WHO/CCO/06.03

Country Support Unit Network 2005

Partnerships for health

Country Focus

World Health Organization

Acknowledgements

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Acronyms

AFRO	WHO Regional Office for Africa
AMRO	WHO Regional Office for the Americas
CAMS	Country Activity Management System
CCA	Common Country Assessment
CCO	Department of Country Focus
CCS	Country Cooperation Strategy
CPC	Office of Caribbean Program Coordination
CSU	Country Support Unit
DFID	United Kingdom Department for International Development
DPM	Director of Programme Management
ECHO	Humanitarian Aid Department of the European Commission
EIP	Evidence and Information for Policy Cluster
EMRO	WHO Regional Office for the Eastern Mediterranean
EURO	WHO Regional Office for Europe
FCH	Family and Child Health Cluster
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GLC	Global Learning Committee
GLP	WHO Global Leadership Programme
GPN	Global Private Network
HAC	Health Action in Crises
HDS	Department of Health and Development Services
HHR	Health and Human Rights
HIV/AIDS	human immunodeficiency virus/acquired immunodeficiency syndrome
IOM	International Organization for Migration
ITT	Department of Information Technology and Telecommunications
JPRM	Joint Programme Review and Planning Mission
LO	Liaison Officer (WHO)
MDG	Millennium Development Goal
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PAHO	Pan American Health Organization
PRP	Department of Planning, Resource Coordination and Performance Monitoring
PRSP	Poverty Reduction Strategy Paper
RPM	Regional Programme Management
SEARO	WHO Regional Office for South-East Asia
SIDA	Swedish International Development Cooperation Agency
SWAp	sector-wide approach
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDG	United Nations Development Group
UNDP	United Nations Development Programme
UNOPS	United Nations Office for Project Services
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VSAT	very small aperture terminal
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organization
WPRO	WHO Regional Office for the Western Pacific
WR	WHO Representative

Table of contents

PART ONE
GENERAL OVERVIEW

1.1	Introduction	6
1.2	Country Support Unit Network events	7
1.3	Achievements of the Country Support Unit Network	8
1.4	Country Cooperation Strategies	19
1.5	Monitoring of progress and performance	24
1.6	Network collaboration with other units and departments	27
1.7	Financial resources report	28
1.8	Challenges and future direction	30

PART TWO
PARTNERSHIPS AND COORDINATION AT COUNTRY LEVEL

2.1	Setting the scene	34
2.2	Country case-study examples	36
	Albania	36
	Bangladesh	37
	Burundi	38
	China	40
	Eritrea	41
	Ghana	42
	Haiti	43
	Kyrgyzstan	44
	Namibia	46
	Viet Nam	47

CD-ROM attached with key reports and documents

COUNTRY FOCUS

Putting countries at the heart of WHO's work

Our Vision

We must do the right things. We must do them in the right places. And we must do them the right way. We are putting countries where they should be - at the heart of WHO's work.

LEE *Jong-wook. Director-General*, 21 *July* 2003

Part One

General Overview

1.1 Introduction

The Country Support Unit (CSU) Network was set up in 2003 – its establishment coincided with the Third Global Meeting of World Health Organization (WHO) Representatives (WRs) and Liaison Officers (LOs) in Geneva in November 2003. The idea behind the Network is to have a mechanism or forum for focused discussion, dialogue and deed across the organization. This mechanism has ensured horizontal as well as vertical communication and collaboration by bringing the whole Organization together around the Country Focus Policy.

The Network has seven constituent elements – there is one CSU in each of the six WHO Regions: the history, organizational and management set-up differ somewhat between the regions but have a shared purpose of providing support for WHO Country Offices and their work. The Department of Country Focus (CCO) at WHO headquarters in Geneva is the seventh element.

This year's report is the third of its kind, the first reported on the biennium 2002–2003 and the second was the Annual Report for 2004. The CSU Network Report 2005 aims at providing readers with an overview of the achievements of the Network in that year. In addition, it will provide information on:

• the extent to which the implementation of the Country Focus Policy is moving forward; and

• how it could be further enhanced with the support of key partners within and outside the organization.

The 2005 report will comprise two parts:

Part I will report on the general progress made by the CSU Network in relation to the Country Focus Policy with a focus on the key events and achievements in 2005. There will also be an update on the financial resources of the Network and a brief discussion of the the future challenges and directions.

Part II will focus on the specific theme of partnerships and coordination, highlighting current trends and experiences with alignment and harmonization, in particular at country level. This part of the report has been prompted by mainstream international development with reform of the way in which development assistance and aid are dispatched from the UN system, from other multilateral organizations, from international health initiatives, e.g. the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) and from the bilateral development assistance community. These changes have serious implications for all agencies involved in development assistance and WHO is no exception. The whole Organization will have to adjust its position at the global level as well as at the country level. What may be perceived as a threat by some, can be seen as opening up new opportunities by others. This section of the report will focus on what is going on at the country level emphasizing the activities of those who are seizing the new opportunities.

1.2 Country Support Unit Network events

From its outset, the CSU Network has manifested itself through focused events varying in substance, format and approach. The CSU Network meeting in Copenhagen[1] (2004) had as its general theme the formalization of the Country Cooperation Strategies (CCS) process – the finalization of the CCS guide was a concrete outcome of that meeting. The meeting in Cairo, also held in 2004,[2] focused on a more programmatic theme: how to use the Country Focus Policy as a vehicle for promoting and facilitating health systems development at the country level. Both these events have been critical for giving impetus to the development in the two areas. In 2005 this event-focused approach was continued with two CSU Network meetings, one in Santo Domingo[3] in the Dominican Republic and the other in Montreux,[4] Switzerland. Without losing the theme-focused approach, the two most recent CSU Network meetings have been used as a medium for discussion and decision-making on a number of issues related to the workplan for the Area of Work WHO's core presence in countries (SCC). In addition, the Santo Domingo meeting addressed the role and responsibilities of the CSU Network. This was the first time that such roles and responsibilities have been made explicit, hence pinpointing the specific role played by the Network in developing a strategy to promote and facilitate the implementation of the Country Focus Policy.

1The Copenhagen Report – Revisiting the country cooperation strategy. The CSU Network Meeting, 3–5 March 2004.

2. The Cairo Report – Country focus and health systems development. The Second CSU Network Meeting, 3–5 August 2004.

3. The Santo Domingo Report – The third meeting of the Country Support Unit Network, 31 May–2 June 2005.

4. The Montreux Report – The fourth meeting of the Country Support Unit Network, October 2005.

Third Country Support Unit Network Meeting Santo Domingo, Dominican Republic, May–June 2005

After the first two thematic CSU Network meetings in Copenhagen and Cairo, the third meeting in Santo Domingo, the Dominican Republic, dealt with more internal matters of the Network. One of the key discussions at this meeting identified the functions of the Network and the roles of the different levels of the Organization for better serving Member States. The role of the Network is seen as evolving, thus, the meeting was an occasion for reiterating, re-emphasizing and renewing the role played by the Network and its constituent partners.

Fourth Country Support Unit Network Meeting Montreux, Switzerland, October 2005

This fourth CSU Network Meeting selected as its specific theme: harmonization and alignment at country level. This theme was selected in response to requests from WHO Representatives and Liaison Officers for more clarity from within WHO on its position on the changing environment at country level in regards to international development assistance, the Paris Declaration and the UN reform.

One of the key outcomes of the working groups at this meeting was the revision of a proposal for the CSU Network strategy for building the capacity of country teams in addressing the harmonization and alignment agenda at country level. The complete strategy will be detailed in an upcoming publication WHO alignment and harmonization: a framework for country action.

1.3 Achievements of the Country Support Unit Network

Country Focus Policy discussed at the 116th session of the Executive Board

A report entitled WHO country offices and country focus was prepared and presented to the 116th session of the Executive Board in May 2005. Besides providing an update on the six components of the Country Focus policy (see below), the paper also attempted to link the implementation of the policy to other WHO processes aimed at improving the performance of the WHO Secretariat overall, emphasizing in particular the decentralization process that was aimed to increase WHO's impact on health and development at country level.

The country focus policy gears WHO's operations to the needs of Member States at country level. The success of the country focus policy is linked to other WHO processes, in particular the change in resources to increase the organization's impact on health and development at country level by providing support for countries to develop their own health systems. The six components used to monitor progress are:

1. country cooperation strategies
2. core competencies and capacities of country teams
3. coherent programmatic and technical support from regional offices and headquarters
4. effective functioning of country offices
5. information and knowledge management to and from countries
6. working with organizations of the United Nations system and development partners.

PRIORITY ACTIONS FOR STRENGTHENING THE COUNTRY FOCUS POLICY

The following priority actions will be undertaken to strengthen the impact of the country focus policy:

- The country cooperation strategy will be used in broad strategic dialogue on WHO's cooperation with Member States, including identification of core competencies needed for technical cooperation and definition of the appropriate core presence in each country.
- Common criteria and approaches will be determined for establishing and maintaining adequate core presence in countries, including support from WHO collaborating centres, so that WHO's core functions are carried out as agreed with Member States, including its normative work and intercountry collaboration.
- The "one WHO country plan and budget" will be progressively implemented as part of WHO's regular budgeting and managerial process, to provide integrated technical support to Member States.
- Mechanisms for accountability of WHO country offices in areas such as management of resources, adherence to technical guidance and quality of technical support will be improved.
- A system will be devised to monitor the performance of WHO at country level, including its influence, together with key partners, on the public health agenda, and its contribution to health outcomes in Member States.

Response of the Country Support Unit Network to the South Asian earthquake and tsunami

In response to the devastating earthquake and tsunami that affected South Asia and parts of Africa on 26 December 2004, the CSU Network provided support to the affected countries. The Department of Country Focus fully engaged in support of emergency relief operations and reconstruction efforts coordinated by the WHO Regional Office for South-East Asia (SEARO) and Health Action in Crises (HAC) in headquarters. Regional offices seconded highly qualified staff to the affected countries for considerable periods of time. The entire Department of Country Focus was made available to HAC during the immediate aftermath of the disaster.

Global survey on WHO country presence

The CSU Network carried out a global survey on WHO country presence from March to May 2005 as part of the work of the cross-WHO working group on WHO country presence under the guidance of the Directors of Programme Management (DPMs). The survey was developed to collect information on WHO country offices and sub-offices; functions of WHO country teams; participation in national health sector processes and the UN country team; priorities for WHO technical cooperation; and human resources and budget. The survey achieved a response rate of 100%[5] and the results were published in the report entitled WHO country presence 2005 (see attached CD-ROM). This was a landmark achievement, giving for the first time a global picture of the current WHO country presence.

5. Data were received from 144 WHO country offices, four desk offices based in the WHO Regional Office for the Eastern Mediterranean, one special office in the Occupied Palestinian Territory, and one field office at the border between Mexico and the United States of America.

Enabling WHO country offices to perform better through improved communications

All country offices in the WHO African Region have the Global Private Network (GPN) connection

A significant milestone was achieved in 2005 in terms of improving communication, with the provision of all country offices in the WHO African Region with the Global Private Network (GPN) connection. The Country Support Unit Network, through the Department of Country Focus, fully advocated and supported this initiative which was led by the Information Technology and Telecommunications (ITT) departments in both headquarters and the WHO Regional Office for Africa (AFRO). The Department of Country Focus also provided funding for the installation of GPN in 27 country offices.

EMRO Improving communication and information exchange

To assist WHO country offices in the administration and management of their work and to monitor the implementation of WHO collaborative programmes, the Country Activity Management System (CAMS) was developed. The system was deployed and training conducted in 13 WHO offices. CAMS will be the channel of communication and information exchange between WHO offices and the Regional Office during the next biennium.

In addition, a country office assessment database was developed which enables country needs to be identified.

