

Country Cooperation Strategy:

INDIA

An evolving document under review by the Government of India; Donor and Development Partners in the Health Sector in India; and the WHO Headquarters, Regional Office for South-East Asia, and India Country Team

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SECTION 1: INTRODUCTION

The Country Cooperation Strategy (CCS) is a medium term, adaptable country specific strategy that provides the framework of cooperation between WHO and the country. It articulates a vision and selective priorities for the work of WHO for health development that are based on systematic assessment of country needs and expectations as well as a country's commitment and capacity. The CCS is, in turn, translated into operational plans that are linked to regular budget and extra budgetary funding.

The CCS is more than a document and it reflects the values, principles and corporate directions of WHO as one organization and is developed in a spirit of partnership and mutual respect in the context of the country's overall efforts for health development. It is a tool that helps in the process of placing health at the center of sustainable development, articulating the linkages between poverty and health, and calling for greater equity in health.

The CCS is based on the following principles that guide WHO's work in and with countries: (1) greater coherence and responsiveness to country needs; (2) more selective focus with fewer priority areas of work; (3) more strategic with greater emphasis on WHO's role as policy advisor and broker; (4) better balance of country needs, regional priorities and global developments; (5) more clearly defined roles of WHO and measures for WHO's performance; (6) broader partnerships; and (7) more complementary work with other development agencies based on WHO's comparative advantage.

In India, the CCS reflects the Vision and Mission of the WHO India Country Team (Annex 1), is an integral part of the reform of WHO at the country level (Annex 2), supports the health priorities of the Indian Government as expressed in the Five-Year Plan (Section 2), and emphasizes collaboration with donor and development partners to attain the highest possible level of health for the peoples of India. Although the CCS reflects the broad priorities in health in India, the specific priorities identified for the work of WHO in India reflect the role and comparative advantage of WHO as a technical collaborative agency.

To date, the process of formulating the CCS in India has been through discussions with Government Officials regarding priorities in the health sector, review of the Ninth Five-Year Plan, discussions with donor and other development partners in the health sector, review of health-related reports and publications, comments received on previous versions of the CCS and lists of priorities for WHO work in India, and staff meetings and retreats of the WHO India Country Team. The CCS is considered a dynamic, evolving document and will continue to be refined through an ongoing process of discussions, reviews of reports and publications, and retreats among Government, donor and development partner, and WHO staff.

Readers of this CCS are welcomed to send their comments and suggestions to the WHO Representative to India.

SECTION 2: GOVERNMENT AND PEOPLE: HEALTH AND DEVELOPMENT CHALLENGES

The macro situation:

India is the second largest country in the world with over one billion people of diverse social-cultural backgrounds. India is a parliamentary democracy with a Federal Government and 25 States, each having their own elected legislatures.¹

Article 21 of the Constitution requires the State to ensure the health and nutritional well-being of all people. Although health is a State subject, the Federal Government has a substantial technical and financial role in the health sector.¹

The recent Economic Survey (1999-2000) shows that the Indian economy registered a growth rate of 6.8% during 1998-99 and it is expected to be 5.9% in 1999-2000. Since 1991, structural reforms and liberalisation measures initiated in India led to an improvement in the GDP. Although per capita GNP increased from US\$280 in 1985 to \$340 in 1995, over 30% of the population are classified as poor.

The Federal and State governments spend 1.3% of the GDP on health. Three-quarters of the total health spending in the country is out of pocket. Health as a percentage of total Federal budget has been about 2-3% over the last 50 years with a gradual increase in emphasis on family welfare programmes of population stabilization and mother and child health.¹

Some 60% of the Federal budget for health is spent on the five national disease control programmes: leprosy, malaria, tuberculosis, HIV/AIDS, and blindness. The remainder is spent on the public health institutions, 5 hospitals and research.¹

The role of the Federal Government is to provide the States with technical guidelines, equipment, consumables, and capacity development through training. The role of the States is to implement health programmes and provide salaries, petrol, consumables and supplies, and construction and maintenance of buildings, including medical colleges and hospitals.¹

Health profile:

India accounts for 16% of the world's population and 21% of the world's global burden of disease. Over the past 50 years, substantial gains in health included increased life expectancy, reduced infant mortality, reduced fertility rates, eradication of smallpox and guinea worm, reduction of poliomyelitis, and reduction of leprosy.¹

The Crude Death Rate (CDR) and Crude Birth Rate (CBR), declined from 27.4 per thousand in 1951 to 9.0 in 1998, and from 40.8 per thousand in 1951 to 26.4 in 1998, respectively.

Life expectancy at birth increased from 32.1 in 1951 to 62.4 in 1996, and the Infant Mortality Rate (IMR) declined from 146 per thousand in 1951 to 72 in 1998. The literacy rate increased from 18.3% in 1951 to an estimated 62.0% in 1997, although the female literacy rate continues to be only two-thirds that of males.

The Maternal Mortality Ratio (MMR) and Under-five Mortality Rate were estimated to be 408 per 100,000 live births and 108 per 1,000 live births in 1997, respectively.

It is estimated that 30% of newborns are low birth weight (less than 2,500 grams at birth), over 50% of children under five are malnourished, and over 80% of pregnant women are anaemic.

However, in a country as vast as India, health indicator averages mask the wide disparities that exist between urban and rural populations, between states, between districts within states, and between communities within districts. For example, in 1996, IMR ranged from 77 per thousand in rural areas to 46 per thousand in urban areas, and from over 90 per thousand in Orissa and Madhya Pradesh to less than 20 per thousand in Kerala. Even within Kerala there are districts where IMR are higher than national levels. Communities in tribal areas have health indicators lower than surrounding communities.

Health sector development:

India was a pioneer in focusing on primary health care even before the Alma Ata Declaration. In 1946, the Health Survey and Development Committee recommended establishing a well-structured and comprehensive health service with a sound primary health care infrastructure (the “Bhore Report”). The primary responsibility for building the infrastructure and manpower rests with the State Governments that are supplemented by funds from the Federal Government and external assistance. Major disease control programmes and the Family Welfare Programmes are Centrally funded (some with external assistance) and implemented through the State Infrastructure. Food supplementation programmes for mothers and children are funded by State Governments and implemented through the Centrally funded Integrated Child Development Services Programme (ICDS) infrastructure. The Department of Urban and Rural Development and the Department of Environment (both Centrally and in the States) fund programmes for safe drinking water and environmental sanitation.²

Universal coverage of the population through primary health service facilities in rural and urban areas is one of the seven Basic Minimum Services (BMS) identified for priority attention under the Minimum Needs Programme (MNP). It is estimated that a properly functioning universal primary health care infrastructure providing integrated promotive, preventive, curative, and rehabilitative services would meet over 80% of the health care needs of the population. The remaining needs would be met through referral to secondary or tertiary health care institutions.²

The national norm for primary health care in rural areas is a three tier infrastructure of Sub-Centres (SCs covering a population between 3,000-5,000), Primary Health Centers (PHCs covering a population between 20,000-30,000), and Community Health Centers (CHCs covering four PHCs).²

For the nearly 30% of the population residing in urban areas, there is a recognized need to create a well-structured infrastructure of urban primary health care consisting of Health and Family Welfare Posts covering populations of between 10,000-15,000 and Health and Family Welfare Centres covering populations of between 100,000-150,000.²

Although India has a vast network of governmental, voluntary, and private health infrastructure manned by a large number of medical and paramedical staff, the government has identified the following problems currently faced by health services:²

1. Persistent gaps in manpower and infrastructure, especially at the primary health care level.
2. Sub-optimal functioning of the infrastructure and poor referral service [that leads to a sub-optimal utilization of health services].

