

Strengthening WHO support to Countries for Better
Health Outcomes in the African Region

The Nairobi Report

April - September 2004



WORLD HEALTH ORGANIZATION
Regional Office for Africa
Department of Country Focus

ACRONYMS

| | |
|-------|---|
| ADG | Assistance Director General |
| AFRO | African Regional Office |
| AMS | Activity Management System |
| ART | Anti-retroviral therapy |
| ASU | Administrative Services Unit |
| CCS | WHO Country Cooperation Strategy |
| CWS | Community Water Supply and Sanitation |
| DGO | Director General Office |
| DSD | Division of Health Systems and Services Development |
| DRH | Division of Family and Reproductive Health |
| DES | Division of Healthy Environment and Sustainable Development |
| DDC | Division of Prevention and Control of Communicable Diseases |
| DPM | Director, Programme Management |
| DPC | Division of Disease Prevention and Control |
| DOTS | Directly Observed Therapy for Short-course chemotherapy |
| EIP | Evidence and Information for Policy |
| EHTP | Essential Health Technology Package |
| EPI | Expanded Programme Immunization |
| FCH | Family and Community Health |
| FTA | Fixed Term Appointment |
| GMG | General Management |
| GMS | Global Management System |
| GPN | Global Public Network |
| HQ | Headquarters |
| HRS | Human Resources Services |
| HDP | Health and Development Policy |
| HTM | HIV/AIDS, TB and Malaria |
| IMCI | Integrated Management of Childhood Illness |
| ICT | Information and Communication Technology |
| KMS | Knowledge Management and Sharing |
| KCO | Kenya Country Office |
| MAL | Malaria |
| MCH | Maternal and Child Health |
| MOSS | Minimum Operating Security Standards |
| MoH | Ministry of Health |
| NOC | National Officer C grade |
| NOD | National Officer D grade |
| NSHI | National Social Health Insurance |
| NHSSP | National Health Sector Strategy Plan |
| PAHO | Pan American Health Organization |
| PHE | Promotion Environmental Health |
| PRSP | Poverty Reduction Strategy Paper |
| PMDS | Performance Management and Development System |
| POA | Plan of Action |
| PRS | Procurement Services |
| PRP | Planning, Resource Coordination and Performance Monitoring |
| RO | Regional Office |
| SDE | Sustainable Development and Health Environments |
| SEARO | Regional Office for South-East Asia |
| SSA | Special Services Agreement |
| TCC | Technical Cooperation with countries |
| TA | Travel Authorization |
| WCO | WHO Country Office |
| WPRO | Regional Office for the Western Pacific |
| WR | WHO Representative |

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Section 1

Executive Summary

WHO's presence in the African region has been developing over many years, and it has recently been enhanced by the introduction of Country Cooperation Strategies (CCS) as part of the first WHO Corporate Strategy in 2000. This work, pioneered in this region, aims to improve the efficiency and effectiveness of WHO's work at country level. In 2003, the Director-General made a commitment to decentralize resources, so as to further enhance WHO's work in-country. This will in part be achieved through the development of One Country Cooperation Strategy, One Plan and One Budget. All countries except one in the African region will have prepared CCS documents by end of 2004. The already prepared CCS documents consistently show that strengthening the national health system as a major priority for WHO's cooperation.

In response to collective needs expressed in the CCS, the Division of Programme Management in AFRO, together with the Department of Country Focus in HQ have collaborated to strengthen WHO support to national health development and better health outcomes. The specific objectives were:

- To strengthen WHO technical support in the African Region so that all WHO efforts are integrated at the country level to enhance the development of national health systems to deliver health services more effectively.
- Agree, and sustain, new ways of working with administrative and technical programs in AFRO & HQ
- Gain endorsement of the approaches with concerned Member States

The work started in three countries, Kenya, Tanzania and Malawi, selected because of their proximity and common language. WHO Representatives led a process to develop new capacities and ways of working to improve the implementation of the Country Cooperation Strategy. Each of the three countries developed and presented a proposal for strengthening WHO support to countries for effective National Health Development and better health outcomes at a major workshop held in Nairobi in April 2004. The Nairobi workshop also mapped out a way forward with the aim of developing a framework and methodologies for the Region as a whole. Following this, various activities and joint

HQ/AFRO missions have taken place to strengthen WHO's work, using the following framework:

- *Country Cooperation Strategy*: re-stating the priorities for WHO, through close interaction with government, development partners and civil society
- *Integrating health systems development*: to identify how the country office could best be positioned amongst partners to strengthen national health development and support the delivery of health outcomes;
- *Re-profiling the country team*: to ensure that proper competencies are available to WHO and workflow in WCOs is organized in a more coherent and integrated way to carry out the business needs derived from the Country Cooperation Strategy;
- *Strengthening administration, financial, and knowledge management capacities*: to enable the country office to carry out its core functions.
- *Develop a One-Country Strategy, One Plan and One Budget*: to ensure WHO work for supports both national health development and WHO's normative work are adequately coordinated at the country level.

Lessons learnt from the three-country experience are outlined in this report, which also provides recommendations on how to proceed at country, regional and HQ levels. Some key issues covered include:

Working across programs: National authorities appreciate the technical soundness and professional neutrality of WHO's support but expect the support to be less fragmented and more consistent. WHO needs to change the way it does business in countries by planning its activities around national development processes and more 'upstream' engagement and integrated work across programmes. The 'health systems' groups in WHO should continue to support the WHO Representative in considering how best to do this. Management tools, technical support missions, performance assessments and allocation of funds across Areas of Work will need to be reviewed with this aim in mind. New capacities will be required at regional and sub-regional levels, so as to provide more effective and responsive technical support to member states.

Country Presence: Key constraints identified include, for example staff working in 'silos' on 'micro' activities and not adequately engaging in strategic developments of the health sector. There was variable quality of HR management, with limited use of performance assessments, many inappropriate short-term contractual arrangements (SSA) for long-term placements and occasional staff in positions with inadequate expertise. More attention is required on defining core functions of the country team, and the proper HR management to ensure adequate high calibre staffing. The region as a whole will need to develop a policy on what constitutes a core team, and business rules for expanding beyond this core without impinging on the role of governments. Each country now has a development and staff plan, which can be taken forward using the Staff Development Funds allocated to the Region. Many of the staff needs were common across the three countries suggesting that staff development strategies can be developed across offices. Delegations of authority for WHO Representatives have

been recently reviewed, but may still need some updating if found necessary to keep them in line with HQ guidance.

WHO Management Support: Country Office Expected Results based on the CCS and agreements with national partners will form the starting point for joint planning of WHO support to national health development in that country. New mechanisms, linked to the development of the One Country Plans, need to be agreed with the Region and HQ, building on lessons being learnt in other regional offices. WHO standards for administration, financial management, and country office web-site need to be agreed and appropriate in-country capacities rolled-out. The Global Management System will eventually enhance management support, but much can be done to improve the management environment using existing systems. Resource mobilisation for WHO activities should now become a country office function as well, and business rules will be required to guide this.

Next steps:

- **Implementing the recommendations in the three countries:** AFRO senior management will review and endorse or provide guidance to address the recommendations that are ready for implementation by the WRs.
- **Finalising a methodology and framework for the region:** Building on the draft framework and the lessons learnt, a strategy for the region can now be developed and monitored, with a view to changing approaches as more is learnt on what works best.
- **Agree the phasing of countries in the Region:** The initial exercise shows that considerable efforts are required to make the necessary changes. Whilst this should become easier as new ways of working come into play, a phased approach is more likely to be successful. Criteria for guiding the choice of countries are being developed within the Region.
- **Costing the strategy and resource mobilisation:** Adopting this emerging strategy will have implications on financial and human resources. While some aspects require no additional finance, others will require re-allocation, and a few an increase in resources. A thorough costing exercise is required, with a view to establishing a cross-WHO resource mobilisation strategy (both internal and external) for the Africa Region.
- **Joint planning and developing the One Country Plans for 2006/7:** The lessons from the African region together with those being learnt in other regions should be pooled to help develop an optimal way forward. Mechanisms will need to be developed, agreed and adopted soon, to fit with the 2006-7 planning cycle.