A new era of communication for the African Region

The GPN will have been installed in 46 country offices in the WHO African Region by mid-December 2005, and we are already witnessing significant improvement in the frequency and quality of communications between the country offices, the regional office, and headquarters. As a result of the reduced rate of international call tariffs via the GPN, country offices now pay a fraction of what they would normally pay to local service providers for international calls. The GPN also brings to country offices the opportunity to improve knowledge sharing, as well as data and information exchange on health-related matters with fellow country offices and partner institutions. This enhances the effectiveness of WHO country offices in combating health challenges, particularly during an emergency health crisis. Thanks to the GPN, the WHO staff is now easily reachable by phone, e-mail or, in some cases, by video. Equally, WHO reaches the world with ease, and in a more reliable and cost-effective manner. Can you imagine the difference the GPN would make if extended to health centres and clinics in the developing countries?

Getachew Sahlu
ITT Department AFRO
November 2005

Cross-WHO working group on "country presence" – report of the survey, outcome and next steps

Work on developing an updated WHO policy on country presence has been an ongoing and evolving process. The issue was initially discussed with the Directors of Programme Management (DPMs) during a meeting in Copenhagen in October 2004. Following this meeting, a cross-WHO working group comprising representatives from the three levels of the Organization was established in January 2005. This group reviewed previous work of the Organization for defining WHO country presence, collected information on current WHO country presence, and proposed a set of criteria and an approach for defining WHO country presence.

Following discussions with the working group, the CSU Network and the DPMs, the work of the group was presented in two parts:

• The first part, Current picture of WHO country presence, provides the first global picture of WHO country presence based on the results of a survey organized by the CSU Network and carried out with the cooperation of all WHO country offices. This report also presents information on WHO Representatives and Liaison Officers based on data extracted from the WHO Representatives Information System. The DPMs considered the report to be extremely useful for providing the first global picture, and recommended that the information be regularly updated and shared throughout the Organization.

• The second part, A proposal on criteria and approaches for defining WHO country presence was discussed in great detail by the DPMs during their meeting in Lima in October 2005. They recommended that this policy proposal be taken forward in a separate paper addressed to the Governing Bodies and clearly proposing a corporate approach for WHO country presence in terms of budget, implementation and evaluation processes.

Following the recommendation of the DPMs, a subgroup with representatives from each region and headquarters has been established to take this new paper forward. This subgroup held its first meeting in January 2006. It was agreed that the policy paper should be strategic, concise, prescriptive and advocating more uniformity in the proposed approach to defining WHO country presence. The paper will focus on: contextual issues (e.g. harmonization and alignment, UN reform, financing mechanisms, results-based management system, medium-term strategic plan and General Programme of Work); and specific issues of country presence (e.g. composition of presence and how it is be defined in relation to the CCS and a needs-based approach, regional diversity, medium-term strategic objectives and programme budget).

The work of this subgroup is carried out through a very participative and inclusive process. Partners and other organizations have participated in focus groups organized at headquarters and the regional offices. A final paper will be presented to the 119th Session of the Executive Board in January 2007.

Regional achievements of the Country Support Unit

From Nairobi to Maputo: strengthening of WHO country office capacity for better support to Member States

Following the lessons learnt from the "Nairobi Process",[6] in 2005 the new Regional Director for Africa decided to initiate a programme to re-profile all 46 WHO country teams in the WHO African Region, starting with three workshops in Accra, Nairobi, Brazzaville and Nairobi to provide the necessary skills and understanding to WHO Representatives and their Administrative Officers. The participants were taken through the process of re-profiling their country teams, enabling their teams to work across programmes and focus on the priorities agreed in the CCS. The WRs were then able to brief their country teams, and prepare plans for the re-profiling process. The CSU/AFRO and the Department of Country Focus in headquarters provided full support to this exercise, in close collaboration with the Departments of Human Resources Services (HRS) from both AFRO and headquarters.

In May 2005, the Regional Director for Africa and the lead of three WHO clusters (Evidence and Information for Policy, Family and Community Health and General Management) agreed on a country/regional/headquarters joint planning exercise for 2006–2007 in 13 African countries (**Angola, Central African Republic, Congo, Democratic Republic of Congo, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Niger, Nigeria, Uganda and the United Republic of Tanzania**). This took place in Maputo, Mozambique on 31 August and 1 September 2005, with the aim of enhancing the feedback provided by the regional office. The overall objective of the meeting was to develop a coherent institutional strategy for the three levels of the Organization in its support to countries, with the aim of promoting universal coverage and access through the strengthening of WHO capacity in countries, supporting the development of national health systems and the scaling up of essential interventions. The specific objectives were to: reach a common understanding of universal coverage and access and the role of WHO in its achievement and to agree on priorities identified by the 13 selected countries for the 2006–2007 biennium for which AFRO and headquarters will provide support.

This process now called the "Maputo Process" is being taken forward by the setting up of joint AFRO–headquarters working groups responsible for topics such as managerial issues, WHO country presence, and technical assistance and universal coverage. The experience of the working groups had been extremely positive with clear interest being shown by members from country offices, the regional office and headquarters. The «Maputo Process» has clearly proven to be an innovative way of doing business – maintaining dialogue across and within the levels of the Organization – for improving health in the African Region.

6. For more details please see WHO support to countries for scaling up essential interventions towards universal coverage in Africa: The Maputo Report. Geneva, World Health Organization, 2006.

Update on re-profiling experiences of country offices in the African Region: towards a new way of working at country level

Since the series of three re-profiling workshops held in July–August 2005, more than 25 country offices have comprehensively briefed their staff members during retreats and a series of meetings on re-profiling. Most of these countries have now come up with new proposals for modified structures to facilitate the delivery of the technical cooperation programme in a more coherent and integrated manner. Working across levels and areas of work is also much more pronounced now than ever before. CCS documents are widely accessible on the WHO web site and Intranet. These are clearly major steps forward for the region in line with the spirit of the Nairobi Process and the follow up Maputo Initiative.

Ghana

The WHO Country Office is organized in five clusters whose staff meet regularly to discuss the various areas of work. This process, which emphasizes sharing of information, joint planning and team building, ultimately ensures coordinated support and avoids duplication of effort. In addition, various categories of staff have benefited from training programmes aimed at enhancing their capacity to improve the quality of work. The programmes include project planning and management training, French language courses, records management and archival administration, and transport management and defensive driving.

Kenya

The WHO Country Office is organized around three clusters based on related areas of work and the Millennium Development Goals (MDGs). Planning around the implementation of joint activities is ongoing together with a joint monitoring process whereby the clusters have developed a framework of technical reports which are shared during bi-weekly technical meetings. The WHO Country Office has also improved on the sharing of available resources in that when one area faces a shortage of funds for a particular activity, resources can be sourced from other areas of work after agreeing with the WR and the focal person.

Seychelles

There is currently a very good joint planning mechanism in place between the WHO Liaison Office, the Ministry of Health (MoH) and Social Services and other partners. Regular meetings are held at the highest level of the MoH to identify constraints and ways in which the problems identified may be overcome. As a result there is little or no duplication of activities A recent example of cooperation between WHO and the United Nations Population Fund (UNFPA) is in the evaluation of educational material on HIV/AIDS and in the preparation of the Indian Ocean Colloquium on HIV/AIDS which was held in November 2005.

Swaziland

During a staff retreat in September 2005, the WHO country office team noted that the Country Cooperation Strategy priorities had a marked emphasis on "a disease approach" to health issues. It was suggested that there was a need to create an enabling environment within which members of the population are able to take charge of their own health; health systems strengthening – addressing structural, managerial and human resources for health constraints; and putting more effort into health promotion. In addressing better and more strategic ways of working, the team examined ways of focusing the 2006–2007 workplans, by narrowing down the number of areas of work in order to become more strategic.

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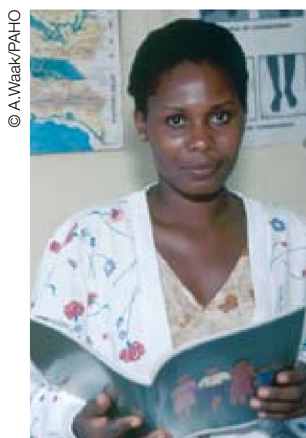

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Country Support Unit Network resource mobilization efforts in the Pan American Health Organization/World Health Organization (PAHO/WHO) Five Priority Countries

General

The resource mobilization efforts included the following:

- development and submission to the WHO Department of Country Focus (CCO), by the CSU, of a proposal for resource mobilization for the five Priority Countries (Bolivia, Guyana, Haiti, Honduras and Nicaragua). The proposal was funded, and supported the development of the CCS, placement of the Program Officers, and enhanced connectivity in Guyana and Haiti;
- the placement of technical advisers for the 3 x 5 initiative on HIV/AIDS in Guyana and Haiti;
- assistance with the development of proposals to the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) in Guyana and Haiti; and
- development and submission of proposals to the European Commission (EC)/WHO Partnership, for health in development, making pregnancy safer, epidemic alert and response, and supporting country cooperation in Guyana and Haiti.

Bolivia

- The PAHO/WHO Proposed Biennial Programme Budget (BPB) regular funds for the period 2004–2005 amounted to US$ 3 000 000. Extrabudgetary funds for the same period reached US$ 2 500 000. Extrabudgetary funds correspond to approximately 80% of the regular funds.
- Extrabudgetary funds are granted from the Inter-American Development Bank (Epidemiological Surveillance strengthening and prevention and control of Chagas Disease).
- Resources for prevention and control of HIV/AIDS and TB were provided by the United Kingdom Department for International Development (DFID).
- Active participation with UNAIDS (thematic group for HIV/AIDS of UN System in Bolivia) including the 3 x 5 strategy.
- Funds have been provided from the Swedish International Development Cooperation (SIDA) to promote extension of social protection in health.
- At the request of the Ministry of Health and Sports, and with funds from the Nordic countries, PAHO/WHO is providing technical cooperation for the acquisition of medical equipment for immunization campaigns and vehicles (ambulances).
- With French funds, PAHO/WHO supports the Ministry of Health and Sports in the organization and running of entomology laboratories.
- Using funds from Brazil and through PAHO/WHO Offices in both Bolivia and Brazil, technical cooperation is being provided for the HIV/AIDS programme in Bolivia, mainly in antiretroviral therapy and medicines donation.

Guyana

- WHO: for improvement in technical capacity in epidemiology; programme management; maternal and child health; HIV/AIDS, focusing on 3 x 5; and for malaria control, through placement of a Roll Back Malaria adviser;
- Support for the development and implementation of the proposal to the GFATM ;
- Technical Cooperation among Countries (TCC): for Integrated Management of Childhood Illness (IMCI) and HIV/AIDS, among other areas.
- The Humanitarian Aid Department of the European Commission (ECHO), the US Government and DFID for disaster response.

The Country Focus Policy and the General Programme of Work

The WHO Regional Office for the Western Pacific (WPRO) organized the Bi-regional Consultation on the 11th General Programme of Work (GPW) in September 2005 in Bangkok to obtain feedback from South-East Asia and Western Pacific-based partners on the content of the draft GPW and the process of preparing the document. The Ministry of Health and Social Affairs of the Government of Sweden funded the meeting; this was a very good example of successful inter-regional collaborative work. It was organized as a part of an ongoing broad consultative process with countries and partners.

Forty-two people attended the meeting, including 14 representatives of partners from WPRO and 17 representatives of partners from the WHO Regional Office for South-East Asia (SEARO). Participants were selected with the aim of obtaining a balance between geographical distribution and discipline.

There was general agreement on the importance for WHO to develop a General Programme of Work, but participants highlighted the need for a more «country-focused» approach especially in addressing the needs of marginalized population groups. It was considered that the analysis presented in the current document was quite sound but that the discussion on future "action" required should be strengthened. The outcomes of the consultation were incorporated into the draft of the 11th General Programme of Work presented to the Executive Board in January 2006.

Country days in SEARO to develop WHO country workplans

A series of country days were organized and were attended by representatives from the respective countries' ministries of health (MoH) and from all levels of WHO.

The country days are intended to foster:

- joint planning among different levels of WHO and the relevant MoH to ensure that the needs of the country are the basis for country workplans;
- a better understanding by regional offices and headquarters of these needs and a commitment to supporting them.

Feedback from all levels strongly recommended holding "country days" not only for programme planning but also for monitoring purposes.

