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Cooperation for Health Development

WHO's support to programmes at country level

Summary

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Summary

Summary of a report on a study sponsored by the governments of Australia, Canada, Italy, Norway, Sweden and the United Kingdom, and carried out with the cooperation of the World Health Organization.*

* **The sponsoring countries do not accept responsibility for the information in this report nor for the views expressed therein, which are those of the study team alone.**

Contents

Introduction

WHO was created half a century ago to work with countries in improving their health services and the health of their populations. In other words, within the family of UN agencies, it was to be the agency specialized in health, providing technical advice, financial support where needed and access to internationally approved standards for health activities and products. And WHO has indeed earned a reputation for its role in a number of major health achievements - most notably, in the eradication of smallpox worldwide in the late 1970s and more recently in ridding the Americas of indigenous polio and bringing onchocerciasis (river blindness) under control in West Africa. Over the years, the organization became widely valued as an international repository of benchmarks for the many technical, political, social and, to some extent, economic factors involved in the delivery of health care by national governments.

Recently, though, against a backdrop of calls for a complete overhaul of the UN system, WHO has had to reassess its role and functions. Today, as the UN prepares to enter the 21st century in slimmer, fitter mode, certain questions about the health organization are pertinent: How well, for example, is it doing and perceived to be doing its job of helping countries with their health systems? How could it perform better and meet their needs more fully? What aspects of its role towards countries does it do best? Where does it fail? How does it rate in relation to other agencies whose work has a health component?

Setting up the study

To find answers to these questions, the governments of six industrialized countries - Australia, Canada, Italy, Norway, Sweden and the United Kingdom - in agreement with WHO, commissioned a study to examine in depth how the health organization is fulfilling its role in 12 developing countries - Bangladesh, Cambodia, Cameroon, Ecuador, Ethiopia, Haiti, Mali, Mozambique, Nicaragua, Papua New Guinea, Tanzania and Thailand.

These countries were selected because they represent a broad range of WHO activities in different regions of the developing world - Africa (with five of the 12 countries), the Americas (three countries), and Asia and the Pacific (four countries). They were also chosen because it was felt that they and the four WHO regional offices to which they pertain (in, respectively, Brazzaville, Congo, for Africa; Washington, DC, USA, for the Americas; New Delhi, India, for South-East Asia; and Manila, Philippines, for the Western Pacific) would provide an insight into how WHO operates and performs under a wide range of economic, social and demographic conditions [*see Table 1.*]. Although they all come under the UN heading of developing countries, some are extremely poor, others decidedly more affluent; some are relatively stable, others are recovering from a period of conflict; and yet others fall somewhere between these extremes. An overriding consideration in selecting countries and in limiting their

number to 12 was that they should provide enough information without exceeding a reasonable cost in time, effort and money.

Table 1. Socioeconomic and health indicators for the 12 countries studied

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	52
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

* Gross National Product

** Papua New Guinea

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

Key

3 4.5 8 13

Poor indicator compared to the twelve countries studied

↓

↓

Positive indicator compared to the twelve countries studied

Gathering the information

For the purposes of the study, teams of three observers - one member of the study "core team", one international consultant and one national consultant - visited each of the 12 countries between October and December 1996. The teams talked, both individually and at round-table meetings, with health ministry officials - often including the health minister - and with representatives of leading aid organizations and groups in each country. In order to gain as full a picture as possible of WHO's work in the individual countries, the teams obtained additional information from the different levels through which WHO impacts with these countries - locally through its country offices, regionally through its regional offices and globally through its headquarters in Geneva. (In Geneva, the organization conducts its main work of setting global priorities and

policies, of "servicing" its principal policy-making bodies, the Executive Board and the World Health Assembly, and of managing its worldwide activities and programmes.)

The teams also gathered data for an in-depth review of how three programmes are performing in countries: the national drugs programme, which aims at ensuring the wide availability of the most important medicinal drugs and vaccines; the immunization programme, which deploys vaccines against the major infectious diseases; and the malaria control programme. These programmes were chosen as markers or "tracers" of WHO's performance in collaborating with countries. All are well defined and organized in accordance with WHO policy. Moreover, they are sufficiently diverse to provide a broad view of WHO country operations. Each of the three faces a special challenge: the immunization programme, a technical challenge; the drugs programme, a political challenge; the malaria control programme, the challenge of involving multiple government sectors.

The teams visited the countries equipped with five "data collection instruments" or data input forms. One instrument, completed by the national consultant, gave background information about each country's economic and political scene and the national and international actors participating in its health work; it also described the country's health system, the structure, staff and basic capabilities of its health ministry, its health budget and other resources for health, and its three tracer programmes. A second instrument, completed by the WHO country offices, detailed WHO's activities in the country. A third, completed by WHO's regional offices, gave information about regional support to countries. A fourth, provided by the heads of divisions at WHO headquarters, showed how WHO programmes support countries. The fifth instrument consisted of a checklist to be used by the visiting teams to help ensure that their investigations covered the same set of agreed topics.

A new classification of WHO's functions

Traditionally, WHO's functions have been classified under two headings: *normative* (for guidelines, standards, norms and goals) and *technical cooperation*. These terms are often used inconsistently and the distinction between them is often blurred. The study team, therefore, proposed a clearer classification, under the headings *common global functions* and *country-specific functions*.

WHO's *common global functions* are of long-term relevance to all countries at all levels of development. WHO's *country-specific functions* are relevant to individual countries requiring assistance with their health services, and will change as the needs of each country change.

