

Building UNFPA/WHO capacity to work with
National Health and
Development Planning Processes
in support of reproductive health



Report of a technical consultation

Geneva, Switzerland
20–21 October 2005

Building UNFPA/WHO capacity to work with
National Health and
Development Planning Processes
in support of reproductive health

Report of a technical consultation

Geneva, Switzerland

20–21 October 2005



Acknowledgements

This report was written by two WHO staff members, Dale Huntington and Rebecca Dodd, based on the deliberations of a consultation meeting entitled "Building UNFPA and WHO Country Office Capacity to Work with National Health and Development Planning Processes in Support of Reproductive Health: Review of Case Studies", held in Geneva, Switzerland, in October 2005. The report also draws on findings from the country case studies prepared by the following WHO staff members: Eugenio Villar Montesinos and Enrique Ezcurra (Nicaragua), Amine Kebe and Alexis Ntabona (Senegal), Alaka Singh and Heli Bathija (Yemen), Rebecca Dodd and Peter Hill, consultant, (Mongolia). The report benefited from the suggestions and inputs from all those present at the meeting. Assistance in finalizing the report was provided by the following UNFPA staff: Dia Timmermans, Rabbi Royan, Lyndsay Edouard, Hedia Belhadj-El Ghouayel, Janet Jackson, Eva Weissman and Hans Opdejin.

Building UNFPA/WHO capacity to work with National Health and Development Planning Processes in support of reproductive health. Report of a technical consultation. Geneva, Switzerland, 20–21 October 2005

© World Health Organization, 2006

All rights reserved. Publications of the World Health Organization can be obtained from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel: +41 22 791 2476; fax: +41 22 791 4857; email: bookorders@who.int). Requests for permission to reproduce or translate WHO publications – whether for sale or for noncommercial distribution – should be addressed to WHO Press, at the above address (fax: +41 22 791 4806; email: permissions@who.int).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either express or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

Printed in

Contents

Summary	1
Background.....	1
The case-studies	2
Synthesis of findings	3
Poverty reduction strategy processes and reproductive health	3
<i>The potential.....</i>	<i>3</i>
<i>Case-study findings.....</i>	<i>3</i>
Sector-wide approaches and reproductive health	5
<i>The potential.....</i>	<i>5</i>
<i>The reality.....</i>	<i>6</i>
<i>Engagement of UNFPA and WHO in sector-wide approaches.....</i>	<i>7</i>
Recommendations and suggested future activities	9
Annexes	
List of participants	11
Agenda.....	13

Abbreviations and acronyms

CCA	Common Country Assessment
ICPD	International Conference on Population and Development, Cairo, 1994
MDG	Millennium Development Goal
PRSP	Poverty Reduction Strategy Paper
SWAp	Sector-Wide Approach
UN	United Nations
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
WHO	World Health Organization

Summary

As part of a United Nations Population Fund (UNFPA)/World Health Organization (WHO) project to strengthen country office capacity to better profile reproductive health in sector-wide approaches (SWAps) and poverty reduction strategy processes (PRSPs), country case-studies were undertaken in Mongolia, Nicaragua, Senegal and Yemen during September–October 2005. This report provides a summary of key findings and makes recommendations for further collaborative work between the two agencies.

All case-studies concluded that it is very appropriate for UNFPA and WHO to play a strategic role in SWAps, either existing or planned. To this end, UNFPA and WHO need to define where each agency can ‘add value’ to the SWAp process. To date, UNFPA has created a role for itself by being the first UN agency to join pooled funding mechanisms, and by mobilizing senior leadership and support for sector-wide planning. WHO’s role in SWAps is more mixed, and dependent on country circumstances and resources. Even so, examples were provided of ways in which both UNFPA and WHO can add value to SWAp processes using existing staff competencies. These include:

- technical support related to tracking resource flows and health expenditures, e.g. strengthening national health accounts for reproductive health;
- strengthening health information systems to ensure that progress towards implementing the Global Reproductive Health Strategy is routinely reported.

In addition to more strategic use of existing staff skills in specific areas, greater engagement in SWAps and PRSPs requires provision of high-quality, independent policy and technical advice which comprehensively addresses sector development. The meeting called on each agency to explore how country offices could be strengthened to provide such advice, while ensuring consistency with UN reform processes and the creation of new United Nations Country Teams (UNCTs). Mobilizing senior management support for this approach is crucial. The point was also made that support on upstream issues should not be at the expense of core reproductive health expertise, which may also need to be strengthened in parallel.