Section 2

Background to Why this Work Took Place

Our Vision

“WHO, through its Country Offices positioning itself to provide responsive, effective, efficient and integrated strategic technical support to Member States for Better Health Outcomes in the African Region”

Improving WHO performance at country level in the African Region

2.1 WHO presence in countries in the African Region has developed through many stages over the last ten years with varying impact on national health systems and policies. In 1995, AFRO developed a ‘Policy Framework for Technical Cooperation with Member Countries of the African Region’¹ to standardise WHO’s modus operandi within the Region. This emphasised the unity of the Organisation and focusing efforts to improve the efficiency and effectiveness of WHO action at country level.

2.2. In response to the policy framework and the overall call of complete overhauling of the UN System, WHO agreed to a study² in twelve developing countries in AFRO, PAHO, SEARO and WPRO in 1997 to reassess its roles and functions in promoting cooperation for health development and support to programmes at country level. The findings resulted in the development of the WHO Corporate Strategy of 2000, which upheld the principles enshrined in the 1995 Policy Framework.

2.3 The 2000 Corporate Strategy introduced the WHO Country Cooperation Strategy with the aim of identifying and articulating individual member state needs and priorities for WHO’s support. The 51st AFRO Regional Committee in 2001 encouraged AFRO to articulate the CCS in all the 46 member states, and the Country Focus Initiative gave further support to this roll-out³. All except one AFRO Member State will have their CCS completed by end of 2004. These Country Cooperation Strategies consistently show that strengthening the national health system is a major priority for WHO’s cooperation. In

addition, the challenge of WHO cooperation in large Member States led to the AFRO 2002 guidance on ‘Decentralizing WHO technical programmes of cooperation in large countries’.

Decentralisation in WHO: One Country Strategy, One Plan & One Budget

2.4 The Director-General J.W. Lee in July 2003 made a commitment to strengthen WHO’s country presence by further decentralizing WHO’s work and ensuring that WHO does ‘*the right thing in the right place at the right time*’. During the 3rd Global Meeting of WHO Representatives in November 2003, the Director General agreed that a key aspect of this will be the development of ‘One Country Plan and One Budget’⁴ largely based on the Country Cooperation Strategy (CCS) and will show all key activities in the country, including inter-country and normative work. Changes to the country plan and budget will be possible, but only after consultation with the WR for that country. This approach will help ensure that WHO’s efforts are better coordinated and focused on improving impact on national health development⁵.

Health Systems strengthening for integrated service delivery

2.5 Over the last two decades, many countries in Africa have seen stagnation, or even a reversal of previous gains in population health⁶. This is largely due to socio-

economic decline, political and civil strife, the HIV/AIDS epidemic and the deterioration of the health infrastructure. In recent years, the severe shortage of qualified health personnel has greatly compromised service delivery. In some situations these problems are compounded by lack of coordination of vertical programs, and poor integration into the local health planning systems. With the international community's commitment to the Millennium Development Goals (MDGs), there have been significant increases in actors and in pledges of funds – especially for HIV/AIDS, TB and Malaria. Now, more than ever, national governments need to effectively exercise their role as 'stewards' of the health system, to balance competing influences, to set priorities, to detect unwanted trends, to articulate the 'case for health' in the development debate, and to build coalitions and ensure accountability of the many actors involved in national health development.

2.6 The lack of alignment between the health systems agendas in WHO and the various health systems strategies of its 'vertical programs' has become a cause of concern. At a time when WHO is scaling up various interventions, including the global effort to reach the 3by5 target for ART and reduction of maternal, newborn & child deaths, it is critical to ensure the effectiveness, efficiency and coherence of WHO's support to countries. WHO needs a more informed and coherent approach to health systems development at country level. This should recognize the need for clear priorities, work to reduce distortions or duplication of systems, and maximize system-wide benefits of focused investments

Objectives for initiating the three-country exercise & the Nairobi meeting

2.7 The commonest challenge expressed by the forty-five Member States with a Country Cooperation Strategies was the need for WHO to support the countries in strengthening their weak and fragmented national health systems. In response, the Division of Programme Management in the WHO African Region with support from the Department of Country Focus in Geneva, initiated the process to develop new ways of working with the country offices, AFRO and HQ in order to strengthen WHO support to national health development for better health outcomes at country level. WHO acknowledges that it has to address some weaknesses in order to be more effective in responding to national demands. The first step was to develop methodologies in a few countries and then use them in a Region-wide strategy. Specific objectives were:

- To strengthen WHO technical support in the African Region so that all WHO efforts are integrated at country level to enhance the development of national health systems so that they can effectively deliver (services such as maternal and child health services, communicable disease prevention and control, 3 by5 etc)
- Agree, and sustain, new ways of working with administrative and technical programs in AFRO and HQ
- Gain endorsement of the approaches with concerned Member States

1. AFR/EXM/95.1; Brazzaville, August 1995
2. Cooperation for Health Development: WHO's support to programmes at country level, 1997.
3. EB 111/33, Jan 2003, The Country Focus Initiative
4. One Country Strategy Plan & Budget, GMG Cairo, August 2004
5. Country Focus and Health Systems Development, Copenhagen, October 2004
6. Health Systems Strengthening for Integrated Service Delivery, Nairobi April 2004

Section 3

Summary of Approach and Progress

Development of country project proposals

3.1 The work started in three countries, Kenya, Tanzania and Malawi which were selected because they share a common language and their proximity within the region. The WHO Representatives developed project proposals for strengthening their country office based on the CCS, using guidance provided by AFRO. A Technical Working Group made up of representatives from all the technical and administrative divisions of AFRO, the three WCOs and the Department of Country Focus HQ reviewed the three preliminary proposals in March 2004 at Brazzaville. The revised proposals were then circulated for detailed review and discussion at the Nairobi Workshop.

The joint WCO/AFRO/HQ Nairobi Workshop

3.2 The meeting, held from 20th – 22nd April, 2004, brought together forty-five members of senior management and staff from the three levels of WHO representing both technical and administrative programmes. Using these project proposals from Kenya, Malawi and Tanzania as a starting point, the meeting discussed modalities for inter and intra-level cooperation; working across technical programmes to build effective health systems; developing the One Country Strategy, One Plan & One Budget ; developing WHO country teams and improving administration and management.

3.3 Major conclusions of the Nairobi meeting included that :

- WCOs should move from many micro-managed programmes with MoH to integrated, strategic technical support.
- They required better cross-departmental support to the clustering of priorities in the WCOs, to make technical support more coherent and effective.
- WCO core functions needed to be better defined, and competency levels in WHO country offices need to be improved through competency audits, re-profiling and re-tooling of country teams while taking

advantage of the decentralization rotation & mobility policy.

3.4 A preliminary framework for taking forward the country strengthening process was agreed consisting of four elements :

- A joint EIP/DSD health system mission to each of the countries to identify how the country office could best position itself to strengthen national health systems.
- A joint AFRO/HQ Human Resource mission to re-profile staff requirements and determine competencies required in the country team.
- The identification of activities to strengthen administration, financial & knowledge management capacities in the country office, and
- The development of a draft 'One WHO country support plan & one budget' for each country office.

The WHA parallel session: follow up on Nairobi Workshop

3.5 The WRs of Kenya, Malawi & Tanzania and representatives from AFRO Country Support Unit and Department of Country Focus HQ held various consultations during the 57th World Health Assembly in Geneva to follow up the Nairobi workshop. The team kept firmly in focus the need to coordinate amongst the three levels and work across programmes. They met with various groups (ADG/EIP, ADG/FCH, HRS, ICT, HIV/AIDS, KMS, HDP & PRP) to take forward the actions agreed in Nairobi.

Integrated health systems missions to country

3.6 The joint EIP/DSD missions to countries proposed above, were subsequently expanded to include other clusters in HQ (FCH, SDE and, in Malawi, GMG & HTM) and all technical Divisions in AFRO. This was done in the interests of promoting work across programmes and to enhance development of the One WHO country strate-

gy, one plan and one budget. The method of work of the missions consisted of presentations followed by plenary discussions, brainstorming, consultations and individual interviews.

3.7 The objectives of these missions were to⁷:

- Achieve a better understanding of the country health system and identify approaches the country office could adopt to enhance the Ministry of Health's ability to develop effective health systems for better health outcomes;
- Elaborate mechanisms for working across technical programmes so that the country office is best placed to support the Ministry of Health in implementing its identified priority package of interventions;
- Identify technical competencies that need to be developed in the country team in area of health systems development;
- Identify technical support that will be needed from other levels of the organisation or external institutions & networks;
- Elaborate a four-year business plan for strengthening the WHO Country Office and identify resources required to implement the plan.