SEARO: Increased delegation of authority to country offices

SEARO has now delegated additional authority to country offices. WHO Country Representatives now have the authority to approve larger contracts, issue international travel authorizations and hire short-term professionals. This has allowed WHO Country Offices to act more quickly to respond to the needs of countries and reduce bureaucratic procedures. In assessing the impact of these changes, it was noted that this increased delegation of authority should be accompanied by efforts to support and strengthen country offices. For example, countries need better rosters of short-term consultants and training in administrative procedures to ensure compliance with Organization procedures. The increased delegation of authority has also helped to shift the roles of Regional Advisers towards more technical tasks (support and monitoring) and reduced their involvement in administrative approvals. More work is still needed to increase the capacity of country offices and the support functions of the regional office, as well as to strengthen the accountability and the ability of country offices to better assess their performance.

EURO country strategy on strengthening health systems

The development of the "next phase of EURO's Country Strategy: strengthening health systems" is a remarkable step forward in being able to provide support to the Member States in a comprehensive way, linking technical assistance, country work and health systems work. The strategy was presented at the 55th session of the Regional Committee and the Health Systems Initiative has been launched. Additionally, a Ministerial Conference on improving health systems stewardship is planned for 2008.

EURO help desk staff

EURO Strengthening of country presence to improve operations at country level

Operations at country level have been more effectively managed and administered as a result of strengthened WHO country presence. Significant efforts have been made at both the regional and country levels to streamline country operations. This has resulted in improved contractual arrangements in country offices. In addition, specific attention has been given to training country teams in the management of country work and health systems.

EMRO Strengthening of WHO presence at country level

Considerable efforts made after the completion of the CCS documents and the outcome of the implementation of the CCS to strengthen WHO presence at country level in the Eastern Mediterranean Region have included the recruitment of National Professional Officers to strengthen support to health systems in the countries, recruitment of international Administration Officers to improve management of support services, construction, expansion and upgrade of premises and facilities, recruitment of IT staff and enhancement of GPN, VSAT[7] and telecommunication facilities in a good number of countries in the Region.

7. Short for *very small aperture terminal*, an earthbound station used in satellite communication of data, voice and video signals, excluding broadcast television.

Communicating WHO country focus policy

Country focus is an organizational policy that means better servicing countries according to their needs. Nevertheless this meaning does not always appear clearly within the Secretariat as well as partners. Interviews conducted with staff from the three levels of WHO, however, have revealed this lack of a clear understanding of what country focus entails. The issue of developing a communication strategy was discussed in-depth at both the CSU Network meetings in 2005. The strategy was designed in 2005 with expertise provided by the PAHO/WHO communication unit.

Whereas the strategy acknowledges the importance of communicating policy messages, it is equally, or possibly more, important to illustrate developments in the implementation of the country focus policy in order to develop a shared understanding and foster support and ownership. Examples of practical changes that have occurred since the policy came into place will be highlighted, by considering the following components:

- **WHO Country Cooperation Strategies** – assessing country needs and developing a strategic focus.
- **Joint planning and the development of One country plan and budget** reflecting the support and contributions of all levels of WHO to countries.
- **Normative documents and guidelines** responding to needs and requirements at country level.
- Adequate **WHO country presence** ensuring operational capacity in countries, which is backed up by all levels of WHO.
- Coordination and collaboration with **UN agencies and development partners** at country level.
- **Information and knowledge management** around countries.

Briefly, in 2005...

...a session on "Country Focus in Action: The Case of Guyana" was held during the 2005 World Health Assembly. The meeting, which was attended by the Minister of Health of Guyana and key WHO partners, provided an excellent opportunity to share PAHO/WHO's strategic agenda for Guyana, the achievements and the lessons learnt, and to invite partners to make a collective effort to improve the health status of the people of Guyana, aligning on national priorities.

...a short **Country Focus video**, was produced to illustrate the meaning of WHO Country Focus policy. It is shown at WHO meetings and induction seminars for new staff.

...a lunchtime seminar on Country Focus was held in Geneva on 6 October 2005, as part of the development process of WHO's 11th General Programme of Work. The seminar, which brought together WHO staff and external partners, also marked the launch of the Country Focus video.

Upcoming activities and products:

A Country Support Unit Network Portal is under construction and will be functional by mid-2006. It will be a collaborative virtual workspace designed and developed in close collaboration with the Programme Planning, Monitoring and Evaluation (PME) Unit in EMRO. The portal will contain useful information such as CCSs and background documents, a log of WR/LOs visiting headquarters, CSU Network meeting reports and selected background reading, WR/LOs meeting reports, WHO country presence data, links to existing country office web sites, WR/LOs database, reports and situational analysis, the WR induction package and useful PowerPoint presentations.

The Country Focus video is being amended to include interviews with high-level officials in countries and senior management in WHO.

Three particular types of product will developed in connection with the CCS:

- **A one-page Question and Answer section.**
- **CCS briefs** highlighting the main health and development challenges and the WHO strategic agenda for each country.
- **Best practices on design and use of the CCS.** Possible topics related to CCS use include: communicating (advocating) the WHO strategic agenda with a particular country; mobilizing resources and support for that strategic agenda inside and outside WHO; guiding planning of WHO's work; strengthening WHO country presence/guiding the re-profiling of country offices; articulating WHO's agenda with others at country level – emphasizing the CCS as a key instrument for harmonization and alignment (poverty reduction strategy papers (PRSPs), sector-wide approaches (SWAps), Common Country Assessment (CCA)/United Nations Development Assistance Framework (UNDAF)).

It is anticipated that some of these products will be presented at one of the parallel technical briefings organized during the 2006 World Health Assembly, at which some ministers of health, partners and WHO staff will be present.

1.4 Country Cooperation Strategies

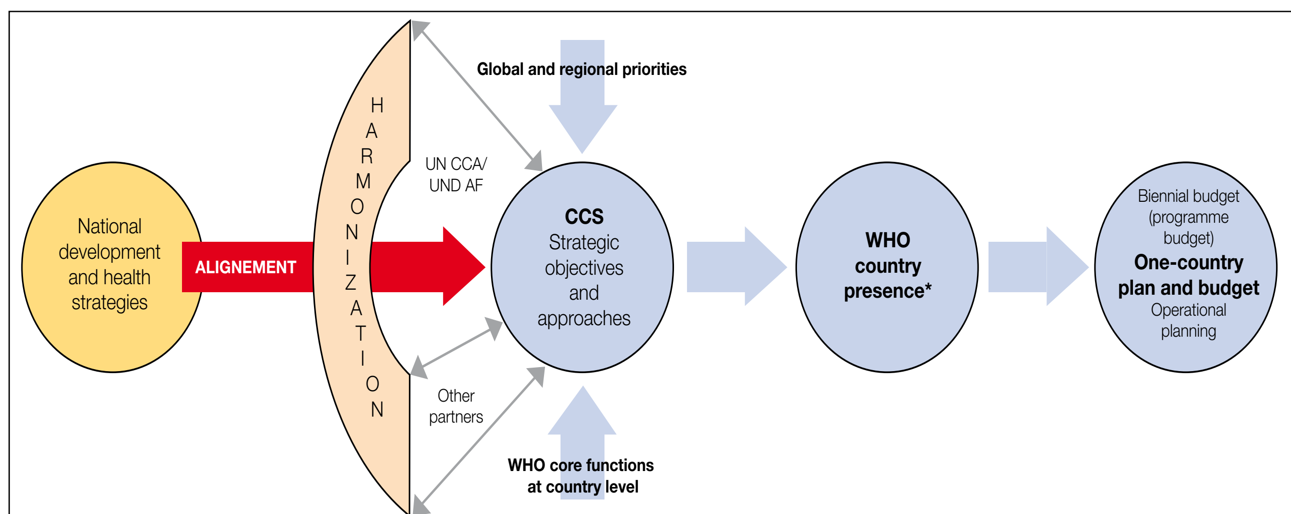
Since 2000, about 130 WHO Country Cooperation Strategies (CCSs) have been formulated with Member States.

In 2005, CCSs were under development in South Africa (WHO African Region), Colombia, El Salvador, Guatemala, Honduras, Suriname, Trinidad and Tobago, Uruguay (WHO Region of the Americas), Afghanistan, Bahrain, Iraq and the Occupied Palestinian Territory (WHO Eastern Mediterranean Region), and 15 countries under the WR's office for the South Pacific, the Philippines and Papua New Guinea. In addition, the CCS for Malaysia was reviewed (WHO Western Pacific Region). The CCS in Sri Lanka was reviewed and development started in India and Indonesia (WHO South-East Asia Region).

There are clear signals that the CCS is now widely recognized by Member States and WHO as the main tool for defining the WHO's mid-term strategic agenda at country level (see Figure 1). It is a vehicle for WHO alignment with national health and development plans and strategies – for example, poverty reduction strategies/ SWAps – and for harmonizing WHO's co-operation with the work of United Nations agencies and other health and development partners.

However, there is still room for improving the quality of both the process and the document and adapting the CCS to a changing context. While the WHO CCS "guide", published in early 2005, is used and appreciated, more guidance is needed to respond to new challenges. The guide will thus be complemented progressively with updates on particular WHO strategies, linking the WHO strategic agenda with its presence at country level and adding a communication component to the CCS. Country Cooperation Strategies are now entering in their "second generation".

Figure 1: Country Cooperation Strategy (CCS) as a key instrument for harmonization and alignment and input to the planning process[8]



8. The UN CCA (United Nations Common Country Assessment) is an analysis of the key causes of poverty within a UN programme country and is a key tool for developing unified processes among the entire UN country team. The assessment identifies priority areas where the UN can collectively make a difference, and responds to national priorities. The UNDAF (United Nations Development Assistance Framework) is the common strategic framework for UN operational activities within a country.

* WHO country presence is a platform for advancing the global agenda as well as contributing to the national strategies and priorities, and bringing country realities and perspectives in the global policies and priorities.

Country Cooperation Strategy-based pledging conference for WHO operations in the Occupied Palestinian Territory

On 22 October 2005, WHO West Bank and Gaza held a pledging conference for WHO operations in the Occupied Palestinian Territory (oPt) during which WHO's newly developed CCS for 2006–2008 for the oPt was presented and discussed. The event took place in Jerusalem and was attended by the Palestinian Minister of Health, the assistant Deputy Minister, and a representative of the Ministry of Planning. Key donors in the health sector also attended the meeting. They included representatives from the United States Agency for International Development (USAID), the Spanish International Cooperation Agency, the Italian Development Cooperation, the European Commission, the Irish Representative Office, the French Consulate, the Swedish Consulate and the World Bank. UN agencies United Nations Office for the Coordination of Humanitarian Affairs (OCHA, United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Children's Fund (UNICEF), United Nations Relief and Works Agency for Palestine (UNRWA) and the Food and Agriculture Organization of the United Nations (FAO)) and the International Committee of the Red Cross (ICRC) and some international nongovernmental organizations working in the health sector were also represented.

Country Cooperation Strategy process expanding in AMRO/PAHO

Countries being proposed as new candidates for the CCS process in the Americas Region include Canada and Cuba. The process is acknowledged as being a unique opportunity to identify PAHO/WHO comparative advantages at country level and linking it to the Organization's strategic framework, especially the «unfinished agenda». Many positive «side-effects» of the CCS process have been highlighted besides formulation of the WHO country strategic agenda itself. The CCS is being seen in the region as an excellent tool for resource mobilization. There is a need, however, to further explain the process, articulate the global and regional guidelines and make them widely available in both English and Spanish. The link with the planning process needs to be emphasized, as well as the clear relationship with the CCA/UNDAF and with national health and development processes. The CCS should inform the AMRO/PAHO Strategic Framework 2008–2013, and as such it has to be supported by all levels of the Secretariat in order to progressively achieve the one country plan and budget at country level.

EMRO Regional Analysis of Country Cooperation Strategy conducted

During 2004–2005, CCS documents for 17 out of the 21 countries of the Eastern Mediterranean Region were completed. Under the leadership of WRs, the process of preparation of these documents at country level has benefited from an extensive and active participation of Regional Advisers and Directors from the regional office as well team members from the Department of Country Focus in headquarters. These documents have been used as the basis for the preparation of Joint Programme Review and Plannning Missions (JPRMs) for 2006–2007. Evaluations of the process and outcome of the CCS documents were carried out with support of an external consultant and the outcomes will form the basis of a regional consultation in the new biennium to enhance the tools and methodology for preparation of the second generation of CCSs in the region.