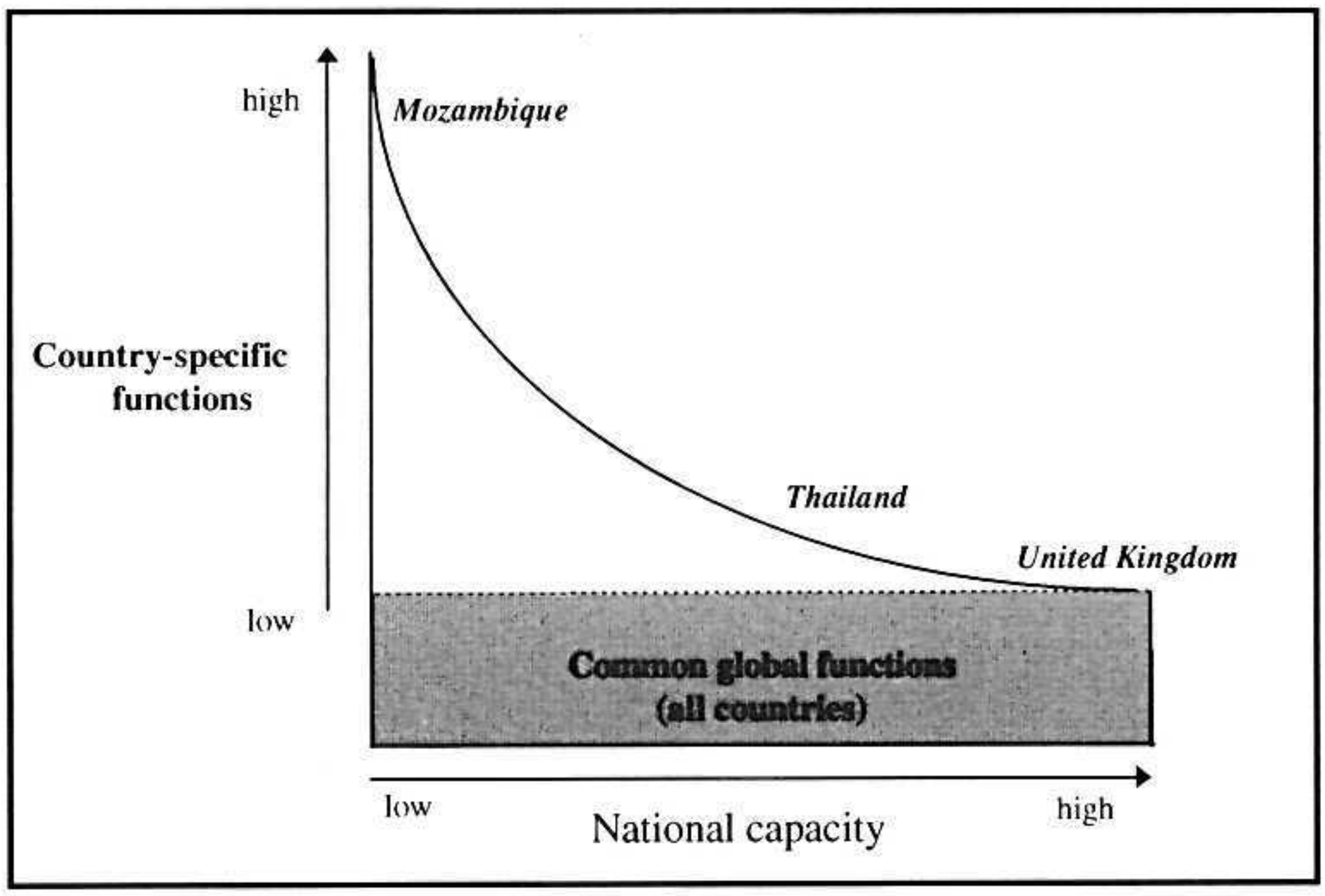
Common global functions are of long-term relevance to all countries. They include efforts to achieve worldwide consensus on global health policies (the 1978 Alma Ata declaration on primary health care is a good example); the exchange of scientific and technical information through meetings of experts; the drawing up of international conventions and standards for vaccines and drugs and for the surveillance and control

of diseases affecting many countries; the definition of priorities for research on health issues of broad common interest; and interdependent activities involving collaboration between countries, developing or developed (for disease control, surveillance, technical standards, pollution control, refugee health care, health research, and so on).

Country-specific functions are of relevance to the needs and interests of individual countries at a given time or over a given period, short or long, and will vary as those needs and interests change. They include activities for the strengthening of the country's health system and of its research capability; the development and application of national health policies and strategies; the promotion of health research on topics of national importance; the dissemination of locally pertinent health information; and cross-border collaboration in the control of diseases.

In principle, all countries participate in common global functions. Those, however, with a lower national capacity will have a greater need for country-specific activities, and conversely *[see Figure 1.]*.

Figure 1. Common global and country-specific WHO functions in relation to national capacity



This graph shows that all countries would be involved in common global health activities. However, those that are self-sufficient in planning and managing their health services, such as the United Kingdom, would have no WHO country-specific activities, while those needing support to develop national capacity, such as Mozambique, would have many.

Key answers to key questions

The study team looked at WHO's performance from four angles: mandate and goals, structures and processes, programmes for collaboration with countries, and relations with other institutions or agencies involved in health.

Mandates and goals

The team sought to determine how WHO interprets and fulfils its role, its mandate and its specific strengths in relation to countries. In particular, the team assessed the extent to which WHO's mandate provides enough direction and flexibility to give countries the support they require.

On the positive side, in most of the countries visited the team found wide recognition of WHO's contribution to building human resources and strengthening the infrastructure of health service delivery. Moreover, the technical information provided by WHO is universally acknowledged as being useful and of high quality, and thus lends credibility to the WHO country offices. In many countries, even where it is not seen as playing a leading role among the different health partners, WHO clearly has a comparative advantage because of its reputation for technical skills, expert advice and good products.

WHO's scientific and technical information is universally acknowledged as being of high quality and value. However, 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 countries studied.

On the negative side, the team often found a discrepancy between the mandate of WHO as stated by its constitution - to "act as the directing and coordinating authority on international health work" - and its actual performance within countries. In some countries WHO's leadership is acknowledged but in others the organization is accorded only a minor role. Of the 12 countries studied, five do and seven do not see WHO as *the* international authority on health or as providing them with the leadership and coordination needed to deal with the technical aspects of their health problems. The five who do see WHO as fulfilling this role are the three countries in WHO's America region (Ecuador, Haiti and Nicaragua) and the two in its Western Pacific region (Cambodia and Papua New Guinea). The seven who do not are the five Africa region countries (Cameroon, Ethiopia, Mali, Mozambique and Tanzania) and the two South-East Asia region countries (Bangladesh and Thailand).

Although WHO's mandate does give enough direction and flexibility for effective support to countries, in many countries the national health ministry, other health partners and WHO itself make poor use of that mandate and of WHO as a resource for

sound technical information. Generally, the expectations the different health partners have of WHO are contradictory or neither clearly nor consistently defined.

WHO could be doing more than it is to encourage countries to pursue activities of global relevance and adopt global policies. Its effectiveness as a neutral advocate for health varies widely, from being prominent in some countries to being almost non-existent in others. Furthermore, WHO's advocacy efforts sometimes suffer from the organization's desire to avoid conflict on politically sensitive issues. Nor does it take enough advantage of the advocacy strengths and relatively neutral status of nongovernmental organizations in countries.

Structures and processes

The team explored the procedures WHO uses to fulfil its role, in particular how WHO country offices interact with the organization's regional offices and how this interaction affects the quality of WHO's performance in countries.

