



*SEMINAR ON RETHINKING INTERNATIONAL TECHNICAL  
COOPERATION IN HEALTH*

*Summary  
International Technical Cooperation in Health*

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# ***TABLE OF CONTENT***

	<b>Page</b>
● Introduction . . . . .	1
● Global Bilateral, Multilateral and Nongovernmental Donor Financial Flows for the Health Sectors of Developing Countries . . . . .	7
● Technical Cooperation in Health by Selected Bilateral and Multilateral Donor Organizations . . . . .	14
● Factors that Influence Decisions on Technical Cooperation . . . . .	23
● Review and Analysis of Country Studies . . . . .	25
● Recommendations . . . . .	40
● Acknowledgements . . . . .	44
● Bibliography . . . . .	45
● Glossary of Acronyms . . . . .	48



## SUMMARY<sup>1</sup>

### INTERNATIONAL TECHNICAL COOPERATION IN HEALTH

#### Overview of Technical Cooperation

##### *1. Introduction*

Within the last half century the concept and implementation of technical assistance in health have changed dramatically. Noteworthy among these changes are the shift in approach from technical assistance to technical cooperation and emergence of multiple providers and resources of technical assistance in the sector, which now include the developed and developing world alike. Furthermore, an estimated 80 percent of all external technical cooperation resources originate from organizations, official and nongovernmental with a multi-sectoral development orientation rather than a primarily health focus. In view of these historical changes and to continue playing an active role in reaching global health goals, are traditional international health organizations in need of a redefinition of their role. What is the current understanding of technical cooperation? How should it be redefined and implemented? Given the current global changes, is there a convergence of ideas on definition, methodology and strategies vis-a-vis technical cooperation?

The Pan American Health Organization is defined within its Constitution as an institution of technical cooperation. The principal goal of PAHO's technical cooperation is to promote, coordinate and support individual and collective efforts by Member countries to apply the strategies of health for all. This technical cooperation implies an active process involving a transaction between the Secretariat and its Member Countries as well as among the Member Countries.

Throughout its years of existence, PAHO has actively sought to incorporate new elements of technical cooperation to ensure a significant impact on health development as part of overall national development. However, in the framework of the ongoing debate over future directions of international technical cooperation in health, PAHO has embarked on a concentrated effort

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<sup>1</sup> The original report, International Technical Cooperation in Health PAHO/AD/94.1, was published by the Pan American Health Organization in 1994. The 419-page document includes an overview of global partners in technical cooperation and a study of 16 countries with reference to technical cooperation including WHO or PAHO relationships at country level.

to reassess its technical cooperation program to respond more efficiently and effectively to the priority problems defined by each of its Member Countries.

The present document begins with an overview of the evolution in the conceptual and operational approaches of technical cooperation. Next, there is an analysis of the amount and sources of financial flows to countries, which attempts to demonstrate the critical role of funding availability for the successful implementation of technical cooperation. Finally, the approaches used by three major donor institutions are examined, in order to determine their internal decision-making process regarding technical cooperation.

A significant part of the study focuses on the review of case studies from five of the six regions of the World Health Organization (WHO).

### *The Global Perspective*

Pre-World War II history shows few instances of sustained joint efforts by nations to provide continuing assistance, usually from more fortunate to less fortunate nations. Following the end of World War II, a growing appreciation for global interconnectedness and genuine international cooperation emerged, which sparked the birth of multilateralism directed toward solving some of the problems of developing nations.

The fledgling United Nations incorporated into its charter *cooperation in solving international problems of an economic, social, cultural or humanitarian character, and its Secretary General presented in 1949 an ambitious program for Technical Assistance for Economic Development.*<sup>(1)</sup> This program offered technical assistance that was comprised of technical advisory services, training, the mounting of demonstration projects, the establishment of pilot plants and the dissemination of technical information. The Secretary General envisaged technical assistance in the form of an expanded cooperative program through the UN and its specialized agencies. WHO portion ranked second and was only marginally lower than that for the Food and Agriculture Organization (FAO).

At the beginning the technical assistance was channelled primarily from the developed to the underdeveloped world. The essence of this approach was described most elegantly by Sufrin<sup>(2)</sup> who brought forward the concept that technical assistance was the diffusion of ideas from a technically rich society to a financially poorer society. A 1960's examination of major UN development programs, prior to the merger of the UN Special Fund and the Expanded Program of Technical Assistance that formed the United Nations Development Program (UNDP), prominent major themes that seemed to characterize UN technical assistance were institution building and human resources development.<sup>(3)</sup>

The United Nations systematically classified its technical assistance as providing the following:<sup>(4)</sup>

- Expert advice -- the services of international experts, recruited individually or through subcontracting firms or institutions;
- Equipment and supplies (in combination with expert advice);
- Training -- through fellowships, training centers and seminars.

Over the last two decades, the United Nations has gradually adopted the term technical cooperation. Nevertheless, the perception as to form and content remain essentially the same. Within major agencies, active at the global level, technical cooperation is essentially something done better *with*, but definitely done *for* developing countries. Therefore, the dominant focus is improvement through transfer. One major change, however, is the active promotion of technical cooperation among developing countries, which has been proposed as an alternative form of technical cooperation in terms of source.<sup>(5)</sup> For reasons to be detailed later, we believe that the appropriate approach is the cultivation of technical cooperation among all countries and not just those that are developing.

The Development Assistance Committee (DAC) of the Organization of Economic Cooperation and Development (OECD), a major participant in the field of international assistance<sup>(6,7)</sup>, has conducted several reviews of its own practices in the area of technical cooperation. In a recent publication: *Principles and New Orientations in Technical Cooperation*, DAC offers the following major principles for technical cooperation:

- The central role of the recipient country and the partnership concept;
- Participatory development;
- Improved functioning of governments and civil services;
- Comprehensive program approaches;
- Greater attention to costs and cost effectiveness;
- Recognition of private sector needs;
- Improved coordination.

#### *Technical Cooperation in the World Health Organization (WHO)*

In this summary version, WHO's (a detailed description of the development of technical cooperation at WHO has been given in other documents.<sup>(8,9)</sup>) Basic functions are described of which the most important are:

- To act as the directing and coordinating authority on international health work;
- To furnish technical assistance, and in emergencies the necessary aid upon the request or acceptance of governments.

Consistent with the definitions of technical assistant mentioned above, WHO's early activities were cast in the assistance mode, and included support for establishing and strengthening national public health systems, training, developing effective methods of disease prevention and control, and issuing up recommendations for establishing norms and standards.

In 1977, WHO formally rejected the concept of technical assistance that implied a donor/recipient relationship and replaced it with technical cooperation based on:

... common and mutual interest of all, whereby Member States cooperate with their Organization, as equal partners, to define and achieve their health goals through programs that are determined by their needs and priorities and that promote their self reliance in health development.<sup>(10)</sup>

The concept of technical cooperation has continued to evolve at WHO and the most current thinking is found in the Ninth General Program of Work for 1996-2001.<sup>(11)</sup> This document, which describes technical cooperation and the directing/coordinating of international health work as being complementary, includes:

- advocacy for health, stimulating specific health action and disseminating information;
- developing norms and standards, plans and policies;
- training;
- research promotion;
- direct technical consultation and resource mobilization.

#### *Technical Cooperation of the Pan American Health Organization (PAHO)*

When PAHO was formally incorporated into WHO as the Regional Office of the Americas in 1949, it adopted most of the terminology and focus of programming of the global organization. (PAHO's technical cooperation approach has also been described before<sup>(8,9)</sup>.) However, PAHO's approach took a point of departure by mid 1970's. It is interesting to point out that PAHO's apparent shift to the concept of cooperation rather than assistance was really a return to its original functions as stated by its founding members. Right from the beginning in 1902, health activities to be facilitated through the Pan American Sanitary Bureau (PASB) were envisaged as cooperative activities among equal sovereign states, i.e., a joint venture in which the Bureau cooperates with the Member Countries individually and collectively and enables their cooperation among themselves in a spirit of Pan Americanism. Our thesis is that the global definition of technical assistance, with a strong emphasis on aid to underdeveloped countries, was grafted on to the original definitions of PAHO.