Inter-regional collaboration on multi-country CCS development in WPRO

The CCS for the 15 island countries and areas under the WHO Representative for the South Pacific was developed in collaboration with PAHO/WHO, a multi-country process comparable with the sub-regional Cooperation Strategy process for Barbados and the countries of the organization of the Eastern Caribbean States in the WHO Region of the Americas.

The CCS articulates a coherent vision, mission and working principles for the whole of WHO: WHO headquarters, the regional office and the subregional office located in Suva, Fiji with four country liaison offices (CLOs) in Kiribati, Solomon Islands, Tonga and Vanuatu. The CCS is based on a careful assessment of the development challenges and health needs in the 15 countries and areas of the Pacific. It represents a balance between country priorities and WHO regional and organization-wide strategic orientations and priorities. It constitutes a framework for WHO cooperation in and with the countries concerned, highlighting what WHO will do, how it will do it, and with whom.

It was a great challenge to develop one strategy for a group of very diverse countries, which are at different stages of development and have different health systems as a result of past and current affiliations to the Commonwealth, France and the United States of America. One of the challenges was to collect reliable data on health and health determinants from countries with small populations and weak health information systems. Staff from AMRO participated in preparations for the CCS, and this interregional collaboration strengthened and enriched the CCS formulation process.

WHO's medium-term strategic agenda in Papua New Guinea

The WHO strategic agenda in Papua New Guinea, as formulated through the CCS process, is structured along three main dimensions:

- Intensified collaboration to minimize the main causes of morbidity and mortality. WHO will in particular, intensify its support to reducing mortality and morbidity from malaria, tuberculosis and HIV/AIDS and to effectively addressing maternal and child health issues.
- District-focused health systems development. This is a major priority of the government and also a focus of support from other agencies and partners. WHO's work will focus on systematic analysis of innovative ways of building district capacity and effective service delivery.
- Supporting national stewardship and partnership building. WHO will support efforts to monitor overall performance of the health system and progress towards Papua New Guinea's stated health goals, with special attention to poverty reduction.

Country Cooperation Strategies: implementation, lessons learnt and the way forward in the African Region

Report of the Regional Director to the Fifty-fifth Session of the Regional Committee for Africa

A report on the follow-up actions on the orientation given at the 51st session of the Regional Committee to develop CCSs in all the 46 Member countries was presented in Maputo, Mozambique in August 2005 during the 55th session of the Regional Committee. The report highlighted the extraordinary Member States' interest in the CCS process, how it is evolving, the lessons learnt and the way forward for maximizing the gains of the CCS process.

Challenges

The challenges include having the capacity to transform the strategies into consistent actions to improve performance and health outcomes at country level; continued preparedness to recognize the CCS as the basis for planning, defining expected results and resource allocation, in view of the many other competing interests; effective coordination of the many activities, actors and agendas in the health sector, taking special account of SWAps, PRSPs and national health plans; pragmatic integration of vertical programmes within the national health system to achieve coherent health service delivery and better results; WHO technical leadership at country level in the face of dwindling regular budget resources for funding core country focus activities; region-wide CCS implementation, particularly aligning the organizational structures of the country and regional offices to reflect the identified programmatic shifts; full integration of CCS into the WHO managerial process and effective decentralization of resources to the country offices; and streamlining WHO managerial processes with the demands of the UN reforms, especially with regard to joint collaborative activities between the UN agencies and the country team.

Opportunities

The existing opportunities that could be explored to maximize the contribution of the CCS to improving WHO services to countries in the African Region include active advocacy by Member States for strengthening national health systems, re-evaluation of the contribution of vertical health programmes to sustainable health development, adoption of a systems approach to health programme delivery and changing modalities for programme funding at country level, with more donors tending towards SWAps and direct budget support.

The CCSs were the starting point of the previously described “Nairobi and Maputo processes”.

Key lessons learnt

- Extensive consultations with various groups and exchange of information at country level were crucial for the successful implementation of the CCS. In particular, effective participation of representatives from ministries of health ensured both coherence and alignment between national and WHO priorities and orientations.
- Involvement of all members of the WHO country office in the entire CCS process enhanced the quality of the process as well as increasing ownership. The constant consultation and collaboration between the three levels of the Organization reinforced the culture of "One WHO" and added value to the formulation process.
- Inadequately coordinated planning across the three levels of the organization and across programmes has led to duplication of effort and inconsistencies at country level. Technical clusters and divisions in headquarters and the regional office need to work together to provide joint cross-departmental support to clusters at country level to make them functional.
- Promotion of a more integrated health care delivery system and effective coordination of health actors are crucial to achieving better health impact.

- As WHO continues to negotiate with partners to act as their executing agency at country level, corresponding support systems must be put in place to strengthen the capacity of country offices to monitor performance, ensure accountability and show greater competence than other agencies in health matters.
- In spite of the existing clear management commitment to putting countries at the heart of WHO's work, consistent advocacy is still required at programme level to fully integrate the CCS into the WHO managerial process.

1.5 Monitoring of progress and performance

The Department of Country Focus (CCO) followed up and monitored the progress made thus far on the recommendations arising from the Third Global Meeting of WHO Representatives and Liaison Officers in held November 2003. A brief November 2005 report showed that to date, 17% of the recommendations had been fully achieved and considerable progress was being made in an additional 75%.

Main recommendations	Progress update
There is a strong consensus on the importance of all countries having a CCS linked to a single workplan and budget.	Most regions have started using the CCS as a basis for planning country work and resource allocation; however, the translation of the CCS into the "one WHO country plan and budget" supported by all three levels of the Organization, has yet to be realized, because of certain issues related to a lack of corporate alignment and support, and to the overall planning structure. However, an important example of a way forward is provided by the Maputo process of scaling up essential interventions towards universal coverage and access in Africa. In a landmark meeting that took place in Maputo, Mozambique from 31 August to 1 September 2005, it was agreed that joint planning between the three levels of WHO would take place for 13 African countries in a pioneering attempt at an integrated and coherent approach to joint planning within the context of scaling up essential interventions towards achieving universal coverage and access to health care in these countries. This is clearly seen as a major step towards a new way of doing business in the Organization.
Further delegation of authority to WRs and LOs is critical.	The Office of the Comptroller (CBF) in headquarters is reviewing programmatic and financial delegation of authority in collaboration with the regions. The work is not yet concluded but reasonable progress is being made. In March 2004, the Regional Director for South-East Asia delegated additional authority to WRs including the authorization to recruit long- and short-term staff in country offices. The delegation of authority for issuing agreements for performance of work (APWs) had been increased to include APWs for up to US $50 000. This has also increased the responsibility of country offices for ensuring that standard procedures are being adhered to in the development and implementation of these contracts.
The efficiency and effectiveness of WHO at country level can be greatly enhanced by the WHO country office functioning as a budget management centre.	A mechanism is being developed by the WHO Briefings and Clearance Office (BCO) for the Global Management System. Implementation is scheduled to take place progressively from 2007. The WHO resource mobilization framework is in preparation and is expected to be finalized and submitted to the Director-General by the end of 2005. A cross-WHO working group has been formed to take this work forward. The framework will be widely circulated to allow the identification of ways in which resource mobilization efforts could be strengthened at regional and country level.

Main recommendations	Progress update
Improving the understanding of the roles and responsibilities of different components of WHO and improved communication are critical to WHO working as one organization.	Recent years have seen an accelerated push towards modernizing and enhancing the IT environment and improving connectivity across the whole organization. The Country Connectivity Strategy has been jointly developed by staff from the Department of Information Technology and Telecommunications (ITT) at both headquarters and regional office to set the framework for the extension of the WHO Global Private Network (GPN) to WHO country offices.[9] As at the end of November 2005, all six regional offices and 85 country offices have been connected to the GPN, with a further 56 country offices in the implementation phase. Excellent progress has been made in particular in the WHO African Region where VSAT installations had been completed in all WHO African Region offices by October 2005.
Significant investment is needed to strengthen the human resource capacity and competency of country offices.	All WRs have participated in the WHO Global Leadership (GLP) programme (now entering its second phase in 2006) that focuses on building management and leadership competencies from the WHO Competency Model to drive change in the organization. The GLP is one of the key initiatives launched by the Director-General which aims at increasing efficiency and accountability among managers and leaders in WHO which will, in turn, improve technical performance. In addition, every regional office has now been allocated funds for staff development. A proportion of these funds have also been allocated for staff development in country offices. The Global Learning Committee (GLC) recently reviewed reports from regions on utilization of the staff development funds during 2004–2005. As well as the GLP, staff development for country office staff includes the global effective writing course, 40% of participants in which are from countries; events organized by regional offices for administrative staff in country offices; and workshops on technical skills. After reviewing these events, the GLC noted that more needed to be done to ensure that training for staff in country offices is organized and planned in a more strategic and systematic way. Methods of learning, other than face-to-face meetings, need to be explored to determine their applicability. There might also be opportunities for developing programmes across regions in certain priority areas.
Improved participation in the United Nations Country Team (UNCT) and partnerships.	A set of tools and guidelines aimed at improving WHO support to national development strategies and other coordination processes had been developed in collaboration with other relevant technical units. These include: • Guidance paper on Global Fund to Fight AIDS, Tuberculosis and Malaria-related activities in WHO; • WHO harmonization and alignment: key resources; • Guide to WHO's role in sector-wide approaches to health development; and • WHO harmonization and alignment: a framework for country action. The latest version of the document WHO and the United Nations Development Group (UNDG) was forwarded by the Department of Governance (EGB) to all regions in October 2005. Much work is also being done to build capacity and strengthen the ability of WHO country offices to deal with issues related to harmonization of WHO actions with country partners and alignment with regard to national policies and strategies.

9. Full details regarding the implementation of the Country Connectivity Strategy will be made available in the "Country Connectivity GPN Rollout Plan" document which is currently under development. This plan will be based on regional office plans (outlining where, when, how and by whom, the country offices will be connected to the GPN) for connecting country offices.

Interregional working group on assessment of WHO performance at country level

Monitoring and evaluation has significantly improved in WHO. WHO activities are regularly monitored under the results based management framework. For the first time, WHO produced an assessment of biennium 2002–2003 and presented it to the Governing Bodies. In addition, the Secretariat performs ad-hoc audits and evaluations.

However, outside initiatives (Oslo study, Multilateral Organisations Performance Assessment Network (MOPAN), DFID Multilateral Effectiveness Framework (MEFF)) and recent discussions by the Governing Bodies have shown that there is still a gap in the existing systems for assessing WHO performance at country level. At the 116th meeting of the Executive Board, Member States highlighted the following priority action for WHO Country Focus and Country Offices (EB 116/6, Item 5.2. May 2005):

"A system will be devised to monitor performance of WHO at country level, including its influence, together with key partners, on the public health agenda, and its contribution to health outcomes in Member States."

The issue was discussed in the network of WHO Country Support Units (CSU) at its third meeting (Santo Domingo, 31 May–2 June 2005) and subsequently with relevant units in WHO headquarters (e.g. the Department of Planning, Resource Coordination and Performance Monitoring, Office of Internal Oversight Services and the Department of Business Change). There is a need to complement the set of existing tools to better assess the work of the WHO Secretariat as a whole: the work of the country office and the support provided by the regional office and headquarters to achieve country objectives. WHO needs to focus more on its contribution to country health and development outcomes and build on positive experiences in the regions and countries. This entails **better use of existing tools, harmonizing with partners and aligning with national frameworks and timetables.**

An interregional/headquarters working group has been set up to design an approach for responding to these requirements. An initial meeting took place in December 2005. The group will be time-limited and agreed on the task (what has to be done), the approach (how it should be done) and finally on responsibilities (which of the existing WHO units should be in charge). Once this is done, the group will report to the Executive Board in January 2007 and then dissolve.