Interestingly, the study team found marked differences in the way in which the regional offices support their country offices and the degree of autonomy they give them. Generally, the regional offices enjoy considerable autonomy from WHO headquarters. The procedures the different regional offices use for supporting country offices are uniform, but they have adapted them to the differing circumstances of the regions in which they are located, to their distinctive managerial styles and to the degree of autonomy they themselves exercise in relation to WHO headquarters.

On the positive side, most countries value their WHO office for the continuity of its presence and its long-term commitment. WHO representatives and their staff are making significant contributions to the strengthening of national resources - in funds, human resources, institutions, physical infrastructure and information management - and are actively stimulating national efforts in a wide range of health-related activities. WHO frequently assumes the role of executing agency for projects funded by other donors in some countries of low capacity, i.e. those lacking the trained staff, health infrastructure and other institutional resources to carry out these projects and programmes themselves.

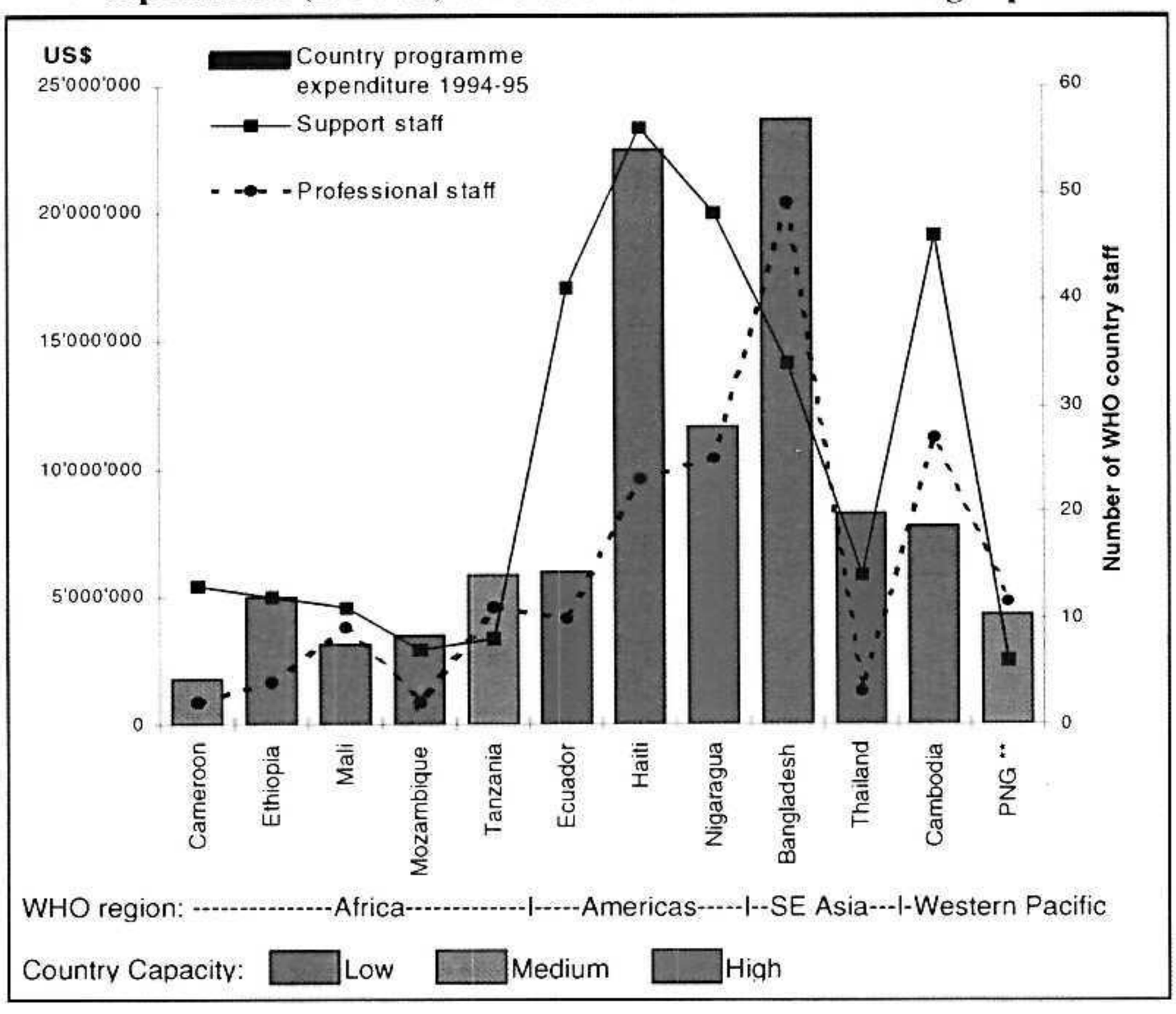
Moreover, some of WHO's overall cost-cutting initiatives in recent years - driven by a zero-growth budget, among other things - have had positive effects. Greater use, for example, is being made of short-term staff in country offices, which could make these offices more responsive to changing local needs. But clearly these needs must be correctly assessed and the WHO regional office must recruit WHO country office staff with the right skills and in a timely fashion - conditions that are not always met.

Another element of flexibility is WHO's local use of regular budgetary funds (WHO's regular budget derives from the membership dues that countries pay to the organization, each according to its economic capacity, whereas its extra-budgetary funds are donated by more affluent countries to supplement the organization's resources). Although small compared to total aid funds flowing into countries, WHO's

regular budgetary funds are appreciated by countries for being more dependable over time and for giving governments greater flexibility in how they are used.

On the negative side, WHO offices tend to vary widely in size, but only rarely in relation to a country's needs. Some of the poorest countries have the smallest WHO offices (Bangladesh is a notable exception) *[see Figure 2.]*. The disparity is more marked for the America region (in favour of the high-capacity countries) and for the Africa region (at the expense of the low-capacity countries). A major reason for the disparity is that WHO does not use clear, objective criteria to decide the degree of support it gives to a country. Similarly, WHO still executes projects in some countries that have the capacity to do the job themselves, and WHO's demands on a country to participate in common global functions often do not take into account the country's capacity to do so.

Figure 2. WHO country office staff (in 1995) and country programme expenditure (1994-95) in relation to countries' differing capacities



** Papua New Guinea

The team noted that WHO country representatives tend to enjoy less decision-making autonomy than those of certain other UN organizations, notably UNICEF, thereby weakening WHO's image in host countries.