Re-profiling missions to countries

3.8 These took place after the integrated health system mission. The method of work involved comprehensive job analysis, panel interviews, consultation with the health systems mission team, staff members and the WR. The objectives were to propose to the WCO:

- a structure in line with business requirements and future challenges as identified through the CCS and guided by the preceding technical missions;
- an assessment of available competencies;
- a Human Resource Plan which should include a development plan for the whole office and ad-hoc measures (recruitment, reassignment, outsourcing etc) in order to meet the staffing needs.

Strengthening administration, financial and knowledge management capacities

3.9 During the Nairobi workshop, a high-level assessment of each of the three countries' managerial and adminis-

trative capacities was performed. While only indicative, [see 'Checklist' in Annex IV] it helped highlight a number of critical gaps in the Country Offices that needed to be addressed, namely staff development, resource mobilization capacity, connectivity, knowledge management and security. A series of responses were agreed, in addition to those already underway. The key areas addressed since Nairobi are connectivity and knowledge management. It was not feasible to consider these three countries to be the first to receive the Global Management System as Angola, Burkina Faso and Ethiopia had already been chosen as the regional country pilots.

Kenya

Integrated health systems mission

3.10 The mission had representatives from AFRO divisions (DSD, DRH, TCC, DES) and HQ (EIP, SDE, FCH), and they held several meetings with the WHO Kenya Country Team, the Ministries of Health, Establishment and Finance as well as development partners. A summary of the mission's findings is as follows:

- *WHO support:* The Kenya Country Office has a very busy agenda in national health development, covering areas such as malaria, health promotion, tobacco control, maternal and child health, environmental health. However the assessment made by the team revealed a gap in two areas (1) health systems development & functioning, and (2) health planning, financing, budgeting, and performance monitoring systems.
- *Ministry of Health priorities:* The Ministry of Health is engaged in two big programmes, associated with a strong political stake (1) the launch of the National Social Health Insurance (NSHI), and (2) the elaboration of the National Health Sector Strategy Plan (NHSSP). The MoH has invited the WHO KCO to give technical support to the government in taking forward these two policies. However the skills gap identified above in the two aspects of health systems development, constitute a major technical capacity constraint that has limited the KCO in providing the required support to the MoH.
- *Technical support to NHSSP and NSHI:* The timeline and process of elaboration of the NHSSP and the institutional mechanism of the NSHI were thoroughly discussed between the team and the officials of the MoH. The team worked out technical proposals,

7. Objectives changed slightly over the three missions; these are those used in the last mission to Malawi.

for the MoH to consider. These covered health financing, health investment plan, health component of the PRSP/ERS, Human Resources for Health, and the overall health policy framework.

- *Priority interventions:* With specific reference to health programme development, the MoH has identified a priority package of health interventions that it is going to implement. These cover activities relating to the following areas; EPI, IMCI, reproductive health with a focus on maternal mortality reduction, HIV/AIDs, TB, malaria and environmental health. To position itself to support the MOH in implementing this package in an integrated manner, the WCO has restructured itself into clusters and identified activities that will be implemented to promote working across programmes and integration.

Health systems business plan

3.11 Through interactions between the focal points of KCO and counterparts in HQ and AFRO, a draft plan was prepared for strengthening the KCO in various areas that shall enable the KCO to support the MoH to develop, implement and monitor the NHSSP and the NSHI. This has eight objectives, namely to support:

- the development of the National Health Sector Strategic Plan II;
- the development of the National Social Health Insurance Plan;
- the improvement of policy dialogue, advocacy, health planning, budgeting and financial management, monitoring and evaluation;
- the development of strategic partnerships and collaboration;
- the improvement of the health component of PRSPs/ERS/PRS;
- integrated service delivery and the developed essential health technology package;
- the development of knowledge management tools in the country office.

Re-profiling and staff development mission

3.12 A joint HQ/AFRO team visited the office, overlapping with the health systems mission who had made recommendations on the structure and technical competencies required in the team. A review of the current

structure on June 1st showed 48 people within the office, 37 in the Country Office and 11 with the inter-country team for EPI. In the WCO, 4 of the 37 were internationally recruited. 10 programme managers covered separate programmes, each under the direct supervision of the WHO Representative. Three types of contracts (FTA, TA and SSA) were in use. The re-profiling focused on the Country Team and the administrative support to the inter-country team. A new structure was proposed, with the following characteristics (Annex VI):

- Two 'technical' clusters (1) Maternal and Child Health - covering IMCI, Reproductive Health and EPI; and (2) Disease Prevention and Control - covering Disease Control, Malaria, HIV/AIDS and '3by5'; TB, Tobacco and Non-Communicable Disease, Essential Drugs and Medicines, PHE and Mental Health.
- A cross-cutting group consisting of the Health Systems Adviser, Health Information and Promotion, and a Health Economist.
- A change in the administration with groups covering (1) information dissemination, (2) Budget & Finance, (3) Human Resources, logistics and Public Relations, and (4) a secretarial pool.

3.13 These final recommendations now need to be reconciled with senior management in AFRO. As this was the first country office to go through this learning-by-doing exercise, the objectives and team dynamics were at an early stage; this improved with successive missions and the process developed in the other two countries should be used for extending across the region.

3.14 Following interviews with staff, a development and learning plan was developed covering program management, policy development, health mapper/EPI info, EHTP (Essential Health Technology Package) people relations, resource mobilization & advocacy, information/knowledge management, administration issues, public relations, human resource management and WHO core competencies. In addition some competency gaps are to be addressed through the creation of posts for a health systems advisor, health economist, MCH cluster coordinator, Disease control coordinator, knowledge and information manager, budget assistant and HR assistant.

Building administration, communication and knowledge management capacities

3.15 Plans to strengthen country office administration & communication capacity are already underway, with

plans to connect to the GPN almost complete, and plans in-place to strengthen registry and archiving. Much of the re-profiling and staff development plans are aimed at improving administrative capacities. The country team also had a knowledge management assessment performed by EIP/KMS; a full report of this is will be available later, with recommendations for Kenya WCO.

Tanzania

Integrated health systems missions

3.16 The mission had representatives from AFRO divisions (DSD, DRH, TCC, DES, and DDC) and HQ (EIP, SDE, FCH), and they held several meetings with the WHO Tanzania Country Team, the Ministry of Health, Department of Public Service Management (President's Office), Ministry of Finance and development partners. The main issues that emerged were as follows:

- *Human resources for health (HRH)*: The key problem identified here was scarcity of trained/skilled staff in the public sector, mainly due to attrition and the downsizing of the public service in the past, now exacerbated by financial and bureaucratic limitations on fresh recruitment to the sector. The related areas of recruitment and retention need specific strengthening, including political negotiation, along with deployment, to ensure a strong HRH strategy.
- *Health financing*: Assistance is required in identifying mechanisms that increase revenues raised within the sector and, at the same time, provide financial protection. Specifically, user-fees have been introduced in the public sector, and WCO needs to provide appropriate advice on the types of charges as well as use of revenues that would have the least negative impact on utilisation. Further, WCO would need to have the capacity to advise on efficiencies in use of available funds through reallocations and also to lobby for increase in the share of health in the budget.
- *Coordination and leadership in the sector*: Most technical programs at the level of the WCO are currently run vertically, constraining the ability of the Office to provide the coordinated/integrated health program support that the MOH requires. Accordingly, there is urgent need for coordination between these programmes as well as with health systems to promote efficiency and effectiveness. The new Team based organizational structure that

the WCO is proceeding to operationalize is critical in promoting this.

- *Health Sector Strategy*: there is clear agreement on the importance of a comprehensive health sector strategy that capitalizes on potential efficiencies from a coordinated approach, both at sector level as well as vis-à-vis development/macro policy. The government has developed the Health Sector Strategic Plan for 2003-2008. The plan has been harmonized with the PRS; what is however still needed is to align the plan with clear bench marks for achieving health and health-related MDGs. Both government and agencies/donors are looking to WHO to take the lead in supporting MoH to strengthen coordination both within the health sector and in relation to national mechanisms, especially the PRS.

Health Systems business plan

3.17 Following the various consultations, this was drafted, under six objectives:

- To operationalize organisational changes at the WCO that promote work across technical programmes and integration.
- To develop capacities that will adequately meet MoH requirements for support
- To improve interactions between the WHO and the two Ministries of Health
- To strengthen management services at the country office
- To develop the Country Cooperation Strategy for 2006-2009

3.18 The focus of this plan, and the one in Malawi, was more on enabling the country office to deliver the health systems agenda identified in the country. It was less on the detailed needs in country (as done in Kenya) or in a review of the health sector, as in the formulation of the Country Cooperation Strategy.