3. A plethora of hospitals not having appropriate manpower, diagnostic and therapeutic services, and drugs in the government, voluntary and private sectors.
4. Massive interstate and intrastate differences in performance as assessed by health and demographic indices with the availability and utilization of services being the poorest in the most needy states and districts.
5. Sub-optimal intersectoral coordination.
6. Increasing dual disease burden of communicable and non-communicable diseases as a result of ongoing demographic, lifestyle, and environmental transitions.
7. Technological advances which widen the spectrum of possible interventions.
8. Increasing awareness and expectations of the population regarding health care services.
9. Escalating costs of health care and ever-widening gaps between what is possible and what the individual or the country can afford.

To address these problems, the Ninth Five-Year Plan has identified the following priority approaches:²

1. Improve access and enhanced quality of primary health care: An absolute and total commitment to improve access to, and enhance the quality of, primary health care in urban and rural areas by providing an optimally functioning primary health care system as part of the BMS.
2. Improve efficiency of the health care infrastructure: To improve the efficiency of existing health care infrastructure at primary, secondary, and tertiary care settings through appropriate institutional strengthening, improvement of referral linkages and operationalization of a Health Management Information System (HMIS).
3. Develop human resources for health: To promote the development of human resources for health, adequate in quantity and appropriate in quality, so that access to essential health care services is available to all so that there is improvement in the health status of the community, through periodically organizing programmes for continuing education in health sciences, updating knowledge and upgrading skills of all workers, and promoting cohesive team work.
4. Improve programmes for control of communicable diseases: To improve the effectiveness of existing programmes for control of communicable diseases to achieve horizontal integration of ongoing vertical programmes at the district and below district level; to strengthen the disease surveillance with the focus on rapid recognition, reporting, and response at district level; to promote production and distribution of appropriate vaccines of assured quality at affordable cost; to improve water quality and environmental sanitation; and to improve hospital infection control and waste management.
5. Develop and implement programmes for non-communicable diseases: To develop and implement integrated non-communicable disease prevention and control programmes within the existing health care infrastructure.
6. Improve nutritional status: To undertake screening for common nutritional deficiencies, especially in vulnerable groups, and initiate appropriate remedial measures; to evolve and

effectively implement programmes for improving nutritional status, including the micronutrient status of the population.

7. Improve programmes for environmental health: To strengthen programmes for prevention, detection, and management of health consequences of the continuing deterioration of ecosystems; to improve linkages between data from ongoing environmental monitoring and health status of the population residing in the area, including health impact assessment as a part of environmental impact assessment in developmental projects.
8. Improve occupational safety and health: To improve the safety of the work environment and worker's health in organized and unorganized industrial and agricultural sectors, especially among vulnerable groups of the population.
9. Improve emergency and disaster prevention and management: To develop capabilities at all levels for emergency and disaster prevention and management; to implement appropriate management systems for emergency, disaster, accident, and trauma care at all levels of health care.
10. Improve food and drug safety: To ensure effective implementation of the provisions for food and drug safety; strengthen the food and drug administration, both at the Centre and in the States.
11. Increase involvement of Indian Systems of Medicine and Homeopathy: To increase the involvement of ISM&H practitioners in meeting the health care needs of the population.
12. Enhance research and accountability to the people: To enable the Panchayati Raj Institutions (PRI) in planning and monitoring of health programmes at the local level so that there is greater responsiveness to health needs of the people and greater accountability; to promote inter-sectoral coordination and utilize local and community resources for health care.

Disease Control Programmes:

The Ninth Five-Year plan mentions the following areas for priority attention:²

Communicable diseases:

1. Malaria: The intensification of the National Malaria Eradication Programme (NMEP) to achieve a 25% reduction in morbidity and mortality due to malaria. However, malaria resurged, accompanied by resistance of the mosquito vector to insecticides and resistance of the parasite to chloroquine, with the number of cases remaining over 2 million.
2. Kala-azar: In 1997, there were 17,429 cases and 255 deaths due to Kala-azar. The focus is on effective implementation of Kala-azar control programme in the 36 endemic districts in Bihar and the 10 districts in West Bengal to prevent outbreaks and eventually control infection.
3. Filariasis: It is estimated that about 428 million people are living in areas at risk for filariasis and annually some 6 million persons suffer from acute lymphatic filariasis. India is expanding filariasis control efforts as a part of the global alliance for the elimination of lymphatic filariasis.

4. Dengue and Japanese Encephalitis: Dengue outbreaks have been reported from all States and some 378 million persons are at risk of Japanese Encephalitis. There is an effort to improve surveillance, strengthen facilities for early diagnosis and treatment, and intensify measures to reduce breeding of the mosquito vectors.
5. Tuberculosis: It is estimated that there are 2 million new tuberculosis cases and nearly 500,000 deaths each year due to tuberculosis. Under the Revised National TB Control Programme (RNTCP) there is an effort to expand DOTS from the current 25% coverage of the country to the entire country.
6. Leprosy: The target for leprosy elimination is to reduce prevalence of leprosy to less than 1 per 10,000 population by the end of the Ninth Plan. In 1999 it was estimated that the prevalence of leprosy was 5 per 10,000 population and that India is likely to reach the elimination target by 2003 nationally and by 2005 at the subnational level.
7. HIV/AIDS: India has some 3.5 million people living with HIV/AIDS. The National AIDS Control Programme priorities under the Ninth Plan include: more effective implementation of the programme to ensure safety of blood and blood products; increasing the number of testing sites in the HIV testing network; augmenting STD and HIV/AIDS care facilities; improving hospital infection control and waste management to reduce accidental infection; improving HIV/AIDS awareness, counseling and care; and strengthening sentinel surveillance.

Non-communicable diseases:

8. Blindness: It is estimated there are 12.5 million economically blind persons in India, over 80% of which is due to cataract. The long term objective of the National Blindness Control Programme is to reduce prevalence of blindness from 1.4% to 0.3%.
9. Cancer: The estimated cancer caseload is around 2 million with some 700,000 new cases each year. Tobacco-related cancers constitute more than 50% of the overall cancer burden in the country. The National Cancer Control Programme's emphasis is on: primary prevention of tobacco-related cancers, secondary prevention of cervical cancer, and extension and strengthening of cancer treatment facilities.
10. Diabetes: The Ninth Plan focuses efforts on detection and management of diabetes as part of developing an integrated programme of non-communicable diseases prevention, detection and management at the primary and secondary levels of care.
11. Mental health: It is estimated that 10-15% of the population suffer from mental health problems. During the Ninth Plan, the National Mental Health Programme will focus on IEC for prevention of stress-related disorders through promotion of healthy lifestyles and research on effective implementation of preventive, promotive and curative programmes in mental health through the existing health infrastructure.
12. Iodine deficiency: It is estimated that about 80% of all edible salt is iodized and the use of iodized salt at the household level increased significantly. The National Iodine Deficiency Disorder Control Programme in the Ninth Plan places emphasis on: production of adequate quantity of appropriate quality iodized salt, appropriate packaging, facilities for testing salt, IEC to encourage consumption of iodized salt, and monitoring of iodine deficiency disorders (IDD). The recent lifting of the ban on non-iodized salt will require increased efforts to avoid a resurgence of IDD.

