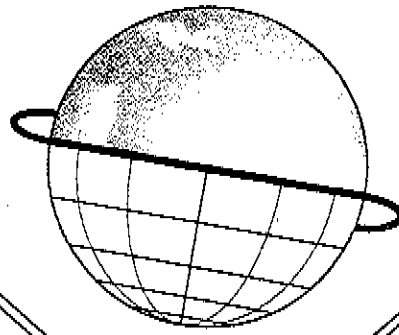


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HEALTH DEVELOPMENT IN
COUNTRIES IN GREATEST NEED :
RECENT EXPERIENCE, CURRENT
TRENDS AND FUTURE DIRECTIONS



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Geneva, May 1993

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Intensified WHO Cooperation with Countries
and Peoples in Greatest Need

IWC

This document presents an analysis of recent experience in implementing Intensified WHO Cooperation with Countries and Peoples in Greatest Need. It is arranged in four parts. Part 1 sets out the IWC Agenda for Action and clarifies what is implied by the IWC approach. Part 2 reviews what has happened in practice. It gives an overview of where IWC is being implemented; sets out how IWC can influence the availability of resources for health; summarises the health development priorities identified by IWC countries; and, with examples from specific countries, it illustrates the effects of IWC. The experience of implementing IWC raises a number of policy issues, which are discussed in Part 3. These relate to the changing context in which health development is taking place, the characteristics of health systems in IWC countries, the role of WHO in consensus building, the need to assess the effectiveness of IWC, and the capacities needed in WHO to fulfil the IWC mandate. Progress over the last four years suggests the need for further development in some areas and a greater degree of concentration in others. Part 4 of the document sets out five areas of particular importance for the future.

Office of International Cooperation

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1 INTENSIFIED WHO COOPERATION: AN AGENDA FOR ACTION

1.1 Introduction

The 1989 World Health Assembly (WHA 42) requested the Director-General of WHO to initiate action to direct and coordinate the resources and programmes of WHO, and to mobilize the international community to meet the basic needs of the world's poorest people. This initiative has come to be known as Intensified WHO Cooperation with Countries and Peoples in Greatest Need (IWC). This document sets out what IWC means in practice and what has been achieved so far. The analysis of experience to date makes it possible to identify what needs to be done to strengthen IWC in the future.

1.2 Objectives

IWC is ultimately concerned with the way in which all aspects of socio-economic development can bring about an improvement in people's health, particularly in the poorest countries. To achieve this overall goal, IWC has four strategic objectives:

- o First, through a country-specific approach, IWC focuses on **strategic issues in national health development**. The aim is not only to help countries mobilize resources to meet health needs, but also to ensure that domestic and external resources are well-coordinated and efficiently used.
- o Second, IWC aims to strengthen and **build national capacity** particularly in relation to health policy development, health systems reform and aid management.
- o Third, it is a means by which WHO can form **effective partnerships** with, and influence the activities of, other development agencies, with the objective of better meeting countries' health development needs
- o Fourth, it is a way of ensuring that WHO is able to respond in a coherent and coordinated fashion to the needs of specific countries. IWC, therefore, is concerned with **change in WHO**, at all levels. Specifically, it aims to reform the Organization's approach to technical cooperation.

The objectives are inter-dependent. WHO's role as a key actor in health development will be compromised if it cannot focus the use of its own human and financial resources. Similarly, reform of WHO's approach to technical cooperation and its relationship with other development agencies, must be based on the premise that it can fulfil a critical and credible

role in national health development, and can help countries improve health care for the poorest.

1.3 What is special about the IWC approach?

WHO, through IWC, is therefore committed to respond to the very specific circumstances of countries in need, and to use its limited resources as strategically as possible. The special characteristics of the IWC approach are reflected in the process of cooperation that has been adopted.

Country strategy development

Agreement to initiate the IWC process is followed by a collaborative review of all aspects of health development. This process examines health in the context of overall national development. Consultations extend beyond the health sector to involve central government ministries of finance, economic planning and the civil service. In considering the financing and provision of health care, country analysis includes an assessment of the form and volume of assistance provided by donor agencies and the role of private for-profit organizations and NGOs. The overall aim is to assess the economic and institutional environment in which health-related activities take place. The review is an analytic and not just a descriptive process. It aims to identify the most critical strategic issues to be addressed, the areas in which resources are most urgently needed, and options for action.

The contacts established during initial missions enable the staff of the WHO Country Office to establish and subsequently build on working relationship with all key actors in health development. The Country Office therefore plays an important role in IWC by facilitating the continuing process of analysis, policy dialogue and information sharing.