This explains, in part, the decision of PAHO to reject the concept of technical cooperation among developing countries as being the main form of inter-country cooperation. The preference is for stimulating cooperation among countries regardless of their state of development. This view is widely accepted today as it becomes clearer that developing countries can offer useful experiences in health that can be of vital interest and importance to all countries.<sup>(12)</sup>

For the purpose of ensuring the optimal use of resources in direct support of Member Countries, PAHO has developed a system of planning, programming and evaluation of its

technical cooperation, the American Region Planning, Programming, Monitoring and Evaluation System (AMPES). This project management program is based on the joint assessment, by PAHO and governments, of the requirements for technical cooperation. Through the successful use of AMPES, PAHO has demonstrated that an effective system of planning and programming provides the necessary flexibility in the allocation of resources to deal with rapidly changing situations at the local level. In AMPES national level programming includes three important sequential processes:

- definition of national health priorities;
- definition of the technical cooperation needs;
- determination as to which of those needs can be satisfied by technical cooperation from PAHO.

There are three critical periods and accompanying instruments in developing the Organization's overall technical cooperation program. PAHO develops a Biennial Program and Budget (BPB) which is approved by its Governing Bodies. This is further refined into annual program budgets (APB). At this level, technical cooperation aims to achieve specific expected results that contribute to a clear purpose and ultimate health goal. Over the last years, PAHO has further emphasized the development of indicators to adequately measure the achievement of outcomes or expected results. It is only on the basis of this definition that activities, which contribute to an expected result can be developed. Recently, attention has focused on joint evaluations of technical cooperation at the country level, an exercise in which government officials and PAHO staff participate.<sup>(13)</sup>

### *Global Changes that Affect Technical Cooperation*

In 1948, WHO was one of the few agencies working in health. Today almost every major bilateral and multilateral agency has developed in-house health expertise.<sup>14/</sup> Given the multiplicity of actors working in the sector, and in an effort to maintain its leadership position, WHO's Member States convened a special Working Group of the Executive Board and prepared an extensive report on WHO's response to global change. The Group offered possible changes in the current functions of WHO aimed at adapting the Organization to the new political and technical realities.

In recent years the major multilateral financial institutions are paying increased attention to health as part of their concern for the social sectors<sup>5</sup>. One possible view is that given the more positive outlook of the international financial system it is now possible to devote resources to the social sectors. Another view has to do with the consensus that has emerged on the need to focus on human development, particularly on health and education issues as a condition to effectively reduce social poverty and ensure sustainable economic growth. The very basic human desire to do good and eliminate human suffering, due to ill health, also cannot be discounted as a reason for increased involvement in funding programs in health. Without reference to WHO as a central coordinating authority, the institutions, each governed by separate

policies, constitutions and program accountability are likely to eventually provide almost 90% of all financial assistance in the health sector.<sup>(14)</sup> Against an estimated 1990 figure of total external resource flows of \$4.8 billion, the WHO 1990 regular budget would approximately account for only 11%.

These new realities has led all major donor institutions to agree on means to more effectively coordinate technical cooperation. However, this is unlikely to occur unless national capabilities of the health sector are strengthened to carryout that coordination at the country level. This study attempts to shed more light on the various roles played by major donors regarding technical cooperation in an effort to highlight potential areas in which donor coordination could be improved.

2. *Global Bilateral, Multilateral and Nongovernmental Donor Financial Flows for the Health Sectors of Developing Countries*

*Flows and Trends*

The World Development Report 1993<sup>(15)</sup> estimates a 1990 total of \$4.8 billion going to the health sector, approximately \$4 billion from official bilateral agencies and multilateral sources such as international banks and agencies of the UN system. A remaining estimated \$0.8 billion originates from non-governmental organizations (NGOs) and foundations.

Table 1 shows the World Bank estimate of the distribution of Official Development Assistance (ODA). Concessional assistance (ODA) represents grants, and low cost loans or credits. Bilateral assistance by DAC-Member Countries averaged 60%, in grant form, in 1991.

Table 1<sup>(16)</sup>  
Official Development Assistance for Health by Demographic Region  
1990\*

Region	Disbursed Aid (\$ millions)
Sub-Saharan Africa	1,251
Asia and Pacific (except China and India)	594
China	77
India	286
Latin America/Caribbean	591
Middle East, North Africa	453
Total	3,252

\* The total does not include ODA for community water supply or sanitation.

**Table 2**  
**Official Development Assistance for Health by External Source**  
**1990**

	\$ Millions	Percent of Total
Bilateral agencies	1,671	35.0
International banks	382	7.9
United Nations agencies <sup>(15,21)</sup>	1,580	32.9
Nongovernmental organizations	1,100	22.9
Foundations	61	1.3
<b>Total</b>	<b>4,794</b>	<b>100.0</b>

Source: World Development Report, 1993.

Among the agencies listed, comparatively few have a predominant health, population and nutrition charter (combining one or more of these three major components). The UN health, population and nutrition agencies provide about one-fifth of the total health resources. Four-fifths of investments in health come from general development agencies which are not constitutionally under the coordinating authority of the UN system. As mentioned before, WHO with a constitutional charter for coordination in health provides only 11% of health resources. The combined annual budget in 1990 for WHO, PAHO, UNICEF and UNFPA was approximately \$1 billion, if one discounts extrabudgetary contributions by other donor agencies (to avoid double counting).

While WHO is the only agency endowed with a specific mandate to serve as the international global coordinating authority for health, it lacks the functional, fiscal or program accountability for administering four-fifths of all external health assistance. These accountabilities remain with each donor agency and its cooperating host developing country.

Within the UN system, UNDP is given the function of coordinating donor support at the country level. Although this policy overlaps with the coordination function of WHO in the health sector, in practice, WHO is not precluded an active role in donor identification and coordination.

The estimated amount and sources of global bilateral, multilateral and NGOs donor financial flows for all development purposes are shown in Table 3.

**Table 3**  
**Total Net Resource Inflows (Net Disbursements) to Developing Countries<sup>(17)</sup>**

Financial Category		1989	Current 1990	1991 (\$ billions)
I.	Official development finance	60.7	69.9	72.8
	Official development assistance	40.3	52.7	55.8
	of which: bilateral	36.5	39.2	41.8
	multilateral	11.7	13.5	14.0
	Other ODF	12.5	17.2	17.0
II.	Total export credits	9.4	4.7	3.1
III.	Private flows of which	46.8	52.7	55.4
	grants by nongovernmental organizations	4.0	4.9	5.2
Total of I, II, and III		116.9	127.3	131.3

Using World Development Report 1993 numbers for the 1990 global health flows as shown in Tables 1 and 2, approximately 6.5% of total 1990 recorded official development flows (\$69.9 billion) were applied to the health sector.<sup>(18)</sup> Total concessional flows for development are increasing at 4% per year, although only at 1% in real terms.

The current trend does not necessarily imply long term stagnation. The totals have doubled in the past ten years (current dollar value). In the health sector, for example, the World Bank has quadrupled its health investments in the last six years and expects to grow from \$350 million in 1992, to about \$1 billion by 1995.<sup>(15)</sup> These numbers do not adequately explain the relationship between sectoral and total development financing.

Aside from private and voluntary sources, the funds within the bilateral and multilateral donor categories are generated predominantly by donor governments. Policies towards financial aid change from year to year, as evident in shifts towards emphasis on Africa, Middle East and Eastern Europe. Contributions by major industrial countries to official development assistance (concessional assistance) averaged 1.8% of central government expenditures. Contributions are

not limited by resource availability, but by government policies on the amount and channel of aid; namely, directly (bilateral) or through international banks and the UN system (multilateral).

