4%	145	28.6%	58	34.5%	20	48.3%	28	17.2%	2	8	0	0
Ecuador	51	80.4%	41	19.6%	10	70.0%	7	10.0%	1	20.0%	1	1		3
Haiti	79	70.9%	56	29.1%	23	26.1%	6	52.2%	12	21.7%	1	4		3
Nicaragua	73	65.8%	48	34.2%	25	28.0%	7	60.0%	15	12.0%		3		3
SEARO average	50	48.0%	48	52.0%	52	38.5%	20	57.7%	30	3.8%	1	1	0	0
Bangladesh	83	41.0%	34	59.0%	49	34.7%	17	61.2%	30	4.1%	1	1		3
Thailand	17	82.4%	14	17.6%	3	100.0%	3	0.0%		0.0%				2
WPRO average	45	57.5%	52	42.5%	39	46.8%	18	0.0%	0	53.2%	5	10	1	5
Cambodia	73	63.0%	46	37.0%	27	44.4%	12	0.0%		55.6%	4	6		3 (1991)
Papua New Guinea	18	34.3%	6	65.7%	11.5	52.2%	6	0.0%		47.8%	0.83	3.67	1	3
Total	472.5	62.6%	296	37.4%	176.5	38.5%	68	38.5%	68	22.9%	12.8	19.7	3	5

Professional total for Cambodia includes Volunteers.

Technical Assistance provided through WHO Country Office:
WHO Country Offices 1995

Days of support provided

Information from WHOCO Data Collection

The number of working days in an average year is calculated as $(52-4)^*5 = 240$
Where countries indicated 365 days for any item, this and other figures have been scaled down accordingly.

	% of Country Office Support	TOTAL Country Office Support	AFRO					WPRO TOTAL	WPRO		SEARO			PAHO			
			Tanzania	Ethiopia	Mozambique	Mali	Cameroon		PNG	Cambodia	SEARO TOTAL	Bangladesh	Thailand	PAHO TOTAL	Ecuador	Nicaragua	Haiti
CDD	2.0%	563	268	240	10		18	0			115	115		180	60	120	
ARI	2.1%	591	286	240	10		36	0			120	115	5	185	65	120	
Malaria	8.4%	2,331	661	85	60	480	36	680	200	480	250	230	20	740	20	240	480
Tuberculosis	4.4%	1,231	270	186	60		24	341		341	360	320	40	260	20		240
Integrated infectious disease	3.0%	822	522	186	60	240	36	0			5		5	295	55	240	
HIV/AIDS	6.3%	1,753	283	151	60		72	720	240	480	350	230	120	400	160		240
DAP	5.0%	1,390	385	85	240		60	0			25		25	980	20	240	720
GPV/EPI	5.4%	1,497	437	85	88	240	24	240		240	100	80	20	720		240	480
Human resources for health	7.6%	2,107	157	85	60	240	12	720	240	480	510	460	50	720		240	480
Environmental health	8.6%	2,397	552	240	60		12	240	240		265	230	35	1,340	380	240	720
Family health	7.3%	2,022	157	85	60		12	0			245	230	15	1,620	180	480	960
School health	1.2%	337	97	85			12	0			0			240		240	
Non-infectious diseases	0.5%	150	90	85			5	0			20		20	40	40		
HRP	3.6%	1,010	65	60			5	0			705	690	15	240		240	
TDR	0.4%	97	62	60			2	0			15		15	20	20		
PHC support	2.8%	767	300	240	60			0			467	460	7	0			
Policy development and sector planning	18.1%	5,035	1,152	240	72	240	120	2,883	660	2,223	280	230	50	720	240	480	
other	0	3,685	720			240		240	240		505	230	275	2,220	1,020	1,200	
TOTAL		27,788	6,468	2,322	1,020	480	2,160	6,064	1,820	4,244	4,337	3,620	717	10,920	2,280	4,320	4,320
Equivalent number of FT staff @ 240 days/year:		115.8	27	9.7	4.3	2.0	9.0	2.0	7.6	17.7	18	15.1	3.0	46	9.5	18.0	18.0
Number of FT professional staff available:		325	28	2.0	9.0	4.0	11.0	2.0	27.0	11.5	52	3.0	49.0	58	10.0	23.0	25.0
Difference		209.2	1	-7.7	4.8	2.0	2.0	0.0	13	-6.2	34	-12.1	46.0	13	0.5	5.0	7.0

Technical Assistance provided through WHO Country Office:

from WHO Headquarters

1995

Days of support provided

Information from WHOCO Data Collection

Programme	% of Headquarters Support	TOTAL Headquarters Support	AFRO						WPRO			SEARO			PAHO				
			AFRO TOTAL	Tanzania	Ethiopia	Mozambique	Mali	Cameroon	WPRO TOTAL	PNG	Cambodia	SEARO TOTAL	Bangladesh	Thailand	PAHO TOTAL	Ecuador	Nicaragua	Haiti	
CDD	6.6%	113	98	50	48					0			15	15	0				
ARI	4.7%	80	80	32	48					0			0		0				
Malaria	9.1%	155	100	3	87		10			8		8	47	27	20	0			
Tuberculosis	7.6%	130	40	1	39					0			90	45	45	0			
Integrated infectious disease	1.5%	26	26	3	23					0			0		0				
HIV/AIDS	16.9%	289	44	7	12				25	11		11	224	54	170	10		10	
DAP	18.3%	313	21	1	5				15	11		11	20	5	15	261		261	
GPV/EPI	2.6%	44	8	2	6					0			36	36		0			
Human resources for health	1.8%	31	3	3						0			8	8		20		20	
Environmental health	6.1%	104	31	1	30					0			61	41	20	12	12		
Family health	3.4%	59	44	1	43					0			15		15	0			
School health	0.0%	0	0							0			0			0			
Non-infectious diseases	0.0%	0	0							0			0			0			
HRP	2.3%	40	10	1	9					0			30		30	0			
TDR	3.9%	66	26	1			25			0			40		40	0			
PHC support	1.3%	22	22				22			0			0			0			
Policy development and sector planning	2.0%	35	2	2						26		26	7	7		0			
other	11.9%	204	6				6			8		8	185	35	150	5	5		
TOTAL		1,711	561	108	350	0	63	40		64	0	64	778	273	505	308	17	0	291
Percentage of support to each region			32.8%							3.7%			45.5%			18.0%			

Technical Assistance provided through WHO Regional Office:

from WHO Regional Offices

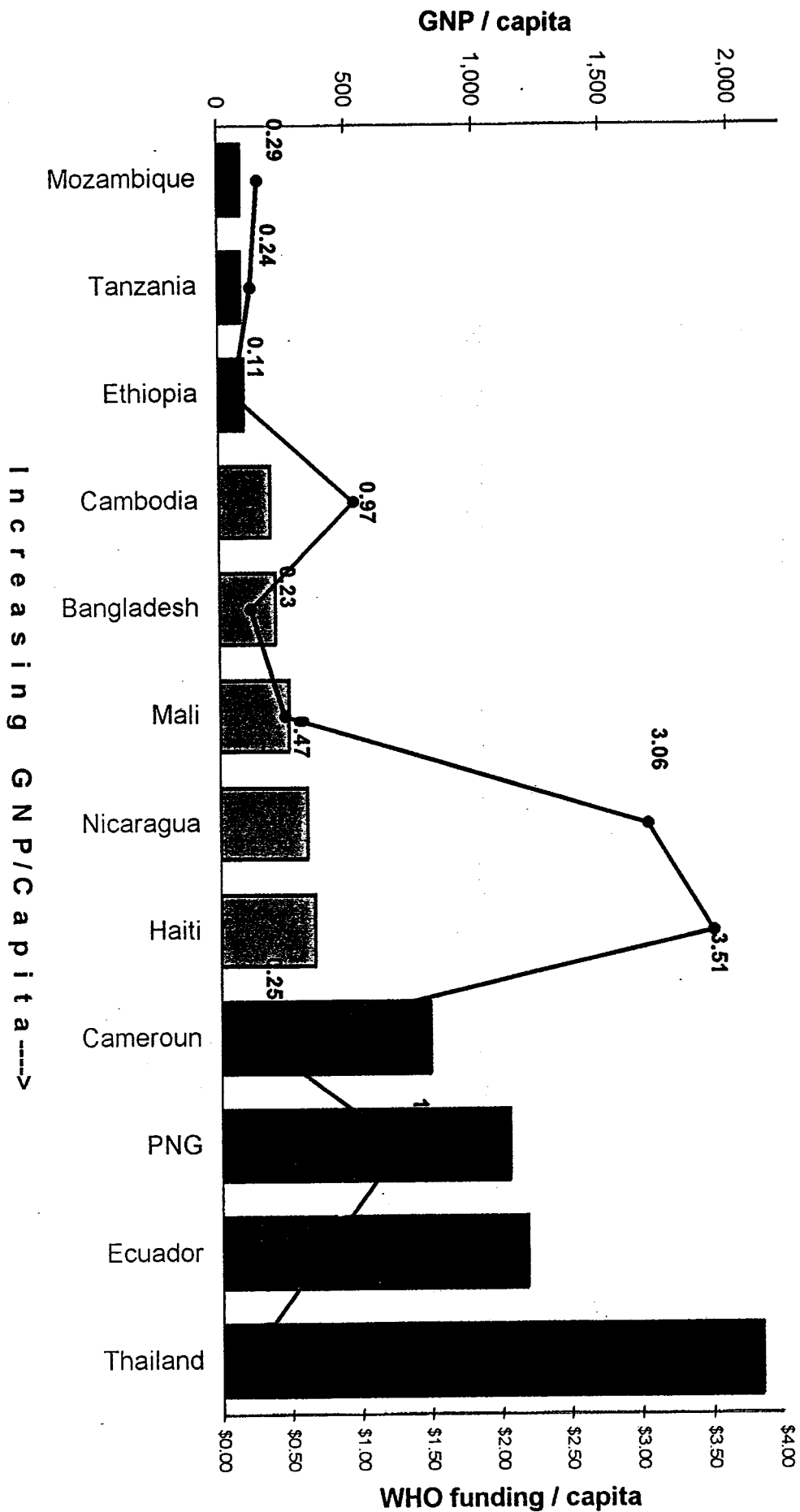
1995

Days of support provided

Information from WHOCO Data Collection

Programme	% of Regional Support	TOTAL Regional Support	AFRO						WPRO			SEARO			PAHO			
			AFRO TOTAL	Tanzania	Ethiopia	Mozambique	Mali	Cameroon	WPRO TOTAL	PNG	Cambodia	SEARO TOTAL	Bangladesh	Thailand	PAHO TOTAL	Ecuador	Nicaragua	Haiti
CDD	2.2%	186	65	15	45	5			102	53	49	15	15		4			
ARI	2.2%	189	57		45	6	6		124	53	71	5		5	3		4	
Malaria	5.8%	494	15				10	5	423	4	419	10		10	46	21	22	3
Tuberculosis	1.9%	158	12		12				61	10	51	73	33	40	12	12		
Integrated infectious disease	2.2%	187	126	2	64	60			0			17	17		44	34	10	
HIV/AIDS	10.5%	886	115	2	12	36	35	30	337	96	241	149	9	140	285	285		
DAP	5.4%	456	20					20	373	41	332	37	7	30	26	26		
GPV/EPI	7.4%	628	105		100			5	355	236	119	86	11	75	82		82	
Human resources for health	2.1%	175	0						144	69	75	5	5		26		25	1
Environmental health	14.9%	1263	3				3		228	135	93	10		10	1022	1008	14	
Family health	1.4%	119.5	6			6			33.5	17	16.5	10		10	70	36	34	
School health	0.4%	38	0						18	18		10		10	10		10	
Non-infectious diseases	0.0%	0	0						0			0			0			
HRP	2.2%	183	0						0			178	18	160	5		5	
TDR	0.4%	32	0						0			32	12	20	0			
PHC support	0.9%	75.5	4				4		16.5		16.5	55		55	0			
Policy development and sector planning	17.1%	1443	17	2		12	3		861	187	674	73	43	30	492	408	84	
other	23.0%	1946	0						1116	550	566	222	52	170	608	425	55	128
TOTAL		8,459	545	21	278	125	61	60	4,192	1,469	2,723	987	222	765	2,735	2,255	348	132
			6.4%						49.6%			11.7%			32.3%			

Comparison of total WHO funding/capita (1994-95) and GNP/capita (1993)



WHO'S ROLE IN RESOURCE MOBILISATION

Annex 5.