1.6 Network collaboration with other units and departments

Work on alignment, harmonization and coordination with partners. The CSU Network worked closely with the **Departments of Governance (GOV)** and MDGs, **Health and Development Policy (HDP)**[10] in the field of alignment, harmonization and coordination with partners.

With GOV and HDP the Department participates in various forums on UN reform, harmonization and alignment as country programme support and quality assurance groups. The added value of the Network lies in a two-way process:

- capturing the feedback from WRs and country teams on the rapidly evolving UN reform including the reform of the UN Resident Coordinator System; and
- helping the relevant departments to address gaps related to WHO policy positions, communications, guidance and capacity building of country teams.

A number of guidance and position papers (see CD-ROM attached) were produced in close collaboration with HDP and GOV to facilitate the work of the country teams.

Department of Planning, Resource Coordination and Performance Monitoring (PRP)

Together with PRP, a consistent joint planning process has been in development with a particular focus on "one WHO country plan and budget", starting from the CCS. This collaboration will need to be enhanced to enable it to address the complex issue of monitoring the performance of WHO country teams, incorporating the **Department of Internal Audit** and the **Department of Business Change**. In August 2005, a rapid analysis of 116 CCSs was conducted, the results of which informed the Eleventh General Programme of Work (2006–2015) and the objectives of the WHO medium-term strategic plan for 2008–2013.

Department of Human Resources Services (HRS)[11]

The Department of Country Focus works closely with HRS in various areas ranging from support to the WR selection process, management of data on WHO country presence and the setting up of a global system, support to regions in the re-profiling and capacity building of country teams and participation in the UN Resident Coordinators selection process.

Health Action in Crisis (HAC)

The articulation with HAC is being strengthened: all aspects of WHO country focus policy are relevant to the different crises which HAC has the primary responsibility for dealing with. Further joint action has been agreed particularly in relation to preparedness for emergencies, and support for countries in transition from recovery to longer term development. In 2005, the entire Department of Country Focus was mobilized in support to HAC to respond to the South Asian tsunami crisis. One staff member was seconded to HAC to contribute to the management of the emergency operations in the country office in Niger in response to the mounting food crisis.

10. With effect from 1 January 2006, HDP has merged with the Department for Health Systems Policy and Operations to form the Department for Health Policy, Development and Services (HDS).

11. With effect from 23 March 2006, the Department of Human Resources Services (HRS) has been renamed the Department of Human Resources Management (HRD).

1.7 Financial resources report

At the end of the biennium 2004–2005, the area of work «WHO Presence in Countries (SCC)» did not reach its income target of US$ 37.5 million in "Other Sources" as indicated in the programme budget for 2004–2005.

The total available extrabudgetary contributions for the SCC Area of Work amounted to approximately US$ 20 million out of which 17% were spent at headquarters and approximately 83% were transferred from the Department of Country Focus to cover activities in the six regions and countries (see Figure 2). EURO succeeded in raising a further US$ 0.5 million in extrabudgetary funding in addition to the amount received from headquarters.

Figure 3 shows the main partners supporting "WHO's Presence in Countries" in 2004–2005.

Figure 2: *Transfer to WHO Regions from the Department of Country Focus in 2004–2005*

AFRO*, WHO Regional Office for Africa;*

AMRO*, WHO Regional Office for the Americas;*

EMRO*, WHO Regional Office for the Eastern Mediterranean;*

EURO*, WHO Regional Office for Europe;*

SEARO*, WHO Regional Office for South-East Asia;*

WPRO*, WHO Regional Office for the Western Pacific.*

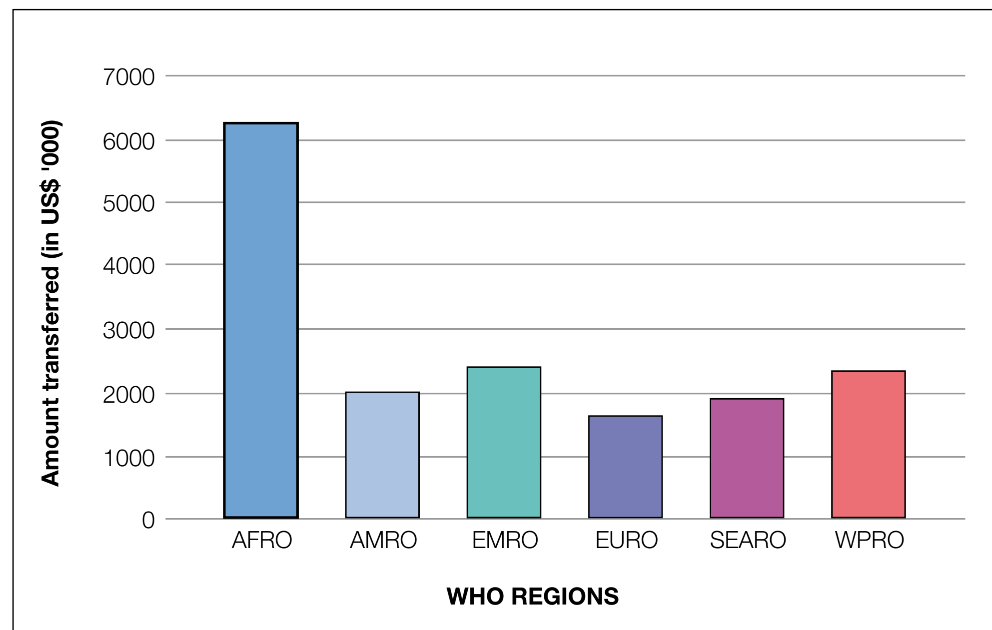
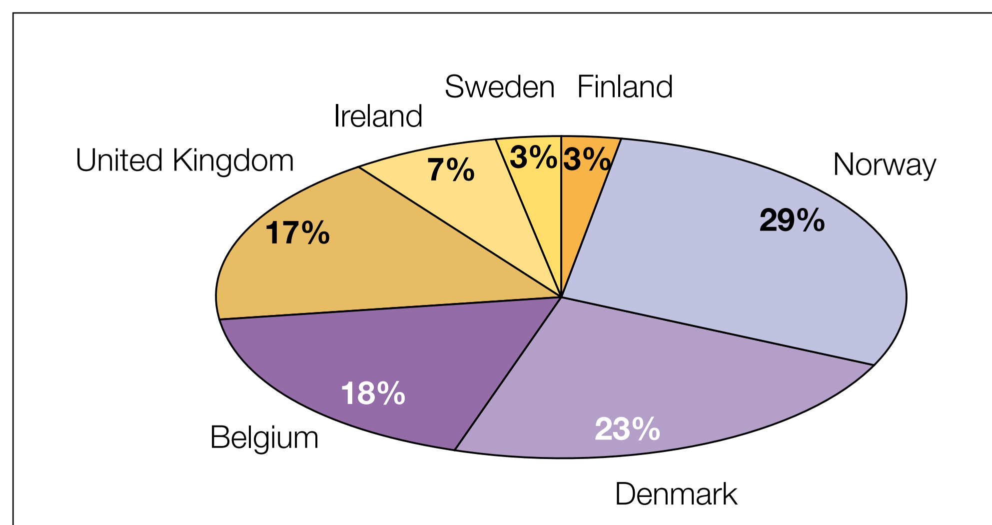


Figure 3: *Contributions from partners in 2004–2005 for the SCC Area of Work*



Use of the funds

- One of the big successes in the WHO African Region during 2004–2005 was the GPN connectivity project. The Department of Country Focus contributed substantially to its successful implementation by financing the local cost in 27 countries, which amounted to US$ 1.6 million. Another important activity was the financing of activities in line with the CCS priorities based on workplans received from 11 countries to the tune of approximately US$ 1.2 million.
- In the WHO Region of the Americas, US$ 700 000 was used for implementing key activities as identified in the CCSs of the five priority countries: Bolivia, Guyana, Haiti, Honduras and Nicaragua, and also in the Office of Caribbean Program Coordination (CPC). In addition, approximately US$ 500 000 was spent on capacity building and strengthening the Country Support Unit.
- In the WHO Eastern Mediterranean Region US$ 1.6 million was used on strengthening the Country Support Unit and on providing support to the CCS process in 17 countries.
- In the WHO European Region US$ 1.4 million went towards strengthening the Country Support Unit and to strengthening the capacity in 28 country offices.
- In the WHO South-East Asia Region the main focus of activity was the strengthening of the Country Support Unit which was supported with an amount of US$ 1.3 million.
- The WHO Western Pacific Region concentrated most of their funds on financing the strengthening of the country presence in China, the Lao People's Democratic Republic, the South Pacific Islands, the Philippines, Samoa, Malaysia and Viet Nam. All in all, US$ 1.2 million was used for this purpose.

Country Support Unit Network helps Democratic People's Republic of Korea country office to secure funds for project proposals

The Department of Country Focus assisted the WHO country office of the Democratic People's Republic of Korea in securing funds from the Norwegian Government in support of two project proposals by the country office: one on a preparedness and response plan for avian influenza and the other a proposal for strengthening the technical capacity in reproductive, child and community health for the WHO Country Office in that country. It is anticipated that the Network will provide greater assistance to WHO country offices in similar resource mobilization efforts in the future.

The future

Even with a transfer of approximately US$ 16 million from the Department of Country Focus to the six regions during the 2004–2005 biennium, the funding gap, as mentioned in the 2004 CSU Network report, also led to a shortfall in funds to cover priorities for strengthening WHO presence at country level in 2005 to implement WHO strategic agenda in each country as identified by the respective CCSs. Many good proposals were turned down during the year due to a lack of funds. There is plentiful evidence that the CSU Network is a powerful tool for strengthening the backstopping of WHO country offices to better service Member States. Although the global allocation of voluntary contributions in the Programme Budget 2006–2007 has increased to approximately US$ 60 million for the SCC Area of Work, the prognosis for the 2006–2007 biennium seems uncertain. To sustain the effort to attain greater efficiency in delivering WHO cooperation will greatly depend on the capacity of the different levels of the Secretariat to mobilize and channel a significant amount of voluntary contributions to this area of work.

1.8 Challenges and future direction

It is now accepted by many that the Millennium Development Goals and the objectives of national Poverty Reduction Strategies will be realized only if there are major increases in the availability of resources aimed at improving health. All WHO partners are increasing their attention and funding to country-level action and are looking for more visible and measurable results at this level. This new situation is heightening the need for more delegation of authority and systems for ensuring accountability of international organizations at the country level. Within WHO, this situation underlines the importance of having effective and efficient country offices, while recognizing that the needs for normative and direct support vary a great deal over time and place.

Indisputable progress is being made, but the WHO Country Focus policy needs to be strongly supported at the highest level and to be better understood and implemented. A number of issues still need to be addressed:

- WHO normative function and the Secretariat's work at country level through its adequate country presence have to be seen as complementary.
- As a consequence of historical trends in each region, the ability of country offices to respond to the needs of Member States is uneven. Information on WHO country presence and country work is often outdated and scattered throughout the Secretariat. A huge effort is required to match WHO country presence to the needs of the Member States according to each specific and mutually agreed strategic agenda. Furthermore, advocacy at the highest level of WHO management will be instrumental in progressively strengthening WHO core functions at country level.
- *The CCS process* allows this strategic agenda to be built. It is increasingly being recognized as the main tool for defining the WHO strategic agenda at country level, aligning the Secretariat to national processes and harmonizing its work with the other agencies within the UN Resident Coordinator System. In building on WHO's comparative advantages in each country there is still a need to scale up the process to cover all Member States, to improve the quality assurance process from the design stage, to the articulation with the corporate planning process, to the monitoring of its implementation.
- *The objective of "one WHO country plan and budget"* has been accepted as a concept, but implementation will require further integration effort from the Secretariat, vertically across the three levels as well as horizontally within each level.
- *Monitoring of performance at country level* is not yet sufficient to fully assess WHO's contribution to health outcomes in Member States. However, progress is being made with the setting up of the interregional working group on assessing performance of WHO at country level.