Background

The first high-level consultation between UNFPA and WHO in December 2003 called for both institutions to collaborate in health sector SWAps, specifically by promoting adequate investments in reproductive health. The second high-level consultation between UNFPA and WHO in June 2004 recognized the progress that had been made and identified the continued importance of complementary efforts to mainstream sexual and reproductive health in national and international planning processes, including SWAps, PRSPs and reporting on Millennium Development Goals (MDGs). The June 2004 consultation specifically called for increased capacity-building activities.

Following the 2004 high-level consultation, a UNFPA/WHO joint working group designed a project that would contribute to the development of in-country office capacity for both agencies on national health and development planning processes. The project was implemented by four departments from within three different clusters of WHO, under the leadership of the Department of Reproductive Health and Research. An important element of this initiative was to conduct four country case-studies.

The case-studies

The purpose of the case-studies was to produce “advisory products based on actual country examples to guide UNFPA and WHO in the development of institutional policy guidelines and capacity-building training materials related to mainstreaming sexual and reproductive health in PRSPs, SWAPs, UNDAF and MDGs”. To this end, it was anticipated that the findings from case-studies would inform future technical assistance and guidance provided by UNFPA and WHO to colleagues working at country level on this complex set of issues.

Case-studies were conducted in Mongolia, Nicaragua, Senegal and Yemen by teams of WHO staff drawn from the Department of Reproductive Health and Research and the Department of MDGs, Health and Development Policy. Site visits were made to each country during September–October 2005. The fieldwork was coordinated with UNFPA and WHO country offices; WHO regional offices participated in the planning of the case-studies.

A common methodology, set of research questions and analytical framework was developed to guide each country case-study. A broad definition of reproductive health was used, in line with the Global Reproductive Health Strategy adopted by the World Health Assembly in 2004. This definition covers the following elements:

maternal and newborn health; family planning; sexually transmitted infections including HIV/AIDS; preventing unsafe abortion; combating harmful sexual and reproductive health practices; and other aspects of sexual and reproductive health (such as reproductive cancers).

Before conducting the fieldwork, locally recruited consultants assembled relevant background documentation and each team conducted literature reviews. During the site visits, meetings were held with UNFPA, WHO, government officials, nongovernmental agencies and representatives of donor agencies. In some countries, visits to provincial offices of the Ministry of Health were conducted; in others, provincial officials travelled to the capital for discussions with the research teams.

Draft versions of the case-studies were presented and the results discussed during an in-house (UNFPA and WHO) technical consultation meeting, held in Geneva on 20–21 October 2005. The list of participants and meeting agenda are included in Annex 1. Specifically, the consultation accomplished the following two objectives:

1. To finalize the findings and recommendations from each of the four country case-studies.
2. To identify cross-cutting issues and key lessons learned common to each country and produce recommendations for capacity-building activities.

All case-studies have now been finalized and are available on-line at the following http addresses: www.unfpa.org and www.who.int/reproductive-health/tcc. This report provides an overview of the principal findings that emerged from the studies, focusing on common themes and cross-cutting issues. It also discusses issues that are intrinsic to the process of a SWAp or PRSP, as well as contextual factors that influenced the findings. The recommendations that emerged from the discussions are presented in terms of how future collaboration between UNFPA and WHO can best be approached; illustrative areas of work that can form the basis for future partnership are also provided.

Synthesis of findings

Poverty reduction strategy processes and reproductive health

The potential

This section explores why PRSPs should be important for reproductive health. First and foremost, the PRSP should set national priorities for economic growth, development and poverty reduction. These priorities should then be reflected in a country’s expenditure framework and annual budget. Thus PRSPs are an opportunity to build political support for reproductive health services beyond the health sector – across government – and to ensure that such support is backed up with adequate financing. It is imperative that social sector issues (including reproductive health) are included in a PRSP because investments in human capital are enabling factors for economic growth generated by “productive sectors”. In addition, it is increasingly recognized that efforts to achieve the MDGs – including the health goals – should be developed within the framework of the PRSP. This approach was recently reconfirmed at the 2005 World Summit, which endorsed the call for all countries to develop “MDG-based PRSPs”.

As PRSPs are multisectoral planning frameworks, their discussion of health in general – and reproductive health in particular – is necessarily limited. They cannot (and should not attempt to) replace existing sector programmes, nor will they contain full details of a comprehensive health strategy. However, through their focus on poverty reduction, PRSPs could catalyse or strengthen a process of prioritizing those reproductive health interventions most likely to improve the health of the poor. This in turn could help protect or increase spending on pro-poor health interventions, and in addition build a case that reproductive health is an investment that contributes to poverty reduction.

PRSPs are not a solution to weak health sector planning and budgeting capacity. However, a high-profile PRSP, taken seriously at senior levels of government and involving development partners and civil society groups, may provide an opportunity to stimulate and strengthen health sector planning. Further, the poverty reduction strategy process has the potential to stimulate cross-sectoral work and ensure policy coherence in efforts to address reproductive health. Finally, by identifying and agreeing priorities for the health sector, PRSPs should encourage greater harmonization among donors supporting health. This in turn should reduce transaction costs for government and align donor policy and procedures behind those of the country.