Family Welfare:

During the Ninth Plan, Family Welfare Programmes are focused on improving the quality and coverage of health care to women, children and adolescents. The priorities of the integrated Reproductive and Child Health Care (RCH) Programme are as follows:²

1. Effective maternal and child health care to ensure safe motherhood (registration and ante-natal care of pregnant women, tetanus toxoid administration, iron and folic acid supplementation, trained birth attendant at each delivery, establishing First Referral Units for emergency obstetric care, and improving referral linkages) and child survival (essential newborn care; essential child care, including ARI and ORT programmes; immunization; vitamin A deficiency and anemia prevention programmes).
2. Increased access to contraceptive care to prevent unwanted pregnancies.
3. Safe management of unwanted pregnancies.
4. Effective nutritional services to vulnerable groups.
5. Prevention and treatment of reproductive tract infections (RTIs) and sexually transmitted diseases (STDs).
6. Reproductive health services for adolescents.
7. Prevention and treatment of gynecological problems, including infertility, menstrual disorders and prolapsed uterus.
8. Screening and treatment of cancers, especially uterine, cervix and breast cancers.

Of special note is the Government's commitment to the eradication of poliomyelitis from India as part of the global effort for the eradication of poliomyelitis by the year 2000. India has made remarkable progress and only 121 cases of poliomyelitis caused by wild poliovirus, to date, have been identified in 2000. National and sub-national immunization days (Intensified Pulse Polio Immunization) and mopping-up operations are being conducted with the aim to eradicate poliomyelitis as close as possible to the target date of the end of 2000 so that certification of eradication from the world in 2005 may be achieved.

Involvement of non-governmental organizations (NGOs):

Steps have been taken to broaden the involvement of NGOs for the promotion of family welfare programmes. Voluntary workers can often work in closer collaboration with the people and bring about desired changes in social and personal attitudes, perceptions and behaviour more than the government staff. Funds have been released to States for giving assistance to smaller NGOs through a network of state SCOVA (Standing Committee On Voluntary Action) Committees. For example, some 600 NGOs were funded for a total of US\$4.22 million during 1996-97 for supporting Family Welfare programmes compared to only 91 NGOs funded for a total of \$0.75 million in 1990-91. Small NGOs receive funds through "Mother NGOs" and a limited number of National NGOs are supported for innovative programmes.

National Population Policy 2000:

The Government of India announced the National Population Policy 2000 on 15 February. The medium term objective is to achieve a Total Fertility Rate of 2.1 and an Infant Mortality Rate (IMR) of less than 30 per 1000 live births by 2010. The policy documents the strategic themes,

including new institutional structures and additional funding, promotional and motivational measures needed for adoption of the Small Family norm to achieve the goals. The major thrusts of the policy are: expanding the coverage and improving the efficiency of reproductive health services, including contraceptive services; active involvement of locally elected bodies (mainly the Panchayats) in the implementation of programmes; and special schemes for empowerment of women to improve their literacy and educational levels and providing them with income generating activities.

Future Directions:

The MoH&FW is currently in the process of providing inputs into the health component of the Tenth Five-Year Plan. It is anticipated that the major priorities noted above from the Ninth Five-Year plan will continue as important areas of work in the Tenth Plan. However, the Tenth Plan is expected to reflect some new emphasis areas, including:

- Decentralization – recognizing that the role of the Center must be to strengthen capacities at State and local levels for them to be able to plan, implement, and monitor priority programmes.
- Public and Private mix of services – recognizing that Government must play a proactive role through an appropriate mix of provision of services in the public sector and regulation of services in the private sector to ensure that the disparities between rich and poor can be reduced.³³
- Integration – recognizing that “vertical” disease-specific programmes need to be more “horizontally” integrated so that fragmentation of services can be avoided while not sacrificing the successes and performance of targeted interventions.
- More emphasis on the determinants of health – recognizing that the health sector needs to work more in partnership with other sectors that have major impacts on health, including: water, sanitation, and education. It also implies the health sector needs to work more in the areas of advocacy and IEC to promote healthy lifestyles (healthy diets, exercise, not using tobacco products, safe sexual practices, etc.).
- Introduction of new technologies – recognizing that the means must be found to introduce new, cost-effective health interventions, e.g., new vaccines such as hepatitis B vaccine.
- Social security – recognizing that health is central to poverty alleviation and also that strengthening social security schemes (including health insurance) can be developed in ways that can achieve better equity in health.
- Globalization – recognizing that the World Trade Organization (WTO) and agreements such as TRIPS have great implications for the health sector and that only by proactively addressing these implications will the potential pitfalls of globalization’s impact on the poor in India be avoided.

SECTION 3: DEVELOPMENT ASSISTANCE AND PARTNERSHIPS

Overall Trends in Aid

The flow of external assistance or aid, directly or indirectly, is aimed at alleviation of poverty by contributing to growth and development and improving people's quality of life through basic services, including education, health, and nutrition. Development aid excludes resources provided for relief, emergency and humanitarian purposes.

Approximately one-third of India's total foreign aid is from bilateral sources and two-thirds is from multilateral sources (Table 1). India has a successful history of forging effective linkages with bilateral as well as multilateral donors. The funding to the Indian not-for-profit sector mainly comes from "International not-for profit organizations" which accounts for 0.5% of total aid to India. Of the total external assistance utilised in 1997-98, loans accounted for 92.2% and grants for 7.8%.

Table 1: Trend in Utilisation of External Assistance to India, 1980 – 1998 (US\$ in Millions)

Source	1980- 81	1990 –91	1997-98
Bilateral Organisations	1100.3	1466.7	1059.0
Multilateral Organisations	1633.4	2269.8	2106.6
World Bank	835.6	1991.4	1415.7
EEC	104.6	28.5	63.6
ADB	-	212.4	601.1
IMF Trust Fund	679.7	-	0.2
Others	4.3	37.5	26.4
Grand Total	2733.7	3736.5	3164.7

Source: Economic Survey (1998-99)

It is important to recognize, however, that the entirety of external assistance to India represents less than 1% of the total budget of the Government of India.

Major Development Agencies Active in the Health Sector

The multi-lateral assistance includes assistance from UN agencies (including WHO, UNFPA, UNICEF, and UNDP). The largest source of UN Development Assistance to India is the World Bank, accounting for a range of 84 to 95% of total UN assistance between 1991 and 1998 (Table 1).

Bilateral support comes from donor nations such as UK, Germany, Netherlands, Japan, and the United States of America, often through development assistance agencies such as DFID, KFW, DANIDA, JICA, and USAID.