This page provides an overview of areas for self-assessment, regarding WHO Country Office Activities. You do not need to do anything on this page. For providing answers, use the forms attached (B.1-B.6)

	Financial Resources	Physical Resources	Human Resources	Information Management Resources	Institutional Resources	Political Support
National resources	• attract non-health resources • more effective use of "non-health" resources • more efficient use of health resources	• more efficient maintenance and use of facilities • more adequate and better maintained equipment • mobilise unused buildings	• mobilising young professionals • more health orientation of education system and adult learning • better use of professionals in health system	• better use of available data • more appropriate data generation • more efficient data management • more constructive media engagement	• universities • other national centres and private groups • NGOs • formation of networks for collaborative research and training	• mobilise national political support for health • more supportive legislation and regulation • social sector reforms more conducive to health
External resources	• additional external health resources • refine use, external non-health resources • more efficient use of external health resources	• more appropriate external ODA procurement • more sustainable ODA investment in new infrastructure	• more appropriate use of health technical assistance personnel • better health orientation of non-health technical assistance personnel	• improved access to relevant international data • better match between national data needs and data collected by External Agencies • better co-ordination of support to information systems	• universities • other international centres • international NGOs	• better justification for external support • strengthened negotiating power with External Agencies • more attention to implications of macroeconomic conditions for health

Overview of WHO links at country level

ANNEX 6

Country	ISS	Other ministries & Government Institutions	UN organisations	NGOs	Private sector	Universities Training Institutions	Bilateral Organisations	Development Banks
Tanzania AFRO	Not applicable	No formal relationship, but some interaction	CSN in transformation to GOT paper UN heads monthly meetings Theme groups on AIDS chaired by WHO Close cooperation UNICEF various workshops, mainly CDD, SMI, EPI	Limited	None	Medium, Research inst. strong	Limited, part of Health sector reform working group Health Population Group	Limited, but part of Health sector reform working group
Cameroon AFRO	Not applicable	Many Animal & Vet, Industries, Mines, Energy and water, Women's affairs, MoF, MoA, MoE, MoCom., Army	CSN, regular meetings, Informal coordination UNICEF/WHO	Limited ad hoc Water Immunisation, AIDS	None	Limited (even antagonistic)	Limited, ad hoc meeting disease control mainly	Limited: will implement the training component of the WB project
Mali AFRO	Not applicable	Hydraulics, Environment	GOM taken lead in developing CSN Heads meet regular,	Limited (low responsiveness)	Not proactive in spite being approached (Pharmacy). + for AIDS	Medium	Lots of bilaterals in the country, but WHO involvement with these is ad hoc.	Participates in various coordinating mechanisms related to the two large WB projects
Ethiopia AFRO	Not applicable		Initiated work on CSN, Heads meet regularly. UN theme group on AIDS WHO chair Cooperation on UN Specific Initiative for Africa UNFPA/UNICEF on adolescent health	Limited, would like more technical support (CRDA)	None/NA	Limited	Medium SIDA on SMI Netherlands on Drugs USAid, Immunisation (Training and Procurement)	Marginal; No formal contacts with WB. WHO approached to collect info. during visits. Marginal contact with ADB.
Mozambique AFRO	Not applicable	None	CSN developed, but not followed-up. Regular meetings. Discussions with MoH on UN Special Initiative on Africa, WHO & UNICEF have working links	Limited	None/NA	Limited	Limited, but increasing proactive	Limited, but increasing
Haiti AMRO	Not applicable	Public Works, Environment, Education, Women's Affairs, Agriculture	Wide, monthly meetings, Beginning reflection on CSN, UNAIDS coordinated rotation	Wide; technical advice, review projects and gives fin. support	Limited Organisations in social marketing	Marginal	Wide	Medium, particularly WB. IDB has little involvement and is reluctant to collaborate because of the tensions between MoH & WR

Country	ISS	Other ministries & Government Institutions	UN organisations	NGOs	Private sector	Universities Training Institutions	Bilateral Organisations	Development Banks
Ecuador AMRO	YES, but limited	National Development Planning Commission, National Women's Bureau, Water and Sanitation,	CNS draft developed. Several coordinated actions UN theme group on AIDS. Wide collaboration in different programmes, Women's health, vaccination, micronutrients. However, indication of disjointed actions	Increasing contacts lately, but NGO community reluctant. Contact with Indigenous peoples groups	Limited	Wide Support to establishment of National Institute of Women	Wide Used as a platform for contact with MOPH	IDB limited, World Bank numerous, but being marginalised in WB relationship with MOPH
Nicaragua AMRO	YES particularly through ISCA	Water and Sanitation, External Cooperation,	A UN position paper to present to new government. UN theme group on AIDS	Wide. Several especially related to programme (EPI)	Limited	Wide Support to establishment of CIES	Wide, through ICC and other mechanisms	Limited, World Bank and IDB
Cambodia WPRO	Not applicable	?	CSN not in place; UN technical Working group on AIDS; UNDP:SHS project UNICEF:EPI, Polio and Provincial advisors	Wide (i.e. support to hospital run by NGOs, IUATLD, MSF YWAM, Health unlimited, MEDICAM	None	Medium Disease Control, Education, Task Force	Wide, support to project development. Mainly disease control (AusAid and JICA DFID:SHS project and Malaria	Wide, participation in project formulation, (HR, Disease control)
PNG WPRO	Not applicable	?	CSN developed. WHO recognised as technical lead agent. Various UN Theme groups	Limited. Sasakawa Foundation, Leprosy Mission, Rotary Int.	Limited Some AIDS, Immunisation	Wide	Very few bilateral donors. Cooperation mostly of Financial nature. But various mechanisms to promote info. sharing	Respected by ADB WB. Mechanisms to promote info. sharing. IDA credit may change the current dynamics.
Bangladesh SEARO	Not applicable	None	CNS under development (GOB did not previously accept it to be developed. Limited participation, UNICEF program planning	Few	-	Limited	Some Links through WB consortium, few other links. Limited participation in USAid programme review	Participated in various ADB missions for policy and project development
Thailand SEARO	No links	Education., Dep. of Technical and Economic. Coop., Bangkok Metrop. Administration; Nat. Economic & Social Dev Board EC Soc. Com. Asia Pacific	CSN developed but bears little weight, UNCAP developed GOT/UNDP, WHO reluctant to endorse the plan. UN Theme group on AIDS established. WHO reluctant partner	Limited (Red Cross)	Medium Participation in various meetings: MEDSEC, International pharmaceutical manufacturers associations, etc.	Medium Some contact in academic terms, mostly ceremonial and diplomatic	WHO important source of advice. Bilateral support decreasing (AusAid) and WHO advice on AIDS currently limited	Not relevant as WB does not have any considerable support to the health sector

Annex 7

Executive Summaries from the Country Case Study Reports

Executive Summaries from the Country Case Study Reports

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Executive Summary - Cameroon

Cameroon counts among the middle-income level countries with correspondingly good health status indicators. However, since 1985 the country has experienced an economic decline, resulting in a 40% decrease in private consumption and a severe financial crises for the government. In spite of an increase of the share of the government budget for health, the infrastructure has been eroded and the private sector has increased its importance.

Up till now the WHO country office has not had a country team and the WR has been the only professional in the office. The WR has enjoyed good relations with the Minister although a great amount of for Cameroon appears to surround his contacts with the MoPH.

The RB country programme is severely fragmented into a large number of small-scale activities most of which are in the areas of general programme and management, PHC and human resources for health. Large amounts of the country budget have remained unspent in recent years. The costs for the country office constitute 49% of the total country allocation for the biennium 1996-97 of US\$ 1.8 million. Extra-budgetary contributions are considerably greater than the RB country allocation for health activities.

Government coordination in the health sector is poor and the WR has therefore taken initiative to regular donor meetings. There is a formal system of coordination within the UN system and coordination in particular between UNICEF and WHO appears to be fairly good.

In conclusion it was found that WHO principles and strategies have been important for health policy development. However, the weakness of the WHO country office has hampered the activities and has also meant a less strong influence than would be desirable in important areas such as drug policy. The World Bank is now emerging as the major actor among the multilateral donors.

WHO does not possess any in-country capacity for support in areas like health economics. Equity is not particularly emphasised in the country programme. A monthly newsletter is widely disseminated and the WHO country report in 1995 fills a void. Apart from that WHO's resources to assist with documentation are limited, the library in the country office is of poor standard and appears to be of limited usefulness.

No one has a full overview of WHO's total support to the country. EBFs from AFRO and HQ are important but the WR has little involvement and even knowledge of EBFs from HQ and their use.

Executive Summary - Ethiopia

Ethiopia, a federal republic in Eastern Africa, has a population of 53.4 million and a land area of 1.1 million sq. Km. The Ethiopia in the past 25 years has had civil strife and violent change of government in 1974 and 1991. It is among the least developed countries with a GNP per capita of \$100, and with a Human Development Index of 0.237 ranks 168 out of 174 countries. The economy is largely agricultural with 2/3 of the population living in absolute poverty. Only 25% of the population has access to safe water, 19% to inadequate sanitation. The disease problems are mainly ineffective and parasitic disease and reproductive health problems because of high fertility, and malnutrition. The health services are poorly developed and inequitable in distribution. Only 40% of the population have access to modern health care. During the civil war 20% of the health institutions were destroyed. There is one physician per 25,000 population and one nurse per 11,000 of the population. The national budget for health in 1995/96 was \$1.76 per capita. The health services have been decentralised to the regions, but the capacity to respond to the needs of the population is low.

WHO occupies cramped offices in the Ministry of Health. The room for documents and library materials is also the office of 2 national programme offices. The Country Office has four professionals working with the Representative. The capacity of the WHO Country Office is clearly inadequate for a complex country of 53.4 million with major health and health system problems. WHO could do more for Ethiopia. The Country Office is tightly controlled by the WHO Regional Office especially in relation to the use of funds. For the 1994/95 biennium Ethiopia spent \$2.77 million from the WHO regular budget and \$2.16 million in extra-budgetary funds. of the 1995 portion 93% of EBFs was for AIDS, and 33% of the RBFs was for human resources development. The WHO Country Programme is being reduced from 16 to 11 to improve monitoring, and increase the funds per project. The support by WHO to the EPI, Drugs and Malaria programmes in Ethiopia illustrate its situation.

In EPI, WHO has been supporting Ethiopia with technical assistance for policy and norms development, training in various aspects of immunisation, the supply of vaccines and cold chain and logistics support. WHO now gives only technical assistance as several other donor agencies provide funding. The Drug Action Programme was also initiated by WHO, which has helped in developing policy, the publication of manuals on treatment, rational use of drugs, regulations on the pharmaceutical sector, and in training. Other donor agencies have been assisting with drug supply. The programme has not been moving forward because of the capacity of the pharmacy department at the MoH. Only a few donor agencies have been interested malaria. WHO assists the programme with training, manuals, guidelines, research, and also with supplies and equipment.

WHO is strong in advocacy, and the normative functions. It is regarded as the leading agency in health, and most of the external support agencies use WHO norms, guidelines and technical reports. USAid and the World Bank use their own expertise. In Ethiopia the formal influence of WHO is through the Ministry of Health. WHO should also have also a formal or working relationship with the Ministry of Economic Development and Cooperation, and the federal development process. Otherwise WHO's influence at the intersectoral level will remain ineffective. WHO capacity is too limited in Ethiopia. The major health problems in Ethiopia relate to poverty, illiteracy, the status of women population growth and food insecurity, and the dearth of potable water and sanitation. The health system capacity is very limited and inequitable.

Ethiopia needs help in developing its basic health infrastructure, health personnel capacity and social and economic policies that enhance equity and sustainable development.

WHO has a limited presence in Ethiopia compared to the size and complexity of the health and health development problems. WHO can use its limited resources to position itself more effectively as the major technical adviser to the Ministry of Health on all health matters and external support to health developments. WHO should become more involved in discussions of policies on the whole range intersectoral actions for Ethiopian development. Besides it should support the development of the regional and zonal health systems - health information, disease surveillance, health planning, and systems research, equity and financing systems and management, possibly forgo becoming an "implementing agency" in specific disease programmes.