Similarly, concessional flows for health, which account for approximately 6.5% of all development flows in 1990, are not necessarily a function of predetermined donor planning. Sector financing is the result of perceptions on the part of each donor as to development priorities in developing countries--priorities which are generally determined by their development planning or finance authorities. In practice, the availability of funds for the health sector is significantly influenced by specific demands of developing country officials in the form of well justified proposals.<sup>(14,15)</sup>

### *Principal Sources of Financing and Technical Cooperation*

Over the past forty years, the category of donor has expanded beyond those listed in Table 2 to include developing countries and organizations within those countries that periodically or on a sustained basis provide technical and financial assistance to selected countries. Estimated financing listed in brackets with each subheading was taken from DAC/OECD's 1992 Annual Report and represents cooperation *in all areas of development*.

#### MULTILATERAL ORGANIZATIONS

##### *United Nations health organizations including those with a major programmatic health function*

The following organizations are not strictly external donors. They are organizations supported by all Member Countries. The UN system functions with large technical and financial resources which are negotiated on a bilateral mode with Member Countries for annual or multi-year programs:

- World Health Organization (WHO);
- Pan American Health Organization (PAHO);
- United Nations Population Fund (UNFPA);
- United Nations Children's Fund (UNICEF);
- International Agency for Research on Cancer (IARC).

##### *United Nations multisectoral development organizations with components having a favorable effect on health:*

- Food and Agriculture Organization of the United Nations (FAO);
- United Nations Development Program (UNDP);
- United Nations Environmental Program (UNEP);
- United Nations Educational, Scientific and Cultural Organization (UNESCO);

- World Food Program (WFP);
- Office of the United Nations Disaster Relief Coordinator (UNDRO).

#### DEVELOPMENT BANKS

(Concessional \$6 billion 1990)

(Nonconcessional \$10 billion 1990)

- African Development Bank (AFDB);
- Asian Development Bank (ADB);
- Central American Bank for Economy Integration (CABEI);
- Caribbean Development Bank (CDB);
- Inter-American Development Bank (IDB);
- International Bank for Reconstruction and Development (World Bank) (IBRD).

#### BILATERAL ORGANIZATIONS

Members of the OECD's Development Assistance Committee, Paris, are usually represented by a specific development organization; for example the United States Agency for International Development (AID) for the United States of America (\$53,845 million, 1991):

Australia	Netherlands
Austria	New Zealand
Belgium	Norway
Canada	Portugal
Denmark	Spain
Finland	Sweden
France	Switzerland
Germany	United Kingdom
Ireland	United States of America
Italy	European Community
Japan	

OTHER OECD MEMBER COUNTRIES (\$36 MILLION, 1991):

- Greece
- Luxembourg
- Iceland

CENTRAL AND EASTERN EUROPE (\$1621 MILLION, 1991):

ARAB DONORS (\$14,271 MILLION REPORTED 1990):

- Abu Dhabi Fund;
- Arab Fund for Economic and Social Development;
- Arab Gulf Fund for United Nations Development Programs
- Iraqi Fund for External Development;
- Islamic Development Fund;
- Kuwait Fund for Arab Economic Development;
- Libyan Fund Foreign Investment Company;
- OPEC Fund for International Development;
- Saudi Fund for Development.

Outside of these special funds, Arab countries individually participate in technical cooperation.

Countries participating in technical and financial cooperation with other developing countries (inadequate data on total flows):

Argentina	Brazil
China	India
Taiwan	Korea
Mexico	Cuba
Venezuela	Israel

#### NONGOVERNMENTAL ORGANIZATIONS

In 1983, OECD estimated that there were 3,000 international foundations or voluntary organizations. This is considered to be an underestimate, since there are inadequate global data on total numbers and distribution. The categories include foundations, charitable organizations, religious organizations, universities, and corporations. OECD estimated the total value of resource flows to be \$5.2 billion in 1991. Efforts have been made to separate voluntary and corporate contributions from funds channelled by governments.

#### *Quality and Availability of Data on External Cooperation Definition of Terms*

Outside the 20-member industrialized countries of DAC, reporting suffers from the lack of agreement on data collection and definition of terms. For comparability purposes among donors, it is essential to include general categories of health services, health development, population and nutrition. With respect to water supply and sanitation, the World Bank Report 1993 has excluded this category. This exclusion eliminates extensive programs in community

water supply and sanitation by sources such as USAID, the Kingdom of the Netherlands, WHO and the large NGO community.

Another major exclusion in sector reporting is data on concessional support by the pharmaceutical industry. Within the annual \$10.3 billion global consumption of drugs concessionally priced drugs are made available by the commercial sector to developing countries. Since the cost of medicine often consumes half of the annual health budget in developing countries, the discount value of drug sales should be noted.<sup>(19)</sup>

### 3. *Technical Cooperation in Health by Selected Bilateral and Multilateral Donor Organizations*

Although technical cooperation, along with coordination, are the two primary constitutional and functional requirements of WHO and, therefore, the **intended product or output** of the Organization, the measurable products and outputs in general health indicators and health levels usually represent the collective efforts of countries themselves, with the support of multiple national and external organizations.

In practice, many factors influence the outcome of technical collaboration between one or more countries or institutions and by one or more external cooperating source. These factors include past experience of collaborating partners, policy framework, financing, and cultural perceptions of collaborators on priority, methods, and professional competence. Given the ever increasing technical cooperation resources provided by organizations other than WHO and PAHO, this section illustrates the variation of factors, including decision-making processes regarding technical collaboration within the United Nations Development Program (UNDP), the World Bank, and the USAID.

It should be noted that from the number of donors listed before, a few examples will not sufficiently characterize overall variations in policies and methods vis-a-vis technical cooperation. Although examples of nongovernmental organizations are not included in this document, many of the earliest lessons of technical cooperation have been derived from the experience of private foundations and voluntary organizations prior to World War II.

For the purpose of describing technical cooperation programs of specific donors in parallel to PAHO and WHO, it is important to highlight similar characteristics among major donors. Although PAHO and WHO are frequent collaborators in the formulation and implementation of health sector investment and technical cooperation agreements, the unique feature of PAHO and WHO is their primarily health orientation and their linkage to Health Ministries in Member States. Their priorities for health investment and technical cooperation are not fundamentally different from those of development organizations.

- They have global representation, except for regional organizations such as the Inter-American Development Bank.
- They are either multisectoral, or economic and social development organizations. Health sector investment and technical cooperation agreements, which represent an estimated 90 percent of all external cooperation in the sector, are approved by the Finance Ministry at the national level.
- Generally, these organizations provide standard technical cooperation instruments for health, such as professional expertise, training, institutional development, and capacity building.

- For most bilateral and multilateral organizations housing global programs, bilateral and multilateral, there is consensus on global health priorities, such as Health-for-All, health system reform, disease control, environmental sanitation, as well as improved financial and administrative management.

### *United Nations Development Program*

Established in 1949 as the Expanded Program of Technical Assistance, the UNDP is the first large scale effort by the UN system for the transfer of technical knowledge and skills through expert advice and fellowships. With a relatively modest budget for its programs in 174 program countries and territories (\$1.5 billion), UNDP expended 2% of all official development assistance by all major donors in 1992. UNDP maximizes its influence through supplementing the technical cooperation activities of 31 executing agencies of the UNDP system.

As a model for technical collaboration, the UNDP requires countries to indicate their priorities for financing within a multi-sectoral Indicative Planning Figure (IPF). In health, technical collaboration by UNDP is usually provided through UN technical health agencies, such as WHO, PAHO and UNFPA.