For all these reasons, PRSPs are potentially significant for the health sector in general and reproductive health in particular. The section below reviews evidence from the case-studies on how well this potential has been realized in practice.

Case-study findings

The findings from these case-studies reconfirmed previous reviews that show weak tangible evidence of reproductive health being valued across sectors in PRSPs. This is despite the prominence of reproductive health (particularly population growth and maternal health) in policy-makers’ discourse and public pronouncements. As one case-study respondent noted, “Reproductive health is talked about everywhere but isn’t located anywhere”. Moreover, PRSPs tend to mention only selective elements of reproductive health, in particular maternal health, and do not reflect the holistic definition of reproductive health as set forth in the Programme of Action of the 1994 International Conference on Population and Development (ICPD). This can be partly attributed to the importance placed on MDG reporting (which has limited explicit reference to reproductive health in the goals or targets). It may also be due to sensitivities associated with some elements of reproductive health (e.g. preventing unsafe abortion, adolescent sexual and reproductive health, harmful practices).

The problem is larger than reproductive health alone being undervalued in poverty reduction strategy processes: the health sector's contribution to poverty reduction generally is not well represented in many PRSPs. The case-studies reported that the PRSP did not necessarily correspond to a prioritization of investments in the social sectors. Indeed, in at least two countries, Nicaragua and Senegal (see Box 1), health and education were referred to as “non-productive” sectors, receiving second-level investment priority over sectors that were considered more directly related to economic growth. This is particularly worrying as both countries have second-generation PRSPs, which have been defended as having a greater focus on human development aspects of poverty reduction.

Box 1 The poverty reduction strategy process in Senegal

Senegal has traditionally benefited from strong donor support and has always been associated with the international development agenda. In the 1990s, a shift occurred in the policies focusing on poverty reduction strategies. During this period, the social sector in general, and health in particular, were regarded by government as non-productive, and therefore subject to low resource allocation (budget and aid) and even budget cut-backs for many years. With support from the International Monetary Fund and the World Bank, the government's poverty reduction policy frameworks focused only on macroeconomic stabilization and management of aggregate demand, creating huge deficits in sector management, especially for health and education.

Even when emphasis is given to reproductive health in PRSPs, this does not necessarily translate into actual budgetary allocations. Financial analyses in Nicaragua and Senegal suggested that funding for reproductive health has not increased and may, in fact, have decreased. In some settings the PRSP has contributed to an over-emphasis on planning at the expense of implementation. For example, in Senegal, multiple national and health sector planning processes and documents existed. The case-studies found that these different plans did not always use the same terminology, and that the multiplicity of documents has contributed to weak implementation. For example, the Ministry of Finance apparently used one plan for the purpose of resource allocation to the health sector, while the Ministry of Health used another to guide programme implementation. All case-studies repeatedly drew attention to insufficient capacity within health ministries to translate a PRSP into pro-poor reproductive health programmes.

Box 2 The poverty reduction strategy in Mongolia

Mongolia's PRSP (the Economic Growth Support Poverty Reduction Strategy 2002–2007) has had a limited impact on health policy and programmes. Drafted largely by a World Bank consultant following consultation with key stakeholders, the process did not result in any sense of local ownership. The document has not been approved by the Mongolian Parliament, and with a change in government, and the failure to attract significant World Bank funding, it is not regarded by current Ministry of Health respondents as relevant. Donor representatives considered that a suitable selection of pro-poor strategies were profiled: strategies for reproductive health, reduced maternal mortality rates and the expansion of health insurance to cover vulnerable groups are included as objectives. But there is no indication of priorities; insufficient detail was provided to promote implementation; and without costings, the strategies have not been linked to the mid-term expenditure framework. The lack of endorsement by Parliament has meant that the health expenditure targets could not be guaranteed.

In all four countries, the Ministry of Health's engagement in the PRSP was quite limited, for example, simply to reviewing text written by others. In part this may be because the locus of control over the PRSP resides outside the health sector (see Box 2). All case-studies found that health ministries were at a disadvantage in dialogues with finance ministries because they lacked staff with macroeconomic competencies. Other influential actors in the PRSP, such as parliamentary committees or political action groups, are commonly outside the reach of health ministries. The ability of the UNFPA or WHO country office to facilitate communications and linkages with the full range of actors in the poverty reduction strategy process was also quite limited in all the countries studied. However, at the review meeting it was pointed out that in

some other countries WHO is strongly engaged in this process. In such cases, the key issues are not so much lack of capacity but relate more to finding agreement on priority reproductive health messages for the PRSP and harmonizing operations with the poverty reduction strategy.