The Department of Country Focus undergoes the strategic direction and competency review (SDCR)

The Department of Country Focus in headquarters completed Phase I of the Strategic Direction and Competency Review exercise to further clarify and reinforce its role and mandate. Through this exercise, two strategic directions and four core functions have been identified for the department:

Strategic directions

- Priority is to be given to articulating WHO's country focus policy, advocacy, guidance, facilitation and monitoring of its implementation.
- There is to be permanent dialogue and networking with regional offices, country offices and headquarters units and a shift in the role of the Department of Country Focus from that of direct implementation to broker and facilitator.

Core functions

The Department of Country Focus will have the following core functions.

- **Policy adviser**

  Articulates the WHO country focus policy and influences other WHO policy processes to assist the Secretariat in responding better to the needs of Member States.

- **Guidance and facilitation**

  Facilitates the formulation and scaling up of the CCS process as a tool for harmonization and alignment, supports the regional Country Support Units and WHO country offices in the managerial and technical backstopping of country teams, and facilitates the process for the selection of WRs and of efforts to strengthen country team competencies and skills.

- **Monitoring and reporting**

  Monitoring the implementation of the WHO country focus policy and its results.

- **Intelligence and information sharing**

  Systematically gathering, organizing and sharing relevant information, knowledge and good practices between countries.

Future directions as outlined in the strategic direction and competency review (SDCR)

- WHO CCSs respond to high-level quality standards and provide the strategic agenda for all WHO effort in a particular country. The CCS strategic objectives feed the "one WHO country plan and budget". Collectively the CCSs influence strategic priorities for the organization as a whole.
- Administrative and management systems enable WHO to effectively fulfil its role within partnership for health development, through its core functions as they apply at country level.
- WHO country presence is well-defined and country teams are well-equipped for implementing the WHO strategic agenda. They are led by a WR, LO or Head of Office (HO) selected through an objective appraisal process, who has undergone a thorough induction, and has adequate managerial authority. Mobility and rotation within WHO ensure that the experience at country level contributes to regional and global knowledge. WHO country presence across WHO regions is clearly defined and based on transparent corporate criteria and mechanisms.
- Adequate backstopping of country offices for policy and normative guidance, and relevant technical support is provided by regions and headquarters, coordinated through the WR, LO or HO and his or her staff. The WRs, LOs and HOs have the ability to mobilize internal and external expertise at short notice, and receive integrated and well-coordinated immediate and longer term support in case of acute emergencies. They and their teams contribute to the development of WHO norms and guidance.
- Information and knowledge on countries and WHO country presence is easily accessible and well-managed, kept up-to-date by country offices themselves, and forms part of a global information network. Country offices have easy and rapid access to information relevant to their work from WHO and other sources.
- Performance measurement for WHO country teams is a participative process, based on complementary existing tools, which incorporates qualitative assessment from the main national and other partners.

Part Two

Partnerships and coordination at country level

2.1 Setting the scene

Faced with major constraints on resources and ever more daunting global challenges, partnerships between all stakeholders are no longer merely an option, but an absolute necessity in today's complex world. The view that the responsibility for health lies solely within the domain of ministries of health is now obsolete. Times have changed and there are now many more players involved in the international health and development agenda. Partnerships hold great promise and potential and can offer huge advantages to all parties involved. It allows for scaling up, intensifying and sustaining support beyond what would have been possible working alone, as well as fostering commitment and encouraging ownership and responsibility. Pitfalls and challenges are common and to be expected, but the outcome of partnership working is much more than the sum of all the parts – it is a synergy of the inputs from all stakeholders that adds value.

Much is currently taking place at the country level. Internationally agreed development goals, notably the MDGs, are providing an overarching framework for national policy setting. There is a big push towards countries having a strong national ownership of development processes and outcomes (for example, the Poverty Reduction Strategy and SWAp processes). The current existence and proliferation of global initiatives and alliances for health (for example, the Global Alliance for Vaccines and Immunization (GAVI), Roll-Back Malaria (RBM) and the Joint United Programme on HIV/AIDS (UNAIDS)) points towards an effort to provide a more coordinated and consolidated response to the pressing global health needs. Recent developments within the UN[12] driven by the UN reform process are urging the international development community to improve coordination, harmonize and reduce duplication of efforts to build up the capacities of countries to take charge of their own development process. Recent changes within the context of the UNDG and the Resident Coordinator System and the dynamic process of joint programming as promoted by the UN Development Assistance Framework/Common Country Assessment (UNDAF/CCA) are all laying the groundwork for a new aid environment characterized by the concepts of national leadership and ownership, alignment, harmonization, results and mutual accountability.

In addition to working closely with governments, WHO engages in partnerships with diverse institutions, notably with UN agencies, intergovernmental agencies, nongovernmental agencies, bilaterals and the private sector. WHO's governing bodies, its UN partners and many of WHO's partners have all placed great emphasis on the need for WHO to work more closely on UN reform processes and harmonization and alignment of operational development activities at the country level.[13] WHO is preparing a series of guidance notes and position papers to build up the capacity of its country teams to seize the opportunities for health and development that are emerging at the country level more effectively (see CD-ROM attached). In addition, a training module is being developed targeting WHO and its partners at country level to enhance and build capacity for dealing with this issue as it relates to the health dimension.

In view of the growing importance of the phenomenon of partnerships, the 2005 WHO Forum was aptly named Making partnerships work for health. Although the power of partnerships is broadly recognized, the Forum attempted to visibly demonstrate what partnerships for health really mean and how they contribute to improving the health of people, in particular vulnerable and marginalized groups. The Forum posed some important questions such as: How are partnerships in health formed? What works best? Who does what once they are formed? What can be learnt from these examples and

12. International Conference of Financing for Development, Monterrey (2002); Rome Declaration on Harmonization (2003); Paris High-Level-Forum on Harmonization, Alignment and Results (2005).

13. WHA 58.25 United Nations reform process and WHO's role in harmonization of operational development activities at country level

how can these modalities be replicated? Can partnerships be taken even further, and if so how?

Given the expanding partnership universe, it is not surprising that practice outstrips analysis. A recent report commissioned by the United Nations Global Compact Office[14] stressed the need for a fact-based, comparative assessment of what partnerships can accomplish and factors determining their success. Such an assessment would be critical in fine-tuning partnership work by helping to answer questions about appropriateness (Where do partnerships work?), selectivity (When and under what circumstances should one get involved in partnerships and what can one contribute to them?); and accountability (How can partnerships be held to account?). It is crucial that work be done to close this gap to facilitate learning from successes as well as failures. Experiences with partnerships need to be pragmatic, progressive and dynamic, building as far as possible, on sustaining and ensuring the best use of each partner's assets and comparative advantage.

The brief selection of illustrative case-studies presented here is intended to highlight some of the practical contributions partnerships make to the work of WHO at the country level and to provide examples of good practices of a coordinated response to promote, solve, or inspire action on a given health issue at the country level. The cases presented here are by no means exhaustive and there are clearly many more examples of how effective partnerships can produce successful results in the field. The snapshots of cases provided here demonstrate the broad variety of partnerships that do exist and highlight the value added by the fact that new and innovative approaches to tackling various health problems can be successfully identified and implemented as a result of strategic collaboration and coordination among different players. In many cases, the role of national authorities in coordinating partnerships is specifically highlighted as an example of good practice. WHO and its partners should continuously strive to work to develop national leadership so that countries themselves lead the various processes of national health development. It is worthwhile to clarify that the purpose of this brief section is to focus on concrete happenings at country level within the wider context of global health partnerships and to highlight some of the efforts made and the way forward.

The Country Support Unit Network is committed to documenting more of these case-studies and success stories to promote learning and sharing of best practices and experience. Through this exchange of knowledge on what types of partnerships for health work and why, it is hoped that this in turn could spark a firm commitment from WHO and its partners to forge new and innovative modalities of working together to better support the health needs of countries.

14. Witte JW, Reinicke W. Business UNusual: facilitating United Nations reform through partnerships. New York, United Nations Global Compact Office, 2005.

2.2 Country case-study examples

ALBANIA

United Nations strategic support in the fight against HIV/AIDS in Albania

During the period 2001–2004 the role of the United Nations Theme Group (UNTG) on HIV/AIDS, chaired by WHO, in providing support to the National Program of HIV/AIDS Prevention and Control was evident and strong. The members of the UNTG include **WHO, UNDP, UNICEF, UNFPA, UNHCR, International Organization for Migration (IOM), the World Food Programme (WFP)** and **the World Bank**.

The three most important achievements of the UNTG on HIV/AIDS in supporting the national efforts for the prevention and control of HIV/AIDS in Albania are:

- assisting the national counterparts in drafting the first National Strategy for the Prevention and Control of HIV/AIDS;
- facilitating the provision of antiretroviral drugs to the People Living with HIV/AIDS (PLWHA) in Albania (again for the first time); and
- contributing to the coordinated activity of the governmental, nongovernmental and international partners (through the organization of the Third National Conference for HIV/AIDS Prevention and Control).

The work of the UNTG on HIV/AIDS during this period included meetings, round-tables and forums with Albanian governmental, nongovernmental and international organizations, as part of its role in ensuring that the international effort and response to the epidemic in Albania is well coordinated. The partnerships developed were instrumental and need to be fostered, and that the multisectoral cooperation of the past four years continues into the future.

The establishment of the UNTG on HIV/AIDS has increased the role and improved the coordination of the UN agencies present in the country. The coordination of activity among the national and international organizations and the continuous work over the past years are two obviously determining factors in maintaining a low prevalence of HIV in Albania.

World AIDS Day celebrations in Tirana

BANGLADESH
WHO in development assistance coordination

Bangladesh is currently implementing the Health, Nutrition and Population Sector Programme (HNPSP 2003-2010) using a sector-wide approach (SWAp), in which the international community agreed to pool resources and coordinate technical contributions within one overall sectoral programme and implementation plan. Several development partners and all UN agencies in Bangladesh, including WHO, have made firm commitments to be an active participant in the SWAp arrangement - through financial contributions to the pool fund or by way of pledging technical support to the programme.

A unique coordination mechanism, known as "the Local Consultative Group (LCG)", was formed to harmonize action and align resources. WHO is an active member of the LCG. The LCG was intricately involved during conceptualisation of the Bangladesh Poverty Reduction Strategy Paper (the PRSP). WHO is now a member of a new LCG endeavour called the "aid governance initiative", which will support the Government in four areas: (1) audit, (2) procurement, (3) training and capacity development, and (4) harmonization of project documents. The WHO Representative to Bangladesh held the position of Chair of the Health, Nutrition and Population (HNP) Consortium for two years, during 2000-2002.

WHO,as a member of the UNCT, is a vibrant player of the development dialogue in Bangladesh. It also collaborates closely and jointly runs projects with other UN agencies as well as participates in various Theme Groups, expanded theme groups, and taskforces. WHO collaborated and contributed to the 2006-2010 UNDAF exercise.

Through its support to national authorities during the development, planning and implementation of the HNPSP, its participation in the UNDAF exercise and its role in the LCG and HNP consortium, the WHO country Office is ensuring a well-attuned and a fully coordinated development assistance mechanism, in line with national priorities.

BURUNDI

Partnership in action: handling health challenges in a transition context and preparing for reconstruction

Burundi is emerging from a long crisis after a successful end-of-transition period in the third quarter of the past year which launched a fragile but promising post-crisis era. Although the country will continue to face huge humanitarian problems for some time, reconstruction and development efforts are being boosted by the important achievements made so far in the peace process.

Signing of Memorandum of Understanding by UNHCR, UNICEF and WHO during a special ceremony led by the Government of Burundi (Minister for Repatriation and Reinsertion and Minister of Health) and the Special Representative of the UN-Secretary-General in July 2004

During the second part of the transition and within the perspective of the expected mass return of refugees from the United Republic of Tanzania, WHO promoted, contributed to the development of, facilitated and supported **the repatriation and health partnership project** to improve the capacity of the health system to respond to additional needs and challenges and to contribute some solutions to an already complex and challenging peace process.