Problems in staffing were noted for a number of WHO country offices, particularly in the Africa and South-East Asia regions - selection and recruitment over-influenced by internal WHO politics, limited search for staff, delays in removing notoriously incompetent personnel and in filling vacancies, poor quality of some consultants (partly

as a result of poor consultant pay rates compared with other agencies). The selection process for WHO country representatives tends to be exclusive rather than inclusive, i.e. restricted to WHO fixed-term staff and involving just the WHO Regional Director and Director-General, with the country consulted only on final approval. Overall, the skill-base of WHO staff in countries is still, as it has traditionally been, predominantly medical, despite the growing need for a wider range of skills that would include, say, financing and management. This shortcoming has weakened WHO's ability to help governments assess and implement the projects and reforms proposed by development banks and other donors.

Budgetary planning tends to be a lengthy, ponderous and far-from-transparent process. The result does not always achieve harmony or balance between the priorities identified at the different levels of WHO - headquarters, regional offices and country offices. Moreover, the allocation of regular budgetary funds is generally based on historical grounds rather than on a country's needs. WHO admits to not having a policy framework for dealing comprehensively with the flow of regular and extra-budgetary funds. The latter account for 40-80% of WHO country expenditures and tend to be unpredictable in size and timing, making it difficult to incorporate them into long-term budget plans. Generally speaking, however, WHO country offices do not play a major role in the mobilization of financial resources.

There are problems matching country level priorities with regional and global priorities. Allocation of WHO regular funds is based more on historical grounds than on country needs. In addition, WHO does not have a policy framework for managing the use of regular and extrabudgetary funds in relation to country needs and priorities.

Finally, WHO does not adequately evaluate its performance in countries. Too much emphasis is placed on accounting for financial input and too little on outcomes and achievements. In some areas, evaluation should not be too difficult, such as in following up the careers of WHO fellows or the use made of WHO technical information. Most WHO country offices lack the skills and experience or are insufficiently motivated to monitor their activities, although in many cases a lack of staff, funding, logistical resources and support from the regional offices may be part of the problem.

Programmes

WHO's programmes for collaboration with countries cover a wide range of activities, including health advocacy, the setting of norms, policies and national plans, research and promotion of research, technical operations, and the dissemination of information. The study team examined how well these programmes meet countries' needs.

Interestingly, in implementing their collaborative programmes with countries, the different WHO country offices place emphasis on different types of activity. Over the four years between 1992 and 1995, support for technical operations, for example,

accounted for 10-44% of their "effort", depending on the country, with an average of 29% for all the countries studied ("effort" was quantified as a combination of budget expenditure and importance - as subjectively rated by WHO country office staff). Advocacy and the setting of norms, policy and plans each took up about a fifth of the total effort. Research received least attention, taking up only 10% of country office effort all-round *[see Box 1. and Figure 3.]*.

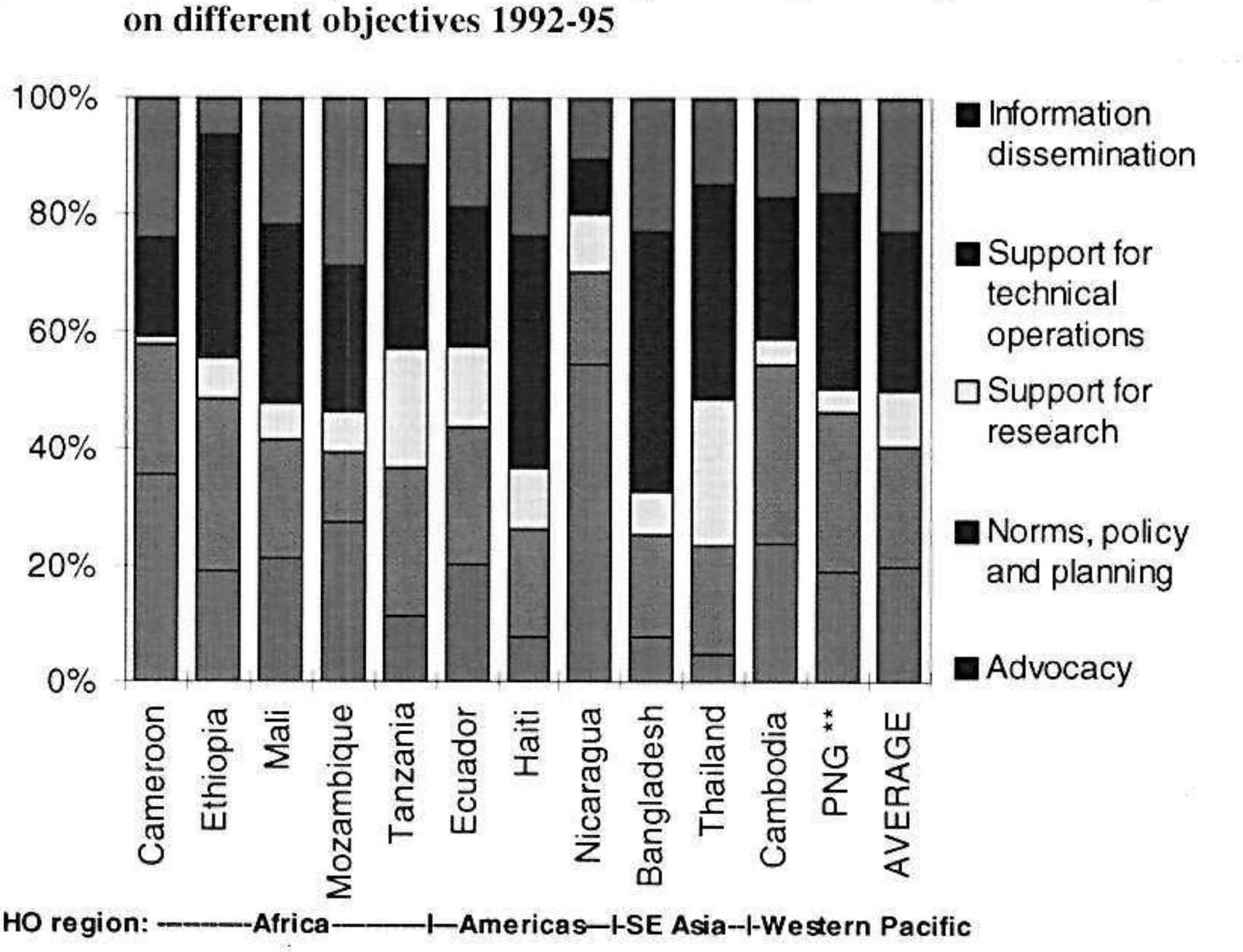
Box 1. Total percentage of effort* spent on different objectives in the 12 countries studied

Objectives	% of effort*
Health advocacy	21
Support for establishing norms, policies and national planning	22
Support for research and research promotion	10
Support for technical operations	29
Support for information dissemination	18

Source: Activity Profile, WHO Country Office Use of Functions, 1992-93 and 1994-95

* calculated from a combination of budget expenditure and importance - as subjectively rated by WHO country office staff

Figure 3. WHO country collaborative programmes: percentage of effort* spent on different objectives 1992-95



** Papua New Guinea

Among the different tools and modalities used by the different WHO country offices for the same period, financial assistance, supplies and equipment together accounted for nearly a third of WHO country office effort, followed by fellowships, courses and seminars, which together made up just over a quarter of the total effort *[see Box 2. and Figure 4.]*.