WHO's response

Interventions in priority areas are designed with national capacity building as an explicit objective. In addition, IWC is not only concerned with the strategic use of WHO resources through its budgeting and programming exercise, but with the mobilization and coordination of resources from other development agencies. Lastly, WHO technical cooperation is set in a clear framework, which specifies the nature of changes intended and the timescale over which they will take place.

The IWC process as set out here is not new. It is one which is followed by many development agencies concerned with technical or financial cooperation. However, it is important for WHO in two ways. It is a means of focusing the resources of all the three levels of the Organization - HQ, Region and Country Office - in a coordinated and strategic way. As such, it is a clear departure from the programme-by-programme approach traditionally adopted by the Organization. Secondly, it describes a *modus operandi* specific to

WHO's role in technical cooperation, as distinct from the Organization's standard setting or normative role.

1.4 The characteristics of priority countries

It is important to emphasize that the country-specific approach is not just applicable in certain types of countries. Indeed, it is the basis of a sound technical cooperation policy in any situation. However, because it is a new departure and, like any new initiative, it is management intensive, there is need to *prioritise*. The number of countries in which IWC can be implemented is limited by WHO's capacity to function in this way. In line with the WHA mandate (WHA 42.3) it has been decided that IWC should focus, in the first instance, on the poorest countries.

Poverty, as well as being inextricably linked with ill health, is likely to be associated with weak institutions and a scarcity of skilled personnel. As an initiative primarily concerned with capacity building, the selection of countries for IWC takes into account national commitment to reform, and the extent to which institutional change is a realistic possibility.

2 INTENSIFIED COOPERATION IN PRACTICE

This part of the report looks at what has happened in practice. It starts with an overview of where IWC is currently being implemented; indicates how IWC can influence the availability of resources for health; and summarises health development priorities identified by IWC countries.

2.1 Where is IWC being implemented?

Table 1 lists those countries where IWC is currently being implemented. For each WHO Region the countries are divided into two groups. Group 1 contains those countries where sustained activities are currently underway. Group 2 contains those countries a) in which a formal commitment for IWC has been made but where, for a variety of reasons, progress has been slow, and b) newly joining countries where activities have only just begun. In addition to the countries shown in the table, a further seven countries¹, all in the African Region, are currently requesting support.

¹ Burkina Faso, Madagascar, Niger, Rwanda, Sierra Leone, Togo, Zaire

Table 1: Countries receiving Intensified WHO Cooperation - May 1993

REGION					
	AFRO	SEARO	WPRO	AMRO/PAHO	EMRO
Group 1	Benin Chad Ethiopia Guinea Guinea-Bissau Mozambique Zambia	Bangladesh Maldives Mongolia Nepal	Cambodia Lao PDR Vietnam	Bolivia Guatemala	Yemen
Group 2	Cape Verde Central African Republic Sao Tome & Principe Uganda	Myanmar		Haiti	Djibouti

The table shows that sustained activities are taking place in 17 out of a total of 24 countries with whom a commitment for support has been made. Since the initiative began in 1989 there has been a slow and steady expansion in the number of countries where on-going support is taking place. In late 1990, technical and financial commitments had been made with a total of 14 countries. By April 1992, agreements had been made with 27 countries, and sustained activities were taking place in 8.

The selection reflects an effort to prioritise and concentrate IWC both where it is needed, and where it will have the most effect. Since the initiative began, missions to 40 potential IWC countries have taken place. In addition to those that have been added to the list, some countries that had initially requested IWC subsequently realised that specific technical inputs from WHO were more appropriate.

2.2 Resources for health development

Intensified cooperation can potentially affect the availability of resources for health in different ways.

- o The aim of IWC, through the development of relationships with ministries of finance and economic planning, may be to affect an increase in the proportion of government spending on health or other health-related sectors. Monitoring

of change in the pattern of public expenditure is taking place in several IWC countries.

- o IWC may also help governments to ensure that existing resources for health are utilised more efficiently. This will involve changes in the pattern of intra-sectoral allocations, for example, between curative and preventive care, salary and non-salary costs, urban and rural health. Improvements in the availability of resources to local health systems may also be brought about through strengthening or reforming financial management systems. The form of monitoring will therefore depend on the objectives of the programme concerned.
- o Partnerships formed, through IWC, with other multilateral and bilateral agencies can result in an increase in the volume of aid flows to countries. Resources from other development agencies may be channelled through WHO or, following joint identification of needs, be channelled directly to the country concerned. In Mozambique, for example, FINNIDA has allocated US\$ 20m over 12 years for a health development programme in Manica Province, following a project development mission organised through IWC. As part of IWC in Chad, UNDP has allocated US\$ 1m to the Government as part of its support to health infrastructure development. In several IWC countries systems have been established for monitoring the volume, source and use of external resources.
- o IWC also influences the allocation of WHO's own resources. As the unit at Headquarters responsible for promoting IWC, the Office of International Cooperation (ICO) is responsible, in collaboration with Regional and Country Offices, for initiating the IWC process. In the period 1 January 1990 to 15 April 1993, ICO obligations for activities in all IWC countries totalled US\$ 4.1 million. Of this amount 88% was spent in the 17 countries where sustained activities are taking place.
- o To support the IWC process, 2% of the WHO regular budget for the biennium 1991-1992 (US\$ 3.1 million) was reallocated to nine technical programmes to be used in support of activities in IWC countries.