Executive Summary - Mali

Mali is among the poorest countries in Africa and the world and has among the highest mortality indicators. The health system is under-funded and gives access to health services only to about a third of the population. A new health sector policy focuses on decentralising management and encouraging community participation and cost sharing.

After a period of disorganisation the WHO country office now has a new country team with 7 professionals. There has been a considerable improvement in administrative procedures in the last two years.

The WHO country programme is divided into a great number of fairly small-scale activities in a large number of programme areas but with a certain focus on management and planning and on training (including fellowships). The costs for the country office are 32% of the total regular budget country allocation of US\$ 2.4 million for the biennium 1996-97. Large extra-budgetary resources have been provided by WHO HQ, especially for research in tropical diseases. The WHO CO has little involvement in the programmes that are funded from WHO HQ and does not concern itself much with research.

Coordination in the health sector is generally perceived as being poor although the World Bank now appears to have taken the lead in connection with its health project and in developing a long-term health sector investment strategy. There is a formal system of coordination within the UN system although it is weak in programme terms. AIDS coordination needs to be strengthened. The issue of common UN premises has been mismanaged.

In conclusion, it was found that WHO earlier had significant influence on national health policy although its role seems to have been overtaken by the World Bank in recent years. In certain sub-sectors, such as water and sanitation and in questions regarding community participation, WHO appears to play an important role. The country team has a generally good relationship with MoH and the WR has a close relationship with the minister and the top level echelons of the ministry. The WHO information and documentation capacity is not being used to any great extent.

WHO activities in Mali are being hampered by WHO bureaucratic procedures and the centralised decision making of AFRO, the politicised staffing at the regional level and the disease orientated "products" that WHO offers its member states. Recruiting national staff directly from the MoH results in a braindrain which needs to be considered more carefully.

WHO needs to focus its efforts more clearly on areas where it has comparative advantage such as national health policy and subsector policies e.g. as regards malaria control, pharmaceuticals and reproductive health. The WHO budget and programming system needs to be changed to increase flexibility and promote concentration. UN coordination needs to be strengthened.

Executive Summary - Mozambique

After years of civil war and vulnerability to drought and natural disasters Mozambique is one of the world's greatest development challenges. It has GNP of US\$90 per capita, chronic malnutrition affecting 30-40% of children, the highest recorded under five mortality rate in the world (at 277 per thousand) and its people have a life expectancy of 46 years. Mozambique depends on external aid financing for approximately 70% of its budget financing and has an unsustainable debt level equivalent to about four times the annual income of every person in the country.

Demands for services will increase as the population for Mozambique is expected to reach 20,000,000 by the year 2000, almost 50% being under 16 years of age. Women begin giving birth very early with little spacing between children and the total fertility is 6.5% while the population growth rate is 1.8%.

During the civil war (approx. 1972-92) Mozambique lost hundreds of thousands of its population and its health infrastructure was devastated. The 15 year war and ensuing economic crisis have had a severe impact on the health system. Between 30 and 40 per cent of rural health units have been destroyed or are no longer in use. Health services are concentrated in urban areas, where about 15% of the population live and in 1995 only 30 % of the rural population had access to health services. In 1995 potable water was available to about 40% of rural areas. The maternal mortality rate in 1992 was estimated to be 300 per 100,000.

The major causes of morbidity are infectious diseases, diarrhoea, acute respiratory infections, measles, malaria tuberculosis and malnutrition.

The Ministry of Health has a budget of about US\$25 million which is just over 4% of public expenditure and represents under 30% of the total health budget. There is a World Bank sponsored Sector Investment Programme planned to commence in late 1996 which will see US\$ 355.7 million invested in the health sector over 6 years to increase health coverage and improve the health status of the population

Critical issues facing the health sector are the need to set health policy in a framework in which there is a contradiction between the demands for restructuring and curtailing spending and the need to increase the provision of health services. It is essential to develop the skills of health sector personnel in technical and managerial areas and to improve their performance, a need to develop the capacity for the Ministry of Health to plan and deliver health services in an increasingly cost effective manner, a need to decentralise the provision of health services and put into place management systems that can be implemented at the provincial and district level and a need to develop the systems and capacity to monitor the outputs and quality assurance of the health system.

The WHO office in Maputo which serves the Ministry of Health has a small technically competent staff but poorly developed planning, management, financial and monitoring systems. The Country Office has a recent history of poor performance but a new WHO Representative (WR) was appointed six months ago. The WR intends to increase staff numbers in the Country Office in order to increase its capacity to mobilise resources and to ensure a better response to the challenge facing WHO in Mozambique today. Interactions with the WHO Regional Office are frequent and responsive but the WHO system is highly centralised and the Country Office has very little autonomy. While interactions with Regional Office are frequent, communication with Headquarters tends to consist of the receipt of policies, procedures and other papers by the Country Office. The WR will not always be made aware of Headquarters initiated activity in country.

The programmes implemented by WHO in country are generally quite small but there was a large well received Emergency Planning and Demobilisation Programme managed by WHO from 1992 to 1994. Other programmes (such as Occupational Health and safety, Mental Health and Environmental Health) are small but considered to be important by the Ministry. WHO performs five major functions in delivering its programs; they are advocacy, support for the establishment of norms, policies and national planning, research, technical programme operation and information dissemination. WHO has been most involved in information dissemination and advocacy in Mozambique and has performed these functions mostly through providing supplies and equipment and courses, seminars and fellowships.

Three tracer programmes were examined in this study; the Drug Action Programme, the Immunisation Programme and the Malaria Programme. WHO's role in each of these programmes was minimal and could have been increased but the projects are now established and carving out a role will require initiative and a demonstration of credible technical, professional performance.

The budgeting and expenditure systems are complicated, based on a two year budgetary time frame and are not related to the achievement of results. It was difficult to obtain reliable financial information so conclusions regarding budgeting and expenditure are tenuous. However the complicated nature of the system and the inability of the WR to have control, or even knowledge at times of RBFs budgets and expenditure, meant that WR had no authority or responsibility for an amount of WHO activity that took place in country. The financial reports do not give information that can measure expenditure against budget and the cost effectiveness of programmes cannot be measured.

While the past WR was involved in mobilising resources for the Emergency and Demobilisation Programme he missed opportunities to mobilise resources for a number of critical health areas for Mozambique at a crucial period in its development.

In the health sector Mozambique has original systems for co-ordination at both the central and local level. There is a donor forum at central level which meets annually to discuss co-ordination of donor funds and is usually chaired by the Minister of Health. A similar forum takes place in each Province with the Health Provincial Director acting as chair for the forum. Sub-groups with special interests e.g. pharmaceuticals are formed to present main issues at forum meetings. In addition "theme" groups (e.g. the community health group) have regular meetings, chaired by one of the donors. A "pooling" system to facilitate the management of funds for important, high cost programmes e.g. drugs has been established. This system needs to be developed further but aims to maximise the use of resources through donor co-operation. WHO has only recently begun to play a role in these coordination meetings. Other donors have "carved out" their roles and there is not an obvious role for WHO. It will be necessary for WHO to work out its role with other donors over a period of time.

WHO has the advantage that it is seen to be objective because it is not a donor agency, it has a world-wide network of health experts, and a history of acknowledged expertise in establishing norms, tackling emergency situations and maintaining surveillance in the areas of epidemiology and tropical diseases.

Stakeholders in Mozambique identified the advocacy role and the establishment of norms, policies and national planning as the functions they thought WHO would best fulfil. The Ministry however, had some reservations based on past performance, about using WHO to a large degree in the area of establishing norms, policies and national planning. There are also concerns about the role of UN agencies, their duplication and lack of clarity. A need is seen for co-ordination of health activities within the UN agencies themselves and WHO was proposed as an agency to facilitate this co-ordination.

WHO has achieved little in Mozambique over the last few years. There have been constraints in the form of the centralised WHO bureaucracy with its supply driven orientation and lack of action when a Country Office was not performing. While WHO was not performing other players have moved in to take over the roles of leadership and co-ordination in the health sector.

Even with these past difficulties there are many opportunities for WHO. There are possibilities for WHO to be involved in regional and national monitoring, review of projects, establishment of norms, quality control, logistical design, translation and dissemination of information in the immunisation programme particularly, but generally in the epidemiology and tropical diseases area. WHO could also contribute to the design of and setting of examinations for health subjects, advising in human resource development in the health area and in providing support for the design and development of a health insurance system. There is a need to coordinate the UN health policies and planning which is a role that WHO could fulfil and which could lead to further involvement in facilitating and coordinating health policy and planning beyond the UN agencies. While undertaking these activities, WHO will be expected to play its advocacy role.

However, as WHO acts to regain credibility in Mozambique, it will also need to "get its own house in order" regarding its planning, management and monitoring procedures involving both financial and human resources, so that it can manage its limited resources as effectively as possible.

Executive Summary - Tanzania

Tanzania is a federal republic in East Africa with a population of 28 million and a surface area of 945,000 sq. km. It is among the least developed nations, with a G.N.P per capita per annum of \$90 (1993), and a Human Development Index of 0.364, ranking it at 144 out of 174 countries. It has an external debt of \$7.5 billion in 1993 which was 301% of GDP, indicating serious national indebtedness. Net official development assistance was 38.4% of the GNP. In spite of its poverty and under-development, Tanzania through social policies favouring equity in its health and social services has seen a significant reduction in mortality rates. Nevertheless the disease burden - ineffective and parasitic disease, malnutrition and diseases related to high fertility remain high. HIV/AIDS, drug resistant malaria and tuberculosis are increasing in incidence. The major problems in Tanzania in health are related to poverty, population growth, the changing epidemiological situation especially with HIV/AIDS, the low contraceptive prevalence rate, the poor quality of care and the deterioration of the services, the dependence on foreign assistance. WHO needs to focus on these in its advocacy and cooperation for better health.

Its health care system is fairly equitably distributed to all regions and districts, and is easily accessible to at least 80% of the population. 50% of the population have access to potable water supply and 64% to adequate sanitation. Immunisation coverage for children under 1 year of age is about 80%. Nevertheless, the capacity of the health system is low because of the shortage of staff (1 doctor per 23,000 people), and the deterioration of health care structures and the low quality of services, and morale.

Until 1994 WHO representation in Tanzania was virtually token: a representative and an information officer, in cramped quarters, away from the Ministry of Health. Now the WHO office has been strengthened by the appointment of 5 National Programme Officers in various fields of cooperation with the MoH. The office is tightly controlled by the Regional Office especially in financial administration. The administrative arrangements are cumbersome although some easing has begun to occur lately.

The regular budget (RBF) has doubled from just over \$1 million in the 1982/83 biennium to just over \$2 million in the 1994/95 biennium. Extra budgetary funds (EBFs) increased significantly from the 1990/91 period to support the AIDS programme.

The WHO Country Office is involved in advocacy, health information, human resources development, research promotion and is regarded by all the other agencies as the lead organisation in health. It supports Tanzania in the development of policies and norms and training for EPI, Drug Action Programme and for Malaria. Several donors have supported the EPI, and also the Drug Action Programme especially DANIDA and UNICEF. WHO is the leading supporter of the Malaria Research and Control Programme.

Currently, Tanzania is implementing Health Sector Reforms, with WHO and other agencies, especially the World Bank and DANIDA, as key actors. WHO's resource contribution is modest compared to other agencies such as DANIDA, UNICEF and the World Bank. DANIDA is the more influential actor in health in Tanzania. WHO need not compete it or with other well-resourced agencies but rather position itself through its obvious comparative advantage of depth and breadth in technical knowledge, the backing of skilled consultants and experts and the high regard that the Ministry of Health has for it.

Executive Summary - Ecuador

Introduction

This Country Case Study Report on PAHO's effectiveness as a technical cooperation agency for health in Ecuador has been carried out as one element of the *Study of WHO Support to Programmes at Country Level* which was undertaken in 1996 and 1997 under the joint direction of the London School of Hygiene and Tropical Medicine and the Diakonhjemmetts Internasjonale Senter (DiS) in Oslo. The Ecuador case study was carried out by a three person team consisting of Ted Freeman of Goss Gilroy Inc. in Ottawa, Sissel Hodne Steen of DiS in Oslo and Dr. Francisco Xavier Solorzano of Quito, Ecuador. In carrying out their work in Ecuador, the team members were ably assisted by the PAHO Representative and by the staff of PAHO. In addition, the team met with full cooperation and support from officials of the Ministry of Health and representatives of Ecuadorean and external agencies engaged in the health sector. The case study team carried out its work in Ecuador in November, 1996.