### HEALTH POLICY

The broad development mandate of UNDP permits inclusion of health, population and nutrition priorities, as expressed through the country programs of Member Countries, and through regional and global programs. In particular, decision-making by Member Countries using available IPF financing, depends on national priorities, among which the health sector appears as one of the major components.

Decisions on health investments, as in other sectors, depend upon the efficiency with which UNDP resources can be applied in relation to funds available from other sources. This policy assumes that decisions will be made at the country level or, as in the case of AIDS, at central programming levels in consultation with the Executing Agencies.

### TYPES OF PROGRAMS AND FINANCING

The mandated programs are broad and include activities in general development, agriculture, forestry, fisheries, industry, health and education, natural resources, transport and communication, science and technology, and employment.

In health, the categories for support are not restricted by policy and may change from year to year. Current programs include development of health system infrastructure, health promotion and care, disease prevention and control, and environmental control and sanitation.

The 1992 UNDP Annual Report listed, among its projects:

- 26 maternal and child health programs with a UNDP value of \$10 million;
- 39 nutrition projects with a value of \$7.9 million;
- 19 family planning projects with a value of \$6.1 million;
- 52 primary health care projects with a value of \$28 million.

In 1990, UNDP committed \$10.8 million for HIV/AIDS control at the country level and an additional \$3.4 million for regional and global programs.

The full detail of the 1993 regional and interregional programs indicates a portfolio of 261 projects.

The Indicative Planning Figure for the fifth four-year cycle (1992-1996) is \$4,194,327. In 1992, the total expenditure for all development sectors was over \$1.4 billion.<sup>(21)</sup> The health expenditure for 1992 was \$57.2 million, of which \$56.8 million came from core funds and \$8.4 million represented trust funds and programs administered by UNDP.

The expenditure in population, humanitarian aid and human settlements from 1992 was \$74.0 million, of which \$54.4 million came from core funds and the remainder from trust funds and UNDP administered programs.

The value of projects is enhanced by government cost sharing which totals one-third of all project costs. The UNDP share of the current 1993 portfolio is \$216 million. Governments are committed to contribute \$116.7 million.

Within the health total, \$10.8 million has been provided to support HIV/AIDS programs in Africa and Asia. The regional bureaus have provided \$2.4 million for program planning plus an additional \$1 million for the UNDP Global program not specifically restricted to regional or country activities.

#### PROGRAM METHODOLOGY AND FACTORS WHICH INFLUENCE DECISION-MAKING IN TECHNICAL COOPERATION

Under the decentralization policy of UNDP country programs, decisions are made at the country level. This process involves issuance to all countries of the UNDP Indicative Planning Figure for the next five-year UNDP planning cycle. The decision-makers are most usually the development Planning or Finance Ministries in consultation with the UNDP Resident Representative. National authorities, knowing the anticipated IPF, may use resources to supplement anticipated national or donor financing.

Although the basis of national development planning may be a national multi-year plan, the quality of such planning in the health sector is often weak in the sense that general objectives

may not be stated in specific outputs and financial requirements. Even though UNDP is prepared to support improvement in planning, experience indicates that many developing countries have limited numbers of professional personnel who are trained in this discipline. Often those with planning experience are reassigned to other duties. Decision-making for UNDP funds, at the country level, reflects the quality of the planning input from relevant health related ministries and organizations.

The effectiveness of UNDP, as well as that of other donors, is dependent on the quality of health sector planning at the local level. Out of this effort, governments as well as donors determine areas for resource allocation. Resource allocation is also dependent on the political and technical justification for resources as expressed in a national plan. While such planning is attempted in most countries, the quality is widely variable.

### *World Bank*

World Bank policy officially emphasizes multi-sectoral economic development even though ultimate benefit in human terms may be implied. Health investment is theoretically based on national health priorities, which are justified by detailed economic and technical analysis. The Bank frequently assists national governments in developing their national health planning capability, to enable them to justify priorities in technical and economic terms, not only to national authorities but also to World Bank authorities. The health sector must compete with other national sectors for financing.

The Bank refers to "technical assistance" as essential component toward the accomplishment of loan objectives. Technical collaboration with countries is assumed to occur, although the conditions of cooperation are specifically detailed in the Bank-country credit or loan agreement, as approved by the Bank's Executive Directors and national development authorities. The WHO concept of cooperation among equals, in the strict sense, may not be intended although, in practice, recipient countries may use Bank resources to employ (with Bank approval) professionals who serve within a national government structure. Although Bank staff are international in origin (developed and developing countries), the premise of investment is that the requesting country requires technical and financial support. Technical collaboration by the Bank is often limited to the planning and preparatory stages.

The Bank invites cooperation from other donors and agencies, such as WHO and NGOs, Notably, however, the Bank itself supplies an increasing number of its own professional experts through contract arrangements. The influence of high-quality Bank professionals, along with the prospect of financing, serves to readily displace influence of non-financing international organizations. Unlike WHO, technical cooperation is not the primary product of the Bank. The product is the outcome of a discrete loan or credit agreement defined to improve national economic or social development.

## HEALTH SECTOR (HEALTH, POPULATION, NUTRITION) POLICY

Early Bank policy (1945-1974) was focussed primarily on lending for economic and social progress and did not originally include lending for health. The concept of a reconstruction and development bank, as the name implies, was originally addressed to the rehabilitation of world economies following World War II. However, a series of studies, directed by their Bank president Robert McNamara in the early 1970's, came to the conclusion that the economic discrepancies in distribution of global wealth were, if anything, increasing. Specific steps were suggested, in parallel with the Bank's preoccupation of economic infrastructure development, to address the most severe effects of poverty. One of the early outcomes of this concern was the emergence of a Bank health sector policy paper. From 1974 to 1978, 70 health components were added to loan projects in 44 countries,<sup>(23)</sup> and in 1980, direct lending for health projects was initiated, thirty-five years after the establishment of the Bank.

In line with its development policies and experience in country programming and analysis, Bank lending in health includes strengthening of sectoral planning, budgeting, cost-effectiveness, and the identification of rationally developed priorities.

The Bank has noted that *Poverty reduction must be the benchmark against which (the Bank's) performance is judged.*<sup>(24)</sup> The poverty-reduction strategy is to promote a pattern of growth that enables the poor to participate through their labor and to support investment in the poor through expanded access to health, education and other social services.

### TYPES OF PROGRAMS

The content of health, population and nutrition (HPN) programs is not restricted. Intervention are subject to analysis of the corresponding sectors, determination of priorities, and relation to the national economic and social development. Specific project emphasis takes into account the provision of support from other donor sources, in order to avoid overlap of function.

HPN project costs may not equal total project costs or Bank financing due to inclusion of integrated projects which cover other sectors such as education. Total HPN financing by the Bank represents 55% of total project financing and indicates the Bank's function of attracting resources from non-Bank donors.

The annual investment in HPN projects has increased from an average of \$315 million in the period 1987-1989, to just over \$1 billion in the period 1990-1992. During the same period, the number of projects increased from an average of 8 per year to 21.

Annual HPN commitments in excess of \$1 billion make the World Bank the largest external health donor, if one keeps in mind the distinction that the Bank is a loan resource rather than a provider of grants, which characterize four-fifths of the HPN donor total flows of approximately \$5 billion.

## PROGRAM METHODOLOGY

The rigorous requirements of loan and credit administration call for detailed preparatory work, sector review, project identification, project appraisal, negotiation, technical monitoring and evaluation. While the loan administration requirements of other donors may be no less rigorous, the Bank's ability to provide loan financing is dependent largely on repayment. The Bank's ability to borrow from its industrialized Member Countries is also dependent on. For example, the World Bank country sector review are usually in far greater detail than health sector assessments by other granting agencies. The requirement for a credible national health sector plan is given greater weight in the Bank, even though the current status of a given plan may require revision.