As a result of these shortcomings, Ministries of Health in the case-study countries did not voice ownership of the PRSP and typically there were poor links between health sector plans and multisectoral instruments. This go-it-alone stance is counterproductive for a number of reasons, as suggested previously. In this planning environment it is not surprising that the case-studies found that reproductive health was neither prominently nor comprehensively valued in multisectoral planning processes. The case-studies failed to identify a good example of a WHO or UNFPA country office assisting a Ministry of Health in promoting reproductive health in a PRSP, even as there is clear recognition of the potential role for United Nations (UN) agencies to facilitate dialogue between the different ministries and the participation of subnational offices and other actors within the PRS process.

In general, the case-studies revealed that UN agencies often maintained a sector- and programme-oriented approach, and tended to be more interested in generic UN processes than national ones. The viewpoint emerged that the way in which UNDAF had been formulated may be more a constraining than enabling framework and process for UNFPA and WHO engagement in national multisectoral planning and processes.

Sector-wide approaches and reproductive health

The potential

Although definitions of what constitutes a SWAp vary, most centre upon a common set of components or elements, including:

- a clear sector policy and/or strategy;
- a formalized government-led process for donor-coordination at sector-level;
- a sectoral medium-term expenditure programme and annual budget that clarifies the expected level of available internal and external resources and how these resources will be used in pursuit of sector policy;
- a performance-monitoring system that measures progress towards the achievement of policy objectives and targets results;
- an effective funding mechanism that provides flexible and predictable funding in support of sector policies;
- an agreed process for moving towards harmonized systems for reporting: budgeting, financial management and procurement;
- a client consultation mechanism.

In reality, while there is considerable support for health SWAps, most countries have some, but not all, of these components in place. Moreover, it is usually the case that some components are well advanced while others are in their infancy, reflecting a developmental or incremental approach to constructing a SWAp. A government commitment to develop and adopt key principles and components of a SWAp is essential. This experience is confirmed by the case-study findings.

From the perspective of reproductive health, a SWAp provides an opportunity to address the systemic and structural constraints on improving reproductive health services. Issues such as lack of staff in rural areas, poor in-service training, deteriorating infrastructure, weak information systems, inadequate financial mechanisms for universal coverage and failing procurement systems are all issues that impact on reproductive health services. These health systems issues need to be tackled

across the sector as a whole. For example, it is impossible to improve the terms and conditions of staff delivering reproductive health services without revising human resources policy for all health workers. Similarly, decreasing the maternal mortality ratio requires improving access to emergency obstetric care, which in turn requires a strengthening of district hospital services and reducing financial risk for patients – something that a reproductive health programme cannot achieve on its own.

On the other hand, it is clear that a SWAp cannot satisfy all the requirements of a comprehensive reproductive health and rights programme. Reproductive health depends on a co-ordinated multisectoral approach involving education, youth and family welfare ministries as well as civil society. Therefore, it must engage partners beyond the health sector. Equally, sensitive issues such as combating harmful practices, and adolescent reproductive health may be better tackled outside a government-led mechanism such as SWAp (unless there is a strong public–private partnership).

Finally, the importance of SWAp remains constant even as donors increasingly move ‘upstream’ towards general budget support and overall poverty reduction strategies and credits. SWAp are an instrumental tool for harmonizing health sector policy planning and budgeting processes, particularly since a poverty reduction strategy process can devote only limited time and space to health issues. Furthermore, as the health sector is characterized by a number of development partners who have traditionally supported reproductive health programmes through projects, SWAp can provide a forum for negotiating key policy issues and harmonizing procedures. It is therefore important to establish a strong, coherent link between the sector strategy and the overall development plans and budget.

The case-studies provided an insight into how countries are handling these issues and tensions. They also provided experience on some of the practical, day-to-day difficulties inherent in operationalizing and managing a SWAp.

The reality

Of the case-study countries, Yemen and Mongolia have identified the development of SWAp as a priority, but are at an early stage. In interviews with the case-study team the major donors to health in those two countries did not express any reservations about supporting a government-led initiative that would culminate in a SWAp. However, most had adopted a ‘wait-and-see’ approach, which meant, in effect, a continuation of ‘business as usual’, i.e. project-oriented support and short-term funding.

In Senegal and Nicaragua, the case-studies identified several unresolved issues around the disconnect between planning and operational processes. The problem is most acute in Senegal, where the first phase of health sector planning (Plan National de Développement Sanitaire (PNDS) Senegal’s SWAp mechanism) was not closely aligned with the PRSP, and suffered from multiple operational deficiencies and implementation shortcomings. In Yemen (see Box 3), the case-study identified an important disconnect between planning and budgeting processes.