Re-profiling and staff development exercises:

3.19 The HQ/AFRO team arrived a few weeks after the health systems mission, who had made various recommendations on structure and competency requirements. They interviewed the entire team, and briefly met with staff based in Zanzibar. The total number as of August

1st, was 51 staff, of which 4 were internationally recruited. A mixture of contract types had been used as in Kenya. The team made recommendations on the structure as follows (Annex V):

- Combining technical programs into two clusters (1) Health Systems cluster, led by MPN and comprising a health economist, a human resources for health officer, a HIP/KMS officer overseeing the library, and EDM; and (2) a Programme Cluster, covering DPC, HIV/AIDS, TB, MAL, IMCI, FHP and EPI, led by one of the existing officers, through an internal selection process. The cluster coordinators should directly supervise the program officers to release the WR from this function, but the program officers should retain a link to their respective regional advisers.
- As for administration, a new Human Resources position will oversee general support and logistics. The drivers and secretaries will be pooled to enhance integration and teamwork across the office.

3.20 Building on the recommendations made by the health systems mission, the development and learning plan includes teambuilding, partnership building, communication skills, negotiation skills, epidemiology, office management, information technology. Some new posts are to be created to fill other competency gaps, including a Human Resources for Health specialist, a health economist, and an epidemiologist for Zanzibar.

Building administration, communication and knowledge management capacities

3.21 The issues of recruiting an international administrator was not covered by the re-profiling team and will need to be reviewed by AFRO at a later stage. Plans to connect to the GPN are almost complete; plans are also underway to ensure full fire security. As in Kenya, EIP/KMS performed a knowledge management assessment, the results of which will be available later. Work has still to be done with AFRO/ASU regarding the strengthening of the Registry service.

Malawi

Integrated health systems missions:

3.22 As was the case for Kenya and Tanzania, the mission had representatives from AFRO divisions (DSD,

DRH, TCC, DES, and DDC) and HQ (EIP, SDE, FCH, HTM & GMG). This mission over-lapped with the second CCS mission, and took part in a meeting to consult on the final draft with partners. The mission also met with Department of Planning in MoH regarding the HR crisis, and Ministry of Economic Planning & Development regarding advocating for more resources for health. The main issues that emerged were as follows:

- Collaboration between programmes and integrated service delivery: At present, the Malawi Country Office programme is overseen by nine National Programme Officers working on specific vertical programmes. WHO needs to work across its programs to be able to promote integration of service delivery, as well as to be able to better manage cross-cutting activities in areas such as planning, training, research, supervision, and monitoring and evaluation. The challenge is not just about integrated approaches to WHO's work, but also about supporting the MoH develop integrated approaches to health programme development and service delivery.
- Health Sector Policy & Development: The SWAp arrangement is strong in Malawi, and will support district implementation. WHO should focus on adapting and using its tools to support effective decentralisation of services and operationalisation of the district implementation plans. This will include support for the 55 ARV treatment centres, particularly in relation to management of service delivery and patient safety.
- Health Sector Financing: Reforms are required to allow both the raising of additional resources as well as ensuring more equitable and effective use of resources, with a move away from user fees to co/prepayment mechanisms. Pooling of resources should allow financial protection against catastrophic costs of accessing care, especially for the poor. Purchasing of services should be considered, given the limitations in capacity of the public sector. To make best use of new initiatives and funds, new expenditure planning tools such as MTEF and resource tracking through the NHA can be used to improve the efficiency in financing, and to inform debates at the macro-economic level.
- Human Resources for Health: The Human Resources for health situation in Malawi presents a crisis situation with extreme shortages at all levels of health service delivery. The situation has been deteriorating with the migration of staff and the impact of HIV/AIDS. This HRH situation has been recognised by the MOH and is identified as a priority issue with a 6 year crisis response plan that has been devel-

oped with the support of DFID, the estimated funding for this plan is 275 million USD which is being sought. However, a comprehensive, well designed medium and long term approach is required and WHO can now support the Ministry in developing this with partners.

- *Equitable service provision:* The provision of health services in an equitable manner is important to the government of Malawi, and the MoH has already undertaken to monitor equity in access to DOTS and ART in the National TB Programme and the HIV Unit. WHO will continue to encourage this and will also help clarify and evaluate how activities related to equitable access to DOTs and ART would best be linked to the monitoring and evaluation of the Joint Programme of Work for a Health Sector Wide Approach (2004-2010).

Health Systems business plan

3.23 Following these consultations, a draft business plan was developed with the following objectives:

- To operationalize organizational changes at the WCO that promote working across technical programmes and integrated service delivery.
- To develop capacities to meet MoH requirement for support;
- To enhance an enabling working environment
- To strengthen management services at the country office

Re-profiling and staff development exercises

3.24 The joint AFRO/HQ team overlapped with the health systems mission, who had arranged a session to brief them on their conclusions. As before, they interviewed the entire team; as of 1st August the total number of staff was 22, with 3 internationally recruited staff and two vacant positions. Recommendations on the structure were as follows:

- There will be two clusters (1) the health system cluster, led by the health systems adviser and comprising

of a health economist, human resources for health officer, an HIP officer, a KMS/Librarian and a programme assistant; and (2) Programme Cluster encompassing DPC, HIV/AIDs, TB, MAL, IMCI and FHP, with a program assistant. This group will be coordinated by the DPC.

- The Health Systems advisor will serve as the interface between the two clusters for cross-cutting issues, and guidance on 'New ways of working across programmes' was introduced to the teams.
- The administrative arrangements were also adjusted, with a Human Resource position overseeing general administration, logistics and transport. Drivers and secretarial staff will be pooled.

3.25 Some competency gaps will be addressed through new posts, in particular a health economist, a human resources officer for health, a KMS/Librarian, Water, Sanitation and Food safety officer, Malaria Specialist and programme assistants. The team noted that some of the existing staff did not have the relevant experience or qualifications to carry out existing work. Re-deployments were recommended for the current MPN to become the HRH officer; the DPC to the CWS post; and the FHP to the HIP post when the current incumbent retires. The Malaria officer will stay in his current post supervised by the new Malaria specialist. The DPC post will be upgraded from NOC to NOD level. Considering the considerable staff changes happening, a succession plan was outlined. Also, it was recommended that the staff in the clusters should allocate about 60 % of time in the PMDS to cluster work, and about 40% to the programme they represent.

Building administration, communication and knowledge management capacities

3.26 To start the process of improving connectivity, a site visit was conducted and plans agreed. MOSS compliance will become possible when the Country Office is re-located. As before, EIP/KMS performed a knowledge management assessment, this time during the 'health systems' mission; the full report will be available later.

Section 4

Working Across Programmes

Lessons learnt from the integrated health system missions

4.1 The central purpose of the 'health systems' missions remains appropriate - to define joint WHO work-plans to strengthen the national health system based on the Country Cooperation Strategy and identified country priorities. The way WHO as an organization works at country level is judged by the national authorities and partners to be fragmented, uncoordinated with sometimes conflicting unsatisfactory instructions and no value added. The WHO country offices should play a stronger coordinating role, and their capacity to fulfil this role, which was a key objective of the mission, should be enhanced. Similar missions should continue as part of the Regional strategy, but should be smaller, with more focused terms of reference and key resource persons. Lessons learned from these first three countries with respect to working across programmes can be summarised as follows:

- Joint HQ/AFRO missions to countries have the potential to facilitate the ability of the three levels of the Organization to get to understand each other, and to work together on country priorities. However, such joint working needs careful preparation and *agreement of objectives with the country team*, if they are to be successful;
- Planning timetables across the three levels of the Organization need to be adjusted to promote an integrated plan and budget at country level and thus more efficiency in the use of WHO funds to support the country.
- The 'integrated health systems mission' that follow the definition of a CCS could be improved through;
 - Providing more detail and structure to the *terms of reference* bring more clarity on leadership, roles of the health systems group and other WHO programmes, the tasks to be undertaken, the overall resource base at the disposal of the mission, time-frame and reporting modalities;
 - Improving the *pre-mission preparation*; this should be more systematic with more sharing of country information. For example, this might involve; Videoconference between these two groups and the country officer before, during and after these visits to country would help;
 - *Consultation* with all HQ and RO programmes working in the country on the existing programs, the extent to which these programmes reflect all the health systems elements, clarity on the resources currently available, and

realistic projections on what might be available in the future;