International not-for-profit organisations have been another source of funding for the development sector, especially to Indian not-for profits involved in participatory development efforts. The major International Not-For Profit Organizations working in India include: Catholic Relief Services, Catholic Fund for Overseas Development, Alternative for India Development Aid, Charles Wallace India Trust, Help Age International, CARE, Christian Children's Fund, Oxfam America, Christian Aid, Save the Children Fund, Action Aid, Ford Foundation, and Aga Khan Foundation. The issues supported by these donor organisations include: eradication of poverty, improvement in the quality of life of the poor, integrated rural development, disability, innovative development initiatives, health care services, family planning and reproductive health, AIDS prevention, environmental protection, and education.³

Some examples of support include: (1) World Bank support to develop State Health Systems across six states in India; (2) Japan grant-in-aid to improve Kalawati Saran Children's Hospital and Urban and Rural health Centres attached to the Smt. Sucheta Kripalani Medical College for Women, New Delhi, and a research project on "emerging diarrhoeal diseases" conducted by the National Institute of Cholera and Enteric Diseases, Calcutta; (3) UK support for several health programmes including, control of malaria, vector control, and tuberculosis; and (4) Netherlands support to improve the intermediate level medical services in the State of Gujarat.

Donor and Development Partner Coordination

Donor and development partner coordination enhances the productivity of development aid, especially when development aid comes from multiple and varied sources. Lack of effective coordination of aid results in duplications and overlap of activities, distortion of aid through conflicting approaches and schemes, and unfilled needs covered by no donor. It has recently been proposed that the Ministry of Health and Family Welfare chair a meeting of all donor and development partners in the health sector.

Donor and development coordination helps to integrate technical collaboration and financial aid with national priorities. This may be carried out through mechanisms like Inter-Agency Coordination Committees (ICCs), as currently used for poliomyelitis eradication (recently expanded to include all immunization), and Consultative Group meetings, as currently held on an annual basis for all major donors to India.

The Comprehensive Development Framework (CDF) approach of the World Bank takes a holistic approach to development and seeks a better balance in policy making by highlighting the inter-dependence of all elements of development – social, structural, human, governance, environmental, economic and financial.

The United Nations System UN Development Assistance Framework (UNDAF) is a framework for more coordinated assistance of the UN System to the Government's development programmes. The cross-cutting themes of gender and decentralisation were selected for emphasis in India. For health, these themes have implications in focusing efforts on such issues as lowering maternal mortality rates; reducing female infanticide; and local collection, analysis and action on disease surveillance data. It also has implications for UN Agencies to work in more decentralized ways at State and, where appropriate, local levels.

The Theme Group of the United Nations Joint Programme on AIDS (UNAIDS) is an example of a coordination mechanism for donor support for HIV/AIDS prevention and control activities that, in India, includes UN Agencies, Government (the National AIDS Control Organization – NACO), and major donor and development partners active in HIV/AIDS. The chairmanship of the UN AIDS Theme Group rotates and WHO will serve as the Chair in 2001.

SECTION 4: WHO CURRENT COUNTRY PROGRAMME

WHO, in India, is in the process of reform (Annex 2). Major areas of reform include: (1) reaffirming the role as a technical collaboration organization rather than a donor organization; (2) emphasizing an advisory and advocacy role rather than an implementer role; (3) building capacity and maximizing the expertise existing in the country; (4) focusing on high priority problems rather than being too diffusely spread out over many programme areas; (5) moving into a closer relationship to the GoI Five-Year Plans; (6) being more collaborative in our work; (7) maximizing the benefits of the close proximity to the Regional Office while minimizing the liabilities; (8) becoming more open and transparent; (9) ensuring a “state of the art” WHO technical collaboration; (10) being more a part of the UN Development Group.

The current WHO country programme, therefore, is one that is in transition. It partly, although not yet fully, is focused on the new priority areas identified for the work of WHO in India based upon discussions with the GoI, donor and development partners, and WHO staff. These include the following highest, high and priority areas (it is understood that the major WHO roles are advocacy, resource mobilization, and technical advice):

Highest priority:

- Eradicating poliomyelitis by 2000;
- Reducing the burden of tuberculosis through expansion of DOTS to the entire country by 2005;
- Drafting, ratifying and implementing the Framework Convention on Tobacco Control;
- Establishing a surveillance system for priority diseases and risk factors that is available on the internet (along with other health indicators for India) and developing a rapid response capability for outbreaks;
- Strengthening routine immunization systems and collaborating on introduction of new vaccines;
- Controlling the HIV/AIDS epidemic within the role as a co-sponsor of UNAIDS;

High priority:

- Eliminating leprosy as a public health problem;
- Reducing malaria, lymphatic filariasis, and visceral leishmaniasis through vector-borne disease treatment and control initiatives, including the roll-back malaria initiative;
- Ensuring availability and rational use of quality essential drugs;
- Reducing of maternal mortality within the framework of a comprehensive reproductive health programme;
- Advocating for health care reform, and health as a basic human right, which improves preventive and curative services and accountability while increasing the effectiveness of

the public and private sector, with particular emphasis on increasing public expenditures on health and strengthening public health;

Priority:

- Introducing the integrated management of childhood illnesses approach within the Child Health programme (covering also blindness and deafness);
- Promoting food safety, chemical safety, safe drinking water, sanitation, and reduction of pollution within the framework of a comprehensive environmental health programme;
- Assessing the magnitude and trends of the burden of priority non-communicable diseases and mental illnesses and piloting intervention programmes;
- Promoting adequate nutrition, including micronutrients, to vulnerable groups;
- Utilizing the themes of gender equity and decentralization in advocating health issues within the UN Development Assistance Framework (UNDAF);
- Developing a scientific basis for Indian systems of medicine;

The regular budget resources of WHO in India are utilized to support technical staff for collaboration and for activities. Where GoI or its other donor and development partners have sufficient funds to support activities, WHO does not need to place large amounts of its own resources to support these activities, even though it may be a recognized priority area. The current apportioning of WHO regular budget resources are shown below (Table 2):

Table 2: WHO REGULAR BUDGET FOR INDIA, 2000-2001

		US\$
Department-wise Plan of Action		
	Department of Health	8,604,200
	Department of Family Welfare	1,275,000
	Department of Indian System of Medicine	510,000
	Other Ministries:	
	Environment	
	Urban Development	738,000
	Rural Development	
		11,127,200
Cluster-wise Plan of Action – Total 29 Projects (4 Cabinet Projects)		
Cabinet Projects		

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	Tuberculosis	425,000
	Malaria	170,000
	HIV/AIDS	170,000
	Tobacco	1,062,500
		1,827,500
Communicable Diseases		
	Leprosy Elimination	85,000
	Yaws Eradication	34,000
	Other communicable diseases	100,000
		219,000
Non-communicable Diseases		
	Health care of the elderly	272,000
	Prevention and control of blindness	110,500
	Deafness	147,900
	Mental Health	127,500
	Community-based rehabilitation	255,000
	Cancer	454,750
	Cardiovascular diseases	170,000
		1,367,820
Sustainable Development and Healthy Environment		
	Nutrition	85,000
	National Food Safety	359,975
	Urban community, water supply and sanitation	119,000
	Healthy cities	188,700
	Rural water & sanitation	210,800
	Environmental Health	219,500
	Health for All	800,000
		1,982,275
Health Technology & Pharmaceuticals		
	Essential Drugs	461,100
	Vaccine Preventable Diseases	175,000
		636,100

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Evidence and Information for Policy		
	Information Systems Mgt.	510,000
	Research & Development (ICMR)	1,130,900
		1,640,900
Health Systems and Community Health		
	Strengthening of Health Systems	266,000
	Primary Health Care for tribal people	512,750
	Health Education for Empowerment of poor	180,000
	Strengthening Nursing and Midwifery	735,250
	Promotion of Health Education for Adolescents/Women's Health	255,000
	Reproductive & Child Health	1,275,000
		3,224,000

The WHO extra-budgetary (EB) resources for the last complete biennium (since EB resources are never certain until actually received) are shown below (Table 3). It should be noted that these resources, although greater in amount than the regular budget resources, are highly specified as to their use.