Funds spent through ICO directly come from the WHO regular budget, the Director-General's Development Fund, voluntary funds contributed by the Governments of Finland, France, Italy, Japan, and the Netherlands, the Sasakawa Foundation and the World Bank. They have been used both in developing country strategies and carrying out specific country activities.

2.3 Health development priorities in IWC countries

Experience over the last four years has shown that there is a remarkable degree of consistency in the health development priorities of countries in which IWC has been implemented. An analysis of 18 IWC countries showed that support requested fell under the following broad headings

- o Health policy and strategy development
- o Health systems decentralization and reorganization
- o Economic analysis, health financing and financial management
- o Human resource policy, planning and management
- o Mobilization, coordination and management of external resources
- o Information systems development
- o Strengthening provincial, regional and district health systems
- o Strengthening and integration of disease control activities
- o Strengthening hospital management

In addition to these generic issues, which appear in most country review documents, IWC countries also identified problems specific to their own circumstances. Of particular importance are those problems which, unless dealt with effectively, divert attention from the institutional aspects of health development. If, for example, ministry of health officials are preoccupied with the epidemiological and political consequences of a cholera epidemic, little progress is likely to be made in discussing health financing or organizational reform.

The clear message emerging from a review of demands made in relation to IWC is that countries look to WHO for support in dealing with policy-level and institutional issues. The implication of this finding is not that the areas listed above should become the substantive focus of an "IWC programme". Indeed, they are all areas in which WHO has expertise already and it is clearly undesirable to set up duplicate or parallel activities. *The question is whether WHO, at different levels of the Organization, has enough expertise or devotes sufficient attention and resources to these issues, given their obvious importance to Member States.*

2.4 What has been the effect of IWC?

The issue of how the effectiveness of IWC should be assessed, both in countries and in WHO, is complex and inevitably somewhat controversial. It is discussed in greater detail in Part 3. The following review is necessarily selective. Rather than present a comprehensive account of country programmes, the aim has been to illustrate important aspects of IWC with country examples. The following questions, based on the four strategic objectives, have been used as a framework of enquiry.

- o Is IWC addressing important strategic issues in health development in the countries in which it is being implemented?
- o Is technical cooperation being directed toward building national capacity?
- o Is WHO working in partnership with other development agencies and/or influencing their activities?
- o Is there evidence that WHO is effectively coordinating its own inputs?

2.5 Is IWC addressing important strategic issues in health development in the countries in which it is being implemented?

In several cases the answer to this question can be unequivocally positive. In **Zambia**, particularly since the new Government took office in 1991, WHO has played a pivotal role in assisting the Ministry of Health to formulate health policy and to operationalize key aspects of health systems reform. The current focus of technical cooperation -- decentralisation, health financing, human resource development and management development at district and tertiary hospital level -- confirms that WHO is addressing issues of strategic importance.

Mongolia, like many republics of the former Soviet Union, has experienced rapid political and economic change. The removal of subsidies has led to acute shortages of drugs and consumables and a need for structural reform as a matter of urgency. Staff from all three levels of WHO have been involved in carrying out a health sector review in collaboration with the World Bank and the Asian Development Bank. WHO has responded to the one of the most critical needs by assisting the Ministry of Health to review policy options and operational implications of different forms of health insurance.

Mozambique is recovering from prolonged armed conflict and severe drought. Domestic resources are scarce and external assistance, although substantial in overall volume, is fragmented in nature and poorly coordinated. The newly-developed national health policy, prepared as part of Intensified WHO Cooperation, forms the basis of a long-term health

development plan and, therefore, is a means by which the government can focus external assistance in line with its own priorities. It will also guide the process of development during the transition from emergency to recovery and rehabilitation.

Involvement in strategic aspects of health development may be expressed in a variety of ways. National level policy-making is not the only *entry point*. In **Guinea Bissau**, for example, regional management was an immediate priority and became the initial focus of IWC. However, strengthening health management at peripheral levels of the system was not an end in itself. The more effective regional management teams that resulted from the first intervention were subsequently able to play a more active role in national policy development. In addition, they were able to do so on the basis of a clearer understanding of how the centre should support the regions.