Box 3 The sector-wide approach in Yemen

The case of Yemen illustrates how the lack of coherence between SWAp planning and budgeting can create problems for reproductive health. Population issues are covered by three separate departments in the Ministry of Health: Reproductive Health, Youth, Women’s Affairs and Health Education. In addition, the National Population Committee implements population-related programmes based on a National Population Strategy. This has created duplication, gaps and some incoherence in policy. This may be partly attributed to a lack of consultation between the National Population Policy development and recent work on the health sector review. In addition, it is unclear where final responsibility and accountability for reproductive health outcomes lie. The vertical approach to planning has resulted in an almost exclusive focus on activities, rather than on addressing underlying issues of poverty and equity. A sector-wide effort that takes into account health systems issues and the role of donors, could help to mainstream reproductive health and ensure a more coherent and effective approach.

In each case-study country, it was perceived that a SWAp requires a pooled funding mechanism. In all cases, this element was defined as the key characteristic of the SWAp, over and above the development of a common approach to sector planning, implementation and monitoring. Familiar donor concerns such as loss of attribution, changing benchmarks of success and lengthening time frames for achieving desired results, were also noted. Although they have been long-discussed at the international level, these concerns still present real obstacles to moving towards a SWAp at country level. In Senegal and Nicaragua (see Box 4), the construction of basket funding mechanisms is still a work in progress.

Donor concerns about moving towards more harmonized approaches are acutely felt by reproductive health programmes, which have commonly benefited from strong donor support (and as a result have been partly insulated from the uncertainties of government planning and funding processes). Changing the operational structure of a reproductive health programme – as under a SWAp – therefore requires strong support from donors (and acceptance that there will be less donor control over the way reproductive health is planned, implemented and evaluated). Governments must also be willing to assume full responsibility for sensitive health services. However, as the consultation meeting discussed, many donor agencies, and in particular the UN, operate in risk-averse environments which makes such a transition difficult. UN agencies and donors must therefore work to ensure senior management support, leadership and engagement as countries move towards a SWAp. The experience of Mongolia, where the Ministry of Health is trying to decrease the dependence of the reproductive health programme on donors, is an example of how government is working to orchestrate a shift in funding for reproductive health, and create conditions for a smooth transition to a SWAp.

All case-studies noted the important role of non-health partners in reproductive health and the limitations of SWAp in effectively engaging other sectors and civil society. In part this reflects the limitations of Ministries of Health in reaching across and outside government or, conversely, in managing strong criticism of sensitive reproductive health services, such as abortion, or even family planning, voiced by these outside groups. Developing partnership with civil society and other private-sector actors is essential for a comprehensive reproductive health programme. Yet in some case-study countries the UNFPA and WHO offices were also poorly positioned to engage civil society actors. In this sense, the shift towards a SWAp may represent a setback for reproductive health programmes. This was clearly witnessed in Nicaragua, with the result that reproductive health concerns are not adequately reflected in the SWAp.

Engagement of UNFPA and WHO in sector-wide approaches

The consultation meeting’s discussion on UNFPA and WHO engagement in national development processes to promote reproductive health focused more on SWAp than on multi-sectoral planning processes such as PRSPs. Several issues emerged from the case-studies and from the interventions of senior staff present during the consultation meeting. Many of these staff had first-hand experience in negotiating a SWAp at country level, and in supporting government during implementation. Clear differences as well as commonalities between UNFPA and WHO were apparent.

Box 4 The sector-wide approach in Nicaragua

The SWAp experience in Nicaragua is particularly noteworthy. Despite its relative newness, and the existence of a coordination mechanism for funding agencies, the SWAp seems to represent a step forward in promoting consensus-based priorities for implementation, coordination among donors and harmonization between their own projects and procedures. It also furthers the alignment of donors with national priorities and programmes (including reproductive health). The process is expected to strengthen the Ministry of Health’s leadership in sector development. One unresolved issue is the position of UN agencies in the SWAp. The UN has not yet signed the memorandum of understanding for joining the basket funding mechanism or working under the guidance of the SWAp, and as such remains the last donor group outside the health SWAp. Although this position is expected to change, at the time of the case-study visit it had not.

UNFPA has a strong and clear institutional position that is supportive of SWAPs and in several countries it has contributed to pooled-funding mechanisms. In some settings (not part of the case-studies) that contribution is significant. In India, for example, approximately 60% of the UNFPA country budget for the next three years is programmed through a SWAP.

WHO's role in SWAPs is more mixed and is dependent on country circumstance. In some places, the WHO country office has led SWAP negotiations, while in others it has not been involved at all. The specificity of each country setting, along with the capacity, experience and interest of senior WHO/UNFPA staff, is a powerful influence in this regard. The forthcoming WHO guidance paper on SWAPs, which will include clarification on operational details such as whether and how WHO can make pooled-funding contributions, should help to establish a more consistent approach across the Organization.