PAHO In Ecuador

Organization

The office or representation of PAHO/WHO in Ecuador represents a considerable body of professional and administrative capacity and expertise in health policy and health services. The PAHO staff in Ecuador were organised in 1996 into major units reflecting the principal lines of work (lineas de trabajo) in the programme of work, plus an administrative unit responsible for finance, personnel, purchasing, computer services and general services. The principle technical units are:

1. Health Systems and Services: Encompassing health and social policy, organization and management of health systems, human resources in health, technical co-operation among countries, essential drugs, the text programme (PALTEX), and the documentation centre.
2. Health Promotion and Protection: Encompassing development of health spaces (a regional programme on health at the municipal level), gender health and development, health of indigenous peoples, family and community health, and food and nutrition.
3. Prevention and Control of Diseases: Encompassing disease surveillance and epidemiology, immunisation, health and environment, public veterinary health, and the prevention and mitigation of disasters.

In 1997, PAHO intends to re-organise its technical units somewhat and to create a fourth unit for environmental health to reflect the priority given to environmental health in the Americas. Finally, the PWR also intends to take steps to improve administrative efficiency and to make better use of personnel resources for administrative support.

As already noted, the PAHO representation in Ecuador represents a strong capacity for health policy development, planning, implementation, and monitoring.

The PAHO/WHO Programme in Ecuador

The priority areas of programme activity for PAHO in Ecuador as measured by expenditures have been National Health Systems and Policies (FASBASE), the Action Programme on Essential Drugs, and Environmental Health, all with expenditures over 10% of the total. Expenditures in environmental health relate mostly to a large project in support of the water and environmental sanitation authority for the municipality of Guayaquil. It appears that regional funds have been used primarily to supplement programme areas in which the country programme was already active rather than to establish whole new lines of work. Thus there seems to be a reasonable inter-relationship between the regional funds and the Ecuador programme funds.

It is important not to read too much into the overall pattern of programme expenditures represented by either the APB numbers or the coded programme components. Some relatively small expenditures may be very strategic. For example, the reported expenditures on health policy advocacy of USD 116,587 for the period 92-95 may have an impact much larger than that indicated by the relative size of the expenditure. Nonetheless, the Ecuador programme of work is quite heavily concentrated in the areas of Essential Drugs and Support to National Health Systems and

Policies (FASBASE) as well as Environmental Health. It should also be stated, however, that the evaluation team gained an impression of other critical areas of programme activity and effectiveness which are spread across these codes. of critical importance among these was support to disease surveillance and the epidemiological functions relating to specific diseases. In particular, the support provided by PAHO to the system of monitoring and communication of information on the incidence of Chaga's disease, malaria, and dengue fever as described to the Study team during a visit to Ministry of Public Health facilities in Guayaquil, has been important in the evolution of strategies and programmes for the control of these diseases.

Tracer Programmes

Essential Drugs Programme

PAHO has been an actor of considerable importance in the essential drugs area in Ecuador. It has had some positive results relating to norms development, application of norms and to training and capacity development in the hospital and pharmaceutical production sectors and has been an active advisor to the Ministry of Public Health. The essential drugs sector seems to be still quite fragmented and weak in Ecuador, despite efforts by PAHO and other external actors to support the GOE in this area.

Immunisation Programme

PAHO's key contribution to immunisation has been in the dissemination of the norms for eradication of polio, tetanus, and measles. PAHO has also promoted co-operation with private clinics and paediatricians regarding surveillance for these diseases. In 1997, this co-operation is to be expanded to general practitioners and other private health service sites. However, PAHO has created some dependency due to the availability of significant resources at the beginning of the programme and because it feels unable to rely on an adequate response in disease surveillance from the Ministry of Public Health. Finally, there is currently no national counterpart for the surveillance of immuno-preventable diseases.

Malaria Control

PAHO provides important support to the disease surveillance aspects of malaria control and has been instrumental in the development of a strategy aimed at better use of resources in malaria control. This three part strategy emphasises:

- improved surveillance;
- vector control only in very endemic areas (no effort at eradication); and,
- mortality reduction through improved diagnostics and case-treatment.

This strategy is similar to the one promoted by PAHO and accepted by the Ministry of Health in Nicaragua.

PAHO/WHO Response to Health Needs in Ecuador Achievements

Key achievements for PAHO/WHO in its programme of collaboration with Ecuador include:

a) Policy and Planning

- implementing a strategy of inclusive and sector-wide processes for policy debate on key national priorities in health sector reform;
- maintaining a recognised position of policy leadership in the international community around health sector reform and advocacy for improved levels of investment in health and planning for equity;
- providing a forum for inter-agency interaction and consensus building on policies and priorities in health sector reform;

b) Programme Implementation and Technical Co-operation

- providing effective technical co-operation services in key areas such as disease surveillance, epidemiology, and essential drugs;
- providing effective programme implementation services to ensure continuity in delivery and efficient administrative processes;

- linking effectively to other key internal and external actors in health for programme implementation and technical support (e.g. the Ministry of Public Health/PAHO/Netherlands programme in essential drugs); and,
- providing quality services in information dissemination in health.

In summary, PAHO in Ecuador has tried to balance (in recent years anyway) its operational roles in technical assistance and project implementation with a fairly public and aggressive strategy of advocacy for critical priorities in health sector development. Not least of all, it has tried to support open and public processes for debating health priorities and reaching a national consensus on health sector reform. At times PAHO has taken considerable risk in pursuing this strategy and the Director of PAHO has provided key support to the PWR when needed.

Key Constraints

As noted in earlier sections, in building on or extending these achievements, PAHO faces a number of serious constraints and challenges. These include:

- the continued fragmentation of the health sector in Ecuador which requires PAHO to support the leadership role of the Ministry of Public Health while striving to avoid becoming so identified with MSP that it diminishes its effectiveness in working with others;
- the need to re-visit the qualifications of its human resource base to try and augment capabilities in health systems planning and management without weakening current strengths in specific sub-sectors;
- the need to strengthen support to health systems research without exceeding its own capacities;
- the need to strengthen GOE systems for health planning and priority setting so as to reduce reliance on external agencies;
- the need to assist the GOE in strengthening its capacity for coordination of external assistance in health; and, most importantly,
- the need to develop and implement a strategy which allows for more effective collaboration between PAHO, the Government of Ecuador, and the World Bank. While PAHO's ability to influence this relationship at country level may be limited, it is essential that these two key actors in external support to health sector development find more effective ways to complement each others activities and to collaborate in policy development and support to health sector reform.

Future Directions

In order to capitalise on its comparative advantages and to improve the level of results achievements in Ecuador, PAHO could emphasise the following developments in terms of its own capacities and the direction of programming:

- proceed with efforts to improve the efficient use of administrative human resources while also increasing its professional capacity at country level in key health systems management areas such as health economics, health financing, health budgeting, and human resource planning;
- examine the need to establish more flexible working teams within PAHO's organisational structure to take better advantage of multi-sectoral opportunities and to reduce hierarchical limitations on staff interaction;
- emphasise (as is apparent in the draft APB for 1997) support to health systems management as a key programme area;
- provide more support to health systems research in upcoming programmes of work;
- continue to strongly support a collaborative, inter-agency strategy for developing policy consensus on health sector reform;
- advocate for an open public debate on health sector reform while continuing to support key normative goals of PAHO as established in the Strategic and Programmatic Orientations for 1995-1998; and,
- attempt to use inter-agency consultation mechanisms at headquarters level (to whatever extent possible) to seek a stronger and more constructive working relationship on essential support to health sector reform between the World Bank and PAHO in Ecuador.

Executive Summary - Haiti

Haiti counts among the poorest countries in Latin-America. During the period 1991 to 1994 the international community applied diplomatic pressure and economic sanctions against the military government to try to reinstate the overthrown constitutional government. During this period of emergency, most external agencies were forced to cut back their activities. Although the constitutional President returned to the country in 1993, the situation has remained far from stable.

Health data are poor, but indicators are generally worse than those of the other two case countries: Ecuador and Nicaragua. Health systems coverage is weak compared to neighbouring countries, and unevenly distributed across the country. The Ministry of Health developed its most recent health policy in 1996, and subsequently a five year plan for the sector. Even before the crises, the capacity of the Ministry was weak, and NGOs were involved to a significant degree in the provision of health services.

The political crises have had a significant effect on the current PAHO/WHO programme. During the crises, PAHO/WHO was responsible for implementing a large, complex humanitarian aid programme - primarily through the NGO community. The number of staff reached about hundred. Today, the institutional capacity of the PAHO/WHO office is still high, but comparable to other offices in PAHO and larger than in many other WHO regions. The WHOCO is widely recognised as having high technical quality technical experts in a range of health issues, and as seen as the leading agency in the health sector. The capacity of the WHOCO appears to be more suited to the emergency situation than it does to a more traditional PAHO/WHO development focused role which would require a stronger focus on health systems development and capacity building. The WHOCO has clearly a stronger sense of identification with the region and PAHO than with WHO at a global level.

WHO/PAHO has had a unique programme of work over the past five years. The responsibility for implementing an emergency programme, placed the office in the non-traditional role of providing technical support - not to the Ministry of Health, but to NGOs which allowed the organisation to experiment with a decentralised, bottom-up approach to programming, which laid the foundation for partnership between the public and private sectors. The assessment of WHO/PAHO's role during this period was generally very positive.

In 1994, WHO/PAHO participated in developing a new economic recovery programme with a key strategy of building capacity in the Ministry of health. As a result, PAHO/WHO is shifting its focus from operations to support to the Ministry with the aim of re-establishing the Ministry's position in the health sector. Whereas during the crises, the organisation was substituting for the Ministry of Health, there is now some subtle evidence to suggest that, although engaged in similar activities, PAHO/WHO is now doing these activities more in collaboration with the Ministry.

Essential drug programme activities constitute one of the major and most visible achievements of PAHO/WHO. WHO plays also a key role as an executing agency for other organisations. Three quarters of public health expenditures in 1995 were covered by bilateral and multi-lateral aid. There are a number of large donors, but PAHO/WHO is perceived to be the lead- and coordination agency in the sector. There are monthly meetings among UN Heads of Agencies, but no strong efforts to prepare a UN Country Strategy Note.

The relative strength of the PAHO/WHO office is its technical capacity in health and the logistic capacity it demonstrated during the emergency. The questions remains whether WHO is the most appropriate organisation to play such a strong operational role during an emergency. PAHO/WHO has given considerable more emphasis to technical operations than to other components of its mandate. Policy development is the second strongest component. Its role in advocacy and research are weaker, and there has been little support from the Ministry of Health to research.

PAHO/WHO has demonstrated an ability to be a flexible and innovative organisation capable of adapting and building on opportunities and needs in Haiti. The close involvement with NGOs provided the opportunity to test the viability and effectiveness of a range of national NGOs.

The strong technical cooperation role has provided the WHOCO with the credibility to support its ongoing advocacy and the role in the development of policies, norms and standards.

The emergency response of WHO/PAHO was unique. Now the organisation clearly faces conceptual and practical constraints in shifting its support from the mode of «emergency response» to «development». The limited capacity of the Ministry represents currently a major constraint. PAHO/WHO is making the transition, albeit very gradually and without an explicit long-term vision and strategy.

Executive Summary - Nicaragua

Introduction

This Country Case Study Report on PAHO's effectiveness as a technical cooperation agency for health in Nicaragua has been carried out as one element of the *Study of WHO Support to Programmes at Country Level* which was undertaken in 1996 and 1997 under the joint direction of the London School of Hygiene and Tropical Medicine and the Diakonhjæmmets Internasjonale Senter (DiS) in Oslo. The Nicaragua case study was carried out by a three person team consisting of Ted Freeman of Goss Gilroy Inc. in Ottawa, Dr. Marie Largaespada-Fredersdorff of Managua, and Sissel Hodne Steen of DiS in Oslo. In carrying out their work in Nicaragua, the team members were ably assisted by the PAHO Representative, Dr. Philip Lamy and by the staff of PAHO. We would like to express our appreciation for the cooperation of Dr. Lamy and his staff. In addition, the team met with full cooperation and support from officials of the Ministry of Health and representatives of Nicaraguan and external agencies engaged in the health sector. The case study team carried out its work in Nicaragua in early December, 1996.