Technical cooperation as a term of joint donor-host country partnership, as used in the UN system, is given effect in many ways within the Bank's joint activities of program preparation and implementation. The Bank Annual Reports continue to use technical assistance to reflect the Bank's responsibility to assure that loan preparation responsibilities meet the requirements for loan approval and implementation. In the Bank's language, technical assistance is crucial to all stages of its program and accounts for an estimated \$2.7 billion in Bank annual expenditures (1993) to perform its functions as lender, provider and administrator.

Given that the borrower is responsible for project implementation, it is easier for the Bank to provide so-called *hard* technical assistance for physical investment than it is to help countries strengthen their capabilities in institutional development, policy reform and program management. Capacity building is gaining increasing attention including the establishment, in 1992, of a grant-making Institutional Development Facility (IDF) for the purpose of helping countries develop skills which are not (at the time of the grant) associated with any specific project. This approach to technical assistance has led to greater coordination and alliance with agencies such as UNDP. This effort, in turn, is designed to strengthen national capability in country economic and sector work, institutional constraints and country assistance strategies. The use of technical expertise from developing countries is widely applied. Efforts include a development training course within professional institutions in developing countries.

Consultative Group Meetings on 26 country programs were held during the 1993 fiscal year. At this level, discussion of Health Population and Nutrition issues have not been a major feature. At the country level, the Bank and UNDP share the consultative function among donors. At this level, WHO offers a major, yet largely unfulfilled, potential for technical assistance. The WHO role within Bank projects is sporadic and dependent essentially on the decisions of decentralized offices and Bank task managers.

## *United States Agency for International Development (USAID)*

USAID is one of 24 major bilateral cooperation agencies which include health within a general development orientation. Like most other bilateral agencies, the financial authority is the legislative or parliamentary authority for the country. Consequently, the levels of financial support vary from year to year with changes in national policy. This characteristic does not preclude joint discussions in the collaborative mode between donors and recipients but the prior determination by a donor of its policy often creates difficulties for joint collaboration on recipient perceived priorities.

Legislative determinations on program are often made two years prior to field implementation. Restrictions on type of program often preclude technical collaboration on the basis of currently perceived national priorities. The award of contracts for program implementation by donor decreases the flexibility of technical collaboration in the health sector on the basis of joint planning. Like most bilateral donors, there is little emphasis on detailed functional health-sector planning in contrast to the current practice of planning around specific programs or projects. The bilateral donor pattern, comparable to the World Bank, requires an internal donor program cycle, and internal national counterpart program cycle, and a third joint cycle of program negotiation. In spite of the programming sequences, the quality of technical cooperation is often high and major attention is given to institutional strengthening, training, and research.

The specific detail of USAID organization and performance, like most donors, is periodically subject to review and reorganization. Data presented should be seen as illustrative only, since legislative mandates influence direction and content. For example, in 1996, major revision of US foreign development assistance programs is anticipated.

### HEALTH POLICY

On technical grounds, USAID has emphasized from the late 1960's that major program efforts be made to cooperate with governments in the formulation of programs that increase access for the poor to basic health services, water supply and sanitation, disease control, population and family planning services and nutrition programs. This policy preceded the WHO sponsored Alma Ata Conference on Primary Health Care in 1978. While supportive of global trends, the specific content of individual country programs depends on assessment of country requirements by the USAID Mission, the availability of alternate resources and the level of funds authorized by Congress.

The recent heightened attention given to increasing coverage of health, population and nutrition services has led to a narrowing of the focus of current programs. These are now less comprehensive and directed to interventions with measurable impact. Emphases include childhood immunization, control of diarrheal disease, Vitamin A supplementation, maternal

health, breast feeding, family planning, acute respiratory disease control, AIDS control, malaria and other vector-borne diseases, water supply and sanitation.

The intervention approach is accelerated through Congressional approval of funds for specific program items within broad categories such as *Child Survival*. The levels of support, over \$500 million annually, take the form of contractible activities which require identification of cooperating countries. The availability of such emphasis often produces favorable technical impact by the administration of highly focused projects. There is less emphasis on sector analysis or on national health planning, than at the World Bank, to determine priorities for donor assistance and development of host-country self-sufficiency. USAID participates in donor coordination at international, regional and country levels.

#### TYPES OF PROGRAMS

In health, bilateral programs are focussed on major child survival initiatives, such as immunization, diarrheal disease control, maternal and child care (emphasis on high risk births, breast feeding, child spacing), control of vector-borne diseases, health care financing, urban health, community water supply and sanitation, malaria vaccine research, health information systems, AIDS control, population and family planning services, nutrition programs and services and control of vitamin A deficiency. Intervention are extended beyond these programmatic limits, but no major support for medical education and linkages with American universities is offered.

#### REGIONAL DISTRIBUTION OF HEALTH, NUTRITION AND POPULATION FINANCING IN FY 1992<sup>(26)</sup>

The statistical methodology of the USAID Health Information System is to identify all projects according to their Child Survival (CS) content as well as other health projects (OCS) and AIDS control (AIDS). Child survival projects include immunization, diarrheal disease control, nutrition, high-risk births (breast-feeding promotion, birth spacing) and maternal health. Other health (OCS) include improving management of primary health care, vector-borne disease control, community water and environmental sanitation, biomedical research, and testing alternative methods for financing health services.

**Table 4**  
**US Contributions and Assessments to International Organizations**  
**1991**  
**(US\$ thousands)**

World Health Organization	61,297
WHO Special Programs	34,387
Pan American Health Organizations	42,003
PAHO Special Health Promotion	12,600
UNICEF*	74,748
<b>Total</b>	<b>225,035</b>

\* The health component may be on the order of 80%.

These estimates under-count health related uses of contributions to the United Nations, UNDP, FAO and the UN High Commissioner for Refugees.

Total health input of the United States through USAID and the State Department for bilateral projects, and contributions to US voluntary organizations and multilateral organizations clearly exceeds \$1 billion annually. Viewed in this perspective, US financial contributions to global health approximate those currently reported for the World Bank.

#### **4. *Factors that Influence Decisions on Technical Cooperation***

Three decision-making cycles influence the outcome of technical cooperation:

- The internal decision-making procedures of potential recipient governments (or groups of countries which have a common sector objective). Development or financial authorities, which control internal sector performance, may in turn control decisions of the health sector. The perceptions of national health sector authorities or cooperating national organizations are critical in the determination of priorities and solutions, including in the choice of collaborating partners and perceptions of professional competence on the part of an external partner.
- The internal decision-making procedures of a potential external collaborating source of professional expertise or financial support. Internal approval processes reflect approvals by policy making boards and financial supervisors. Bilateral agency policy are determined ultimately by the policies and funding levels of their legislative or parliamentary bodies. In practice, bilateral agencies and international organizations need to always refer to their policy guidelines, professional judgement, and financial constraints.
- Finally, joint negotiations between two parties or group of organizations or countries determine the specific program or project framework and content of technical cooperation. Joint negotiations may be complex and lengthy when detailed economic and technical justification is required (as is the case at international banks), or relatively straight-forward and rapid when negotiation authority and financial decisions are vested in negotiators (for example: NGOs, WHO, PAHO)

Technical cooperation and its inherent demand for professional expertise, sharing of knowledge and financial support could be defined as a socially acceptable term for methods by which two or more countries or organizations work together for mutual interest (policy-defined interest). The purpose of this section is to identify key factors that influence the decision-making process of institutions or governments when advancing towards a common objective. This issue is pertinent not only to the health sector, but to overall development as well.