- Systematic analysis of the *country* POA to assess the extent to which it covers the priority items in the CCS, and also cross-cutting health systems development work (e.g training, health care financing), and assess how resources are currently being used;
- The *methods* used by the health systems mission need to be agreed well in advance; various techniques were used for exploring priorities and building the capacity of the team - plenary presentations, group discussions, break-out groups, role-playing. As this is a learning-by-doing process, these methods should be reviewed, together with techniques used in re-profiling, to agree how best to reach the desired objectives in future missions;
- There should be a deeper review of *the business process* in country offices to enable the organization identify activities to be outsourced, operational procedures to be streamlined, and level and type of country team members to be hired within the funding constraints;
- There must be mechanisms to ensure a permanent and close consultation of the HRS team with those responsible for a health system over-view, so that timely submissions to AFRO's Management on re-profiling recommendations and their implementation could take place without delay in WCOs;
- Whilst the prime purpose was to consider the priorities that WHO should focus on to support the strengthening of national health development for better health outcomes, as well as the capacity of the Country office to coordinate this, future missions should also be empowered to assist the WR in the *re-programming* that is required to deliver on the Country Cooperation Strategy. Where possible such missions could be done in conjunction with a review of the CCS, or at the time of an in-depth country evaluation;
- Much effort went into coordination of the missions, and this should continue into coordinating the final *products*, between mission members and between the health system and re-profiling missions.

Implications for WHO

4.2 Early lessons: Some implications became clear early on, and cover areas where solutions have already been proposed or are now being considered:

- Staff allotted to Areas of Work were frequently *working in their own 'silo'* with little evidence of team work, which would allow for the mobilisation of expertise from across programs to deliver on WCO objectives;
- The *clustering of programs* within country teams to encourage better integration and more coherence with national policies & programs should be promoted
- *High calibre health systems expertise* to engage the complex array of national and international partners working in the health sector and involved in health systems work, and to promote work across different programs in the country office;
- There is need to develop *staff capacities of the country teams* to better understand how to support the development of health systems through a more strategic engagement with partners, as well as the development of competencies specifically to facilitate enhanced co-ordination & partnerships at the country level.

Lessons covering more systemic issues in WHO

4.3 These need to be explored in more detail, and come from the reports and the debriefings from those involved in the missions:

- WHO needs to change the way it does business at country level, by *planning its activities around national development processes* and timetables with the practical steps identified more clearly demonstrated to others in WHO;
- Country teams, and regional advisers should re-consider how the use of management tools such as AMS, PMDS and guidance from regional advisers could be better adapted to *encourage better team working* and collaboration across programs;
- WHO, particularly at country level, needs to be *stronger in supporting national health systems work*, including broad policy development and its translation into action, country sector strategic planning and budgeting, use of WHO funds/resources to kick-start actions and overall health sector performance and monitoring;
- WHO should be more self-critical in its review of *country level performance*, and identify constraints across its three levels that inhibit performance;
- The imbalance in the *distribution of funds by Area of Work* will need to be addressed to look for efficiencies, whilst not losing the ability to deliver products and services for individual programs as negotiated with national partners and WHO regional advisers;
- The CCS should be *institutionalised* as a WHO Managerial mechanism, so that the way it informs the General Programme of Work, Programme Budgets and Work-plan

is formalized, and the Monitoring and Evaluation mechanisms also take it into account;

- These will be useful at country level as we improve collaboration, coordination or integration at the Regional and Headquarter levels.

Mobilising technical support from within WHO & implications for individual programs

4.4 The clustering of programs within the country offices will have implications for the way the country team interacts with the various programs in WHO. Country teams will engage a proactive as opposed to reactive approach to using technical support from various programmes within WHO. For example:

- *Consultancies from the region* or HQ should be coordinated by staff in these clusters and using terms of references and timetables agreed with partners in-country. Where possible, and with increasing frequency, missions will be across programs and not confined to single Areas of Work. This will lead to maximisation of resource use and benefits from synergies in addition to enhancing partnerships. This will, in addition, present a common message to countries of a more focused response;
- *Region-wide Pools of experts*, accredited by WHO, should be made available for WHO country teams, to enable a more responsive pull-down arrangement for work with Member States. Timely availability and deployment of the technical expertise shall be assured through availing expert lists and a reserve budget at country level;
- *The Country Team will coordinate* WHO normative work involving individuals or institutions in the country. However, supervision and other technical support will be given by the Region in collaboration with HQ to reflect the involvement of the three levels of the Organization in the normative functions of WHO;
- *Inter-country teams* working in collaboration with the Region and HQ will offer timely and closer technical support to WHO country teams.

Systems for enhancing knowledge and information

4.5 The efforts to enhance the core competencies and the leadership and management capacities of country team, will be the most critical aspects of strengthening the knowledge management capacities of the WHO country team. In addition to this, other capacities will need to be enhanced, including improving the use of information communication technology, including web-based systems for managing and promoting knowledge to develop local capacities.

Section 5

Country Presence

Lessons learnt from the missions

5.1 This was the first time the country office as a whole was reviewed in a comprehensive manner, using the latest 'good practice' in human resource management. All participants saw it as a very worthwhile exercise. Some critical lessons learned were identified as follows:

- Staff of WCOs are very busy supporting a large number of Areas of Work that are based on *numerous micro-managed activities* which are quite often not based on their CCS nor linked with the larger picture of national health development, hence the limited concrete impact at country level;
- There are no *benchmarks for staffing* in WCOs to determine the number and types of programme officers to be hired for any given programme, irrespective of the availability of programme funds;
- *Staff contracts varied* a great deal, and some mechanisms (e.g. SSAs) were being used inappropriately for long-term placements. This had been known for sometime, but plans to phase this out were not clear. Uncertain job security affects the calibre and level of commitment of staff within the organization;
- Technical staff engaged to work in country offices need to have the *qualifications, experience and skills* to carry out the work especially with respect to being able to advise national authorities on program issues;
- As it became clear during the re-profiling exercises, the *PMDS is still not fully used* in country; this will need to be rectified if WHO is to develop effective teams in line with modern day management techniques;
- Some staff were in positions for which they did not have the necessary expertise hence their *inability to perform* their duties at a level expected of WHO experts;
- The *re-profiling exercise* should be seen as an opportunity enabling the adjustment of the staffing composition and level to the requirements of the business. It should constitute a tool for planning purposes and be regularly undertaken at all levels of WHO;
- Strengthening the capacities of the WCOs as outlined in the report involves a high investment, which must be categorically *costed and planned* for by WHO in addition to putting a system in place to source the funds;
- Within the country team, the new clusters and the team as a whole should have *incentives for better team working* – these could be 'soft' such as out-of-country visits for staff development, or 'hard' such as payment awards e.g. 2 steps increase or deferments linked to team performance. For the latter, this will require a fundamental look at how pay incentives are used, based on experience in other parts of the UN and other international agencies.

Core functions of WHO country teams

5.2 Core functions will be based on the Country Cooperation Strategy. Whilst some functions will be common to all country offices (in particular those linked to general management and the facilitation of WHO's normative and standard setting role), others will be defined country by country allowing the flexibility of the CCS and its subsequent review to guide WHO's work in a country.

What constitutes a 'core' team

5.3 The WHO country office team should have two components:

- *A core team*: consisting of a WHO Representative, an Administrative/Finance Officer, a Health Systems Adviser, Disease Prevention Control Adviser, Family Health & Planning Adviser, Health Economics Adviser and Health Information/Promotion & Knowledge Management Officer together with support staff. The core team should be covered by regular budget while the grade of the members would vary according to their responsibilities and the size of the office as a whole.
- Depending on country specific situation, additional staff consisting of technical and administrative staff,

grouped in clusters or teams led by core team members would be included. This group may change over time as program content changes, as modalities of technical support vary, and as more harmonisation with partner agencies takes place. The exact cluster structure may vary from country to country depending on the size, administrative governance structure, complex emergencies and programme funding; but it is expected that there would be about two to four such clusters per country bringing together related programmes under specified thematic areas.