PAHO in Nicaragua

a) Organization

PAHO's professional and administrative staffing capacity in Nicaragua represents a strong comparative advantage for the organization. PAHO is seen by all agencies active in health sector development in Nicaragua as a strong force for health policy development, health planning, normative standards development, and programme implementation. PAHO's professional human resources in Nicaragua are well qualified and have a strong knowledge of the context of health development in the country and of the current situation in health services.

b) Programme

The most important strategic areas in PAHO's program of cooperation, as emphasised by PAHO and the Ministry of Health and as reflected in the 1997 Annual Programme Budget are disease prevention and control and support to health systems. Disease Prevention and Control accounts for 18% of the 1997 budget, while support to health systems encompasses 64%. A retrospective review of key programme component expenditures in the period 1992-1995 shows the predominance of PAHO activities in the period were concentrated in the areas of immunisation and support to health services. In that period 33% of all programming could be classified under support to health services, when immunisation expenditures are added to that total, it rises to 45% of all programme spending. Total PAHO programme expenditures in the period from 1992 to 1995 in Nicaragua amounted to 25.4 million USD.

Tracer Programmes

a) Drugs Policy

PAHO's role in the development and implementation of national drugs policies and systems in the period 1992 to 1996 was both positive and essential. PAHO has assisted the sub-ministry responsible in the development of a policy, legal, and regulatory framework for essential drugs while other donors have supported research on rational usage and have provided logistic and material support. The Ministry of Health (MINSAL) foresees PAHO maintaining a focus on policy oriented and normative technical assistance (as well as assistance in human resource development) in the medium-term future.

b) Immunisation

PAHO's major areas of collaboration in immunisation can be described under the headings of:

- Policy and Management;
- Disease Surveillance and Epidemiology;
- Infrastructure;
- Logistics and Resources: and,

Co-ordination and Integration.

PAHO's active support to immunisation programming in these functional areas was confirmed during the study team's visits and interviews with MINSA staff at national level and during the study team's visit to the Esteli SILAIS. MINSA staff emphasised PAHO's role in technical, logistic, and administrative support to immunisation. of special importance was support in epidemiology and disease surveillance. MINSA staff also noted that the immunisation programme is integrated and coordinated through the work of the Inter-Agency Working Group on Immunisation which is chaired by the Ministry of Health with support from PAHO.

In summary, PAHO has been a very strong component in the Enhanced Programme of Immunisation in Nicaragua. While it has provided support in the areas of logistics, training, policy development, and the development of norms and standards; the study team was particularly impressed by the effectiveness of PAHO's support to disease surveillance and epidemiology, especially at the SILAIS level.

c) Malaria Policy

PAHO in Nicaragua, has been active in the development of norms and standards and of strategies for malaria control. It has also devoted some effort to assisting in the integration of control of vector-borne diseases into the SILAIS. In the absence of a comprehensive evaluation of the malaria program of MINSA, at both the national and SILAIS level, it is difficult for the study team to develop conclusions in this area. Nonetheless, MINSA staff and representatives of bilateral and multi-lateral agencies indicated that there has been some real difficulty in having malaria control and treatment strategies effectively integrated into the SILAIS system, with negative consequences to the effectiveness of national malaria control strategies. This is perhaps an area of some urgency for support by PAHO and other agencies active in supporting health reform and the decentralisation process in health in Nicaragua.

Country Needs and PAHO/WHO Response

Key achievements for PAHO/WHO in its program of collaboration with Nicaragua include:

Policy and Planning

- assisting in the development of the national health plan in 1990 with its emphasis on decentralisation of health services;
- continuing assistance to the development of a legal framework for health sector reform, including critical areas such as essential drugs;
- effective participation in national and local systems of program planning for such operational programs as immunisation; and,
- continued advocacy for the health sector priorities established at regional and sub-regional level by PAHO and the Ministers of Health of the Americas.

Programme Implementation and Technical Cooperation

- providing effective technical and logistics support to key programme areas such as immunisation;
- effective technical co-operation and support in functional areas such as disease surveillance and epidemiology;
- provision of substantive expertise to the six SILAIS of PROSILAIS, especially in the operational areas of immunisation, and disease surveillance;
- promotion of an interchange among the countries of Central America on experience in decentralisation of health systems;
- effective collaboration with other agencies supporting common programmes in health (i.e. MINSA/PAHO/SIDA in PROSILAIS and US-AID/MINSA/PAHO in immunisation); and,
- providing services in communications nationally and internationally in the health sector.

In summary, PAHO has pursued a strategy of balanced support to technical areas relating to disease control and to specific sub-sectoral activities in health with support to the development of health systems (especially the SILAIS system). It has had considerable success in this attempt based on its strong professional capacity in the country and its reliance on a strong regional consensus on health priorities. PAHO has also contributed to the development of a consensus on the direction of health care reform in Nicaragua. This must, however, also be credited to the relative strength and organisational continuity of the Ministry of Health in Nicaragua.

Key Constraints for PAHO in Nicaragua

The most critical challenges and constraints to PAHO's continued effectiveness in Nicaragua include:

- the risk of a radical change in direction in health policy by the new government. Any effort to reverse decentralisation or consolidate more power at central level could jeopardise years of progress and tens of millions of dollars of investment;
- the need to ensure that PAHO's own professional resources match the continually emerging need for support to health systems management at provincial and local level;
- the need to balance its project implementation and execution role with its role as an impartial advisor on policies and operational norms and standards;
- the need to develop a consensus among donors on means of measuring the effectiveness of the SILAIS and making operational improvements; and,
- the need to better specify the realities of health service decentralisation to municipal level.

Future Directions

In order to meet these challenges and to realise more fully on its comparative advantages in the health sector in Nicaragua, PAHO could emphasise the following evolution in the direction of its own organisational capacities and its programme of co-operation:

- continued efforts to re-balance human resources and strengthen its capacity in support to the planning, management and implementation of health services at the provincial and municipal level with an emphasis on determining the cost of services, establishing productivity standards and measures and ensuring the quality of locally delivered health services;
- attempt to develop a programme in collaboration with MINSA, the SILAIS and the donor community which will develop results definitions, indicators and a system for monitoring and reporting on the effectiveness of SILAIS in the delivery of health services;
- establishing with MINSA a process for collating and reviewing the experience of SILAIS and their effectiveness in an open forum with participation by the external donor agencies;
- attempt to develop, with MINSA, a program for improving budgeting processes in the ministry so that recurrent cost implications of investment decisions are fully considered and provisions for recurrent costs are required when capital investment decisions are approved (especially when capital costs are financed with external co-operation funds);
- provide support to MINSA and the SILAIS for the development of quality of service standards; and,
- promote, through MINSA, the development of mechanisms for inter-agency co-ordination in support to the health sector, including inter-agency meetings on health sector reform policy and on operational issues in supporting the SILAIS process.

Executive Summary - Bangladesh

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 90/1000 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. Vectorborne 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 inservice 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.

Executive Summary - Thailand

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 ageing 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, of about US\$6 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.

Executive Summary - Cambodia

After the Pol Pot regime, Cambodia was left in a very poor state. Little tangible evidence remained of either government infrastructure or previously existing services. Within health, little in the way of a viable system was operable, professional and skilled technical staff numbers had been decimated, institutional memory had by and large been lost, and the general level of health of the population was in a deplorable state. Moreover, ongoing political instability and military incursions by the Khmer Rouge continued.

Cooperation between WHO and Cambodia was suspended from 1975-1980, after which time WHO support to Cambodia was carried out under the auspices of UNICEF and the International Committee of the Red Cross (ICRC). WHO re-established a presence in Cambodia in 1991.

In providing technical advisory support in key programme areas within the MoH, WHO has played a pivotal role in building the framework for health sector development, and in so doing, providing uniformity of direction in terms of the development of health systems and structures, policy reforms and standards of practice. Although much of the progress made in coordinating and directing health sector development has been attributed to the WHO/ODA/UNDP SHS programme, other WHO technical advisers have similarly provided direction and established a normative base in each of their respective programmes. At another level, the WR has been influential in providing guidance to bilateral and multilateral agencies visiting Cambodia. While the approach adopted by WHO has not been supported by all agencies, recognition is nevertheless made of the need for programme collaboration and for WHO to assume a coordinating role.

WHO has had a very relevant and appropriate policy level involvement in systems development. There has been a high ambition for being comprehensive, at the cost of policy application in provinces and districts. Monitoring and quality assurance are areas with very limited involvement.

A gradual shift towards support for application of policies is taking place. WHO contribution to health sector planning has been highly appreciated and used by the MoH, Ministry of Finance and the external partner agencies. The coverage plan that has been developed is used as a basis for the WB and other donors. The work on financing policies was seen as possibly being too experimental in design to be considered appropriate within the context, while the support for capacity building in health financing was considered relevant and significant.

In its support to service implementation, WHO has largely concentrated efforts at the central level and in specific disease control efforts (Malaria, TB, Polio). Generally, WHO is highly regarded for its contributions to these areas.

WHO support to human resource development has been significant. The Study did however note that insufficient emphasis is made regarding human resource management issues, and very little attention is paid to critical issues affecting the effective functioning of staff, such as working conditions, incentive systems etc. The very limited research inputs are relevant but inadequate and without appropriate links to the rest of the WHO country involvement. WHO has not been able to fill the expected role and make appropriate and adequate responses in the area of drugs and reproductive health. The expectations from UNICEF and USAid to WHO in these areas have been poorly met.

The absence of sufficient resources was also found to impinge upon the recruitment of long term technical advisory staff resulting in an increased reliance upon short term appointments. This situation was not found to be entirely satisfactory in terms of continuity of programming or for

short term appointees in terms of conditions of contract particularly the absence of regular staff entitlements.

While at one level WPRO support was seen to increase the institutional capacity of the WHOCO, the nature of support provided also diminished the ability of the Country Office to function as an autonomous unit. It was the opinion of other agencies dealing with WHO that decisions were often delayed because of the need to defer to Manila. Outsiders also found WHO administrative procedures complex and confusing.

Overall, opportunities have not so much been missed as not been made the most of. The lack of opportunism relates back to a combination of inadequate resources and to WHO's management systems and structures which, in spite of efforts to improve flexibility and responsiveness, constrains arrangements for strategic partnerships with other agencies. The rigidity of WHO's financial system in association with insufficient financial resources to fund essential programmes is seen to impinge upon WHO's potential effectiveness at country level and has served to diminish WHO's status in the eyes of other donors.

In sum, WHO has made a significant contribution in supporting the Cambodia Government in its desire to not only improve the health situation of its population but to catch up with its near neighbours.

Executive Summary - Papua New Guinea

Background

Papua New Guinea is a small Pacific island state of some 4.3 million people located in the South West Pacific Ocean. Based upon revenue derived from mineral exports PNG is ranked a middle income country by World Bank standards. However, according to the UNDP Human Development Index, PNG rates very poorly across all indices.

After a decade of political and macro-economic instability the capacity of the Department of Health to deliver primary health services has been adversely affected. Marked discrepancies exist in the capacity of provinces to provide family health services, control disease and meet basic infrastructure standards. In addition, institution of constitutional reforms, which have brought about greater devolvement of authority to provincial and local government have considerably complicated administrative procedures requiring the development of new administrative models. With a dearth of experienced senior administrators within the DOH, the Policy, Planning and Evaluation Unit is dependent upon the support of nine external advisers to bring into effect the necessary changes.

The consequent effect of a decade of deteriorating health services has had a negative impact on the health status of the population. PNG now lags behind other Pacific island states in terms of life expectancy, child survival and adult literacy. The infant mortality rate increased during 1980-1995 from 72-82 per 1,000 live births while maternal mortality remains exceptionally high at an estimated 8 deaths per 1,000 births.

In 1995, a new five year National Health Plan was formulated to carry the DOH through to the year 2,000. Plan priorities seek to both increase primary health services to the rural majority and strengthen the institutional capacity of the DOH. Against this background, WHO is supporting Government in achieving its task.

Study Terms of Reference

Between October 19-28th 1996, the WHO Country Office in Papua New Guinea was visited as part of a wider twelve country study examining WHO's support to programmes at country level. In the process of review four key areas were examined: WHO Country Office structures and processes, programmes and activities, linkages with other partners in health development, and WHO's mandate and role.

Study Findings

Overall, WHO country operations were found to be responsive to a changing environment, relevant to country needs, supportive of national efforts and to have contributed to strengthening national health capacity.