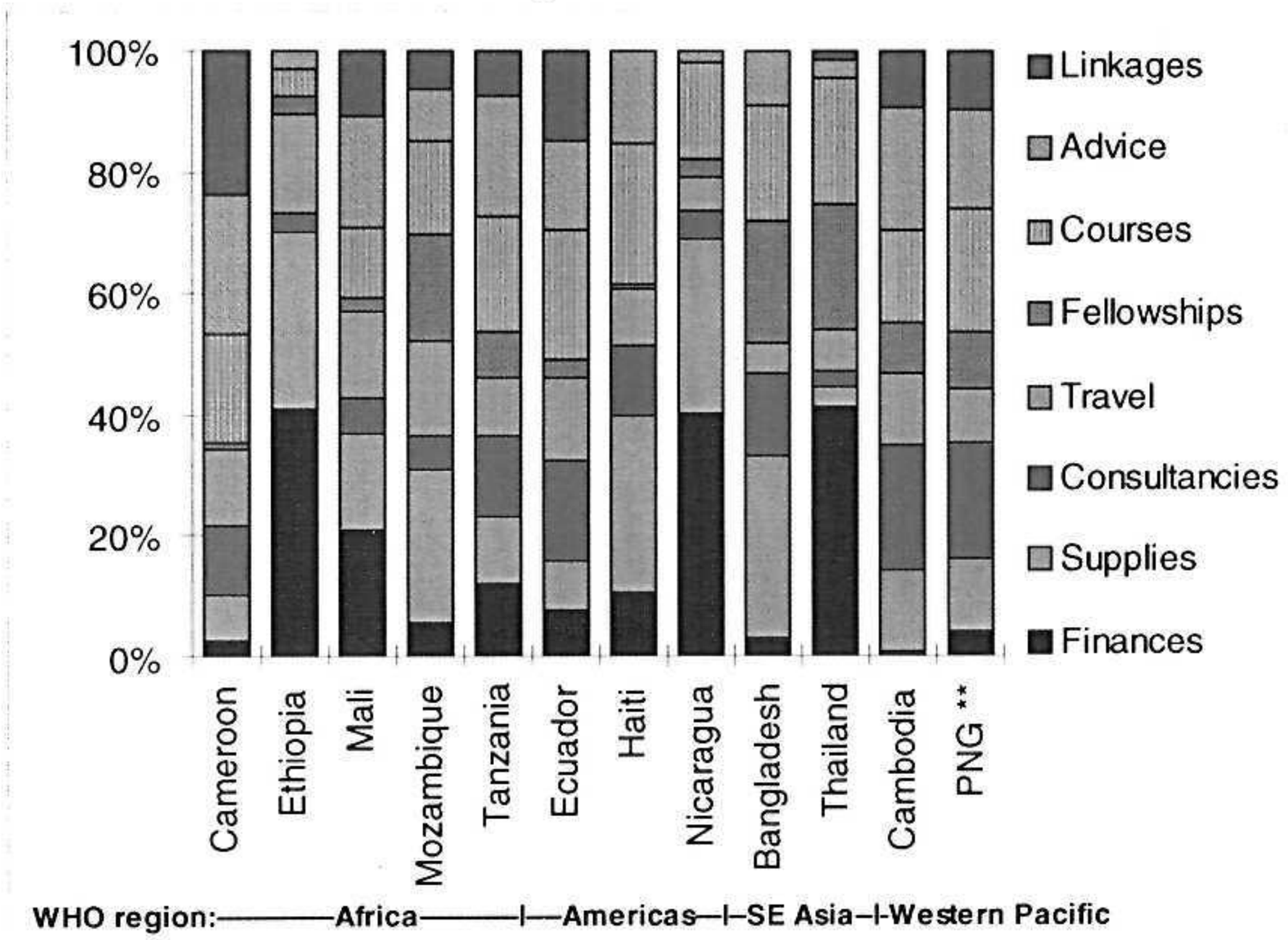
Box 2. Total percentage of effort* spent on different activities used to achieve objectives 1992-95 for the 12 countries studied

Activities	% of effort *
Courses and seminars	18
Supplies and equipment	17
Financial assistance	14
WHO advice and facilitation	13
Consultancies	12
Travel visits	10
Fellowships	8
Linkages with other health actors	8

Source: Activity Profile, WHO Country Office Use of Tools, 1992-95.

* calculated from a combination of budget expenditure and importance - as subjectively rated by WHO country office staff

Figure 4. WHO country collaborative programmes: effort* spent on different activities to achieve objectives (1992-95)



** Papua New Guinea

Furthermore, the study team found that the degree to which countries are financing their tracer programmes differs considerably, more or less in accordance with the country's general health infrastructure capacity: for example, only three of the 12 countries studied use their national health budgets to cover the bulk of the costs of their immunization programmes, while others, particularly in Africa, cover hardly any. Public spending on national (medicinal) drugs programmes tends to be low throughout, with the exception of Thailand. WHO support of these programmes varied widely between countries during the period studied (1992-1995) - again, not necessarily in relation to the capacity of the individual countries. Wide variability was also seen in WHO's financial support for the tracer programmes, with immunization receiving $10 million vs. $5.5 million for drugs and $5.6 for malaria, most of the funds coming from extrabudgetary sources (79% for immunization, 70% for drugs and 60% for malaria).

On the positive side, WHO's programmes for collaboration with countries do fill gaps in the countries' capacities to meet the priorities defined by their health ministries. The team found no evidence suggesting that a more standard package of interventions would meet more cost-effectively the diverse needs of the different countries. Often, the activities supported by WHO spawn new initiatives or nurture fledgling initiatives until other sources of support take over. WHO's work in strengthening local capacity is generally seen to be distinctive and potentially sustainable in that it stems from a basic philosophy of encouraging, supporting and working with (rather than for) countries - and this despite the relatively low level of funding and visibility for capacity building.

As regards the tracer programmes (on medicinal drugs, immunization and control of malaria), the global norms and instruments established by WHO to help countries set policies and formulate strategies are effective and relevant to the policies both of the countries themselves and of donors. The National Immunization Days (NIDs) strategy, for example, whereby an entire population is mobilized through a mass immunization campaign in a drive to halt or greatly reduce the transmission of a disease, is valued not only for its immediate results but also for its effect in raising a country's immunization coverage and in strengthening its overall health delivery system.