The business rules for expanding beyond the 'core' team

5.4 Non-core staff will be recruited for very specific, time-bound activities with inclusion in regional HR databases to ensure that WHO is fully aware of prevailing situation. A set of business rules will guide this, for example:

- **Project staff:** Wherever possible development projects should be developed through other institutions (government & non-government) so that staffs are hired using the respective institutions personnel mechanism. Directly managed WHO projects, with WHO contracted staff, should be limited, and restricted to circumstances where national institutions are very weak or temporarily unavailable (e.g in times of conflict or national disaster).
- **Temporary specialist assignments:** For temporary assignments requiring specialist functions, preference should be given to local expertise within the concerned WCO or from a neighbouring WCO. If not, temporary assignments of WHO staff should be requested from RO or HQ. Where no WHO resource is available, appropriate contractual arrangements will be used to hire staff outside of WHO or to sub-contract tasks, depending on the nature of activities to be performed.

Introducing changes to the profile of current teams

5.5 When WHO priorities are reviewed after the CCS, or in the course of a review of the CCS, the WHO Representative will need to consider, together with the Regional Planning and HR departments, the level of change that is likely to be required in the country team program and staffing. If significant change is likely, a *formal change management program (project)* should be designed and managed, with regional support. Depending on the changes required, this extra support may need to come from planning, HR or health systems colleagues. If large complex change is required, the WHO Representative should be supplied with executive support on a time bound basis to help plan the changes.

5.6 Once the profile of the country office has been agreed, the WHO Representative will be responsible for maintaining the team, and planning succession of its members with support from the regional office. *The WR should be a champion of staff development activities*, with personal development plans for all of the country team. More formal policies need to be designed for staff development and career support for nationally and internationally recruited offices. The US\$ 230,000 Staff Development Funds recently transferred to the African Region for country team development can now be used to help take forward the recommendations from the initial missions.

5.7 The shift towards working across programmes within a coordinated *clustering system* has implications on individual staff PMDS. In order to adequately assess the contribution of the individual staff members to the organization, it becomes highly pertinent to base part of this assessment (60%-65%) on the objectives assigned to the cluster to which the staff members belong and (35%-40%) on the objectives of the individual programme. The current PMDS must be used to support the new way of working at country level with implications for Regional Office work as well in order to facilitate integration and clustering at country-level.

Section 6

Implications for WHO Management Support Systems

Formulating Expected Results based on country specific needs & priorities

6.1 Country-level expected results in line with the CCS will become the starting point for the One Country Strategy, One Plan and One Budget, and will be backed up by the region and HQ as appropriate. These new "integrated" plans will be worked out with the WCOs by some regional office and HQ programmes during the current 2004-2005 biennium. It is important to note that they do not fully represent the comprehensive joint planning across the three levels expected in the coming biennia, starting with 2006-2007. The current integrated plans should be seen as an entry point.

6.2 The One Country Strategy, One Plan and One Budget exercise is at an early stage, but should become the instrument for joint planning of all WHO's work in a country. The key aspect of this, is showing how the Expected Results agreed in country will be achieved through resources (financial and expertise) provided by the country, region and HQ, under the direction of the WHO Representative. The one country plan and budget will also allow the normative and inter-country work of HQ and the Region in a country to be made more explicit. It will be updated by the WHO country team according to timetables agreed with the Region and HQ and will be accessible across WHO, through the current AMS and the future GMS.

6.3 Once the 'One Country Plan and budget' is finalized, it could be used by all levels of the Organization as an instrument to guide resource mobilization for country activities. The current system of funding narrowly by Area of Work does not sufficiently allow the WR, in conjunction with region and Member State partners, to look for efficiencies in the use of WHO funds. It also encourages funds to be dissipated on a wide range of MoH activities not directly linked to the CCS.

6.4 The focal points for health systems Areas of Work should have as part of their function the development of

mechanisms to integrate health systems development outputs and activities across Areas of Work, and to explicitly link these efforts to those countries as guided by the CCS.

6.5 The introduction of the new Global Management System will take some time; so much of these new changes of working across programmes will need to be developed with the existing AMS system. The global AMS database has the potential to provide access to some useful information until the GMS is up and running. Lessons will need to continue to be drawn and fed into the development and roll out of the GMS. Future phasing of the African strategy should be linked to the phased introduction of the GMS.

Connectivity, Communications and Website Development Capacities

6.6 The starting point for improving communication and the management of WHO's knowledge is the improvement in connectivity, now being completed in the three countries. For the larger country offices, video-conferences should become the norm, and will need to be costed into further development plans.

6.7 Further work is required to map out how the WHO country website can be developed and managed using a mixture of WHO standards and local design. This should provide access to all WHO country information, and that of government and key partners.

6.8 The communication capacity of staff members will be enhanced through training and staff development activities linked to development of WHO core competencies. More specialised technical competencies need to be developed to improve working with the media and for promoting health through building capacities in Ministries of Health at central and local level, and in communities through strategic and local communication channels.

Funding and Resource mobilisation

6.9 With the development of results based management, funding should be increasingly linked to products and services defined in countries, and be less 'earmarked' as inputs into individual Areas of Work. This should be acceptable to donors, who will see their funds used not only to deliver the Expected Results in an individual Area of Work, but also for broader based products. Reporting to donors should be based on results, and not on inputs. For donors where this is unacceptable, then 'projects' requiring earmarked funds must be integrated into the planning and management systems to avoid parallel reporting systems.

6.10 As WHO capacities in-country grow, the Organization will have to become robust in only accepting funds for Areas of Work already defined in the CCS and the Country Plan, or for new activities only where this is acceptable to government, and consistent with the CCS priorities.

Administrative capacities

6.11 Administrative staffing capacity will be determined during the re-profiling process, with cross-country adjust-

ments as capacities develop in different country teams. A critical aspect to consider going forward will be the skills and competencies needed at the country level to work in a "Global Management System" environment, with increased accountability and responsibility at the country level as well as increased use of electronic, as against paper-based, administrative systems. As this new system is introduced there will be a need to streamline and align WHO management procedures, policies and financial rules with the requirement of the new way of working across programmes.

Delegations of authority

6.12 AFRO has recently reviewed its policies on delegations of authority, linking them to the increasing capacities and accountability measures that are being put in place. There will be a tension between the demands for delegations of authority and the timetable for increasing capacity of the Country Teams; the matrix of delegations of authority for WHO as a whole should help guide this. As this is implemented, it will require considerable changes of behaviour of HQ and Regional departments, who will increasingly be negotiating their in-country work with WHO Representatives and their teams.

Section 7

Costing the Change Process and Budgeting the AFRO Strategy

Proposals for what could be done immediately using current procedures & resource allocations;

7.1 WHO Country Teams should define more clearly the priority areas and opportunities for integrating their work to support the national health systems. The CCS has been a starting point, but does not currently provide sufficient detail for WHO to plan its approaches. The new corporate guidance being developed on the CCS will provide a more structured health systems and stakeholders analyses, and a more focused strategic agenda; this could be used during future reviews. (See Annexe VII)

7.2 Following the definition of the CCS, the WHO country team should make clear its core functions and business requirements, so as to allow more systematic profiling of the office. This may or may not require adjustments in staffing levels, but will require systematic use of staff development resources being made available to country teams.

7.3 New ways of working within the country team, and with AFRO and HQ, need to be clearly laid out, with business rules on how integrated technical support will be mobilised using the new country structures. WHO, as a whole, will need to be more consistent in the use of business rules to support more effective and efficient ways of working. AFRO and HQ will need to revisit current business guidance to determine the extent to which they make room for integrated technical support and capacity development at country, as well as new interventions to be introduced for strengthening the CCS process.

7.4 New ways of working also bring synergy between the efforts to improve the institutional arrangements through which health interventions are delivered (the health system), and the efforts to develop health interventions for improving prevention, treatment and care, which the system delivers. In light of this, health system focal points at the Regional and HQ levels, shall in addition to relevant country office staff, also support WRs to review the One Country Plans, in order to ensure their coher-

ence in supporting the development of national health policies and systems.

7.5 For all this to happen, a high profile for this change process is required, given the profound nature of the envisaged changes. HQ and AFRO will need to move forward systematically upholding corporate policy and strategy without losing the tenet of 'learning by doing', and by ensuring an inclusive approach. Cohesive driving themes for managing the change, such as 'Working Together to Achieve More' have to be increasingly brought to the attention of all players, since this is about 'creating *'win-win' scenarios*.