Mandate and Role

A clear notion of WHO's mandate in PNG was apparent. Global and regional initiatives such as polio eradication, Health For All and more recently, the New Horizons in Health initiative, formed the thrust of the 1996-2000 National Health Plan. Associated WHO policy guidelines and technical standards were effectively incorporated into Department of Health policy framework. Similarly, the Health Promoting Schools concept was endorsed by the Ministry of Education. In the light of constitutional reforms WHO has also supported Government in revising health legislation particularly in the areas of health financing and pharmaceutical regulation.

It was generally acknowledged by UN agencies with a presence in PNG that WHO is the technical lead agency in health, the position being formally acknowledged in the UN Country Strategy Note.

Structures and Processes

While the Western Pacific Regional Office (WPRO) was found to exert considerable influence over country operations, institutional structures linking the WHOCO with Manila were not found to be an obstacle to field effectiveness. Clearly defined planning, management and reporting procedures were in place and regular communication maintained between the two offices. Little if any direct communication was however seen to exist between WHOCO and WHOHQ other than the institution of technical standards and policies generated in Geneva.

In terms of funding arrangements, the long standing policy of zero real growth in regular budget has served to constrain WHO's potential capacity in PNG. The impact of which was most evident in the areas of staff recruitment and the often times inability of WHO to translate policy advice into programme activity. It would also appear, given that a continuous process of re-negotiation is undertaken between WHO and the DOH during the programme implementation phase, that the lengthy biennial planning process is not wholly compatible with a system that frequently has to respond to change both within and external to the health system. At the country level, flexibility to reallocate programmed funds was found to be limited. In general, the WHOCO depends heavily upon Regional Office approval and support in the form of either financial, logistical and or technical inputs to carry out extraordinary functions. Despite the apparent limitations, the WHOCO with support from WPRO was found capable of responding to emergency situations in a timely and appropriate manner.

Programmes

At the time of the Study a close working relationship of mutual trust and respect was found to exist between WHO and the MoH. WHO technical advisers were located in key programme areas providing support in the areas of health policy, management and planning, finance, nursing reform, human resource development and the eradication and control of selected diseases. Overall, WHO programme composition provided a balanced approach between strengthening health systems and addressing those diseases and conditions which give rise to high rates of morbidity and mortality. Recognition was made though of the need to consolidate the number of project areas and to review the balance between support towards policy and planning and discrete programme implementation at district and community level. Two areas found to be poorly served were reproductive, maternal child health and operational research.

Linkages

In the absence of a strong resource base WHO is at potential risk of being marginalised by the emergence of large donors within the health sector. In recognition of this fact the WHO Country Representative (WR) has sought to further consolidate WHO's position in PNG both with Government and other partners in health through increasing WHO's role in advocacy, facilitation, coordination and resource mobilisation. Formal coordination mechanisms have been established with other donors to promote this effort while a strong partnership is maintained with other UN agencies.

In terms of future directions it would appear that greater emphasis may be placed upon normative functions, particularly the use of advocacy and in focusing in upon key policy issues and reforms. The 1998/99 Collaborative Programme Plan reflects that some consolidation in the area of technical operations has already been planned. In addition, in the light of a substantial increase in planned programme activities by donors over the next few years in association with near absent Government monitoring of donor activities, a potential role identified by the WR is in assisting Government to monitor health system balances.

In conclusion, against a background of difficult country contextual factors along with limited resources the WHOCO demonstrated an ability to provide effective ongoing support to key programme areas while remaining responsive to a frequently changing environment.

Gaps in National Health Systems Capacity and WHO's Contribution : Ethiopia

AREAS OF CONCERN:	GAPS IN NATIONAL CAPACITY	WHO's CONTRIBUTION	ASSESES RELEVANCE
POLICY ISSUES:			
Policy framework	Major constitutional & administrative reforms towards regional governments. WB economic recovery policies. Mismatch health sector needs and economic reforms. Lack of forums for policy discussion and consensus building.	None.	Lack of response/adjustment to new challenges.
Organisation	Federalisation has resulted in weak capacity at both regional and central levels.	Marginal inputs.	Inadequate.
Planning & budgeting	Planning and implementation functions moved to regions. Unclear roles and responsibilities.	Participates in developing norms and standards in special areas/programmes.	Contribution appreciated by partners.
Financing capacity	Low level of Government spending.	No contribution.	
Monitoring & info. dissemination	Weak health information system. Statistics not regularly produced.	Health education materials and publications.	Low profile.
Service implementation	Uneven distribution. Infrastructure poor. Low coverage.	Low CO technical capacity. More external consultants. Executes projects. Emergency role.	Low profile. Executed projects relevant, but appropriate role for WHO?
Research	A National Health Research Commission - but marginal role for MOH.	Support to fellows and research institutions.	Not a key focus of WHO assistance. Poor use of research findings.
International cooperation	Government seeks to avoid donor coordination. No external agency dominates.	No active role.	WHO perceived as lead agency in theory, but plays marginal role in practice. Ignored by major donors like World Bank.
HUMAN RESOURCES ISSUES:			
Quantity	Thin spread of available trained staff. Under-served regions.		
Skills & experience	Uneven distribution.	Programme related trg.	Relevant.
Working conditions	Few incentives/low salaries. Poor infrastructure.	None. Involved in health centre rehabilitation.	Physical rehabilitation of health centres relevant, but maybe not appropriate for WHO.
Training & education	Low capacity.	Training (HRD) one third of RB. (fellowships)	No evaluation. High drop out rate.

Gaps in National Capacity and WHO's contribution: Tanzania

AREAS OF CONCERN:	GAPS IN NATIONAL CAPACITY	WHO's CONTRIBUTION	ASSESSED RELEVANCE
POLICY ISSUES:			
Policy framework	Major health sector reform underway. Lack of consensus on specific content/normative framework for reform. Multiple actors and interests. No analysis of consequences.	Active in health reform discussions. Chairs donor health group. Distributes technical and policy related documents.	Visible presence in discussions. Difficult to determine with what effects and content of WHO substantive input. Plays role as facilitator and moderator
Organisation	Low absorptive capacity. Donor dependence. Poor incentives/compensations.	Works closely with MOH staff in all programmes.	Marginal, but difficult to assess.
Planning & budgeting	Government and donor planning still too isolated. Planning process in principle district based. Weak capacity for comprehensive national planning. New PHC Directorate to be established.	Provided advice/guidelines on standards and norms in training.	The limited contribution found useful.
Financing capacity	Very low. Large donor contributions raising concerns about sustainability. A quarter of health care expenditure on national referral hospitals. Cost recovery programmes instituted.	Some TA in health financing (?)	Marginal relevance. Few financial resources.
Monitoring & info. dissemination	Poor quality of data	Health trends/info.support	Useful.
Service implementation	Health services fairly extensive. Distribution relatively equitable, but very low health status. Low system effectiveness.	Increased CO technical capacity in several areas. Considerable service delivery support.	Still inadequate techn.capacity. CO wants to increase policy support. Ambivalent to service delivery role.
Research	Multiple actors & interests involved. Weak national coordination.	Both EBF/RBF inputs. Support provided to Health Systems Research Unit. Nutrition research, TDR, Tanzania Essential Health Intervention.	Relevant support to capacity building. Lack of information to assess effects and impact.
International cooperation	Multiple, strong actors. Donor dominance. Weak MOH coordination.	Chairing several donor groups. Has a coordinating role.	Visible profile. Difficult to observe practical effects of coordination.
HUMAN RESOURCES ISSUES:			
Quantity	Health manpower inadequate.	No contribution to formal education, but contributions from fellowship programme..	
Skills & experience	Low quality. Community health agents & TBAs poorly trained and supervised	Supports TCDC through universities and trg.instit.	Fill gaps in academic programmes.
Working conditions	Low salaries, staff morale and performance.	No contribution.	
Training & education	No health manpower plan	Provide long term training opportunities. Fellowship programme. Short term training courses.	Relevant needs. No evaluation of effects.

Gaps in National Capacity and WHO's contribution in filling these gaps: Cameroon

Component	Gaps in National Capacity	WHO contribution	Relevance
Policy and Planning	Most recent health policy: 1989 Health system restructuring and decentralisation, MPA, integrated services, rational use of drugs, co-financing and co-management of services.	WHO global policies have been important for health policy development in Cameroon. WHOCO has offered to assist the MoH to write a new NH Plan.	Lack of continuity of WR presence, and lack of capacity in health sector reforms has reduced WHOCO effectiveness. WHOCO now has to be careful to assist MoH rather than to take over its role.
Financing Capacity	Total health expenditure in 1990: \$29/capita 26% govt., 62% private, and 12% external. Health % of Govt. expenditure increased from 4.6% in 1992 to 7.2% in 1996, but larger % of smaller budget (economic crisis) Several national plans developed but have no funding: HIS, Malaria, Nutrition External assistance decreasing.	For the HIS WHO had provided comparative documentation and training, but has withdrawn from shouldering any further responsibility although badly needed.	Govt. increase in health expenditure as a consequence of SAP and policy dialogue with World Bank. More strategic use of the CO budget could be of greater use to the country in specific areas.
Monitoring and QA Service Implementation	Regulation and QA system not fully developed Access to health care: 40% of rural and 70% of urban population. Churches provide a large proportion of services. Donors work in specific provinces with little overall coordination. General deterioration of facilities and services with economic crisis.	WHO Country programme budget is used to support small aspects of service implementation. There is virtually no support to a malaria control programme - malaria is a major problem in the country.	Relevant and needs to be strengthened MoH seems to be happy with dividing the WHO country programme budget into many small components so that most divisions get some funds for activities. More strategic use of the CO budget could be of greater use to the country in a limited number of specific areas.
Research	National Epidemiology Board of Cameroon supported by Rockefeller, supports research in population, environmental issues, health systems management and health technology, and develops national protocols of care.	Protocols of care are based on WHO standards and guidelines. The WHOCO has little input to research activities	
International Co-operation	Overall coordination of external support to Cameroon has been weak or non-existent. The Prime Minister heads a new Coordinating Committee for Development Aid, secretariat in Min. of Economy. No longer any regular formal mechanisms for donor coordination in the health sector. Donors work in specific provinces with little overall coordination. Some project level coordination.	WR chairs a monthly informal donor coordination meeting, but no regular MoH representation. WR is the chair of the thematic group for UNAIDS but this is not very active.	WR is seen by many as the neutral spokesman for the group of donors - but this raises questions as to the WR's allegiance with the MoH, and could place him in a difficult position in case of any controversies.
Human Resources Quantity		No obvious contribution	
Skills and Experience		Significant numbers of senior MoH staff have been trained through WHO Fellowships	Fellowship programme has not been evaluated.
Working Conditions	Staff salaries have been significantly cut (with the economic crisis) → motivation and performance is deteriorating	No apparent contribution.	
Training and Education	Well established Faculty of Medicine - showing signs of physical and financial deterioration as a result of the economic crisis.	The Faculty of Medicine was established with considerable support from WHO, but this has been gradually phased out - felt they had a right to more support from WHO	No effective response from WHO to the financial crisis or the feelings expressed as a result - insufficient explanation of appropriateness of withdrawal of support and increasing independence