On the negative side, the team often found a striking discrepancy between the level of WHO support to a country and the country's inherent capacity or needs. For the 1992-93 and 1994-95 biennia, WHO total expenditure (regular and extrabudgetary funds from all levels of the organization) in countries ranged from $7.8 million to $41.3 million. However, Nicaragua is one example of a country with relatively high national capacity that was a favoured recipient ($39.7 million over the two biennia), whereas several countries with low national capacity received much less - Cameroon $7.8 million, Mozambique $8.5 million, Mali $10 million and Ethiopia $11.8 million, and all from the Africa region.

The disparity was particularly evident in the tracer programmes, where WHO's official criteria for support to countries do not always tally with its actual involvement "on the ground". WHO's strongest support for the drugs programme over the two biennia ($2.5 million) went to Ecuador, a high capacity country, whereas its weakest support for this programme went to Papua New Guinea ($15,800) and Cameroon ($43,400), both medium capacity countries. Similar disparities were found for the immunization

programme. The disparity itself is not the problem. It is rather that in many countries it is not clear why WHO has fixed its support to programmes at a given level or if it has done so on coherent, strategic grounds. In some countries, the degree to which the health ministry is committed to availing itself of WHO's support is the determining factor, in some it is the role of other actors, while in other countries the reason could not be identified.

Across the countries studied, WHO's financial support does not correspond to countries' needs. Countries that receive the lowest levels of WHO financial support are in the Africa region and those that receive the highest are in the America region.

WHO support for a country's efforts to strengthen its national capacity should be an integral part of a country office's activity. This is not always the case. In some instances the organization's country offices fail to provide any support. In others, local WHO activity may even be counterproductive to building capacity. Moreover, most country offices do not regard the strengthening of research capacity as part of their mandate and generally place research low on their list of priorities. Since WHO headquarters gives strong support to building countries' research capacity, notably through its tropical disease and human reproduction research programmes, one reason for local apathy regarding research could be inadequate interaction between headquarters and country offices. Another could be a general lack of research background among country office staff.

Linkages

The team investigated the relations of WHO country staff with other health partners - health ministries, other governmental or multilateral aid organizations, and nongovernmental organizations - and the extent to which WHO supports countries through strategic alliances with these partners.

The type of role that WHO plays at country level depends not only on the capacity of the WHO representative and of WHO systems to respond to a country's needs, but also on the interest of the health ministry and other partners to use WHO as an ally in health development.

Generally speaking, the extent to which WHO can play a role as a neutral broker, adviser and facilitator within a country depends not only on the capabilities and preferences of the organization's representatives but, more importantly, on how the national health ministry and other agencies in the area perceive WHO and seek to take advantage of its strengths. The health ministry is WHO's key partner in countries. WHO's unique, privileged relationship with the health ministry and its distinctive strength as a technical rather than financial resource together give WHO its specificity. This special relationship has its dangers, though: a weak health ministry, for example,

can weaken WHO's role and effectiveness in a country and a very close relationship can compromise WHO's neutrality. Overall, the study team found that WHO could broaden its links with other national institutions in countries without sacrificing the advantages of its special relationship with health ministries.

On the positive side, many of the countries visited by the team perceive WHO's main advantage over other agencies to be its relatively neutral position and technical expertise, whether in the form of consultants' advice or as guidelines, norms, standards and training materials. Similarly, other aid agencies appreciate WHO for its strategic, influential position in relation to health ministries. In several of the countries studied WHO country offices are energetically building strategic alliances to channel coordinated support to the countries. WHO country staff may act as brokers between bilateral donors and health ministries or may be collaborating with donors in strengthening national capacity and the health delivery system. The team found examples in some countries where WHO is apparently drawing on the specific strengths of its partners, notably UNICEF and the World Bank (which has in recent years considerably increased its loans to the social sector).

On the negative side, in some instances, bilateral agencies do not view WHO as a resource of excellence and prefer to draw on their own technical expertise. Specific partnerships do not always work in harmony. In some countries, for example, the marriage between UNICEF's "operational culture" and WHO's "technical culture" has not been a smooth one. There are examples, too, where the differing strengths of WHO and the World Bank do not always match in practice the intentions outlined in formal collaborative agreements between the two organizations. In some cases, national policy is influenced more by hefty World Bank loans than by WHO advice. In others, the World Bank is seen as a potential threat to the lead role that WHO has established in supporting the health ministry.

WHO is particularly active as an executing agency in a number of low-capacity countries, such as Bangladesh and Mali, as well as, paradoxically, in some high-capacity countries, like Ecuador and Nicaragua. The paradox tends to arise because WHO's record as an executing agency has been more successful in higher- than in lower-capacity countries. The team therefore suggested certain principles that could guide WHO's decision to act as executing agency in a country *[see Table 2.]*.

The team noted that there have been many attempts to coordinate the work of WHO with that of other UN agencies at the country level. The so-called Country Strategy Note, designed to provide a framework for UN cooperation in countries, is one example. Generally speaking, the study team found that such efforts have been only partially successful. Since the study was completed in July 1997, the UN Secretary-General has announced new initiatives aimed at strengthening coordination among UN agencies in countries.

WHO country offices seldom take the lead in bringing together the various actors in the health arena in formal collaborative arrangements. They have been particularly reticent about nurturing relationships with nongovernmental organizations, especially in the Africa and South-East Asia regions. Nongovernmental organizations often perceive WHO as aligned with governments and not interested in working with the

nongovernmental community. In one area where WHO would welcome a stronger relationship with nongovernmental organizations, namely, in the monitoring of progress in achieving equity in health and in establishing health more firmly as a basic human right, the study team found little evidence of local interest from either side in collaborating on this important topic.

Table 2. Circumstances under which WHO should act as executing agency

CIRCUMSTANCE	CONDITION
No national or other external actor to execute project	Contract with other actors to limit period of project and its transfer to a national agency
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 for eventual transfer.
Required expertise only available from WHO	Establish technical cooperation with national institution to transfer knowledge and skills, and build capacity.
Emergency situation requiring immediate action, but national government unable to execute project	Incorporate long-term strategy for strengthening national capacity. Ensure limited time-frame.

Recommendations

The study team's recommendations stem overall from its general conclusion that WHO needs to tailor its role in a given country to the inherent capacity and needs of that country and to the contribution already being made by other actors on the country's health scene. In some countries, that would require WHO to expand its role; in others, to contract it.