A review of country reports shows that there is a need for persistence if IWC is to achieve its full potential in assisting countries to address strategic sectoral issues. In **Bolivia** and **Vietnam**, for example, the initial review suggested that, in both countries, there was need to strengthen national capacity in health planning and financing. However, in practice, and in part because of the difficulties that governments and development agencies have to face in addressing these complex issues, there has been a tendency for the main thrust of cooperation to be diverted to less strategic, and thus more conventional *project* activities. In both countries, plans are in place to redress this trend.

2.6 Is technical cooperation being directed toward building national capacity?

WHO, through IWC, aims to build national capacity to address strategic issues in health development. The aim is therefore not just to provide expert advice. Technical cooperation strategies need to ensure that national officials, from both governmental and other agencies, are better equipped to fulfil their various responsibilities as a result of the process. Where WHO is involved in national policy and planning (for example in **Yemen**) working groups have been established in the Ministry of Health, which are supported by intermittent visits from consultants.

In **Guinea**, IWC is concerned with strengthening national capacity in hospital management. In several countries (eg **Bolivia**, **Guinea Bissau**), the focus of capacity building has been the strengthening of health systems at district, provincial and regional level, through improved management.

Benin is a country at the centre of the international debate about community financing. A working group, whose members include representatives from the Ministry of Health and the Ministry of Finance and Planning has been established, and supported through IWC. This group aims to review and synthesize the experience of the many different groups in the country that have been pursuing a range of different, and sometimes

conflicting, financing strategies. The aim of IWC support is both to develop analytic capacity in the country and to enable the Ministry of Health to establish a more coherent country-wide financing system.

Developing capacity to undertake economic analysis has been a major thrust of work carried out as part of IWC. In **Vietnam**, a Health Economics Unit has been established in the Ministry of Health. In **Nepal**, starting with a workshop on Health Economics and Health Care Financing, IWC has resulted in the establishment of an Inter-Ministry Task Force on Health Economics. Nepal faces extremely difficult choices in preparing and implementing a sustainable health development policy. With IWC support, the Task Force is now in a position to analyse the implications for health development of different scenarios in relation to national economic growth and changes in the availability of external financing.

The other main thrust of capacity building through IWC is support to governments in the field of aid management. This has included assistance in the preparation and conduct of Round Table Meetings. IWC has also introduced ministries of health officials to computer software programmes, developed in other parts of WHO, which can be used to track the volume, purpose and disbursement of donor funds. IWC has provided specific technical assistance in aid management to Ministries of Health in **Mongolia** and **Bangladesh**. The importance of aid management to the future of IWC strategy is discussed in more detail in the final part of this document.

2.7 Is WHO working in partnership with other development agencies and/or influencing their activities?

Working in close collaboration with other development agencies is an essential part of Intensified Cooperation. In practice, partnerships between WHO and other organizations can fulfil a number of functions as illustrated in the following examples.

WHO, through IWC, may work in partnership with other agencies to help countries address strategic health development issues directly. In **Yemen**, WHO (with funds from the Governments of Japan and Austria) is working in collaboration with USAID and UNICEF to strengthen health planning capacity.

If WHO works closely with ministries of health officials on policy formulation, it is logical that it will also work with them to ensure that external cooperation from other agencies conforms to the thrust of those policies. The countries in which IWC has been most successful in establishing this kind of relationship (for example in **Zambia**) are also those in which WHO has successfully assumed a role, albeit modest, in ensuring a coherent response from other donors.

Intensified WHO Cooperation in **Bangladesh** illustrates two important aspects of partnership with other agencies. Donor coordination in health and population has been managed by the World Bank through a multi-donor consortium. In the 4th Population and Health Project, WHO will be the executing agency for 20 of the 65 project components. The partnership, therefore, not only allows the project to gain from the combined efforts of all three levels of the Organization, it also gives WHO an influential voice in the donor consortium. An issue of concern to the Government of Bangladesh, taken up by WHO, is the degree to which the planned increases in peripheral health personnel envisaged under the Fourth Project, are sustainable in the long term.

In **Chad**, the Government designated WHO and the African Development Bank to coordinate the preparation of a health sector review, culminating in a Round Table Meeting. The whole process was conducted in close collaboration with the World Bank. Despite agreement on health development strategies between the Ministry of Health and the development agencies involved in the consultation, difficulties subsequently arose as a result of conflicting commitments, involving two tertiary hospitals, on the part of the Government of Chad. WHO's partnership with other development agencies, in this case, facilitates the development of a consensus between development agencies, which may influence the Chadian authorities when ultimately deciding on overall priorities for the sector.