Table 3: EXTRA-BUDGETARY RESOURCES FOR INDIA, 1998-1999

Programme Area	US\$
Leprosy	10,792,347
Poliomyelitis Eradication	7,737,674
Essential Drugs	6,441
TOTAL	18,536,462

Areas of Major Cooperation

Some of the major areas of cooperation included in the current biennium are highlighted below:

1. Polio Eradication: The final push for eradication of poliomyelitis from India is taking place in this biennium. Major technical collaboration in surveillance, conduct of national and sub-national immunization days, mopping up operations, vaccine supply and logistics, and strengthening the laboratory network is ongoing at Central, State and Local

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levels through the National Polio Surveillance Project supported by WHO and its donor partners.

2. Tuberculosis: The introduction and expansion of the DOTS strategy (Directly Observed Treatment, Short-course) continues as a major area of programme emphasis.
3. Tobacco Free Initiative (TFI): Some US\$1 million is budgeted for the TFI and WHO is recruiting a National Professional Officer for TFI as well as an economist, media specialist and epidemiologist for a TFI cell in the Ministry of Health and Family Welfare.
4. HIV/AIDS: WHO actively collaborates with the National AIDS Control Organisation (NACO) for strengthening blood banks and safe blood transfusion services. WHO also collaborates on the preparation and implementation of the World Bank funded projects for Control of STD/AIDS in India
5. Promotion of Indian Systems of Medicine and Homeopathy: WHO supports workshops in specific aspects of traditional medicine, including Ayurveda and Unani. The objectives are to strengthen the scientific basis for Indian systems of medicine, the education and practice of indigenous systems and medicine, and the capacity to regulate food supplements and herbal medicines.
6. Leprosy Elimination: WHO supports technical collaboration in the high risk states for the final push for leprosy elimination.
7. Malaria control: WHO, through its “roll back malaria” programme places high priority on technical collaboration to reduce the 2 to 3 million cases annually.
8. Strengthening national and institutional capacity: WHO supports the participation of senior officials at important international conferences so as to enhance the technical and operational capability of personnel. Study tours are arranged in priority areas such as environmental health, nursing, communicable diseases, population and reproductive health management, and epidemiology. A major change in this biennium is the shifting of support of international fellowships to support of in-country fellowships that are more cost-effective and provide strengthen national training institutions to become regional and global training centres.
9. Disease Surveillance: Following the recent super-cyclone in Orissa State, WHO, with support of DFID, prepared and help implement plan for an emergency epidemiological surveillance system in affected districts which provided an example of effective WHO support at State and local levels. WHO, with financial support from USAID, is providing technical collaboration in establishing a national disease surveillance system.
10. Reproductive, Family and Community Health Issues: WHO is technically collaborating in the Family Welfare reproductive and child health programme. The Making Pregnancy Safer initiative is directed at reducing the high levels of maternal mortality, especially among the poor and underserved. The recent formation of the Global Alliance for Vaccines and Immunization (GAVI) provides an opportunity for enhanced technical collaboration in strengthening routine immunization systems and the introduction of new vaccines, especially hepatitis B vaccine
11. Health Information System: WHO is working with the Central Bureau for Health Intelligence (CBHI) to strengthen the health information system through improved

interconnectivity and web-based publishing of information for easy access for Government and all its donor and development partners to health data of India. WHO, together with the Government, the UN Foundation, the Gates Foundation, and WebMD anticipates initiating a Health InfoNet to help reduce the “digital divide” and increase access to health information.

12. Environmental Health and Food Safety: WHO is technically collaborating with the Ministry of Environment and Forests, the Ministry of Health and Family Welfare, donors and development partners in issues such as hazard analysis at critical control points for food processing and handling, and excessive fluoride, arsenic, and lead in certain water supplies. WHO, the Ministry of Health and Family Welfare and the Ministry of Urban Development, which are all located within the Nirman Bhawan building, are working together on a Healthy Public Building initiative as a demonstration project of a safe, clean and healthy public building.

Collaborative efforts with other development partners

The Ministry of Health and Family Welfare is the nodal agency for WHO. However, WHO technically collaborates with all branches of Government, all levels of Government, UN Agencies, other donor and development partners of the Ministry of Health and Family Welfare, and health-related NGOs. Such collaboration usually entails providing technical assistance in planning, implementing, monitoring or evaluation of health programmes and projects. As appropriate, WHO may support activities of development partners and NGOs in identified priority areas of the health sector.

Examples of such collaboration with other Ministries include the work on environmental health with the Ministry of Environment and Forests. Examples of collaboration with other branches of the Government include WHO’s work to inform members of Parliament and the Judiciary of the Framework Convention on Tobacco Control (FCTC). Examples of collaboration with State and Local levels of Government include WHO’s work in Orissa to help strengthen disease surveillance systems in the aftermath of the Super Cyclone. Examples of collaboration with UN Agencies include WHO’s work on strengthening HIV/AIDS surveillance together with the Joint UN Programme on AIDS (UNAIDS) and WHO’s work on strengthening immunization programmes with UNICEF. Examples of collaboration with other donor and development partners include the massive effort to eradicate poliomyelitis where WHO works closely with the Government and all partners to strengthen the National Polio Surveillance Project (NPSP) and help ensure all children under 5 years of age receive polio vaccines during the Intensified Pulse Polio Immunization (IPPI) and “mopping up” days. Examples of working on health-related issues with NGOs includes WHO’s collaboration with Indian Professional Societies (e.g., the Indian Medical Association and the Indian Public Health Association), Indian Industrial Groups (e.g., the CII and FICCI), and Indian Voluntary Organizations (e.g. Rotary Clubs and the Voluntary Health Association of India).

SECTION 5: WHO CORPORATE POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS

The **objective of WHO**, as set out in its Constitution, is the attainment, for all people, of the highest possible level of health.⁴

The **corporate policy framework of WHO** is more specific and intended to enable WHO to make the greatest possible contribution to world health through increasing its technical, intellectual, and political leadership.⁴

The **corporate strategy for the WHO Secretariat** reflects the values and principles articulated in the Global Strategy for Health for All as reaffirmed by the Fifty-first World Health Assembly in 1998.⁴

The work of WHO, to respond effectively to a changing international environment, takes the following new ways:⁴

- Adopting a broader approach to health within the context of human development, humanitarian action and human rights, focusing particularly on the links between health and poverty reduction;
- Playing a greater role in establishing wider national and international consensus on health policy, strategies and standards by managing the generation and application of research, knowledge and expertise;
- Triggering more effective action to improve health, and to decrease inequities in health outcomes by carefully negotiating partnerships and catalyzing action on the part of others; and
- Creating an organizational culture that encourages strategic thinking, global influence, prompt action, creative networking, and innovation.