An important element in this debate is the topic of efficiency. Efficiency in performance of technical cooperation calls for an understanding of the foregoing cycle in its many variations. Efficiency requires an information system which provides insight into the advantages, disadvantages and options available in international collaboration. A major constraint to greater efficiency in achieving a defined objective is the preoccupation of each cooperating partner with its own internal program cycle. Accountability for technical and financial performance is assessed by joint sponsoring organizations. Consequently, overlap of functions are not uncommon. For example, both international banks and bilateral often duplicate a technical support function which may be done at less cost by an international specialized agency.

Health sector topical content is extensive. Priorities for technical cooperation must be carefully selected. Subject matter extends from the most fundamental biomedical research, medical care systems, professional training and practice, components of modern preventive medicine, sector policy, planning, management, financing and ultimately to national development planning. This spectrum of activity is clearly beyond the in-house professional capability of any one institution.

Beyond the disaggregation of factors or creation of a taxonomy, technical cooperation in health has not yet been objectively studied to codify the large body of anecdotal experience and analyze the traditional biases among donors and recipients.

The following are some queries that arise from a consideration of the factor that influence the offer and receipt of technical cooperation:

- Are financial donors endowed with greater expertise than that already existing in developing countries? If so, how does one explain the increasing number of highly qualified professional experts from developing countries who serve in senior technical capacities at international organizations?
- What factors preclude a recipient country from knowledge of alternate sources of technical expertise and the financial resources to make them available?
- Who determines the appropriateness of professional expertise? Peer review among experts? Satisfaction of the recipient? In-house or regional perceptions of consultant choice that are marginal to professional expertise?
- How do recipients regard the quality of technical and professional expertise from external sources? For example, what is the perception by recipients of organizations originally designed to provide health sector expertise, such as WHO and PAHO?
- Is there evidence that bilateral agencies and international banks have major gaps in-house technical expertise which diminish judgement in the selection of consultants and design of technical cooperation programs? Is it objective to argue that bilateral agency and international bank sector staff are most often project development specialists than subject matter specialists?

## 5. *Review and Analysis of Country Studies*

To illustrate key factors that determine the outcome of technical cooperation at the recipient country level, sixteen country studies were prepared by five WHO Regional Offices (other than the European Office) in cooperation with one or more Member Governments in their respective Regions. Five of these studies (India, Indonesia, Jamaica, Morocco, Philippines) are sufficiently detailed to allow greater depth of analysis.

It should be noted that the focus of these studies is technical cooperation rather than analysis of the health or financial situation. The basic question is how countries, international organizations, and nongovernmental organizations cooperate, at the country level, towards searching national health goals, and how WHO and PAHO contributes to this process.

### *Background to Studies*

The countries were selected primarily on the basis of availability with which relevant data and degree of similarity in terms of size and complexity. Logistical difficulties prevented the inclusion of equal numbers of countries from the various Regions.

Country Studies from the European Region were not included, since it was felt that those countries with a long standing relationship with WHO were more likely to be in a donor position, and that the newly independent states would have limited experience with technical cooperation. The material is presented in two steps:

**Inter-country Comparison of Study Countries:** For background purposes, key indicators are summarized in Tables 5 through 9. These indicators have been taken from the World Development Report, 1993. While there will be some statistical variation in individual country reports, the context of economic status, basic health data, and financing is maintained. It should be noted that World Bank data are occasionally at variance with country study data.

**Country Studies:** Fourteen of the sixteen studies prepared by WHO Regional and Country Offices are summarized. From these, five studies are selected for special attention and analysis to illustrate key factors and dynamics of technical cooperation. All sixteen studies prepared by WHO Regional Offices offer a range of useful responses to a standard outline of inquiry. These responses vary in depth of detail.

**Table 5**

**List of Fourteen Reviewed Country Studies**

Africa	Americas	Eastern Mediterranean	South East Asia	Western Pacific
Cameroon Ivory Coast Kenya Uganda	Bolivia Ecuador Honduras Jamaica* Mexico	Egypt Morocco*	India* Indonesia*	Philippines*

\* Country studies selected for special analysis.

*Inter-country Comparison of Key Economic and Health Indicators in Study Countries*

**Table 6**  
**Ranking of Sixteen Country Studies According to Gross National Product**

WHO Regional Office	Country Study	Global Ranking by GNP	GNP Per Capita
Africa	Cameroon	46	850
	Ivory Coast	42	690
	Kenya	29	340
	Uganda	4	170
	Zimbabwe	38	650
Americas	Bolivia	41	650
	Ecuador	49	1,000
	Honduras	34	560
	Jamaica	60	1,380
	Mexico	92	3,030
Eastern Mediterranean	Egypt	37	610
	Morocco	50	1,030
South East Asia	India	19	330
	Indonesia	36	610
Western Pacific	Fiji	nd	nd
	Philippines	44	730

Source: World Development Report, 1993. World Bank, 1994.<sup>2</sup>  
nd = Data not available from World Development Report, 1993.

Based on the World Bank's classification of economic status, six of the country studies fall into the low-income category, that is with less than \$635 GNP per capita: Egypt, Honduras, India, Indonesia, Kenya, and Uganda. The remaining 10 fall into the lower one-half of middle income countries, with a range of: \$635-\$7,909 GNP per capita.

In order to provide greater uniformity of economic and health indicators, data presented in Tables 7 through 9 are also derived from the World Development Report, 1993.

**Table 7**  
**Basic Population and Health Indicators for Sixteen Countries, 1991**

Country Study	Population Million	Population Growth Rate %	Life Expectancy (1)	Child Mortality (2)	Infant Mortality 1991 (3)
Cameroon	11.7	2.8	55	125	64
Ivory Coast	11.9	3.8	52	90	95
Kenya	24.1	3.8	59	81	67
Uganda	16.3	2.5	46	185	118
Zimbabwe	10.0	3.4	60	58	48
Bolivia	7.2	2.5	59	125	83
Ecuador	10.3	2.6	66	42	47
Honduras	5.1	3.3	65	62	49
Jamaica	2.4	1.4	73	nd	27*
Mexico	86.0	2.0	70	38	36
Egypt	52.0	2.5	61	56	59
Morocco	25.0	2.6	63	71	57
India	849.5	2.1	60	127	90
Indonesia	178.2	1.8	60	111	74
Fiji		na	na	nd	nd
Philippines	761.5	2.4	65	62	41

Source: World Development Report, 1993.

\* The MOH Jamaica quotes an IMR of 27, while other studies indicate a figure of approximately 17.

(1) Life expectancy: The number of years a person born in a given year could expect to live given the age-specific mortality rates for that year.

(2) Child mortality: Probability of dying by age 5 years.

(3) Infant mortality: Deaths under one year of life per 1,000 live births.

Table 8  
Total Health Expenditures and Health Expenditures Per Capita for Sixteen  
Country Studies, 1990-1991

Country Study	Total Health Expenditure \$ Million	Health Expenditure Per Capita	Health Expenditure as Percent of Total Central Expenditures
Cameroon	286	29	3.4
Ivory Coast	332	42	nd
Kenya	375	16	5.4
Uganda	95	6	nd
Zimbabwe	416	42	7.6
Bolivia	181	25	3.3
Ecuador	441	43	11.0
Honduras	134	26	nd
Jamaica	nd	nd	nd
Mexico	7,648	89	1.9
Egypt	921	18	2.8
Morocco	661	26	nd
India	7,740	21	1.6
Indonesia	2,148	12	2.4
Fiji	nd	nd	nd
Philippines	883	14	4.2

Source: World Development Report, 1993.  
Note that no data (nd) is available for certain countries. For Jamaica, see narrative on Country Study.