The relationship established through IWC with health development authorities in Member States enables WHO to work in partnership with other development agencies on the identification, design and implementation of specific projects. In **Cambodia**, for example, the need to coordinate the training provided to different categories of health personnel was recognized. In response, the Government of Belgium has provided two long-term coordinators of studies for the Faculty of Medicine and the Technical School for Health Workers. In **Mozambique**, IWC has resulted in the preparation of a 12-year programme of support for Manica Province funded by FINNIDA.

In addition to work on preparing specific projects, partnerships have also been established with development agencies concerned with overall sectoral funding. In **Ethiopia**, WHO will be working with the European Community to review how counterpart funds generated from budget support can best be used to promote health development.

2.8 Is there evidence that WHO is coordinating its own inputs effectively?

Part of the rationale for IWC is that it is a means of promoting a sharper strategic focus and greater efficiency in the way WHO uses its resources for technical cooperation. In practice this can be expressed in a number of ways.

It is widely recognized that WHO's effectiveness is dependent on the quality of its staff at country level. This implies not only that staff have the technical competence to

provide high quality advice in relation to strategic health issues, the country office must also have the managerial capacity to coordinate inputs from other levels of WHO. Where WHO has a role in donor coordination it must work effectively with other agencies as well. To strengthen the technical capacity of WHO at country level, staff with skills in health planning and management have been posted to **Bolivia, Benin, Laos, Cambodia** and **Zambia** using funds from the Governments of Belgium and the Netherlands. The strengthening of country offices by the posting of additional technical staff complements the approach adopted in countries in the African Region where nationally-recruited Country Support Teams have been established.

Most IWC missions involve staff from HQ, Regional and Country Offices. Of crucial importance, however, is that coordination does not stop after each mission and that the on-going process of cooperation in countries draws on the resources of all three levels of the Organization. This is working well in **Bangladesh**, where each level of the Organization has an agreed role to play in support of the Fourth Population and Health Project specifically, and the Ministry of Health and Family Planning generally.

IWC is a process which identifies development needs which are then fulfilled by different parts of WHO. Many of the technical inputs required in relation to the health development priorities of IWC countries are provided by staff and consultants from Regional Offices, infrastructure divisions and, to some extent, by staff in the Office of International Collaboration (ICO) itself. However, a need for other technical inputs is also often identified. This process has been supported by the reallocation of 2% of the whole of the WHO regular budget for the 1991-1992 biennium, which is to be used by 9 technical programmes in support of IWC countries. In addition, technical divisions support IWC countries from their own regular and extra-budgetary funds. Examples of technical divisions working in support of IWC include the activities of Community Water Supply in **Mozambique** and the Drug Action Programme in **Bolivia**.

Finally, a critical expression of greater focus in the use of WHO resources is the degree to which the WHO country budget reflects health development priorities in each of the countries concerned. Similarly, at other levels of the Organization, the allocation of resources should begin to reflect the priorities of countries set out in paragraph 2.3. At this stage it is not possible to assess the effect of IWC in these terms.

3 POLICY ISSUES

The experience of implementing Intensified WHO Cooperation raises a number of important issues. These relate to the changing context in which health development is taking place, the characteristics of health systems in IWC countries, the role of WHO in consensus building and harmonising diverse donor inputs and approaches, the need to assess the effectiveness of IWC, and the capacities needed in WHO to fulfil the IWC mandate.

3.1 The changing context: health development in the 1990's

Slow but sustained progress in the improvement of health status is evident in many IWC countries. Despite these gains, however, governments continue to face difficulties ensuring that their citizens have access to a basic minimum of health care. This is made particularly difficult in countries where the need to restructure the economy reduces the flow of resources to the social sector. In addition to the goal of improving health status, countries have a number of policy objectives in common. They need to ensure that an appropriate share of government revenues are allocated to health; that the benefits of publicly-funded health care are equitably distributed; and that resources are used as efficiently as possible - both in terms of maximum health gain for the funds invested and minimum cost for the package of services provided. They will also be concerned that users are satisfied with the form and content of the services offered and that individuals are protected from catastrophic expenditure in the event of serious accident or illness. These objectives have to be achieved in an economic environment where, at best, only modest increases in spending can be expected or, more commonly, total expenditure on health may actually be falling.