To realize the goals of building healthy populations and communities and to combat ill-health, WHO has identified four **strategic directions**:⁵

1. Reducing excess mortality, morbidity and disability, especially in poor and marginalized populations.
2. Promoting healthy lifestyles and reducing factors of risk to human health that arise from environmental, economic, social and behavioral causes.
3. Developing health systems that equitably improve health outcomes, respond to peoples' legitimate needs, and are financially fair.
4. Developing an enabling policy and institutional environment in the health sector, and promoting an effective health dimension to social, economic, environmental and development policy.

The WHO Secretariate works towards these strategic directions through a set of **core functions** that are based in the Constitution and are focused on:⁵

- Articulating consistent, ethical and evidence-based policy and advocacy positions;
- Managing information, assessing trends and comparing performance of health systems; setting the agenda for, and stimulating, research and development;

- Catalyzing change through technical and policy support, in ways that stimulate action and help to build sustainable national capacity in the health sector;
- Negotiating and sustaining national and global partnerships;
- Setting, validating, monitoring, and pursuing the proper implementation of, norms and standards;
- Stimulating the development and testing of new technologies, tools and guidelines for disease control, risk reduction, health care management and service delivery.

The **criteria for identifying the priorities** for the work of WHO are as follows:

- Potential for significant change in burden of disease with existing cost-effective interventions;
- Health problems with major impact on socioeconomic development and a disproportionate impact on the lives of the poor;
- Urgent need for new technologies;
- Opportunities to reduce health inequalities within and between countries;
- WHO's advantages, particularly in relation to provision of public goods; building consensus around policies, strategies and standards; initiation and management of partnerships;
- Major demand for WHO support from Member States.

The **specific priorities of WHO** are as follows:

- **Malaria, tuberculosis and HIV/AIDS** – these three major communicable diseases all pose a serious threat to health and economic development and have a disproportionate impact on the lives of poor people.
- **Cancer, cardiovascular disease and diabetes** – these are all growing to epidemic proportions in poor and transitional economies. This also includes developing programmes for surveillance, prevention and management of non-communicable diseases.
- **Tobacco** – A major killer in all societies and a rapidly growing problem in developing countries.
- **Maternal health (including making pregnancy safer)** – Many developing countries, including India, have unacceptably high levels of maternal mortality and will require improvements in the health system to reduce these high levels.
- **Food safety** – A growing public concern with potentially serious economic consequences.
- **Mental health (including substance abuse)** – Five out of the 10 leading causes of disability are mental health problems and major depression is the fifth contributor to the global burden of disease (and may rise to be the second by 2020).

- **Safe blood** – It is both a potential source of infection and a major component of treatment which has been neglected in many countries.
- **Health systems (including evidence for health policy)** – An effective and sustainable health system underpins all the other priorities.
- **Investing in change in WHO** – WHO must become a more efficient and productive organization, capable of responding within an increasingly complex international environment. This will require reform of WHO and the development of new skills, systems and processes.

The Member Countries of South-East Asia Region, during the Regional Committee in August 2000, emphasized these same priority areas as reflected in the Regional Framework and the Regional Specific Priority Areas for 2002-2003 contained in the Part II of the WHO Proposed Programme Budget 2002-2003.⁶ These priorities are consistent with the Health Ministers' "Declaration on Health Development in the South-East Asia Region in the 21st Century" endorsed by the Regional Committee that includes the commitment to: ensure universal access to quality health care; accord the highest priority to alleviate the burdens of disease, disability, premature death and suffering afflicting people, especially the poor; invest in women's health and development to eliminate gender discrimination and disparities; strengthen existing partnerships and forge new ones for health development at all levels; and develop regional self-reliance.

SECTION 6: STRATEGIC AGENDA FOR INDIA: THE NEXT FIVE YEARS

The WHO in India is embarked on a series of reforms (Annex 2) that are influencing the current WHO country programme (Section 4) and will greatly impact on this strategic agenda.

As an outcome of this strategic agenda, WHO will develop a Five-Year WHO country programme harmonized with the health related priorities of the GoI Five-Year Plan. Future WHO biennium Detailed Plans of Action will represent two-year tranches of this WHO India Five-Year Plan.

The selection of the items on the strategic agenda is based on dialog among the WHO Country Team; between WHO Headquarters, Regional Office and Country Team; between the GoI (with MoH&FW as the nodal agency and using a WHO/GoI collaborative meeting mechanism) and the WHO Country Team; and between other donor and development partners of the MoH&FW and the WHO Country Team. Criteria for selection include the following:

- Country needs and challenges (reflected in Section 2);
- The activities of other agencies and donors (partially reflected in Section 3);
- WHO corporate objectives and directions (reflected in Section 5);
- The perspectives of different stakeholders of the role of WHO;
- WHO's actual and potential comparative advantage; and
- WHO's actual and potential capacity to implement and support the strategic agenda, and the opportunity for new and strengthened partnerships.

The perspective of the MoH&FW and donor and development partners on the areas of comparative advantage for WHO include the following:

- Capacity building – WHO should help build capacity at Central, State and local levels through training programmes, transfer of information technologies, and strategy development. The new approach to using Indian Centers of Excellence as the sites for placement of WHO-supported in-country fellowships is appreciated as being a more cost-effective use of fellowship funds and strengthening of these Centers.
- Information dissemination – WHO should develop a documentation and information center (both on line and physically within the MoH&FW) to ensure easy access to health-related information (including, GoI, WHO, and other development and donor partner publications and reports). This is done as a “two-way” street so that India benefits from the lessons learned in other countries while also contributing its vast experience for the benefit of other countries.
- State-of-the-art policies and strategies – WHO should support speakers to seminars, organized by Indian Centers of Excellence, on state-of-the-art “cutting edge” issues of importance to India.
- Neutrality – WHO should use its reputation as an objective and neutral agency to prepare situation analyses and organize external evaluations of GoI and donor projects and programmes.

- Specific disease eradication, elimination, and reduction – WHO should use its technical resources to focus on specific disease targets that are feasible, in the Indian context, for eradication, elimination, or reduction (including, polio, tuberculosis, malaria, leprosy, yaws, lymphatic filariasis, and kala-azar). In high priority programme areas, this may include placement of staff at State and local levels.