Collaboration between UNFPA and WHO at country level is also highly variable and context-specific. The consultation meeting therefore agreed on the need to establish more systematic processes to enhance institutional linkages. The UNDAF can assist to this end, but the meeting's discussions indicated that more needs to be done.

Regardless of the intensity of engagement in SWAPs on the part of UNFPA and WHO, all case-studies reported a strong interest from the agencies' country offices in playing a more strategic and influential role in the local SWAP process. This viewpoint was echoed by local donors and government representatives who all wanted UNFPA and WHO to play a more prominent role in SWAPs, and better coordinate support for reproductive health. The relevance of this engagement to the broader issue of UN reform was emphasized in the consultation meeting's discussions. It was pointed out that if the country office does not have a role in the SWAP or other sector-wide development assistance initiatives, then it is likely to be increasingly marginalized.

While there was support for UNFPA and WHO playing a more prominent role, concern remained about country office capacity to do so. Core competencies in health economics (including public finance management), monitoring and evaluation and socioeconomic analyses are lacking in many country offices of both organizations. Yet these skills are needed if UNFPA and WHO are to influence the SWAP in favour of reproductive health. In three of the four case-study countries no WHO staff member had been assigned to follow the SWAP process; it was rather one more item among many on a busy agenda of the WHO Representative. The exception is Nicaragua, where a PAHO regional strategy to place national development planning staff in priority country offices has created a post on these issues in the Nicaragua office.

It will only be possible to increase the availability at country level of staff with the necessary skills for working on SWAPs if an institutional environment supportive of SWAPs is created at higher levels of UNFPA and WHO. The influence of senior staff leadership was mentioned during the consultation meeting as being crucial to that end. For example, headquarters must understand that more harmonized approaches may mean a lower institutional profile at country level ('lowering the flag'). Differences between UNFPA and WHO organizational structures became very apparent in this discussion: in WHO, regional office support is essential to advance country office engagement in SWAPs; in UNFPA, headquarters has a more direct influence.

The limited ability of WHO to pool funds was repeatedly mentioned, but most agreed that this was more a perceived than an actual constraint. However, the need remains for WHO country offices to establish a role for themselves in the SWAP processes. UNFPA has succeeded in doing so by making contributions to pooled funding mechanisms; UNFPA has focused on the issue of financial management preparedness, which has helped the agency to create alternative funding modalities for its use (e.g. pooled or parallel funding). While pooled funding is not often an option for WHO, it could, as an alternative, assume the role of 'honest broker' in SWAP processes. This relates both to balancing the influence of large donors (who are often pushing a particular reform agenda, e.g. the Asian Development Bank in Mongolia, or the World Bank in Nicaragua), and to helping a Ministry of Health negotiate the politics of institutional reform. Repositioning technical assistance to work on upstream planning processes related to developing a SWAP (to ensure adequate financial support

for reproductive health) or assisting the government in implementing health sector reforms that underpin many SWAPs are among the different ways that both UNFPA and WHO can establish a clear niche for the country office in a SWAP, regardless of whether funds are pooled or not.

The case-studies and discussions during the consultation meeting also identified real-world constraints on UNFPA programming through SWAPs, despite the institutional leadership that clearly exists. For example, there is concern that the emphasis on planning has been at the expense of maintaining operational familiarity. In addition, headquarters' commitment towards SWAPs and harmonization is sometimes in contradiction to UNFPA operations at country level, which may remain in a project mode. Both UNFPA and WHO need to minimize the number of 'off-budget' projects that are carried out in-country. Finally, it was feared that support for sector programmes structured around the MDGs might compromise the goals of broad reproductive health programmes set out at the ICPD.

Through a discussion of these and related issues, the consultation meeting identified several areas where UNFPA and WHO can work together to improve performance and collaboration in support of SWAPs. The meeting also identified areas tailored to the specific needs and competencies of each agency. Future directions will need to maintain this approach, i.e. of clearly differentiating between common needs and agency-specific circumstances.

Recommendations and suggested future activities

Three overarching considerations influenced the discussions on how to move forward with developing UNFPA and WHO country office capacity to promote reproductive health through national development planning processes.