7.6 The WR and the country teams can review individual PMDS objectives to clarify new responsibilities and provide objectives for new ways of working. Objectives should focus on collaborative working, and achieving objectives through better joint work.

What could be achieved through changing distribution of existing resources

7.7 Once the resource envelope for a country office is agreed against the Expected Results it has to achieve, the WHO Representative should allocate resources across Areas of Work so as to best achieve identified collective Expected Results. This will require the performance of the WCO to be assessed as a whole, and not just by individual Areas of Work. This should result in WCOs being able to achieve more Expected Results, or a higher quality Expected Result (e.g. wider coverage etc).

7.8 Changing the focus of the WCOs work will require staff competencies to be developed as initially outlined by the re-profiling teams. Some of the re-programming required should allow Area of Work funds to be used to compliment staff development activities and resources provided by the Region and HQ. There should be a regular review of country competencies against the changing needs in the country team.

7.9 A small compliment of 'core' staff should be identified and protected in the country budget. The larger number of technical staff in the office should be funded by technical areas of work, and should be reviewed over time. This would allow flexibility in the use of resources for technical staff, which could be reviewed over time to consider (for example):

- moving responsibilities from the WHO office to a national institution;
- moving from staff centred activities to more virtual methods of technical assistance (web-based etc);
- using staff in partner agencies (UN and others) to achieve WHO Expected Results;
- using more 'problem solving' techniques with government partners to compliment formal technical assistance from WHO & partners.

What are the additional costs and the budgetary implications

7.10 Developing or reviewing the Country Cooperation Strategy, and carrying out the follow up missions to strengthen an integrated approach to building the health system and re-profile the team all require finances and staff time. This is essential if WHO is to continue to grow in strength and improve its performance at country level through the most cost-effective strategies. Resources for this will need to be prioritized from across Areas of Work to ensure a fair and effective distribution.

7.11 The extensive staff development activities required by the country team will require extra resources, given that WHO is generally behind in allocating resources for this. Funds will need to come from technical programs, central (AFRO & HQ) staff development services (e.g. the Management and Leadership Development Program and the Global Learning Fund), and resources allocated to countries for staff development. Other funds can be used to develop learning resources and tools for access by country teams.

7.12 The follow-up to CCS taking place in these three countries has shown the central importance of certain key staff. Where these are not present, or are absent for some time, the performance of the WHO Country Office as a whole suffers. New resources will be required to ensure the presence of:

- An improved selection and succession process for WHO Representatives;
- Internationally recruited administrative officers, at a level commensurate with their responsibilities;
- A general health systems specialist to support national efforts for development of the health sector as a whole, and to ensure all WHO work is properly integrated to re-inforce national efforts;

7.13 Available resources are probably not sufficient. The three levels of the Organization will need to work closely together to jointly mobilize resources in order for this effort to be extended across the entire region.

Section 8

Summary of Recommendations: what decisions are required and by whom

WHO Country Offices

- Once the recommendations of the missions have been endorsed by AFRO Senior Management, *implement the changes to the team*, which including:
 - Operationalize the new 'cluster' arrangements through dedicating time to consider the implications of this new way of working (office retreats etc);
 - Working with the Regional Office to fill new or vacant posts;
 - Engage AFRO/HRS to cost out the staff development plan, and apply for AFRO support in taking this forward through the application of staff development funds for country offices;
 - Harmonisation of country contracts, as guided by AFRO/HRS.
- *Amend the Country Plan of Action* in the usual way, to take into consideration the activities recommended by the country strengthening missions, and endorsed by AFRO senior management, and, in the case of Malawi, the necessary re-programming to reflect the new priorities outlined in the CCS. The POA budget should be adjusted accordingly to reflect planned costs and remaining resource gaps.
- Work with AFRO and HQ to *develop an interim 'One Country Plan and One Budget'* covering country, regional and HQ work in the country. Once finished this should be implemented with the countries, partners, Regional Office and HQ in a way that discourages distortions to planned activities and non-integrated technical support. The Country Cooperation Strategy must be kept central.
- Use the One country strategy, one plan & one budget as a *resource mobilization* tool particularly for bilateral funding and the basis for budget allocation and performance monitoring. As more resources become available, these will go to identified resource gaps, or to fund additional activities through agreeing amendments to the Country Plan.
- Institutionalize mechanisms for continuous environmental scanning and policy analysis to *keep the CCS*

documents current with the support of the CAS Unit; and ensure that the office specific Expected Results are always primarily based on countries priority health needs as expressed in the CCS.

WHO Regional Office for Africa

- AFRO senior management to review and *endorse recommendations* arising from the country strengthening process.
- Finalize, in collaboration with WCOs & HQ, the report of the *'Strengthening WHO support to national health development and better health outcomes'*, establishing the methodologies and framework for region-wide strategy, and incorporating the aspects highlighted in the decentralisation 'checklist' for country offices.
- *Review the methodologies* for taking forward the country strengthening process, as suggested in this report, and update the AFRO guidance to strengthening country WHO country presence.
- *Link the on going WCO* strengthening process to other sub-regional, regional and global health strategies like that of NEPAD and the MDGs.
- Make explicit the *criteria for choosing the next phase of countries* to go through the country strengthening process, and then prepare a timetable for the entire region, taking into consideration the availability of resources and the time it takes to implement changes given current resources and capacities.
- Put in place a *timetable* for implementing the AFRO-wide strengthening of WHO support to countries, obtaining the relevant buy-ins and management endorsements for implementing the change process.
- WHO should define clear *objective criteria that determine the degree of support* it gives to each country within the region, and which can guide levels of country presence and technical support, in recognition that WHO is not a substitute for the Ministry of Health or national health actors in each country. In the light of recent macro-economic issues

impacting on health policies, AFRO should establish a cross-divisional team to consider *sub-regional grouping* of some key non-core team members of WCO to enable them offer technical assistance to groups of countries. e.g. Essential Drug Advisers, Nutrition Advisers, Human Resource for Health Specialists etc.

- *Cost the change process* within the initial three countries and for the region-wide strategy and establish a resource mobilization framework for implementing the change process.
- Develop a regional *resource mobilisation* strategy based on the regional framework and the development of One Country strategy, one plan & one budget, and then use this as the basis for budget allocation and performance monitoring.
- The *Human Resource Service* group should work with WRs, HQ, HRS and relevant technical programs to:
 - Develop a staff development plan for the three Country Teams, as part of a *Regional Staff Development Strategy*, using funds recently made available for this purpose. This should be done in close collaboration with HRS/HQ and an approved Training Center to allow systematic implementation;
 - Review in collaboration with technical programs how the *PMDS* can be better used in country teams to encourage better team work in the new cluster arrangements;
 - Make re-profiling exercise a tool *within the WHO planning process* utilised at all levels of the organization.
- Programme management and WHO Country offices together to consider
 - Management tools such as AMS and Programme Funds Management could better support working across levels & programmes at Regional office, HQ and WCO.
 - Performing a critical review of the business process in WHO country offices, streamline operational procedures, establish benchmarks for the various procedures and a new WCO profile to meet WHO business requirements.

- Agree timetable for joint planning and developing One Country Plans for 2006-7.

WHO HQ

- *ADGs & DGO* should remain fully committed to supporting the overall WHO strategy to improve the Organization's performance at the country level, through reviewing new ways of collaborating around common goals at the country level.
- Implement a balanced approach to centralized and decentralized resource mobilization and devolve resources to regions and countries in line with the DG's declared policy.
- *ADGs* to promote the *decentralisation of resources*, and promote the new way of working with the Regional and Country Offices
 - Through joint planning and the development of One Country Plans.
 - Through working across programmes to provide more effective and efficient technical support in the three countries.
- Engage in *active dialogue with Donors* to consider the implications of supporting integrated technical cooperation with countries rather than just vertical program-specific support.
- Use the *One country strategy, plan & budget as a resource mobilization tool* and basis for budget allocation and performance monitoring.
- EIP/HQ to work in collaboration with regions and programmes to articulate a *health systems platform* for programmes in country, through policy papers, positions and developing competencies on Health Systems issues and elements for use at country level.
- There is urgent need for HQ, working in close consultation with the Regions and Country offices, to *adapt existing tools*, methodologies and guidelines or develop new ones as necessary to encourage working across programmes and integrated service delivery at the country level