Based upon the dialog, to date, the following are the major programme areas, with an indicative level of effort, and the priority areas of work, ranked by level of priority, for WHO over the next five years, starting with the 2002-2003 biennium (Table 4):

Table 4: PRIORITY AREAS OF WORK FOR WHO, 2002-2006

MAJOR PROGRAMMES	PRIORITY AREAS	LEVEL OF PRIORITY
DISEASE CONTROL		45-50% of all effort
A	Multi-disease surveillance (Communicable and Non-Communicable)	Highest priority
B	Communicable disease prevention, control, elimination or eradication of:	
	TB	Highest priority
	Malaria and Kala-azar	High priority
	HIV/AIDS	High priority
	Polio	Priority
	Leprosy	Priority
	Yaws	Priority
	Other: cholera, rabies, etc.	Priority
DISEASES OF LIFESTYLE AND DISEASES RELATED TO ENVIRONMENTAL RISK FACTORS		20-25% of all effort
	Tobacco	Highest priority
	Specific high burden Non-Communicable diseases (cardiovascular disease, cancer and diabetes)	Highest priority
	Nutrition	Highest priority

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MAJOR PROGRAMMES	PRIORITY AREAS	LEVEL OF PRIORITY
	Occupational health	High priority
	Road traffic accidents and rehabilitation	High priority
	Food safety	High priority
	Water quality (flourosis and arsenic)	Priority
	Mental health	Priority
	Chemical safety	Priority
INTEGRATING HEALTH SERVICES		15-20% of all effort
	Women's health and making pregnancy safer	Highest priority
	Immunization (including introduction of new vaccines)	Highest priority
	Child health, School health, and Adolescent health	High priority
	Rational use of drugs and pharmaceuticals	High priority
	Quality assurance and quality control	Priority
HEALTH SECTOR REFORMS AND SYSTEMS DEVELOPMENT		10-15% of all effort
	Enhancing health systems performance (level and distribution of health, level and distribution of responsiveness)	Highest priority
	Health policy: Private/Public mix	Highest priority
	Health policy: health financing and insurance (fairness in financing)	High priority
	Health policy: decentralization	Priority

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MAJOR PROGRAMMES	PRIORITY AREAS	LEVEL OF PRIORITY
SMALL SCALE TECHNICAL SUPPORT (HEALTH FOR ALL)	Miscellaneous areas of support funded at levels that are not at the project level (<\$100,000) and for activities of importance that arise in the course of the biennium	5-10% of all effort

For these priority areas of work, WHO has varying functional areas, or roles, that would best serve India depending on the developmental stage of the priority area. These roles include:

- **Supporting programme implementation:** Supporting routine long-term implementation or special eradication/elimination/control efforts;
- **Catalyzing innovation:** catalyzing adoption of technical strategies and innovations; country-specific adaptation of guidelines; and seeding large-scale implementation;
- **Stimulating monitoring, evaluation, research and development:** policy experimentation; development of guidelines; stimulating monitoring of health sector performance; trends assessment and anticipation;
- **Sharing information and advocacy:** generic policy options and positions; guidelines and standards; case studies of good practice; advocacy; and
- **Providing policy advice:** providing specific high level authoritative policy and technical advice; serving as broker and arbiter; exercising influence on policy, action, and spending of government and development partners.

Based upon discussions, to date, the following are the level of effort in these various roles, by priority area, for WHO in India (Table 5):

Table 5: LEVELS OF EFFORT, BY FUNCTIONAL AREA, OR ROLE, FOR THE PRIORITY AREAS OF WORK FOR WHO, 2002-2006

(Level of effort as a percentage for each role out of 100% of the effort in each priority area)

PRIORITY AREAS	Supporting programme implementation	Catalyzing innovation	Stimulating monitoring, evaluation, research and development	Sharing information and advocacy	Providing policy advice
Multi-disease surveillance	0	40	20	30	10
TB	30	10	30	10	20

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PRIORITY AREAS	Supporting programme implementation	Catalyzing innovation	Stimulating monitoring, evaluation, research and development	Sharing information and advocacy	Providing policy advice
Malaria and Kala-azar	0	30	30	20	20
HIV/AIDS	0	30	20	20	30
Polio	60	10	10	0	20
Leprosy	70	0	0	0	30
Yaws	0	60	0	0	40
Other: cholera, rabies, etc.	0	50	0	10	40
Tobacco	0	20	20	30	30
Specific high burden Non-Communicable diseases	0	30	30	20	20
Nutrition	20	20	20	20	20
Occupational health	0	30	30	20	20
Road traffic accidents and rehabilitation	0	20	30	30	20
Food safety	0	30	20	30	20
Water quality (flourosis and arsenic)	0	20	20	30	30
Mental health	20	20	20	30	10
Chemical safety	20	30	20	20	10
Women's health and making pregnancy safer	0	10	20	30	40
Immunization	0	20	40	30	10
Child, School, and Adolescent health	0	40	30	10	20

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PRIORITY AREAS	Supporting programme implementation	Catalyzing innovation	Stimulating monitoring, evaluation, research and development	Sharing information and advocacy	Providing policy advice
Rational use of drugs and pharmaceuticals	10	20	20	20	30
Quality assurance and quality control	10	30	30	10	20
Enhancing health systems performance	10	30	30	10	20
Health policy: Private/Public mix	20	20	20	10	30
Health policy: health financing and insurance	20	10	30	10	30
Health policy: decentralization	20	10	20	20	30

It is significant to note that, taking all of these priority areas as a whole, the greatest foci for WHO's role are in the areas of providing policy advice and catalyzing innovation, whereas the area of supporting routine programme implementation is the least area of focus. This is consistent with WHO's overall role as a technical collaborative agency rather than a donor agency.

SECTION 7: SUPPORTING AND IMPLEMENTING THE CCS

The CCS priorities and the functional areas of work, or roles, of WHO in outlined in Section 6 have direct implications on the country level staffing, financial resources, information support, and WHO Headquarters and Regional Office technical support to India.

However, because of the reform process of WHO at the country level, the staffing resources for the India Country Team for the period 2002-2006 is not expected to change from what is anticipated to be in place by the end of the 2000-2001 biennium. The WHO in India is committed to an open and transparent process of determining appropriate staffing mix and recruitment. Furthermore, WHO in India is committed to maximize the use of Indian nationals as staff members of the WHO India Country Team in recognition of the excellent human resources and talent available in the country.

For each of the priority areas of work, a suggested mix of staffing has been identified using the following definitions:

- **Part time staffing:** implies the use of short term (ST) consultants under Agreements for Performance of Work (APW), as Special Services Agreements (ST-SSA) holders, National Professional Officers (ST-NPO), external Short Term Consultants (STC), external Short Term Professionals (STP), or visits of WHO HQ or Regional Office Long Term Staff (LTS) for periods of time of under 6 months.
- **Full time staffing:** implies the use of long term staff for periods of time of over 6 months utilizing APW, SSA, NPO, or LTS mechanisms of recruitment.
- **Team:** implies the use of more than one full time or part time staff for periods of time of over 6 months.

It should be understood that if a priority area has been identified for full or team staffing levels, there still exists the possible need for part time staff as consultants for specialized work within the priority area.

Also for each of the priority areas of work, a suggested level of financial resources has been identified using the following definitions:

- **Low:** implies less than US\$ 100,000 per biennium.
- **Medium:** implies between US\$ 100,000 to \$250,000 per biennium.
- **High:** implies greater than US\$ 250,000 per biennium.

It should be noted that no special programme area has been identified for fellowships. This is consistent with the approach of WHO in India to fund fellowships, as needed, from monies allocated to the different programme areas. Furthermore, there will be an increasing use of in-country fellowships in recognition of the number of excellent training institutions in India that WHO will utilize for placement of trainees – thus also strengthening those institutions through tuition costs and, as appropriate, designation as WHO Collaborating Centers.