First, although the consultation meeting focused primarily on the role of UNFPA and WHO country offices in SWAPs, the importance of PRSPs was acknowledged. Both agencies should be able to support governments to produce poverty reduction strategies that value health in general, and reproductive health in particular as a key element to reducing poverty. The critical issues for Ministries of Health are frequently centred on ensuring that the national budgetary allocations correspond to health sector plans, and that reproductive health figures prominently in both planning/ budget and operational strategies. A SWAP can be an effective bridge between these two management dimensions when there is a clear system for sectoral budgetary analysis. SWAPs are clearly valued by both donors and governments, and will continue to be a powerful tool for harmonizing health sector strategic planning/budgeting with national and international financial planning processes in the coming years. As such, it is imperative that the UNFPA and WHO country offices are engaged and support the inclusion of reproductive health within those frameworks as fully as possible. In countries without SWAPs, UNFPA and WHO need to work together to agree on core reproductive health messages to feed into sector and national planning processes.

Second, UN reform and the evolution of the UN Country Team (UNCT) were seen as another important consideration. Furthermore, UNFPA and WHO efforts should be firmly rooted within the CCA-UNDAF. The need to capitalize on joint programming, harmonization of planning cycles and other management processes, among other points, was a recurrent theme. Sharing needed expertise with other UN agencies – such as on economics with UNDP – was also suggested. To this end, the meeting stressed the need for UNFPA and WHO to become more actively engaged in UN reform processes, and to use their role within the UNCT to encourage it to participate more actively in new, more harmonized approaches to development assistance that support reproductive health.

A third cross-cutting topic in the meeting's discussions was the pressing need to sustain support for reproductive health. Although resource flows into reproductive health will meet the 2005 financial targets set at the ICPD, support is weighted towards HIV/AIDS and some elements of reproductive health have actually declined (e.g. family planning). Related to this point are concerns about the effect on reproductive health support as the shift occurs away from donor-supported projects to the

sector-wide programme, or even more upstream, direct budgetary support. It was suggested that one way forward was more direct collaboration between UNFPA and WHO at country level to mobilize resources related to the full range of reproductive health services.

The forces that, on the one hand, are changing how development assistance is programmed and, on the other hand, are contributing to declining financial support for some elements of reproductive health, combine to create a sense of urgency for UNFPA and WHO to work together on SWAp in support of reproductive health.

Creating an institutional environment that supports pro-active responses to these challenges will require different strategies for UNFPA and WHO, reflecting each agency's unique organizational structure and management processes. For WHO, the important role of the regional office in providing oversight and assistance to country offices is crucial. Future activities that seek to develop country office capacity must therefore engage regional senior management and work through regional structures for supporting country offices. Where appropriate, this should be done within the context of the "Maputo Process" of WHO's Country Focus Department (which seeks to strengthen country office capacity in 13 African countries), using this process and support materials. For example, guidance papers on WHO's role in SWAp and training materials on harmonization and alignment for WHO country offices will become available in early 2006. Future UNFPA/WHO collaboration on this issue should also explore mechanisms for strengthening the Country Technical Services Teams of UNFPA.

While the meeting recognized that engagement in these larger issues will entail longer-term commitments, several other more short-term or immediate actions were also discussed. Among the actions suggested were the following:

- Developing effective knowledge management processes to clarify terminology and concepts and share widely country experiences around SWAp or PRSP.
- Training and professional development opportunities to enhance country and regional staff competencies in new policy directions relating to poverty reduction, sector-wide programming and UN reform; and exploring how these relate to reproductive health, including strengthening connections with other branches of government outside the health sector. Related to this is the question of which staff should be selected for upgrading of competencies on these issues, i.e., heads of office, reproductive health, and/or poverty-reduction advisers.
- Guidance on repositioning policy and technical support so that it assists in bridging the gap between planning, operations and level of expenditures. This requires, among other things, technical assistance for comprehensive sector analysis and planning (grounded in decentralized processes) that can feed into the development and maintenance of sector-wide programmes.
- Strategic technical support, for example: national health accounts for reproductive health, technical assistance mapping, resource analyses, mid-term expenditure framework analysis, monitoring and evaluation of reproductive health programmes that relates to evidence-based priority-setting processes. A key consideration will be to provide this support in a way that responds to immediate needs at country level (such as the completion of a poverty reduction strategy), while building UNFPA and WHO country office capacity.
- Guidance on engaging civil society and nongovernmental organizations active in reproductive health in poverty reduction and sector-wide programming processes, and building appropriate country office capacity to facilitate public-private partnerships.

The case-studies were useful for generating discussion of the issues presented in this summary and provided a reference point from actual country experiences for many of these recommendations. The meeting recognized that there are several unresolved areas, which will require further discussion on how to move forward. These include whether and how to identify a select group of countries for intensified support; and effective modalities for engaging WHO regional offices and UNFPA Country Technical Services Teams.