9. Way forward: Summary of recommendations and related action plan

| S/n | Area of Focus | Recommended Action | By Whom | Timeline |
|-----|--|--|--|-------------------------|
| 1. | AFRO senior management to review and endorse recommendations arising from three country strengthening missions that can be taken forward in the short term using available resources; | <ol style="list-style-type: none"> Clarify with WRs the short term, recommendations awaiting AFRO/MDC endorsement MDC review & endorsement WRs and relevant AFRO officers to implement | <ol style="list-style-type: none"> AFRO/CAS MDC WR/WCOs | Oct. 2004 |
| 2. | WHO Country Offices (Kenya, Tanzania & Malawi) to implement the recommended changes, subject to AFRO endorsement | <ol style="list-style-type: none"> Operationalise the new cluster arrangements Fill vacant positions & establish and fill new posts with AFRO Work with AFRO/HRS to cost the staff development plan & map out an implementation schedule Harmonise WCO contracts in line with WHO guidance Update Plan of Action to incorporate agreed programmatic and managerial changes Work with AFRO & HQ to finalise interim One Country Plans, and help in providing guidance for other countries; Collaborate with AFRO & HQ on joint resource mobilisation strategies for their country using approved plans; Ensure Country Cooperation Strategy is kept upto date, in line with regional guidance | WR/WCO | Oct. 2004- Feb 2005 |
| 3. | AFRO Regional Office to take forward recommendations for the Regional Strategy | <ol style="list-style-type: none"> Complete the final report, including the methodology & framework for the regional strategy Refine methodologies for strengthening country presence, and update guidance for WCO's Finalise & disseminate criteria for phasing across countries in the region Agree a timetable for phasing the changes across the region AFRO to perform a study to make recommendations on sub-regional grouping of technical support to countries Develop objective criteria to guide levels of technical support to be provided to a country AFRO/HRS to <ul style="list-style-type: none"> develop a regional staff development strategy for WHO country offices, using funds made available for this purpose Provide guidance & support in using the PMDS for team working Institutionalise re-profiling into the normal planning process AFRO/PPE to <ul style="list-style-type: none"> Review use of AMS and management of programme funds to support working across Areas of Work Perform a critical review of business procedures in WCOs | <ol style="list-style-type: none"> AFRO/CAS & HQ/CCO AFRO/CAS AFRO/CAS AFRO/CAS MDC AFRO/CAS AFRO/HRS AFRO/PPE | Oct. 2004- June 2005 |
| 4. | HQ/AFRO/WCOs to define a resource mobilisation strategy for strengthening WHO support to National Health Development and better health outcomes | <ol style="list-style-type: none"> Cost out changes for the AFRO regional strategy, and clarify resource gaps, Summarise (interim) One Country Plans for use in Resource Mobilisation strategies Agree a joint HQ/RO/WCO resource mobilisation strategy | <ol style="list-style-type: none"> AFRO/CAS & HQ/CCO WRs, AFRO/CAS, HQ/CCO & PRP, AFRO & HQ external relations | Nov. 2004- Jan 2005 |
| 5. | HQ/AFRO/WCOs to start Country Planning using joint planning mechanisms for 06-07 | <ol style="list-style-type: none"> Review progress and lessons from three pilot countries Consider experience of other regional pilots Agree joint programming timetable for development of the AFRO 06/07 Country Plans | <ol style="list-style-type: none"> AFRO/PPE AFRO/CAS & PRP, HQ/CCO & PRP AFRO/PPE | Nov. 2004- Jan 2005 |
| 6. | WHO HQ to take forward the recommendations to support the regional strategy for Africa | <ol style="list-style-type: none"> ADGs & DGO to provide necessary support and advocate support to the regional strategy ADGs to decentralise resources to regions and countries as directed by the DG Explore with donor partners how best to support integrated technical cooperation at the country level Use the One Country Plan as a resource mobilisation tool EIP to work with all programmes in articulating a health systems platform for priority programmes GMG to work with the region to consider how existing management support tools could be adapted to support effective team work across Areas of Work | <ol style="list-style-type: none"> ADGs, DGO ADGs EIP & priority programmes GMG/PRP & EGB/GPR Technical clusters GMG | Oct. 2004- June 2005 |

Annex I.

List of participants at the joint WCO/AFRO/HQ Workshop in Nairobi,

Participation in April Workshop (20-22 April 2004) and follow up missions

| Working across programs | Developing Country Teams | Developing administrative capacities |
|---|--|--|
| Mrs Joy Phumaphi Dr Rufaro Chatora Dr Sabri Belqacem Dr Orvill Adams Dr Dan Makuto Dr Dominique Egger Dr Paolo Teixeira Dr Therese Lesikel Dr Tuoyo Okorosobo Dr Carol Presern Dr Joanne Greenfield Dr Funke Bogunjoko | Dr Tim Evans Dr Luis Sambo Dr Abdalla Assaedi Dr Marie-Andree Diouf Dr Raphael Bengoa Dr Alejandro Henning Dr Kadri Tankari Mr Alvaro Durao Dr Arabang Maruping Dr Alexis Ntabona Mme Thomas-Mapleh Dr Assumpta Muriithi Dr Bob Fryatt | Mr Bernard Chandra Dr Dositree Ngobebe Mr Chris Bailey Dr Abdelhay Mechbal Mr Pascal Bijleveld Dr Lulu Muhe Mr Getachew Sahlu Dr Eleuther Tarimo Dr Ibrahim Betelmal Dr Wilfred Ndegwa Mr Bernardino Cardoso |

Team Members for the Integrated Technical and Re-profiling Missions.

WCOs

Kenya : WR & WCO members

Malawi: WR & WCO members

Tanzania : WR & WCO members

AFRO

DSD : Dr R. Chatora (Team leader for the Technical missions); Dr J. Nyoni, Mr Mwase,

DAF: Mr M. Ndiaye (Team leader for the re-profiling missions)

DDC: Dr Mgalula & Dr T. Okorosobo

DES: Drs A. Mawaya, B. Nganda & C. Mwikisa

DRH: Dr S. Mothebesoane-Anoh

DPM: Drs J. Mwanzia & F. Bogunjoko and Mr P. Lessimi

HQ

EIP: Drs Orville Adams, P. Kadama, L. Hawken, C. Bailey, N.Valentine & G. Gedik,

FCH : Dr Dan Makuto

HTM: Dr H. Getahun

SDE: Dr Alaka Singh & Mr Amine Kebe

GMG: Dr H. Feirman, Ms Kelly Robertson, Sidibe Pimpie, & P. Desai and Mr W. Fallon.

CCO: Dr Bob Fryatt.

Annex II

Roles and Functions of WHO Country Office Clusters & Coordinators to improve efficiency and integration across programmes.

Generic functions of the WCO team

Relevant to the specific topic or programme

1. Assessing health system challenges and agreeing on AOWs in consultation with MoH at policy and support levels.
2. Engaging with the Ministry of health and maintaining policy dialogue
3. Policy initiation, development, analysis, monitoring and review
4. Gathering and sharing information
5. Coordination and communication with government and partners
6. Strategic and operational planning
7. Offering expert technical advice
8. Environmental scanning for continuous health systems performance monitoring
9. Improving service delivery
10. Support to national capacity development
11. Initiating, Developing and Managing operational research as relevant
12. Coordination and communication with the Regional Office and HQ and following up country level activities
13. Monitoring and evaluation

Within the teams/clusters

- Generating team consensus on strategic engagement with the health sector
- Synchronizing AOW plans and budgets.
- Planning, monitoring and evaluation for biennial plans and budget
- Coordinating technical support to MoH

- Coordination and communication among team members
- Joint planning across programmes on areas such as training, supervision, needs assessment, guidelines development, adaptation & review etc.
- Information sharing within and across clusters
- Knowledge management relevant to the teams AOW and thematic focus.
- Covering for each other when absent

Across teams

- Sharing information
- Coordination and communication across teams
- Capacity building across teams
- Joint planning across teams on areas such as training, supervision, needs assessment, guidelines development, adaptation & review, development of integrated training manual etc.

Role of Cluster Coordinator

- Enhancing teamwork and ensuring that activities are coordinated.
- Lead planning to ensure that response covers major areas of work in the cluster.
- Ensuring that appropriate remedial measures are taken where there is a gap in activities.
- Organizing regular meetings for exchange of information and to address emerging issues
- Participate in briefing and debriefing meetings when missions and consultants come into the country.
- Exercising powers delegated by the WR.

** Preferred option is that all colleagues within each cluster will be eligible to apply and the best candidate selected as the Cluster Coordinator.*



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