The process was participatory and inclusive, involving the support by UN agencies (UNICEF, United Nations High Commissioner for Refugees (UNHCR), UNFPA and WHO), nongovernmental organizations and donors of the Ministry of Health and the government of Burundi, Starting from a situation analysis the process developed through joint programming with a plan of action and a joint UN proposal supported by national authorities and donors (DFID, ECHO, USAID and the Belgium Development Cooperation). Funds were raised quickly, and the process progressed rapidly to the implementation stage after being formalized with a Memorandum of Understanding signed by the UN agencies during a special ceremony led by the government of Burundi (Minister for Repatriation and Reinsertion and Minister of Health) and the Special Representative of the UN Secretary-General in July 2004.

The project is intended to: (i) strengthen the health system through ensuring the availability and use of an essential care package (ECP) in 210 health facilities of the 10 most affected provinces; (ii) with free access to returnees and the most vulnerable among the total population; (iii) improve the referral system with particular attention to emergency obstetric care in the 10 most affected provinces; (iv) develop and run an epidemiological alert system and surveillance countrywide; and (v) support the preparatory process for development and reconstruction with particular attention to capacity building. Extension to the six remaining provinces of the country will take place in a second stage.

WHO's specific contribution was to provide technical support for strategic planning, capacity development, supervision, monitoring and evaluation and to facilitate the coordination among partners. UNICEF was in charge of providing medicines, equipment and nutritional support; the UNHCR was in charge of all support provided during the transit of the returnees, including the management of the transit posts and the rehabilitation of selected priority health facilities; the contribution of UNFPA was to align its sup-

port with the strategy supported by the partnership; the nongovernmental organizations that were involved accepted the need to support the strategy and the dynamics of the partnership project.

The implementation and follow-up have been supported by a steering committee and a technical committee both led by the Ministry of Health and involving all partners. Joint field missions, joint evaluations and a joint technical report supported the implementation process.

A cross-border initiative has been coordinated with partners working in the camps in the United Republic of Tanzania. Three cross-border health meetings were organized by WHO in Burundi and UNHCR in the United Republic of Tanzania. The goal of the initiative was to coordinate efforts and to facilitate sharing of information and resources between the two countries with regards to health and repatriation. Monthly health reports from Burundi and the United Republic of Tanzania have been shared as well as information on recent epidemics and health services.

Progress and achievements:

- drugs, consumables and equipment that contribute to the ECP were made available in the 210 health centres of the 10 targeted provinces;
- the capacity of around 400 health workers was strengthened in care management, monitoring, drug storage management and audit. This led to an appropriate use of the tableau de bord in 85% of health facilities and a functional management of drug stock in 88% of them;
- a referral system has been organized with community participation in five provinces with particular attention being paid to maternal and newborn mortality; in five other hospitals surgery and obstetric care have been strengthened;
- the epidemiological surveillance and alert system has been implemented and is contributing to early warning and responses;
- more and improved supervision is available thanks to WHO technical and field-posted staff and to the logistical support provided to the provincial health teams;
- the partnership fully supported the process of elaboration of the already validated new health national policy, the national health development plan and the roadmap to reduce maternal and neonatal mortality.

One lesson learnt concerns the evolution and **progressive maturation** of the partnership-building process. With the repatriation and health partnership project, an important step forward has been taken to improve on the previous experience that was much closer to an ad hoc coordination/facilitation to support convergent actions (i.e. epidemic, urgent humanitarian need, new malaria treatment protocol using artemisinin combination therapy) to a more formalized process dealing with a variety of complex and sometimes structural issues. This may have been even more challenging without the previous experience. This partnership has also contributed to the creation of the foundation of a much broader partnership supporting the Ministry of Health and Burundi in implementing the New Health Policy and the National Development Plan in the context of the ongoing PRSP preparatory process and later in the context of a SWAp for the health sector.

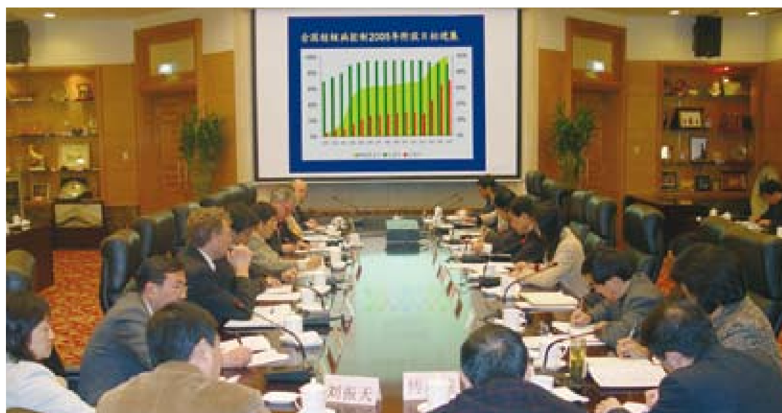
Another lesson learnt is that the appropriate and timely support provided by the WHO regional office and headquarters was critical in sustaining and reinforcing the role, contribution and credibility of WHO in the country.

Last but not least, a lesson was learnt relating to fundraising which is made easier at country level when involving or supported by key health partners through a participatory and transparent mechanisms.

CHINA

Partnership building to support national efforts to achieve global targets for the control of tuberculosis (TB) by 2005 and to reduce the burden of TB

In 2000, the Chinese government developed the 10-year National TB Control Programme (2001–2010). The Programme seeks to expand the WHO-recommended directly observed treatment, short course (DOTS) strategy nationwide, to increase case-detection, and to increase the cure rate of patients treated for TB. Under the coordination of the Ministry of Health, national and international partners are working together to support the implementation of a single national TB control plan.



2005 joint TB monitoring mission during the debriefing by international and national experts to the Ministry of Health. International partners present included WHO, World Bank, GFATM, United Nations Office for Project Services (UNOPS) and the Damien Foundation Belgium. The meeting was chaired by Vice-Minister Wang Longde.

Partners have worked together to mobilize the resources necessary to implement this national plan. Funds from different sources are being used in a complementary manner to support different aspects of the national programme. A combination of governmental funds, loan funds from the World Bank, grant funds from the Department of International Development (DFID) of the United Kingdom and from the Global Fund to Fight AIDS, TB and Malaria (GFATM) are being used to provide equipment and meet the operational costs of the national TB control programme. A grant from the Government of Japan will provide free TB drugs through 2005; the distribution of these drugs is being coordinated with that of free TB drugs supplied by the Chinese Government.

Partners are also working together to support the implementation of the National TB Control Programme. An Inter-agency Coordination Committee, chaired by the Ministry of Health, meets every 6–12 months to review programme progress, all partners join in an annual joint TB-monitoring mission, and a TB working group meets every 4–6 weeks to discuss issues and problems related to the implementation of the programme. This working group also operates as part of the Country Coordination Mechanism (CCM) to oversee the implementation of the GFATM TB projects.

WHO provides support to the Ministry of Health for the development of national policies in TB control and provides technical assistance to the China Communicable Diseases Centre (CDC) and partners in the planning and implementation of various TB control projects. WHO supported the World Bank, DFID and the Government of Japan/Japanese International Cooperation Agency in the development of their TB control projects in China. WHO was the main technical partner supporting the Ministry of Health in their successful funding applications to three different GFATM TB projects. In addition, WHO plays a key role in the monitoring and evaluation of the national programme and various other TB control projects as well as chairing the national TB working group.

As a result of this partnership, China is well on its way to reaching the global targets for TB control in 2005. By mid-2005, coverage of the DOTS strategy had expanded to 100% of the country's population. The detection of infectious TB cases in China increased from 30% of estimated cases in 2002 to 64% in 2004. Although much more work is needed before the TB burden can be substantially reduced, the current partnership gives hope to thousands of TB patients across the country by giving them access to free, life-saving TB services.

ERITREA

WHO in partnership with the United Nations Children's Fund (UNICEF), the Italian Government and the United States Agency for International Development (USAID)

Eritrea is a country recovering from war in a situation compounded by low per capita income and droughts. The country is faced with huge health-related problems ranging from communicable and noncommunicable diseases to maternal and child health problems – and is not helped by a weakened national health structure and poor basic infrastructure and access to health services.

WHO, through the Ministry of Health, is playing a key role in coordinating joint efforts between four main partners and organizations (UNICEF, the Italian Government, USAID and WHO) in responding to the pressing health needs of the population. The comparative advantages of the four partners are fully exploited in this partnership. The WHO Country Office in Eritrea invested in technical expertise through staff and consultants as well as positioning itself in strategic committees formed by the Ministry of Health. Through these strategies, resources provided by the other three main partners as well as other fund providers have been invested strategically.

The combination of the above factors has led to the implementation of sound disease control, health promotion and health system strengthening strategies which have produced promising results such as:

- reduction in malaria morbidity and mortality by more than 80% in five years;
- control and elimination of vaccine-preventable diseases such as neonatal tetanus and measles; and
- increasing physical access to basic health services to at least 70% of the population.

In view of the apparent successes of these strategies, the WHO Country Office will continue to expand its partnership, strengthen its technical support base and mobilize more resources.

Partnership in action in Eritrea

GHANA

Towards achieving the Millennium Development Goals: a health investment plan for Ghana

In light of the recommendations of the report of the Commission on Macroeconomics and Health released by WHO in 2001, the Government of Ghana not only accepted the recommendations but went a step further in recognizing this as an opportunity to set the agenda for health as a resource for economic development in Ghana. In order to apply the recommendations to the local setting, the Ghana Macroeconomics and Health Initiative (GMHI) was established in November 2002.

The GMHI is a participatory national health and development mechanism which serves to analyse the barriers to utilization of health services and health-related services and identify ways to increase the efficiency of health spending and improve the response to the health needs of the poor. By boosting inter-sectoral collaboration and promoting locally-developed evidence, the GMHI aims to:

- Mobilize political support for enhanced investment in health and health-related sectors.
- Improve priority-setting in the health sector.
- Guide decisions on resource allocation to health at the central and peripheral levels.
- Increase aid effectiveness.

The GMHI brings together key players in the health sector and in sectors that influence health to deliberate and take a common stand on pressing health and development issues. Members include representatives from the Ministries of Health, Economic Planning and Regional Cooperation, Finance, Local Government and Rural Development and related agencies such as the Ghana Health Services, Community Water and Sanitation Agency and Institute of Social, Statistics and Economic Research (ISSER) of the University of Ghana. All major health partners in Ghana participate in the GMHI, including **WHO, which not only facilitated the process but also provided technical and financial support**, UNDP, UNICEF, the Danish International Development Agency (DANIDA), the United Kingdom Department for International Development (DFID) and the World Bank.

In 2005, the GMHI produced a report entitled Scaling-up health investments for better health, economic growth and accelerated poverty reduction which presents an investment plan/costings for achieving the health MDGs through the GMHI. The investment plan substantiates the proposed health package by detailing resource requirements, financing gaps and resource allocation in line with policy priorities. The GMHI Report is aligned with completed and ongoing planning activities such as the Ghana Poverty Reduction Strategy, the Medium-Term Expenditure Framework and the Ministry of Health Programme of Work (2007–2011). Districts have also been requested to refer to this report when drawing up their health plans and budgets. More importantly, the report will serve as an advocacy tool for soliciting commitments and attracting increased resources to the health, water and sanitation sectors and aligning development partners with regard to national health priorities.

This report is seen by partners as a best practice for other sectors and WHO's role in facilitating a broad partnership between government (health, water and sanitation sectors), the private sector, the UN agencies and bilateral partners under the government's leadership to develop a health investment plan for achieving the health-related MDGs is a good example of how effective partnerships are moving and shaping the health agenda at country level.

HAITI

Partnerships forge new hope

Haiti is one of the five Key Countries – the others are Bolivia, Guyana, Honduras and Nicaragua – that have been singled out for special attention in the PAHO Strategic Plan 2003–2007 in an effort to improve their health institutions, infrastructure and overall health status.