**Table 9**  
**Official Development Assistance (ODA) for All Sectors, Including the**  
**Health Component, 1990**

Country Study	Total ODA All Sectors \$ Million	Total Health Sector ODA \$ Million	Percent Health ODA of Total ODA Flows for All Sectors
Cameroon	431	38	8.8
Ivory Coast	693	11	1.6
Kenya	1,053	54	5.0
Uganda	531	46	8.6
Zimbabwe	340	42	12.3
Bolivia	506	37	7.3
Ecuador	155	31	20.0
Honduras	450	20	4.4
Jamaica	273	nd	nd
Mexico	141	65	46.0
Egypt	5,444	111	2.0
Morocco	1,026	20	1.9
India	1,524	286	18.7
Indonesia	1,724	159	9.2
Fiji	nd	nd	nd
Philippines	1,279	69	5.4

Source: World Development Report, 1993.

In Table 9, and as mentioned before donor concessional assistance for health omits contributions from the UN, including WHO, community water supply and sanitation, which are major project components by banks and bilateral, and support by nongovernmental organizations. Data exclude commercial flows, rather than concessional flows, which are used in the economically better off countries like Mexico and Ecuador.

Table 9 illustrates the wide range of allocations for the health sector as a percent of total concessional assistance. Such data however do not provide an adequate measure of technical cooperation, nor of country allocations of all resources. The data suggest that countries vary widely in their policies for allocation of external aid, a factor which includes lack of knowledge of sources.

For comparative purposes, per capita ODA for health is a less meaningful figure than the gap between total ODA and health ODA. Since health ODA is only a small fraction of total national health resources, ODA for health is usually used as special support for national projects which may favor certain populations or projects. However, the variation in percentage of health to total ODA suggests either differences in national priorities for health or lack of health sector

ability to attract financing. External allocations are not exclusively external decisions, but rather the outcome of national/external dialogue.

### *Summary of Country Studies*

The purpose of this section is to determine key factors in technical cooperation rather than to evaluate health status or other background factors. The assessment of technical cooperation of 16 countries is aimed at showing the dynamics and principal loci of decision-making.

The provision of technical cooperation in the form of expertise, financing, training, information dissemination and other institutional support originates from a large number of official agencies within developed and less developed countries, official multilateral banks, UN organizations including WHO, UNICEF, UNFPA, FAO, and nongovernmental organizations. It should be noted, that official donors and governments with policies which are supportive of the health sector are estimated to be around 60. At the same time, the number of international private and voluntary organizations, including foundations, is estimated to exceed 3,000 worldwide.

External sources negotiate at various levels within the government and of the private sectors. Official agencies usually negotiate through its development, financial or foreign affairs authorities; WHO negotiates directly with Ministries of Health; NGO's, on the other hand, seek agreements with private entities, government ministries, and with universities and other institutions.

Ministries of Health are aware of varying degrees of in-country donor sources, which are cooperating with the government. These studies suggest that Health Ministries are less aware of the full range of potentially available sources. Furthermore, according to the mentioned country studies, the number of external sources cooperating in health may be only one-third or less of the total number of sources with defined policies favorable to health. The fraction of external resources applied to health varies widely from 2% (Egypt, Jamaica) to 46% (Mexico). See Table 9.

Countries with extensive experience in external cooperation, such as Mexico, India and the Philippines appear to be fully informed of in-country donor sources, although even here there appears to be little awareness of the global potential, particularly from those donors that have no in-country representation. Countries with less experience express frustration at the process. For example, the Cameroon study suggests that donors often demand that their funds be used in areas of donor interest. The Government has little choice and the program submitted does not always follow the set health development plan. Other country studies mention that countries with well-defined, financed and approved sector plans, such as India, have complete control over their choice of donor collaboration. The key factor at play is the degree to health authorities are able to develop a health plan which has the backing of the country's development officials.

These studies suggest that WHO's record in assisting countries to identify donor sources is not entirely clear. Resource mobilization is a policy function of WHO, despite the efforts made at WHO Headquarters and Regional Offices over the past ten years, the studies indicate that WHO staff at the country level are not necessarily familiarized with and current on the issue of potentially-available donor sources. The majority of reports do not indicate the magnitude of donor support. If donor data are not available to governments, it may also not be available to the WHO Country Team. In practice, however, there are multiple sources of donor data, including UNDP and the national Ministry of Planning or Finance.

The capability of Ministries of Health to identify priorities in the development context and to attract resources varies with country training and experience. Certain countries like India, Indonesia, and the Philippines have established well-defined procedures for project development which are tied to an approved national development plan.

For official development assistance, sector priorities are determined by a national health sector plan, which has official approval at the highest national development and political levels. The studies indicate that there are countries which lack a play for the health sector, which has been approved by a national development authority. In these cases, the term priority is often used to indicate an internal preference, which may or may not have the approval of a national development authority.

Health sector resource mobilization, in its full technical, institutional, human and financial sense, follows a set of policies and decisions made within departments at the Ministry of Health or, in the case of NGOs, through joint discussions among national and external representatives. Throughout this process, clearances and approvals come in direct competition with intra-sectoral and inter-sectoral interests. The success with which requests are fulfilled depends on the capability of the health sector to prepare well-justified proposals, which are linked to overall national development goals. Ultimately, all national decisions are of political nature, the sense that a national authority must grant the corresponding approval.

In spite of the global dissemination of information on guidelines for decisions-making, including those through WHO, the studies indicate that the quality of the national health plans requires strengthening. The costs, duration and technical methods to be used, as well as expected results and personnel requirements are not sufficiently defined to allow national central and development authorities to make a decision. In effect, the practice of functional analysis as a basis of national planning is not yet widely utilized. In at least one study country, a detailed national health plan was rejected by the national development planning authority, because the funding implications of programs were not compatible with the state of the economy.

The country studies, since the country studies were prepared by WHO Regional and Country Offices, emphasize is placed on the content and costs of the WHO Country Programs, often to the exclusion of detail on the function and contributions of other external sources.

The role of the WHO is significant in each country. WHO provides continuity and readiness to the Ministry of health. However, the procedures and programs of WHO are not always understood by its Member States. One study reports the tendency of WHO to perform as if it were an external donor, by requiring joint WHO-country preparation of annual programs. These jointly determined programs, in the form of staff training, consultancies and other forms of collaboration, are viewed by some countries as poorly linked to national priorities (see the Indonesia report). On the other hand, extrabudgetary resources are allocated for WHO-managed programs of national and inter-regional priority, such as AIDS and other disease control. Therefore, the country may perceive WHO guidelines in a different light than its own stated priorities.

WHO serves in its constitutional directing and coordinating role with varying degrees of acceptance. The development context of technical cooperation places a heavy burden of coordination in the hands of established national development authorities, such as the Ministry of Development or Planning and their external counterparts at the international banks or bilateral agencies. On behalf of the United Nations, the designated coordinator of development programs is the UNDP. An emerging issue, therefore, is how can WHO improve its coordinating function in the health sector at the country level or, more appropriately, strengthen the capacity of the Ministry of Health to coordinate the inputs into the health sector.

Country studies verify the large, albeit poorly-quantified NGOs resource. Within the range of available services and scientific groups, many have long-term links which permit credibility and high regard. Organizational preoccupation by multiple various official and government agencies often preclude encouragement of a far greater role for the NGOs, not only in the delivery of health services, but in pioneering medical and public health research.

The reviewed studies offer an initial insight into technical cooperation at the country level. In a more anecdotal sense, each collaborating partner may have specific project-related documentation on evaluation, outcome and impact. There is, however, little evidence of in-depth assessments of technical cooperation in given country as a whole. As a result, perceptions are in the eye of the beholder. Future studies would benefit from standardization of questions and statistics, which would permit an international organization like WHO to assess the impact of technical cooperation programs supported by government with all its partners. For example, it would be valuable to assess the performance of technical cooperation, in terms of the management and effects of consultancies, project implementation, capability in national sector planning, training, measurement of resource mobilization, results of coordination, development of research promotion and progress towards agreed international goals.