Experience shows the limitations of many previously-accepted assumptions about strengthening the capacity of national health systems. Firstly, there are limits to what can be achieved by interventions within the ministry of health itself. Several constraints to effective health management are common to all operating ministries and need to be dealt with in relation to civil service reform and to the management of the public sector as a whole. Secondly, traditional bureaucratic structures do not necessarily provide sufficient incentive to guarantee either cost-effective or user-friendly public services. Thirdly, it is recognized that there are several functions, previously assumed to be the responsibility of government, which can be better fulfilled by organizations in the private sector. Lastly, in many IWC countries there are insufficient funds from tax revenues to finance a credible health system. The process of development or reform in the health sector needs to address these kind of institutional issues if countries are to be able to achieve their health care objectives.

The main stimulus for reform in industrialised countries has been the need to contain the costs of health care, whilst responding to client demand for improvements in quality. Reforms therefore concentrate on measures to improve the efficiency and responsiveness of publicly-funded services. In developing countries, by contrast, reforms are most strongly

influenced by the need to improve coverage and to attract more resources to the sector. Although reform in the past has been virtually equated with the process of privatisation, it is becoming increasingly clear that unregulated private markets are not capable of achieving the broad mix of objectives that health systems seek to satisfy. The continuing importance of the public sector in health financing, in defining priorities, identifying needs, ensuring equity and as the agency responsible for regulating and monitoring service provision, must not be ignored.

3.2 Implementing change: the magnitude of the challenge

It is clear from the experience of IWC to date that countries give the highest priority to policy-level, institutional and structural issues in health development. However, the process of IWC also provides an insight into the characteristics of health systems in the countries concerned and therefore an indication of the challenge facing those responsible for implementing change. A demonstrated understanding of these issues is important in establishing WHO's leadership role in country-specific health development, and ensuring that expectations for change remain realistic.

Health systems in countries where IWC is being implemented have several common characteristics. The core of the system is usually the Ministry of Health or its equivalent. The ministry is generally taken to mean not just a central government department but the complete organization, from political head to village-level health facility. It is often difficult to separate political, administrative, managerial and technical roles, which frequently results in organizational conflict.

It is axiomatic that to improve management performance it is necessary to decentralize authority to the lowest possible level of an organization consistent with retaining accountability. However, the widespread agreement about the need for decentralization often disguises different motives underlying decentralization policies. In practice, political and managerial objectives are sometimes in competition. Political considerations often dictate decentralization to a large number of small geographical units, whilst managerial purposes might be better served by larger districts or a strong intermediate level.

Health policies in many countries are still based on an implicit assumption that government remains ultimately responsible for all aspects of the financing and provision of health care. Voluntary and private sector organizations, which are responsible for a substantial proportion of all health care delivery in many countries, operate independently without regulation, and according to their own agenda.

Not only is the task of changing the structure and practice of large, complex organizations extremely difficult, there tend to be very few individuals with the combination of technical, political and managerial skills needed to design and implement the changes

required. Those that have these talents tend inevitably to be overcommitted, often to the point where their effectiveness is compromised.

In several countries building capacity to carry out economic analysis has been an important focus of work. The aim has been to ensure that resource allocation decisions are at least based on a realistic assessment of costs. However, it is important to recognize that in many IWC countries, even if the total funds available from public and private sources were spent as cost-effectively as possible, they would be insufficient to meet critical health needs. Absolute scarcity makes it hard to deal with relative imbalances - between preventive and curative care, urban and rural health, salary and operating costs.

3.3 Building consensus: the role of IWC in health development

Given the nature and magnitude of the problems facing IWC countries there is a need for a consensus in planning how they can most effectively be addressed. However, it is important not to underestimate the difficulty of achieving agreement on priorities or strategies for health development.

Few ministries of health have developed effective systems for reaching agreement on priorities. It is far more common to find that different divisions, programmes and professional groups compete for resources on the basis of their own interests. The frequency with which attempts to implement effective management structures in ministries of health fail to result in genuine operational change, illustrates this problem.

It is also common to find that it is easier for ministries of health to react to budgetary cuts imposed by ministries of finance or to staff ceilings set by a public service commission, than to adopt a pro-active role in deciding on what can be done given existing constraints. Ministries of finance frequently criticise ministries of health for their weak management structures and their reluctance to effectively justify their demands - a situation which makes consensus building difficult.

Despite a general trend away from specific projects toward more broad-based sector-wide support, and from capital investment to greater support for recurrent costs, there remain significant inconsistencies in the health development policies of major donor agencies. Given their different organizational imperatives and the different constituencies to which they are accountable, donor coordination is likely to remain a somewhat elusive ideal. However, priority at international level must be given to the definition of areas where consensus is possible. At country level efforts should be focused on achieving congruence with national priorities and avoiding overlap and duplication.

WHO, through IWC, can play a pivotal role in consensus building, within ministries of health, between ministries of health and other central government departments, between

development agencies and between development agencies and ministries of health. However, this is only possible in situations where WHO is intimately involved with government officials in dealing with strategic and policy issues. In countries where this is the case, WHO is in a position to be an effective "broker" between the different parties involved. Its position as a technical agency, allows to it play the role of interpreting or explaining one side to the other.