• In 2004, in an attempt to restore constitutional order and stabilize the situation in Haiti, 26 bilateral, multilateral and United Nations agencies including WHO, in coordination with the interim government put in place for 17 months, elaborated an Interim Cooperation Framework (ICF) to be translated into projects intended to provide tangible results in the period 2004–2006. Presidential elections were held on 7 February 2006 representing an important step towards the re-establishment of democracy. Among the priority objectives of the public health component of the first phase of the ICF (2004–2005) were resumption of the operation of principal hospitals and priority programmes in the country, extension of a minimum package of health services to 2.5 million Haitians, strengthening the management and coordination capacity of the Ministry of Public Health and Population, and improving access to health care for the general population and vulnerable groups. PAHO/WHO has played an important and definitive role in this exercise through hosting and conducting the meetings of the working group and mobilizing the technical expertise needed with regards to the health sector. In addition, it also acts as a focal point for donors and agencies in three of the 18 "Sectoral Tables", which are the implementation mechanisms of the ICF. Donors have agreed to extend the ICF until December 2007, to allow them to continue to support the newly elected government during the delicate post-election stabilization phase, and to pave the way to the elaboration of the Poverty Reduction Strategy Paper, which would facilitate Haiti's access to much needed funds and debt relief.

• PAHO/WHO established an Emergency Operations Centre in Gonaives and developed a network of partners to assist the most affected areas (e.g. with provision of medical supplies, cold chain assessment and needs assessment evaluations) to coordinate managerial response to the sociopolitical crisis and the tropical storm Jeanne.

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• PAHO/WHO successfully mobilized over US$ 10 million in extrabudgetary funds for Haiti. Most of these resources were granted by traditional partners to support a wide variety of projects and initiatives including: support from the Inter-American Development Bank (IADB) for a project on basic services for HIV/AIDS; support from the Canadian International Development Agency (CIDA) for the acquisition of essential drugs and medical supplies; from the World Bank for vaccinations, maternal and childhood essential medicines, nutrition and the healthy schools programme; from ECHO for the rehabilitation of the water supply network; and from USAID, the Office for US Foreign Disaster Assistance (OFDA) and the Swedish International Development Cooperation Agency (SIDA) for several projects on interventions during post-disaster situations.

KYRGYZSTAN

Partnership for the strengthening of evidence-based health policy-making in the Kyrgyzstan: From the Health Policy Analysis Project to the Center for Health System Development

In 2000, WHO in partnership with DFID embarked on a highly innovative project for Kyrgyzstan. The project aimed to create demand for evidence in health policy decision-making by demonstrating the usefulness of empirical research in policy formulation and implementation.

The Project and its activities

The Project team consisted of a young cadre of enthusiastic Kyrgyz nationals trained in policy analysis during the course of the Project. The Project was managed by a resident WHO–DFID policy adviser to the Ministry of Health who also fulfilled a mentoring role for the Project team. The Project was successfully embedded into the Ministry of Health and functioned as an integral part of the Ministry while retaining independence and objectivity in the analysis and support provided.

The main activities of the Project included research on topics jointly chosen by the Ministry of Health and the research team, development of indicators for monitoring performance of the health system, and frequent seminars and round-table discussions.

Six years later, the project can boast of success in developing sustainable local capacity in policy analysis and in creating demand for analytical and evaluative work to support evidence-based policy-making. The project had strong local ownership and became a fully integrated arm of the Ministry of Health providing health sector leadership with objective analysis of key issues, a critique of policy options and generating evidence-based research. WHO's leadership in the process added objectivity, transparency, de-politicization and independence of the analysis and recommendations. The presence of such an objective analytical and synthesis function created an enabling environment for evidence-based policy-making.

Institutionalization and sustainability

The usefulness of the evidence-based approach for policy-making has gained such prominence in the Kyrgyz health system that the approach of the end of the project prompted the Ministry of Health to tackle the difficult question of institutionalization head-on rather than losing the activities and capacity built during the project. As a result, on November 2005, the **Center for Health System Development** was established with health policy analysis as one of its core departments (the other four being: evidence-based medicine, a health policy and management training programme, library services and information technology.

The role of partnerships and what it has achieved

The Project and now the Center aim to build a network with other projects and organizations. For instance, researchers from the Project have quickly established themselves as experts on particular policy questions (e.g. human resources, health economics and finance) and they have became sought-after trainers in the health policy and management courses supported by the World Bank and USAID funded ZdravPlus.[15]

The research and evaluation experience of the team became an important asset when the Ministry of Health began to monitor the success of the implementation of the primary care practice guidelines developed with professional associations.

15 Through the ZdravPlus Project, The United States Agency for International Development (USAID) provides resources to help the governments of Central Asia to improve the financial sustainability, efficiency, and quality of their health care while preserving equitable access. Implemented by the US-based consulting firm Abt Associates and partners, the ZdravPlus Quality Public Health and Primary Health Care in Central Asia Project operates in Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan.

Similarly, collaboration with the Swiss Development Cooperation (SDC)-funded Kyrgyz–Swiss Health Reform Support Project empowering local communities to engage in health promotion activities led to several joint analytical projects, for example on iodine deficiency; on people's perception of the new co-payment for health care policy; on the development of an index of socioeconomic status for use in health surveys; and on assessing the effectiveness of a rural revolving drug fund project.

The Center has entered into a partnership with the World Bank Institute to adapt and deliver flagship courses for the countries of Central Asia and the Caucasus in collaboration with the WHO Regional Office for Europe. Two regional flagship courses have already been delivered. The Center will be delivering another flagship course on health systems in 2006, with a focus on primary health care and including an adapted version of the World Bank's MDG course.

Each of the activities that are now conducted by the Center was previously a donor-supported project with a clear end-date. Collaboration between the projects as described above facilitated development of good working relationships at the technical level and promoted automatic coordination among donors.

Lessons learnt

The demonstrated effectiveness of these collaborative arrangements led to the realization that institutionalizing these activities together under the Center for Health System Development would provide an invaluable platform for sustainability, capacity building and sound institutional development. In conclusion, the development and establishment of the Center on the basis of several projects is a good example of how bottom-up working level partnerships can lead to a sustainable model of capacity and institution building and demonstrates the success of strategic partnerships when applied to the general problem of local capacity building.

More information on this partnership is available at:

http://eng.hpap.med.kg/

NAMIBIA

The Partnership Forum on HIV/AIDS and the Small Grants Fund

In 2001, the UN Theme Group on HIV/AIDS facilitated the establishment of the Partnership Forum on HIV/AIDS with the overall purpose of supporting national priorities for responding to the rising HIV/AIDS epidemic in Namibia. The Partnership Forum on HIV/AIDS is a broad-based forum that brings together a range of actors involved in the HIV/AIDS response in Namibia through coordination of development actors, information sharing and policy dialogue. It includes the following development partners: senior representatives of HIV/AIDS government coordination bodies and other senior government officials, heads of UN Agencies, senior technical representatives of diplomatic missions and umbrella organizations i.e. Lironga Eparu, the national Association of People Living with HIV/AIDS (PLWHA), the Namibia Business Coalition on AIDS (NABCOA), and the Namibia Network of AIDS Service Organizations (NANASO). WHO chairs this forum.

Ongendo Development Trust Project: Community Education on HIV/AIDS, sexually transmitted diseases and tuberculosis

Resources are being mobilized through the Partnership Forum to support the Government's response to HIV/AIDS, mainly at the community level. It is evident that the participation of communities and civil society groups, particularly PLWHA, is crucial in obtaining a comprehensive response to these challenges. The Partnership Forum also assists in identifying gaps in the response and in suggesting ways to bridge them. For example, in August 2002, members established the Small Grants Fund, an initiative to complement the national response by supporting community interventions through local nongovernmental organizations and community-based organizations. These organizations are called to apply for funds through development of proposals for quality projects. By December 2005, a total of 145 organizations from all 13 regions of Namibia had been supported by this initiative. These small grants are channelled to organize preventive and care activities on HIV/AIDS, to catalyse income-generating initiatives such as vegetable gardens, to provide psychosocial support to orphans who have lost their parents to AIDS, and to tackle issues related to adolescent and reproductive health.

It is clear from this example that in order to have a successful partnership and collaboration, the full commitment and involvement of all partners are absolutely essential. The participatory approach of including and empowering local communities to take ownership and accountability of the process is crucial for ensuring the success and sustainability of such a partnership.

VIET NAM

Partnership with the Communist Party in Viet Nam for HIV/AIDS Prevention

The majority of reported HIV infections in Viet Nam are associated with vulnerable groups such as sex-workers and injecting drug users requiring effective harm reduction interventions are urgently needed to provide at-risk groups with access to preventive measures In the field of public heath, the overarching goal of harm reduction is to minimize harmful behaviours. In Viet Nam where the HIV epidemic is fuelled by the sharing of injecting equipment among drug users, unprotected sexual relations and by sex-workers not using condoms with their clients, a series of preventive measures must be promoted. These measures consist of provision of information to people who are at risk, supply of clean needles, syringes and condoms, and STI services.

Harm reduction is a best practice fully endorsed by WHO and the UN system to be implemented for prevention among vulnerable groups.

Workshop (consensus and dissemination) organized by the Commission of Ideology and Culture of the Communist Party in Hanoi.

Since 2003, WHO and other stakeholders have actively supported harm reduction measures through the Commission of Ideology and Culture of the Communist Party. This Commission plays an important role in promoting principles for integration into the political system.

In 2005, WHO worked with the Commission to support the introduction of harm reduction into the new law on HIV/AIDS.

As a result, harm reduction activities have been included in the recent HIV/AIDS Strategy for Viet Nam, and harm reduction measures including drug substitution are being discussed by the National Assembly. This illustrates the role that WHO can play within the political system through successful and strategic partnerships to promote effective health interventions.

CSU Network recommendations on WHO strategy on alignment and harmonization at the country level[16]

a. **WHO will strengthen its engagement in the global effort to harmonize and align international assistance.**

b. **WHO will engage in UN reform**, as a member of the UNCT, with the aim of keeping public health high on the agenda.

c. **WHO's CCS is the key instrument** for aligning WHO work with national priorities.

d. **Headquarters and the regional office will provide back-up** to WHO country offices to help define and adjust WHO's role in a changing environment.

e. **WHO will communicate more effectively on reforms** in the UN and the international development architecture.

f. **WHO will prepare and update coherent global, regional and local policy positions** for engaging with the UN and other development partners at the country level.

g. **WHO country teams will communicate to all partners the role of WHO** at the country, regional and global levels so that all partners have a clear idea of how WHO operates and the value it brings.

h. **Where Basic Agreements with Member States are problematic WHO will review** the situation and ensure that the organization as a whole learns from the process.

i. **WHO is developing a cross-regional strategy to build its country capacity** for engagement in the alignment and harmonization agenda, including documenting and sharing good practice, and induction and training of country teams.

j. **Regional offices and headquarters will engage in global and regional dialogue** regarding new health partnerships, development architecture, development effectiveness and capacity building needs and ensure that the views of country teams are represented.

k. **Headquarters will provide short briefs** to regions and country offices to keep them updated.

l. **WHO will review its internal policies and procedures,** in particular its planning systems, during 2006–2007 with a view to considering better synchronization with national timetables from 2008.

m. **A WHO policy on UN common country processes will be developed in 2006**, and a cross-regional review of its planning systems will be made during 2006–2007.

n. **WHO will monitor progress in three ways:**

- by reporting to Governing Bodies on overall progress made in the areas highlighted in the WHA resolution 58.25;
- by monitoring the development and implementation of the capacity building strategy; and
- by developing a cross-regional mechanism for assessing WHO country effectiveness that involves the UNCT and development partners.

16. Following discussion held during the Fourth Country Support Unit Network Meeting, Montreux, Switzerland 20-21 October 2005.

Key documents included on the attached CD-ROM

- EB 116 Paper on WHO Country Offices and Country Presence (Arabic, Chinese, English, French, Russian, Spanish)
- CSU Network Report 2004 (English, French, Spanish)
- Copenhagen Report (English)
- Cairo Report (English)
- Santo Domingo Report (English)
- Montreux Report (English)
- Nairobi Report (English and French)
- Maputo Report (English)
- Guidance Paper on Global Fund to Fight AIDS, Tuberculosis and Malaria-Related Activities (English and French)
- Harmonization and Alignment Key Resources (English)
- SWAps guidance paper (English)
- WHO Country Presence 2004 (English)
- WHO Country Cooperation Strategies: a guiding framework (Arabic, English, Chinese, French and Spanish

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