Gaps in National Capacity and WHO's contribution in filling these gaps: Mali

Component	Gaps in National Capacity	WHO contribution	Relevance
Policy and Planning	No National Health Plan since 1990; Health Sector Reform includes: CSCOMs, Decentralisation, Individual cost sharing, Improving access and quality. Essential Drugs, Integrated service delivery	NPO (economist) on committee to develop NHP for 1997 to 2000 In the 1970s and 80s WHO had significant input in health policy such as PHC, HIFA and Bamako initiative.	Appropriate WHO role, but poor reputation of WHO over several years has marginalised WHO in this area of work with the MoH - World Bank is very active in policy and planning with MoH.
Financing Capacity	Total health expenditure in 1990- \$15/capita 25% govt., 47% private, and 28% external. Health % of Govt. expenditure increased from 5.2% in 1990 to 9.7% in 1997	NPO economist is planning with MoH a survey on health spending and service utilisation.	Govt. increase in health expenditure as a consequence of SAP and policy dialogue with World Bank.
Monitoring and QA	Regulation and QA system not fully developed	Some contribution in registration of drugs	Relevant and needs to be strengthened
Service Implementation	Only 30% of population have access to health care. CSCOMs are expected to improve access - pilots have been successful.	WHO Country programme budget is used to support small aspects of service implementation. CO staff and TAs are used for specific project planning.	WHO allows the country to set its own priorities for use of the small WHO budget - unlike other donors who impose priorities. Does this value balance the fragmented nature of WHO spending?
Research	National Institute for Public Health Research has \$1.2 million budget and 150 staff doing health systems, community health and specific disease research - supported by Rockefeller (?) Faculty of Medicine and Science also important research centre.	TDR HQ has been important in strengthening the research activities in entomology in the Faculty of Medicine and Science. The WHOCCO has little input to research activities	The strength of malaria research has not been transferred to a strong malaria control programme. A suitable role for WHO would be to assist the MoH to coordinate research efforts, and to use research results in policy and planning.
International Co-operation	Poor coordination in the health sector overall, but stronger coordination at the level of specific projects. A new Ministry of International Cooperation has developed a framework of coordination which is expected to be accepted by the Govt.	WHO participates as a member rather than a leader in the various coordination mechanisms that exist. WHO contributed some technical assistance to the new MoIC framework.	WB states that WHO should be the main health adviser to Govt. however, more on medical issues rather than on the broader political, economic and social issues which are the focus of health sector reform.
Human Resources Quantity	Govt. plans to increase the number of nursing staff.	No obvious contribution	
Skills and Experience	Few specialists (i.e. gyn/obs etc.) Few higher level trained nursing staff Management skills limited esp. in province/district	Significant numbers of senior MoH staff have been trained through WHO Fellowships	Fellowship programme has not been evaluated.
Working Conditions	Need to create acceptable working conditions at district level so skilled staff can be retained. - Incentive schemes and Career development Staff motivation and performance in many cases is low	No apparent contribution. (Employment of national officer can be seen as further exacerbating dissatisfaction with the Govt. conditions, or as a way of retaining skilled staff in the country.) Fellowships	This is a critical area identified in most African countries and a legitimate area of WHO activity and support: development of national human resources to deliver appropriate health services close to the people.
Training and Education	Limited training institutions for higher degrees other than medical (i.e. midwifery, pharmacy) Monitoring of quality of training, few trainees	No contribution	

Gaps in National Capacity and WHO's contribution in filling these gaps:.. Mozambique

Policy and organisation	Gaps in national capacity	WHO contribution	Relevance
Policy Framework	Norms and policies for key reform issues still to be established; Decentralisation, Health financing, Public/private mix Drug registration, QC and inspection Integrated service delivery Mismatch between health sector visions and macro-economic policies set by IMF/WB	Very little input. Provided Consultant Has provided Technical Assistant on registration, general guidelines	Acknowledged and plans include further involvement Rather verticalised effect of programmes Could WHO involve itself in discussion on the terms set by IMF/WB?
Planning and budgeting	Unequal distribution of resources from donors in the decentralised P&B system Limited planning capacity at local levels	Does not participate in decentralised planning exercises	
Financing capacity	Dependency in an environment of generally decreased external resources Need to explore other sources for internal funds.	Provided TA in health financing (insurance)	
Monitoring / QA	Regulation and QA system not fully developed	Some contribution in registration of drugs	Relevant and needs to be strengthened
Service Implementation	Still gaps in coverage Gap between rehab. in infrastructure and staff and other resources	Has taken initiative to act in most disadvantaged province (executing agency)	Should rather contribute to development of standards, coordination and distribution i
Research	Limited resource base for evidence based policy development	WHO Joint HSR project has contributed to development of capacity, research policy, Support to Mosambik Medical Journal No obvious contribution	Subregional project; complement other research activities going on; relevant
Human Resources Quantity	Unequally distributed MD/Specialists concentrated in Maputo. Turnover especially MDs high - Expanding coverage of facilities, needs extra staff		
Skills and Experience	Inappropriate skill-mix (50% untrained auxiliary staff) Few specialists (i.e.gyn/obs etc.) Few higher level trained nursing staff Management skills limited especially in province/district	Fellowships Support to Centro Regional de Desenvolvimento Sanitario - CRDS	Support to CRDS is relevant as management is focused. However, some concerns of cost-effectiveness. Several Fellowships awarded to nurses in the area of administration. No fellowships to gyn/obs
Working Conditions	Create acceptable working conditions at district level so that posts for doctors may be established Incentive schemes / Development of career Staff motivation and performance in low*	No contribution	This is a critical area identified in most African countries. One would question why WHO as a global organisation does not seem to have given this issue priority.
Training and Education	Limited training institutions for higher degrees other than medical (i.e. midwifery, pharmacy) Monitoring of quality of training, few trainees (Curriculum development, standardisation of examination) Language barrier (material available)	Support to CRDS* Fellowships No contribution	None of these are for midwives or pharmacists WHO could emphasise more translation of key material to Portuguese

*Centro Regional de Desenvolvimento Sanitario

Gaps in National Capacity and WHO's contribution in filling these gaps: Ecuador

	Critical Gaps	WHO/PAHO contribution	Relevance
Policy	• Unstable political environment • Fragmented and non participatory policy development and priority setting - CNS* not functioning • Multiple actors for policy development • No consensus on content of reform • Apparent lack of focus on indigenous people needs	Permanent presence Strong support to sector wide approach, but historical relationship to MoH may antagonise this, as especially NGOs experience an environment of government control However, PAHO has been able to established a wide network . Strong normative and advocacy stand for equity and indigenous groups	PAHO partakes in CNS when in function., & represents a corporate memory which may be a strength, but also a disadvantage. Policies are set by Ministers at inter-governmental level for Americas which strengthens and puts some pressures on the government to follow-up. The CO has limited capacity in the area of systems development and management.
Planning	• No normative framework for reform • Fragmented and non participatory planning development • Lack of capacity for comprehensive planning • Government and donor planning isolated	Many initiatives to support planning from many actors. The inter-agency co-ordination group has been instrumental. However, developments lately have shown very clearly that PAHO can only act on a clear mandate from Government	Developing indicators for equity Inter-government processes provides legitimacy in dialogue for priority-setting
Organisation	• Multiple systems in public sector • Competition • Low absorptive capacity • Weak co-ordination of key programme areas i.e. drugs • Weak accountability (all actors)	Works with various actors and is open to establish multiple links	Does not have close relationship to IESS which is an important player in service delivery
Service Implementation	• Parallel project implementation units • Some strong vertical programmes • Curative bias • Gaps in coverage of service	WHO is administrating one of these (Fasbase)	Ensures continuity in programme delivery in a context of instability i.e. EPI (including supplies)
Financial Resources	• Inadequate Government expenditure in health • Divided between various organisations • Inequity in expenditures • Reliance on external funding • No integrated budgeting process	Contributes with considerable funds	Has not been able to establish political will to give priority to health in government budget. No apparent signs that PAHO has been able to address the issue of inequities in expenditure
Human Resource	• Turnover in critical staff • HR weakened/Civil Service Reform • Concentration of HR in urban centres • Staff motivation low • Low salaries/Incentives • Private sector has a strong HR base • No HR development plan	Supports development of Public Health discipline and education	Has succeeded to contribute to establishment of «critical mass» in public health. Not addressing critical issues related to HR in the sector (Civil service reform - carrier paths, HR development plan) The strong presence of HR in CO may fall in the danger of filling gaps in delivery of services rather than building MoH capacity
Research	• Lack of health systems oriented research • No proper analysis of private sector expenditure	Support to specific disease control research and epidemiological surveillance (TDR)	There is need for support to such research, but the need for HSR not sufficiently supported or/and advocated for (little resources in the PAHO system)
International Co-operation	• Readiness to use parallel structures for project implementation • Autonomous planning Counter position to government? • Competition • Lack in aid co-ordination for health • Declining core resources for health	WHO is administrating one of these	• Lead agency in co-ordination of external agencies involved in Health sector reform • Clear mandate for leadership in health sector involvement from UN co-ordinator • Joint ventures with other agencies

Gaps in National Capacity and WHO's contribution in filling these gaps: Nicaragua

Nicaragua	Critical gaps	WHO/PAHO contribution	Relevance
Policy	- Continuity of defined health policies - Consensus in definition of decentralisation	Permanent presence contributing to continuity Various processes within the region on conceptualisation of «SILOS» and sharing of experiences lead by PAHO. Operational involvement in decentralised project	Has been able to position itself in changing environment PAHO's involvement («SILOS») highly appreciated and valuable.
Planning	• Approval of legal «mark» • Allocation of budgeted funds • Conciliation of internal and external resources • Strengthen monitoring and implementation of plans • Participation of appropriate actors in civil society • Proper estimation of recurrent resources in relation to investments		May impede «neutral» contribution and stand Possibility to advocate?
Service Implementation	• Systematization and documentation of experiences related to Integrated PHC • Institutional Integration of the PEUs • Standardisation of service delivery at SILAIS level	Active participation in PROSILAIS	May have limitations in relation to various actors in civil society
Financial Resources	• Cost-effectiveness/identification of service costs • Identification of alternative national financial resources • Assure external support	PAHO is heavily involved in various ways of mobilising national and international resources. Has had a fairly constant financial input itself	May inhibit participation of standardisation. But should be in a good position to document experiences. This is not done in a systematised manner. CO feels it is not in a position to take initiative for standardisation
Human Resources	• Appropriate staff mix (medicalisation of basic services) • Appropriate distribution and utilisation of staff between central/local level • Staff motivation	The organisation itself is dominated by medical people and some other categories, but not have health cadres such as nurses.	What is done is relevant, but WHO has no significant contribution to systematic work on health financing issues in general. Has established a network on health financing (REDES) co-ordinated with HQ+WB. Not obvious how it is utilised at country level.
Research	• Strengthen mechanisms for prioritisation of ENHR and mobilise resources • Increased quality and quantity • Match critical reform issues with research	Does support CIES long-term - build «coll. centre» Some TDR support	This is an area of great concern that WHO/PAHO should involve itself (civil service reform issues)
International Co-operation	• In spite of long-term core donor group well co-ordinated by MoH, need for overall co-ordination of the various inputs; models, systems for planning and monitoring, information system towards government • evaluation and measurement of impact	Strong role in Interagency committees such as EPI, Drugs, Health and environment. Good knowledge of Nicaragua. Health sector development	Relevant and interesting manner of support and capacity building and to enhance quality. Not obvious how support from TDR contributes to critical needs in Disease control Needs more support to HSR in critical reform areas Has a strong position as secretariat for committees. Needs to strengthen its leadership role in the health sector, motivate other partners for co-ordinated development of models and evaluation

Gaps in National Capacity and WHO's contribution in filling these gaps: Haiti

AREAS OF CONCERN:	GAPS IN NATIONAL CAPACITY	WHOS CONTRIBUTION	ASSESSED RELEVANCE
POLICY ISSUES:			
Policy framework	Unstable political/ policy environment. Suffer from effects of crisis/int.embargo. Impetus for health sector reform outside MOH.	Operational role during crises. Shifting emphasis towards capacity building. Contributed to National health Plan and to development of policies and norms in specific areas.	Effective role during emergency. Discussion of what is appropriate role for WHO during and after emergencies. Lead technical agency. Lack of skills in reform&systems oriented issues.
Organisation	Instability of staffing Lack of coordination between public/private	Instit. planning support	Effects of inst.support uncertain. Need new skills&approaches.
Planning & budgeting	MOH weak planning mandate and low capacity. Seek to reinforce authority.	Works more closely with MOH staff than before, but WHO activities not fully integrated..	Tend to "micro-manage" and substitute when MOH does not deliver.
Financing capacity	Declining health expenditure. Only one third of facilities public.	Support to health financing. Participates in Commission discussion hospital reforms	Useful, but limited. Lack of CO-expertise.
Monitoring&information dissemination	Adequate health information not available.	Situation analysis prepared. Library&info.role.	Info.dissemination appreciated.
Service implementation	Weak coverage in regional context. Uneven distribution. Declining quality.	Was responsible for large humanitarian programme - to large extent through NGOs during crises.	Complex transition from service delivery to cap.bldg.role. Provides quality expertise in range of health issues.
Research	No tradition of health research in MOH.	Marginal role.	Low.
International cooperation	Need for new forms of donor coordination..	Active in donor coordination	Positive donor coordination.
HUMAN RESOURCES ISSUES:			
Quantity	Inadequate in public sector. Moved to NGOs.	Part of policy discussions.	Difficult to assess.
Skills&experience	Lack of mgt.&research skills.	Developed and delivered trg.programmes for NGOs, and recently as part of several programmes.	Adapts well to needs. Useful.
Working conditions	Low morale. Few incentives/compensations.	Provides TA, financial&morale support to MOH staff.	Relevant to immediate needs, but may have term effects.
Training&education	Lack of public health training. 7 training institutions	No role in formal training.	