Building UNFPA and WHO Country Office Capacity to Work with National Health and Development Planning Processes in Support of Reproductive Health: Review of Case-Studies

WHO/HQ Geneva, 20–21 October 2005

List of participants

Technical Advisers

Dr Abdul Bun Hatib N'jie
PO Box 843
Banjul
Gambia
Email: abhatibnjie@yahoo.com

Dr Peter Hill
School of Population Health
University of Queensland
Herston Road
Herston 4006
Australia
Email: peter.hill@sph.uq.edu.au

WHO Regional and Country staff

Dr Philippe Lamy
Regional Office for the Americas
Washington, DC
USA
Email: lamyphil@paho.org

Dr Antonio Toro Ocampo
WHO Representative, Brazil
Caixa Postal 08-729
70912-970 Brasilia DF
Brazil
Email: htoro@bra.ops-oms.org

UNFPA Staff

Dr Vincent Fauveau
UNFPA
Geneva
Email: fauveau@unfpa.org

Ms Kristine Nilsen
UNFPA
Geneva
Email: nilsen@unfpa.org

Dr Hendrik van der Pol
UNFPA Country Representative
Delhi
India
Email: hendrik.vanderpol@unfpa.org.in

Dr Dia Timmermans
UNFPA
New York, NY
USA
Email: timmermans@unfpa.org

WHO Headquarters staff (Geneva)

Coordination with the UN and other Intergovernmental Agencies

Mr Peter Mertens
Email: mertensp@who.int

Health Systems Policy and Operations

Ms Lou Compennolle
Email: compennolle@who.int

MDGs, Health and Development Policy/ Cooperation and Country Focus

now renamed:

Health Policy Development and Services

Ms Rebecca Dodd
Email: doddr@who.int

Mr Amine Kebe
Email: kebea@who.int

Ms Brenda Killen
Email: killenb@who.int

Ms Alaka Singh
Email: singha@who.int

Dr Eugenio Villar Montesinos
Email: villare@who.int

Planning, Resource Coordination and Performance Monitoring

Ms Pascale Brudon
Email: brudonp@who.int

Reproductive Health and Research

Dr Heli Bathija
Email: bathijah@who.int

Dr Enrique Ezcurra
Email: ezcurrae@who.int

Dr Peter Fajans
Email: fajansp@who.int

Dr Dale Huntington
Email: huntingtond@who.int

Ms Ruth Malaguti
Email: malagutir@who.int

Dr Alexis Ntabona
Email: ntabonaa@who.int

Ms Margaret Usher-Patel
Email: usherm@who.int

**Building UNFPA and WHO Country Office Capacity to Work with National Health and
Development Planning Processes in Support of Reproductive Health:
Review of Case Studies**

WHO/HQ Geneva, 20–21 October 2005

Agenda

20 October 2005

- 09:00 - 09:15 Welcome and introductions
Dale Huntington
- 09:15 - 12:30 **Panel 1:** National development planning processes and reproductive health programmes: How well does the SWAp and PRSP process facilitate or constrain reproductive health policy and programmes?
Moderator: Brenda Killen
- 09:15 - 09:45 Mongolia
Presenter: Peter Hill
- 09:40 - 10:15 Senegal
Presenter: Amine Kebe
- 10:30 - 10:50 Yemen
Presenter: Alaka Singh
- 10:50 - 11:20 Nicaragua
Presenter: Eugenio Raul Villar Montesinos
- 11:20 - 11:40 **Discussants panel:**
Hatib Nj'ie
Hendrik van der Pol
- 11:40 - 12:30 General discussion
- 13:30 - 16:30 **Panel 2:** Contextual factors affecting collaboration between WHO and UNFPA, and between these agencies, national governments, and donors (including support and institutional guidance provided by regional offices and headquarters)
Moderator: Dia Timmermans
- 13:30 - 13:45 Mongolia
Presenter: Becky Dodd
- 13:45 - 14:00 Senegal
Presenter: Alexis Ntabonna
- 14:15 - 14:30 Yemen
Presenter: Heli Bathija
- 14:30 - 14:45 Nicaragua
Presenter: Enrique Ezcurra Ferrer

14:45 - 15:05 **Discussants panel:**
Antonio Toro Ocampo
Vincent Fauveau
Peter Mertens
Pascale Brudon

15:05 - 16:00 General Discussion

21 October 2005

09:00 - 10:15 **Breakaway discussion groups**

- Identification of cross-cutting issues and lessons learned
- Listing of key recommendations for future capacity building activities

Group 1: Facilitator: Dale Huntington

Rapporteur: Peter Hill


Group 2: Facilitator: Dia Timmermans

Rapporteur: Becky Dodd

10:45 - 12:00 Presentation of breakaway groups

Synthesis Moderator: Eugenio Villar Montesinos

Closing statements: Dale Huntington

Department of Reproductive Health and Research 
World Health Organization
Geneva
Switzerland
email: rhrreform@who.int
www.who.int/reproductive-health



World Health
Organization