The team found that WHO's effectiveness in countries depends not only on the performance of its country office staff but also on the attitude and responsiveness to WHO of the host government and of other agencies in the health sector. For this reason, the team's recommendations, although addressed mainly to WHO, include suggestions as to how countries might make better use of WHO and how the different actors on a country's health scene could work more effectively together.

WHO's "essential presence"

Most of the study team's recommendations revolve around the concept of "essential presence" as the basis for WHO's relationship with its member states. The team noted that the extent or strength of WHO's presence in a country does not always match the country's needs and capacities. To illustrate how a more equitable mechanism might work, the team postulated WHO's essential presence as a continuum ranging over the widely differing circumstances of its member states. At one end of the continuum, for example, would be developing countries with very limited resources: to such "category 1" countries WHO would offer a large office to provide adequate support to the health ministry in developing, strengthening and, if requested by the country, reforming its national health system. At the other end of the continuum would be affluent, developed countries with high national capacity: in such "category 5" countries the health ministry and other national institutions perform internationally relevant activities and WHO's presence would be functional (i.e. through collaborative agreements) rather than physical (i.e. through a WHO country office). Between these extremes would be a range of options tailored to countries' needs.

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 countries' needs and capacities, and in relation to other actors in the health sector.

Clearly, a careful analysis of a country's needs and capacities is critical to the concept of essential presence. The team therefore recommends that WHO generally improve its analytical capacity at all levels of the organization but most specifically in assessing a country's situation with a view to establishing an appropriate level of essential presence there. The assessment would take into account the activities of other actors in the health sector - national institutions and foreign agencies, both multilateral and

bilateral - and would serve to determine the form that a WHO essential presence should take in the country. Criteria that the assessment might take into account include total population and population growth rate; infant, child and maternal mortality rates; life expectancy; per capita gross national product (GNP) and the percentage of GNP used for the health budget; immunization coverage rates; literacy rate; and the availability of skilled health personnel. The assessment would, in addition, review whether countries are making full use of, and contributing to, WHO's common global functions and country-specific functions *[see Tables 3. and 4.]*.

Table 3. WHO's common global functions: what countries should do and what WHO country offices should do

COMMON GLOBAL FUNCTIONS	
COUNTRY ACTION	WHO COUNTRY OFFICE SUPPORT
Consensus building and advocacy	
• Participate in WHO governing bodies. • Consult all stakeholders to achieve consensus on national health issues. • Conduct monitoring and exercise vigilance.	• Guide and support national authorities in preparing for the World Health Assembly and regional committee meetings. • Stimulate and promote interactions between health ministry, other ministries, the private sector and other external actors, including nongovernmental organizations.
Cross-learning and transfer of knowledge	
• Disseminate WHO publications to relevant institutions - service, research, academic. • Use WHO manuals, guidelines, standards in design of intervention programmes. • Incorporate WHO guidelines, standards and recommended procedures in training programmes for health personnel.	• Promote wide dissemination of WHO documents within public and private sectors. • Advocate use of WHO standards in design of health programmes. • Promote and facilitate use of WHO manuals, guidelines and other publications in training programmes. • Support inter-country programmes.
Production and sharing of international public goods	
• Observe international conventions for disease control, undertake surveillance. • Use WHO technical standards e.g. for vaccines, nomenclature of drugs, etc. • Participate in global health research in neglected areas of high priority. • Ensure integration of research findings into policy and practice.	• Advocate WHO and other international conventions relevant to control of diseases, communicable and noncommunicable. • Advocate use of WHO standards. • Encourage national institutions to engage in global health research on the basis of national capacity.

Table 4. WHO's country-specific functions: what countries should do and what WHO country offices should do

COUNTRY-SPECIFIC FUNCTIONS	
COUNTRY ACTION	WHO COUNTRY OFFICE SUPPORT
• Define and update national health policy and an overall framework for health sector planning.	• Stimulate and support 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 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 mobilization 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 building or strengthening capacity or for enhancing performance.	• Support national strategies for improving capacity aimed at self-reliance.

If it is decided that WHO should have a physical presence, i.e. a country office, the country would negotiate with WHO a time-limited, renewable contract. Such a contract could be part of a broader agreement between the country and UN agencies. The contract would stipulate the responsibilities of each party, the expected outcomes of WHO's essential presence and the indicators to be used to measure those outcomes. The contract would not imply conditionality ("attached strings"), as World Bank loans do, for example, but would call for a periodic review of the extent to which either partner is or is not fulfilling its agreed responsibilities, and if not, why not.

WHO needs to strengthen its analytical capacity at all levels of the organization in order to regularly reassess its level of *essential presence*, thereby ensuring that country-specific activities and the size of its country offices are adjusted in response to changes in national capacity.

The contract for a WHO essential presence would be reviewed regularly - perhaps every five to seven years - to make sure its terms, particularly the level of essential presence, still correspond to the country's needs. This review is crucial, because the purpose of WHO's essential presence is to help countries ultimately assume complete responsibility for fulfilling their own health needs. As that purpose is progressively achieved, a country's capacity would increase and its need for WHO diminish, and WHO's essential presence would be downsized. Conversely, if for any reason (conflict

or natural disaster, for example) a country's health needs increase or its health delivery capacity diminishes, the category of essential presence would be raised accordingly. In this sense, the essential presence concept is both flexible and forward-looking.

With country health scenes becoming increasingly crowded with a variety of actors, there is a pressing need for WHO to define more precisely its optimal role in the different countries. The essential presence concept forms a solid yet dynamic basis on which the organization can maintain a key role in international health work, build strategic alliances with other actors in health and capitalize on its technical and scientific reputation. The team believes, therefore, that WHO technical support to countries should embrace a broad range of areas, both traditional and new, including health sector reform. It should strengthen its own and member states' capacity to analyse and monitor the activities of other partners and to respond to changes in the increasingly complex interplay of these partners on the health scene. WHO should take advantage of every opportunity to forge alliances with these partners and broaden its relationships with government ministries other than the health ministry.

The essential presence concept calls, moreover, for changes in the way WHO's regional offices function. They need to provide stronger management support to country offices, assist in assessing the level of essential presence required in individual countries and encourage country offices to participate more actively in inter-country activities, including research on regional health problems.

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.