WHO must be in a position to take an independent view on health development issues. To fulfil an effective leadership role, WHO cannot give *a priori* or uncritical support to any one of the actors involved. Neither, however, can it revert to offering prescriptive advice if it is to remain true to the spirit of country-specific development. Rather, the thrust of IWC is to help Member States analyse the economic and organizational implications of different policy options.

3.4 IWC: assessing effectiveness and impact

In any discussion about the effectiveness or impact of IWC there will be those who take the view that unless IWC results in a positive effect on health status, nothing of value will have been achieved. Others, however, will argue that institutional development as a focus of IWC is a necessary, even if not a sufficient cause for improved health. Recognizing the multiple influences on health status, the second group will argue that it is a legitimate objective to try and improve the effectiveness of those institutions, which might reasonably be expected to have an influence on people's health. The corollary of this argument is that if institutional development and capacity building are objectives of IWC, then means must be found for monitoring achievements of this nature.

In practice, it is important to recognize that IWC will be concerned with a *hierarchy of outcomes*. This hierarchy will extend from an assessment of whether appropriate systems (for example for formulating policies, determining staff requirements, monitoring expenditure or procuring drugs) have been established, whether they are functioning effectively, whether they result in improvements in service delivery, and ultimately, whether policy-level interventions under IWC result in positive changes in health status. While not losing sight of the importance of health outcomes, there is clearly a need to substantiate the link between IWC and changes in institutional capacity.

To assess the effectiveness of IWC in this way requires a clear understanding of the changes that are planned and, tools and methods for determining whether change has actually taken place. At present, capacity to do either is limited. Although the country analysis provides a picture of the constraints facing the health system, the objectives of IWC in terms of institutional change have not always been clearly established. Even though blue-print style plans would be inappropriate, there is nevertheless a need for a more concrete expression about what changes in capacity might be expected as a result of IWC. WHO is

not alone in being poorly equipped with means for assessing institutional change. The experience of IWC emphasizes the need to develop tools and methods for monitoring change in the performance of health systems, which do not rely solely on measures of service outputs or health outcomes.

Finally, it is important that the effect of IWC is not assessed solely in relation to changes in countries. IWC aims to bring about change in WHO. Systems for assessing change in the degree to which resource allocation for technical cooperation matches the health development priorities of countries and peoples in greatest needs should be an integral part of the IWC monitoring.

3.5 Supporting IWC: what capacities are needed?

The experience of implementing IWC makes it possible to draw some conclusions about the characteristics of effective technical cooperation. The lessons that have been learned are important for organizational development in WHO, and other development agencies. It is useful to consider capacities in terms of orientation, process and technical skills.

The country-specific IWC approach makes it necessary to distinguish between the *modus operandi* of a normative or standard setting organization and a technical cooperation agency. For fully understandable reasons, many staff are more accustomed to operating in the normative mode. They are therefore more used to synthesizing experience from a wide range of countries in order to prepare standards, protocols, guidelines or manuals of global or regional relevance. Country-specific work requires a somewhat different approach. Firstly, there is a need to concentrate on some countries, identified on the basis of need, rather than others. In selected countries, health development priorities defined in partnership with national authorities determine the nature of the interventions required and thus how resources should be allocated. Tools, methods and guidelines will still be required but they will be based on countries' needs and adapted to their specific circumstances.

In terms of the *process* of technical cooperation, ensuring that it results in the development of local capacity is by far the most important issue. In many cases, intermittent visits from the same individual or group of consultants to support the work of local groups or organizations may be more effective than long-term counterpart relationships. However, given the right combination of individual skills and temperament, long-term technical cooperation can also be effective. In either case, it is clear that the effective implementation of IWC requires a substantial commitment of time to individual countries, by staff from HQ and Regional Offices.

With regard to *technical expertise* the experience of implementing IWC over the last four years is very clear. Countries request support in relation to health policy, planning,

financing and management; the development of capacity to analyse the economic implications of different policy options and to manage external resources; and the reform and reorganization of key institutional structures. To respond effectively, WHO must have access to a sufficient number of people with the relevant technical expertise. However, unlike a conventional scientific discipline, the need is not just for highly qualified specialists to act as advisers in their particular subject. What is needed to ensure credibility with legislators and senior managers is an understanding of the difficulties of managing and introducing change in large complex organizations. It is important to recognize that such experience is not always associated with academic excellence in a particular technical or scientific subject.