With these definitions, the following table identifies the mix of staffing and level of financial resources for each priority area (Table 6):

**Table 6: LEVELS OF EFFORT FOR THE PRIORITY AREAS OF WORK FOR WHO,
2002-2006**

PRIORITY AREAS	MIX OF STAFFING			LEVEL OF FINANCIAL RESOURCES		
	PART TIME	FULL TIME	TEAM	LOW	MEDIUM	HIGH
Multi-disease surveillance			X		X	
TB			X		X	
Malaria and Kala-azar		X			X	
HIV/AIDS		X			X	
Polio			X			X
Leprosy			X		X	
Yaws	X			X		
Other: cholera, rabies, etc.	X				X	
Tobacco			X			X
Specific high burden Non-Communicable diseases		X			X	
Nutrition		X			X	
Occupational health	X			X		
Road traffic accidents and rehabilitation	X			X		
Food safety			X		X	
Water quality (flourosis and arsenic)	X				X	
Mental health	X				X	
Chemical safety	X			X		
Women's health and making pregnancy safer		X				X
Immunization		X			X	
Child, School, and Adolescent health		X			X	

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PRIORITY AREAS	MIX OF STAFFING			LEVEL OF FINANCIAL RESOURCES		
	PART TIME	FULL TIME	TEAM	LOW	MEDIUM	HIGH
Rational use of drugs and pharmaceuticals			X		X	
Quality assurance and quality control	X				X	
Health Sector Reforms and Systems Development		X			X	
Miscellaneous areas of support funded at levels that are not at the project level (<\$100,000) and for activities of importance that arise in the course of the biennium	X				X	

The information support needed for implementing the CCS and focusing the country programme will be derived from: (1) improved disease surveillance systems to better measure burden of disease, its distribution, and the impact of interventions; (2) the enhancing health systems performance initiative to better measure level and distribution of health, level and distribution of responsiveness of the health system, and fairness in financing; and (3) a WHO supported resource center located in the Ministry of Health and Family Welfare and an online database of important health-related reports and documents anticipated to be established by the end of 2001.

WHO Headquarters and Regional Office will provide WHO recommended norms and standards, policies and strategies, and prototype guidelines and training materials suitable for adoption or adaptation at country level. WHO Headquarters and Regional Office staff will provide technical inputs and, as needed, visit India for direct technical collaboration with the Government, health-related donor and development partners, and the WHO India Country Team.

Acknowledgements

The WHO India Country Team would like to acknowledge the valuable and continuing inputs of the Government of India, especially the nodal Ministry of Health and Family Welfare; UN Agencies resident in India, Donor and Development Partners in the Health Sector; Non-Governmental Organizations; and WHO Headquarters and South-East Asia Regional Offices in the creation and evolution of this WHO Country Cooperation Strategy for India.

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Annex 1: VISION AND MISSION OF WHO COUNTRY TEAM IN INDIA



World Health Organization Country Team in India

Vision **S**tatement

To facilitate attainment of the highest possible level of health, through a strong, proactive, technically excellent and dedicated WHO country team, part of a global network; provide leadership in health; and collaborate with governments, civil society and other partners.

Mission **S**tatement

Provide technical expertise in public health through partnerships with Ministry of Health and Family Welfare; national, state and local governments; development and other partners; and civil society; with focus on:

- Promoting health as a fundamental human right, and working to place health as an integral part of poverty alleviation and development for the people of India;
- Proactive and dependable leadership in public health, including:
 - ❑ setting norms and standards;
 - ❑ reducing the burden of excessive mortality and disability;
 - ❑ reducing the risk factors associated with major causes of disease;
 - ❑ developing health systems to ensure equity in health;
 - ❑ promoting an effective health dimension to development policies in social, economic and environmental areas;
- Mobilizing, developing and optimally utilizing human and financial resources and promoting conducive working environments.

Annex 2: REFORM OF WHO AT THE COUNTRY LEVEL

AREAS OF REFORM FOR UNDER CONSIDERATION:

1. Technical collaboration organization rather than a donor organization:

Implies an increase in the technical work of the WHO through involvement of additional WHO Staff, more WHO Collaborating Centers, and other “Centers of Excellence.”

2. Advisory and advocacy role rather than an implementer:

Implies activities and technical collaboration in innovative and new areas rather than routine activities. Includes technical collaboration in the development of policies, strategies, guidelines, training materials, pilot projects, training of trainers, etc.

3. Capacity building and maximizing the expertise existing in the country:

Implies utilizing more Indian institutions and individuals to provide the technical collaboration in India rather than expatriates.

Implies a greater use of Indian institutions for placement of fellowships (for fellows from within as well as outside of India)

4. Focused on high priority problems rather than too diffusely spread out over many programme areas:

Implies a reduction in the number of WHO funded programme areas and the integration of closely related programmes as is being done under the integrated management of childhood illnesses.

Implies more active involvement in the important issues of health care reform and health care financing.

5. Closer relationship to the GOI Five-year plan:

Implies harmonization of the WHO Country Programme with the health related priorities of the GOI Five-year Plan. A harmonized WHO Five-year Plan of Action in India could be developed covering the same time period as the GOI Five-year Plan. The WHO biennium Plans of Action would then represent two-year tranches of this WHO India Five-year Plan.

6. A more collaborative WHO:

Implies ensuring that WHO is a “two-way street” whereby the success stories and lessons learned in India are widely disseminated to other countries in the world. Lessons learned in other countries would also be made widely available in India.

Implies ensuring that Indian experts are well represented in technical expert committees of WHO.

Implies maintaining a special relationship with the MOH&FW while also advising and advocating for health with other Ministries and branches of GOI, both national and state, which impact health.

Implies that WHO “reach out” to the other donor and development partners in health (other UN agencies, bilateral development assistance agencies, and NGOs) to attract additional support to the health sector and provide technical collaboration.

Implies WHO collaborate with GOI to create or strengthen coordination meetings between the GOI and donor and development partners in the health sector (includes meetings for specific areas within health such as polio eradication, reproductive health, integrated management of childhood illnesses, health care reform, etc.)

7. Maximizing the benefits of the close proximity to the Regional Office while minimizing the liabilities:

Implies utilizing the close proximity of SEARO to maximize benefits (providing quick backup for technical collaboration and ease of follow-up of items requiring SEARO approvals) and minimizing the problems (over dependence on SEARO resulting in a lack of breadth and depth of full-time technical collaboration that the largest WHO country program in the world deserves).

8. An open and transparent WHO:

Implies developing an agreed-upon written procedures of work (respecting the rules and regulations of all parties) between GOI and WHO covering such issues as nominations for meetings and expert groups, class of travel and per diems, recruitment and selection of staff, and release and accounting of funds.

9. A “state of the art” WHO technical collaboration:

Implies an in-service staff development and training programme for all WHO supported technical collaborators (staff and consultants) who are recruited or contracted for 11 months or more to ensure that these persons stay at the “cutting edge” in their field of professional expertise.

10. A WHO within the United Nations Development Group:

Implies that WHO strengthen its partnership with other UN agencies within the UNDG group (which WHO has just joined) and play its role within the UN Development Assistance Framework (UNDAF) and the World Bank Country Development Framework (CDF). The UNDAF themes of gender and decentralization should be used to promote gender and decentralization aspects of health as well.