Gaps in National Capacity and WHO's contribution in filling these gaps: Bangladesh

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

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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.

BANGLADESH COUNTRY STUDY

FUNCTIONS	CONTENTS	ISSUES
CORE "NORMATIVE" "GLOBAL"	• Consensus building on shared values, common vision	WHO needs to intensify its advocacy function aimed at strengthening its position as the credible adviser of the Ministry of Health on policy matters.
	• Cross-learning, transfer of knowledge	As in many countries, there is little penetration of WHO's publications beyond the Ministry of Health and major libraries. Bangladesh is not making appropriate use of accumulated knowledge and experience from other countries.
	• Public goods with externalities	Bangladesh is not making significant contribution to global research.
COUNTRY-SPECIFIC "ADDITIONAL" "TECHNICAL CO-OPERATION"	• Development of country health systems, policies, and strategies	Major review of the health system is required. The Ministry of Health is using the World Bank as its chief adviser in this exercise with WHO playing a subordinate role.
	• Support for implementation of health programmes • Promotion of country specific research	WHO has done fairly well in supporting the development of specific health programmes as shown in the tracer programmes. WHO's role as executing agency on behalf of the Consortium needs to be reviewed. The research culture needs to be developed and nurtured
INTER -- COUNTRY	Regional/Sub-regional	No specific issues.

Gaps in National Capacity and WHO's contribution: 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 totalled 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 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. 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. 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.

Gaps in National Capacity and WHO's contribution: Cambodia

National Capacity	WHO contribution	Critical gaps	Donor contribution to filling gaps	WHO relevance and appropriateness
Policy • Norms and policy framework for all critical areas largely in place • All developed since 1991	• Significant through the WHO/ODA/UNDP SHS project • Shared contribution with UNICEF in Drugs and EPI • Key policy actor in polio eradication, TB and malaria control • Equity - some involvement, poverty strategies • Inventories and financial information collected, systematised and made available for policy level decision-makers • Capacity for policy analysis and policy based decisions developed • Coverage plan developed • District level management strengthening initiated • Planning systems, malaria and polio established • Health manpower planning - some contribution	• Application in some policy areas (drugs) • Reproductive health policy • Community co-management, cost sharing/ private practitioners • No major actor in advocacy and policy development re. equity • Planning capacity vulnerable, not broad based • Not linked to emerging national health systems research initiatives • Very limited capacity and fragmented efforts in the periphery	• ADB, GTZ, UNICEF, WHO • USAID, JICA • UNICEF, NGOs/MEDICAM • Many actors, including ADB, interested in health reform and participating in piloting. • Accepting guidance through SHS, WB not directly involved in reform • UNICEF; drugs and EPI • GTZ, Health systems research • NGO support, district level and below	• Very relevant policy involvement • High ambition to be comprehensive - at the cost of policy application • Financing policy too experimental in design for the context? • Has not been able to fill expected role and make appropriate response in drugs and reproductive health • Some tension in policy dialogue working with UNICEF & USAID • Highly appreciated and used, by MoH, Ministry of Finance and donor community • Coverage plan used as base for WB and other donors • Insufficient emphasis on operationalisation of policies through setting out framework for planning
Monitoring, QA • Project based, generally not well developed system. • HFA indicators not seen as very relevant	• High in Polio and Malaria, Tuberculosis • Scattered efforts in drugs • Internal quality assurance limited in SHS project (evaluation based on external reviews)	• Only facility based Health information in place. • Severe gaps • Poorly developed systems, both at centre and periphery	UNICEF WHO	• Not highly and consistently on the agenda, neither in activities directly supported by WHO nor in systems development
Organisation • Critical institutional capacity largely in place, central level • A high proportion of the overall capacity linked to technical assistance in policy and planning	• Provided fellowships/training opportunities • «on the job» training through consultancies, workshops, meetings • Facilitated TCDC; exchange	• Central level capacity vulnerable (inflated by technical assistance) Major gaps in basic management skills and overall capacity in the periphery • Management systems in a decentralised structure not yet worked out • Administrative barriers in the relationship between local government and health	• Various bilateral and multilateral agencies and NGOs	• Relevant at central level. The relative size and scope of the SHS project is questioned in terms of appropriateness. • Human resource development contribution has been significant

National Capacity	WHO contribution	Critical gaps	Donor contribution to filling gaps	WHO relevance and appropriateness
Service implementation - Guidelines, norms and standards largely in place - Coverage plan in place - Poor access in periphery; damaged, poorly maintained infrastructure and constrained mobility	Helped translate global norms and standards to national situation	- Some tension between vertical and integrated approaches. Under pressure from vertical disease control strategies - Low utilisation, public services - Little emphasis on quality of care - Reproductive health services and HIV/AIDS - Flourishing and poorly coordinated and supervised private sector	- NGOs highly involved - Various agencies supporting service delivery	- WHO has largely concentrated efforts at the central level, + specific disease control efforts (malaria, TB, polio). - Has been highly relevant, yet not sufficiently balanced in favour of the implementation level - WHO recognised for expertise in HIV/AIDS, but does not help when no funds forthcoming
Financing capacity - Public expenditure reviews undertaken - High degree of dependence, foreign assistance	- Piloting financing models - Supporting development of institutional capacity	Cost sharing and contracting arrangements introduced in parallel to privatisation in a system of low quality and low utilisation	External agencies have their own agenda, different planning cycles and long procedures, causing added strain	
Human resources - Thin resource base, due to major losses during civil unrest. - Mixed resource base, recruited from different fractions, needs harmonisation - Generally high motivation for catching up	- Fellowships, training and seminars contributed to ensure critical skills in place centrally - Little involvement in harmonisation of interests between fractions	- Overall surplus in relation to functioning units, particularly in the periphery - Limited skilled personnel for recruitment to senior posts. - Multiple categories of workers. Highly politicised area. Insufficient skills and experience at the peripheral level - Attrition? - Overload of technical assistance: inappropriate donor strategies	Very limited inputs from other actors	The support for human resource development has been significant, but one can question whether there is an appropriate balance between human resource development and management systems
Working Conditions - Critical elements in place at central level, still requiring further investment - Hierarchical structure with limited room for innovation. - Compartmentalised, with limited intradepartmental interaction - Scattered offices centrally	- Equipment and supplies - Support systems	- Under-resourced in all areas in the periphery - Low salaries, need for additional income	NGOs and various agencies supporting service delivery	- Limited inputs - Insufficient attention when planning other aspects of support
Research Very limited capacity in place	TDR/Malaria research	- Policy and systems research - Basic epidemiological research	- French support to Pasteur Institute - GTZ support to National Institute for Public Health	Relevant, but inadequate and without links to the rest of the WHO country involvement

Gaps in National Capacity and WHO's contribution: Papua New Guinea

National Capacity	WHO contribution	Critical gaps	Donor contribution to filling gaps	WHO relevance and appropriateness
Policy - National Health Plan in place and widely owned, not executed - Rapid turn over of governments and rapid change in policy environment - WPRO policy documents (New Horizons and Healthy Islands) incorporated in national policies	- Provided broad support to national health plan development - Contributed WPRO policies and helped apply them to national context - Drug Policy; Public Health Act	- Some critical policy areas yet to be finalised, i.e. drugs, essential packages, regulatory and legislative framework in reformed system, reproductive health - Mechanisms for accountability to national plan not yet established	- AUSAID Note some conflicting positions AUSAID/MOH-WHO - Insufficient attention to church agencies in the policy dialogue, given their major role in service delivery	- Significant, relevant and appropriate, according to all parties - Not strong «corrective voice» (low profile in questions such as equity, service access and quality) - Inadequate «normative» response, drugs and reproductive health
Planning - Essential planning capacity in place - Budgeting systems that match plan priorities being developed	- Significant contribution to capacity building, planning at central level - Increasing attention to provincial level	- Systems not yet developed in response to the demands of reform - Policies not translated to implementation plans in provinces	- AUSAID (hospital planning and management) - ADB - UN volunteers, all provinces	Significant, relevant and appropriate
Monitoring, QA - Capacity for regulating, inspecting and quality assurance not yet established/ or not in use - Facility based information system	- Computers to Laboratory sector - National Quality Assurance Programme, lab sector - Inputs to malaria surveillance, disease control data, EPI - Contributed to surveys and studies - Water and sanitation monitoring	- Major gaps in health information systems, facility based - Information systems inadequate for management in reformed structure - Limited supervision, including cold chain and drug supply	- Inadequate and fragmented attention by donors - UNFPA	- WHO inputs been relevant and useful, in each defined area, such as laboratory medicine and water and sanitation. - Inadequate inputs to address the major problem of HIS and quality assurance
Organisation - Devolved government functions - Critical institutional capacity largely in place, central level	- Provided fellowships and training opportunities - On the job training and support for senior officers, central level - Facilitated TCDC - Participated in Min Adv Comm dealing with organisational issues	- Unfinished agenda regarding nationally equitable development opportunities - Administrative barriers between local government and health	- SNIDs have positive spin offs in terms of communicating health concerns to politicians - UNICEF - UNDP	Central level inputs relevant as such, but limited focus on the broad organisational issues arising from devolved government functions in a under-resourced system
Service implementation - Standardised procedures in place and used in periphery - Adequate no. of beds, ongoing rehabilitation of facilities - Fixed base services available - Capacity for immunisation services in place	- Helped translate global norms and standards to national situation - Introduced «subnational immunisation days SNID» - Health Laboratory Services - Water and sanitation	- Rural outreach impaired by services being under-resourced - No standardisation of equipment and equipment maintenance systems - Constrained referral system - Many public rural facilities under-utilised - Many church related rural facilities over-utilised - Very varied quality	- NGOs (largely church-related) highly involved, rural areas - UNICEF - AUSAID - JICA	- Very significant contribution, national laboratory services - SNIDs introduction caused debate but now accepted as relevant and appropriate - Limited significance as actor in implementation of programmes - Significant actor, water and sanitation/emergency preparedness

National Capacity	WHO contribution	Critical gaps	Donor contribution to filling gaps	WHO relevance and appropriateness
Financing capacity - Constrained national capacity for financing operational costs - Delays in disbursement - Constrained absorptive capacity, external funds - Resource allocation to health sector vulnerable	Workshops for provincial health staff to be more accountable of revenues from government budget allocations	- Allocations to health vulnerable to provincial political interest - Mismatch salary expenditure (health workers highly paid) and operating costs	- Church services highly dependent on public financing. Under-resourced - Severe shortages in operating costs, all peripheral units (public and NGO)	Limited involvement, inadequate in relation to severity of situation and consequences for service delivery
Human resources - Thin crust of highly skilled senior officers - Uneven distribution among provinces - SAP cuts hits periphery	- Training fellowships - Courses and seminars focus on disease control and community medicine - Nursing data bank	- High turn over, key positions not updated - Many seniors, all levels, with skills not updated - Doctors lost from public service - Clinical orientation with insufficient management skills	Limited involvement	- Inadequate involvement in human resource management (a «normative gap») - Involvement in human resource development relevant and appropriate
Working Conditions - Basic tools in place, deteriorating infrastructure - Openness for reform and reorganisation	- Inputs to laboratories - Water and sanitation systems development - Support for developing team management and problem solving	- Mobility due to security problems - Limited career opportunity - Professional isolation and poor follow up - Problems with discipline in public service	- Church related services have been able to solve some of these issues within own systems - AUSAID	- Inputs relevant and appropriate in the specialised areas where they are made. - Insufficient attention to the broad systems nature of the problems
Research - HSR location established in DOH - UPNG - IMR	- Promotes Diploma, Community Medicine, UPNG - Some inputs, HSR - Some contacts, TDR (malaria) - Limited interaction IMR	- Weak links between policy/service and the national research base - Weak resource base for policy research - Investment in research not resulted in national capacity	- IMR supported through a number of collaborative agreements with universities - UNFPA research grants, reproductive health - Clinical/epidemic. research: largely other partners	Very limited involvement - inadequate in terms of policy and systems research given WHO's role