A less specific, but equally important, type of expertise is the ability to look holistically at country health development. There is a need for people with the analytic skills to take in the complexity of the whole, identify the most important issues, and suggest where and what kind of interventions are most likely to result in change. These skills are of central importance to the developmental and country-specific approach of IWC.

Finally, to re-emphasize a point that was made earlier in the document, it is important that IWC is not defined in terms of particular areas of technical expertise. Rather, it is the means by which WHO can respond to countries' needs for assistance in these areas. It is therefore of critical importance to ensure that, firstly WHO devotes sufficient attention to developing capacity in these areas at all levels of the Organization and, secondly, that it enables countries to draw on these resources as and when required.

4 FUTURE DIRECTIONS

The experience of IWC over the last four years suggests the need for further development in some areas and a greater degree of concentration in others. The final part of the document sets out five areas of particular importance.

4.1 Health as an integral part of socio-economic development

IWC is ultimately concerned with improving people's health. It is also a means of focusing resources on those people who are potentially the most disadvantaged in terms of health status: the populations of low income countries as a whole, and poor people elsewhere. In addition, IWC must necessarily be concerned with the alleviation of poverty as a major determinant of disease.

Given these aims, it is important that the underlying philosophy of IWC continues to be reflected in the process of institutional development for health. This can be expressed in a number of ways. Health systems, at both national and local level, should have the capacity to

recognize and effectively act on the needs of groups in the population that are deprived or disadvantaged. Similarly, in exploring the options for health financing, it is essential to ensure that the poor are not further disadvantaged by the strategies selected. In some IWC countries, WHO through its partnerships with other development agencies, can help to ensure that district or province-based health development programmes are directed towards those parts of the country where needs are greatest. Finally, it is important that IWC results in the strengthening of links between the formal health system and other sectoral agencies. There is a need for ways of ensuring that development activities in other sectors benefit from the advice of health professionals, and that the process of health development promoted through IWC acknowledges the contribution of other sectors.

4.2 Health systems reform: putting economic analysis into practice

IWC has been concerned to develop analytic capacity, especially in those countries facing the most difficult economic choices in the provision of health care. Health economics, like epidemiology, provides information and analytical tools that can inform decision making. There is, however, no guarantee that they will be used. The strategy adopted in several IWC countries has been to convene an inter-ministerial Health Economics Task Force. Other countries have established Health Economics Units in their Ministry of Health. It is clearly important that, having established the capacity to carry out economic analysis, steps are taken to ensure that the information generated is put to good use. It is also crucial to recognize, however, that the process of reform will be influenced by a wide range of institutional, and political issues. It will not be guided by economic considerations alone.

4.3 Developing capacity for aid management

It is useful to distinguish three concepts: resource mobilization for health; inter-agency coordination of donors active in a particular country; and the development of government systems for managing external assistance. WHO has an important role in resource mobilization through its partnerships with different agencies. In relation to the second concept, WHO plays an important role in bringing development issues to the attention of health sector donors even if the role of coordinator is fulfilled by a different agency. Developing systems for managing and tracking the use of external resources has been identified as a priority in many, if not all, IWC countries. Aid management represents an area where WHO, by virtue of its particular status, has a comparative advantage over other health development agencies. Building on the work that has already taken place in IWC countries, there is a need to develop WHO's capacity to assist countries in this way. This will involve not only helping to organize meetings and providing training opportunities, but also setting up management systems and developing tools, methods and software to be used by ministries of health.

4.4 IWC and UN reform

IWC's strategy is consistent with the role envisaged for specialised agencies in the UN General Assembly Resolution (47/199), adopted in December 1992, on the operational activities of the UN development system. Of particular importance to the future development of IWC is the intention to improve the coordination of assistance provided by UN agencies at country level. Support to countries will be guided by a country strategy note outlining the contribution to be made to the country's national development strategies by the UN development system. Specialised agencies will have particular responsibility for policy dialogue, sectoral advice, aid coordination and the design and formulation of national development and (sub)sector programmes. This concept is clearly in line with the IWC approach.

4.5 Strengthening WHO capacity to coordinate the use of resources

Given the importance of ensuring greater efficiency and effectiveness in times of financial constraints, there is a need to look at how WHO's own resources are allocated in IWC countries. Ministries of health are keen to ensure that the allocations in WHO country budgets reflect national priorities. From WHO's point of view, allocations should show how limited funds can be used most effectively. The experience gained through the implementation of IWC needs to become an integral part of WHO's planning and programming process. This implies, *inter alia*, strengthening WHO's capacity to help countries analyse and articulate needs, and to translate these into strategically focused plans and budgets. Also, to demonstrate the effectiveness of WHO inputs, a link must be established between the allocation of resources in the country budget and outcomes in terms of specific aspects of health development.