Most importantly, application of the essential presence concept would form the basis of a more equitable and logical distribution of WHO resources to countries and remove certain anomalies, namely that some richer countries receive more WHO resources than some poorer countries. These anomalies have arisen essentially because of the "top-down" system WHO uses to distribute its resources. It allocates funds first to its six regional offices, each of which then decides how much will go to individual countries within the region - a decision often based more on historical grounds than on a careful evaluation of a country's needs. Moreover, the team noted a lack of coordination of funds going into a country from the different levels of the organization. The team therefore recommends that WHO's budget requirements be calculated on a "bottom-up" estimate of the total resources needed to support the agreed level of essential presence in each country. Application of the essential presence concept would redistribute resources going into regions and countries, with some WHO country offices receiving more, some less resources, and some even being closed down. The team further recommends that the WHO country office, where one exists, should be fully involved in the management of all WHO resources flowing into the country from the different levels of the organization.

The team noted that WHO's current attempts at efficient budgetary management are thwarted by the difficulty of integrating extra-budgetary and regular budget funds

under a single budget plan. Part of the difficulty is that the amount of extrabudgetary funds and the time of their receipt tend to be unpredictable. The team suggests that multilateral and bilateral agencies, which constitute the main source of extrabudgetary funds, work with WHO to develop a rational policy framework for managing extrabudgetary funds in relation to the essential presence concept. It also calls on WHO country offices to be more proactive in mobilizing a wide range of resources, including funds.

For a more efficient, relevant WHO presence

WHO has admitted that the processes and procedures it uses to manage its financial and human resources are fragmented and inefficient. Its attempts to remedy this problem have not yet produced the desired result. The team suggests therefore that WHO more effectively coordinate all its activities impacting on countries, from whatever level of the organization they are initiated, and assist health ministries in coordinating the inputs of all their health partners.

Among the negative findings of the study was the observation that WHO has not been able to respond to the needs of many countries for advice on health system reforms. This shortcoming has resulted in the organization generally not being perceived in this area as a credible adviser to national governments or as an attractive partner to other health actors. The team suggests that WHO strengthen its capabilities at all levels in order to meet these challenges. Specifically, it should support countries in their health reform efforts and indicate how agreed global policies on reducing health inequities and improving health can be applied to reforming national health systems.

Furthermore, the organization should be more selective in assuming the role of executing agency, which it should do only for projects where its specific expertise is called for, only for a limited period of time and always with capacity building as an explicit and integral component.

The team also suggests that WHO introduce changes in its mechanisms for recruiting and managing staff and consultants - for example, widening searches, avoiding politically motivated appointments, bringing consultancy fees more in line with those of other health partners and strengthening staff supervision and appraisal procedures.

In addition, financing systems used by regional offices should be based more on sound financial management (i.e. on results achieved with funds) than on accountancy (i.e. on simply itemizing what funds are spent on what activities).

The team recommends that country office activities be monitored more effectively by identifying problems and possible solutions, rather than simply listing activities. A more dynamic interaction between country and regional offices is needed for proper monitoring and evaluation of the impact of WHO's work in countries.

One frequent observation of the team was a discrepancy between policies and decisions made by WHO's governing bodies, committed to by member states, and the implementation in practice of these policies and decisions. To remedy the problem, the

team suggests that WHO country offices should work more strategically with health ministries to review background papers and resolutions of the World Health Assembly and of regional committee meetings, and to help countries incorporate agreed common global goals and standards into national health programmes. Health ministries, for example, should be encouraged to monitor national performance on sensitive issues such as equity, either themselves or through nongovernmental organizations or development institutes.

The team believes that WHO should take more advantage of its role as an enabler and adviser to assist health ministries in assessing their staff management needs, in building a solid base of knowledge and technical expertise for health system development and, crucially, in improving staff working conditions.

Generally speaking, the organization could make better use of its global perspective of health research to assist national institutions in building their research capacity and in using the findings of research more effectively. Where, for example, support for research is part of an essential presence contract, WHO country staff should have the skills needed to help a country make best use of its research resources and ensure that research end-points are relevant to the country's problems and needs. WHO country offices should be more active in disseminating information about WHO's research programmes. They should also make stronger efforts to seek out a country's scientists and institutions able and willing to participate in regional and global research or research capacity strengthening programmes.

WHO's partners in health

The study found a lack of continuity of senior staff in the health ministries of the 12 countries studied. In the ten-year period from 1987 to 1996, for example, health ministers changed 4-11 times, directors of medical services 4-12 times and administrative heads 3-9 times. Greater stability in the upper levels of ministry management could strengthen countries' interactions with the WHO governing bodies (the World Health Assembly and Executive Board) and its regional and country offices. The team therefore recommends that member states strive to reduce the often rapid turnover of health ministry management staff. Countries should play a more energetic role in WHO's policy-making process and take steps to reduce gaps between policy decisions which they have endorsed through their participation in these governing bodies and the implementation of these decisions nationally and internationally. The study team calls on member states to speed up the approval of local WHO staff appointments, including consultants, and generally to collaborate more effectively with WHO in the recruitment of WHO country staff.

The study found that WHO's publications often do not reach relevant institutions and health personnel in a country. The team therefore recommends that member states and WHO work more closely and more energetically in disseminating technical and scientific information within and between countries.

The team was also concerned that bilateral agencies of industrialized countries subscribe, in their health-related work, to the global standards set by WHO for health

products and health activities. It therefore recommends that the key health partners in a country agree on certain codes of conduct relating to the sharing of information about policy, activities, resources and any other areas mutually agreed to be pertinent to their common aims. Such a strategic alliance would be of particular importance in activities relating to national plans and priorities, and on health system reform. By the same token, all countries should participate more actively in supporting WHO's work in health advocacy and in the promotion of globally agreed policies.

Conclusion

The most salient impression the team gained from its year-long study was how widely countries differ - in their capacity to cope with health problems; in their economic, human and logistical resources; and in the degree to which other players, from within and outside a country, participate in supporting its health system and health activities.

Most pertinently to the study's objective, the team found a striking variation in the extent to which WHO is supporting countries' health programmes and providing leadership in international health work. In some cases WHO's response meets countries' needs, while in others it is inadequate.

Hence, the team's main recommendation that WHO improve its ability to analyse just what each country needs in terms of external support and tailor its presence - its "essential presence" - in the country to those needs. This essential presence would form the basis for WHO's relationship with its member states and a framework for all WHO's decisions relating to individual countries. In many instances, it would call for *a change in the relationship:* some of the neediest countries, for example, would probably require a more substantial physical WHO presence, with a well-endowed office; other less needy countries may require a smaller WHO presence than they currently have; and yet others, especially at the top end of the economic scale, require only a functional WHO presence, whereby their national institutions would collaborate with WHO in its global health functions.

The team is convinced that the recommendations it addresses to WHO, its member states and its partners could, if put into effect, revitalize the relationship of WHO with its member states, bring greater consistency, coherence and efficiency to its work supporting the health-related activities of these states and, overall, restore its reputation and value as a leading member of the international health community.

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