The reviewed studies leave the impression that there is no uniformity in WHO's programming of technical cooperation as a basis for dialogue with other agencies involved in health, or as a prerequisite for the necessary evaluation of the effectiveness of such cooperation.

It is not clear that there is an agreement by Governments or WHO vis-a-vis the nature of the expected cooperation that might be expected from the various actors in the health field,

some of which are viewed particularly as donors, some as purveyors of technical cooperation, and others as a mixture of various types of assistance.

### *Analysis of Factors that Influence Technical Cooperation*

This document attempts to define some of the *key factors which influence technical cooperation in health*. The purpose extends beyond the definition of problems to the ultimate purpose which, at least at the government level, means the achievement of Health for All. However, achievement of national health objectives, within some reasonable technical, cultural and economic context remains an unfilled goal in most countries. For example, the United States has been having a major debate on the content and costs of *health care reform*.

This document is not intended to serve as a mechanical discourse on the dynamics of interaction. Official intentions, as expressed in mandates or foreign policies, differ widely. Recipient countries and their public and private institutions are in a better position to attract and negotiate joint projects, if there is a reasonable understanding of those intentions. From the viewpoint of WHO and its Member Countries, the intent will be to achieve national goals regardless of the policies of most donors. In the UN system, including the World Bank, the criteria for resource allocation will be largely apolitical or dependent on need and economic status. For the bilateral, health may be an acceptable sector, but the distribution of bilateral programs tends to focus on political or trade factors which concentrate aid in certain countries.<sup>(27)</sup>

Considering the foreign policy and economic criteria which are the most effective mechanisms for technical cooperation in the health sector between an external official and nongovernmental sources? Given the progressive dominance of multisectoral economic and social development constraints and factors in developing countries, what does current experience suggest in the way of improving technical cooperation?

The question of definitions and mechanisms applies to as many as 60 official sources and more than 3,000 NGOs whose primary task is the provision of technical cooperation in the form of finance, technical expertise and guidance.

The same questions apply to over 100 developing countries seeking to advance their health status in cooperation with external organizations, including WHO, although WHO is not technically external to its Member Countries.

This document does not provide universally applicable answers. The review of sixteen countries, marginally over 10% of developing countries, helps define some of the key factors and key issues in technical cooperation. The variation in determinants is so wide, the changes in status of cooperation are so frequent, and the cooperation experience so diffuse that improvement calls for continuous study, monitoring and evaluation. Prerogatives and mandates for improving technical cooperation are perceived as constitutional requirements not only for WHO but for other UN organizations. In the burgeoning external donor community,

international banks and bilateral will claim constitutional, legislative or parliamentary requirements for carrying out technical cooperation in all sectors of development, within which health is commonly considered to be an inherent component.

Are the functions of WHO in directing and coordinating international health sufficiently distinct from the international mandates for development? Or does the constitutional restriction of WHO to the health sector via Ministries of Health isolate technical cooperation in health to the *WHO Country Program*, rather than directing coordination and technical cooperation efforts funded by the far larger human and financial resources of development agencies and approved by Ministries of Development, Planning and/or Foreign Affairs?

There is no major disagreement that prevents WHO involvement in technical cooperation as an integral part of development. In the detail of implementation, WHO cannot afford to be seen as a self-contained external (*donor*) program, with project goals which are not linked to national development priorities. Nevertheless, there are examples of sector planning and other nation-wide public health planning to which WHO is not invited by the government to participate in project formulation or review because of the assumption that cooperation in health is an issue for donors and recipients to determine.

*For WHO, the matter of its role at the country level is pivotal to its constitutional function.* WHO policies are sanctioned and reaffirmed by all countries including the same countries that finance the development agencies and international banks. The draft Ninth General Program of Work (1996-2001)<sup>(11)</sup> notes:

- The two main functions of WHO are technical cooperation with countries, and directing and coordinating international health work. They are complementary and include: advocacy for health, stimulating specific health action and disseminating information, developing norms and standards, plans and policies, training, research promotion, direct technical consultation, and resource mobilization.

- The statement reaffirms the need to identify health problems, population groups at risk, and

... on setting of priorities and related targets and on the development of a health program and the related strategy for WHO action should be formulated accordingly. This analysis must take into account cooperation in progress or planned with other agencies or countries and should find a way for WHO to deliver technical expertise more effectively at country level...

George Alleyne<sup>(9)</sup> has elaborated on required strategies by proposing a taxonomy of technical cooperation in health, which spells out the content of PAHO approaches to resource mobilization (financial, physical, human, informational and political resources), dissemination of information, training, development of norms, plans and policies, research promotion and direct consultancy.

A sense of the history of international cooperation is helpful in testing policy against actual experience. As was shown, we have seen a transition from a world, 45 years ago, when WHO along with UNICEF and USAID were among the only agencies active in technical cooperation. With time, almost 90% of all external assistance now comes from agencies other than WHO/PAHO. With this passage of time, countries have begun to accumulate their own national cadre of public health experts. The 16 country studies confirm this natural transition in financial, human, technical, institutional and informational resources.

In this perspective, has the WHO sufficiently modified or adapted its approach to its Members Countries? Although WHO remains the major global professional resource, the effective resources for planning, implementing, monitoring, evaluating and financing the large majority of technical health programs are being progressively assumed by bilateral donors and international banks. If WHO/PAHO are responsible or accountable for the performance of global technical cooperation on a diminishing scale, what changes are required in WHO/PAHO strategy? And if the quality of WHO professionals is perceived by Member States to be no better than professionals available through bilateral and banks, how is WHO to maintain its credibility with its Member States?

If historical changes are occurring in the volume of supply of technical cooperation, as the preceding paragraph suggests, what is the situation regarding the demand by Member States? The country studies show a wide variation in expression of demand for a number of reasons which include definition of priorities, the quality of national health sector planning, the pressure of "donor-driven" projects which absorb the attention and financing of government health departments, and the preoccupation of each donor or external agency, including WHO, with the performance of its own negotiated program. Where countries are preoccupied in the implementation of 20 or more technical cooperation programs, professional attention is focussed on those programs rather than on the broad direction which a sector can take, given its limited human and financial resources. In effect, country acceptance of donor priorities may distort a balanced sector view, particularly in the absence of a well-prepared and approved sector plan which has national approval.

How does WHO respond to national changes in demand for technical cooperation services? The studies point to a WHO action strategy which, if the Indonesia report is an indicator, may not be central to national strategy even though a program of fellowships, meetings, training workshops and consultancies are welcome. Yet, there are clear and favorable exceptions in the WHO managed global and regional programs which are supported by extrabudgetary funds from the donor community. Programs of epidemiological surveillance, institutional strengthening, and special campaigns such as AIDS and immunization are important from a global point of view. Would these programs have been included as country priorities if the programs were not financed and managed by WHO Headquarters or Regional Offices? The issue here is not only the technical merit of a program but the way in which decisions are made.

Decisions made by countries and their technical cooperation partners are often difficult to assess simply on the grounds of the type of technical cooperation program. The starting point

for evaluation is to assess the quality of the national health sector plan. This starting point may also become a sticking point. Sector analysis, to be done correctly, is not always a simple task. Sector planning professionals are few within the WHO system in comparison with international agencies where sector analysis is mandatory, not only for sector objectives, but because financial justification is ultimately determined by Financial Ministries or Development Authorities who must allocate resources between many sectors of development. As a consequence, a major problem is that country health priorities may not be adjusted to national development plans. Technical cooperation, however correct in principle, may not represent the identification and solution of financially feasible or sustainable sector goals. In the context of resource mobilization, a major role for WHO/PAHO is to progressively change its mix of skills so that health economics, sector planning and resource mobilization become as professionally prominent and credible as traditional skills such as disease control, immunization, and maternal and child health. Concomitantly expertise in sector analysis must become part of the armamentarium of WHO and perhaps more importantly WHO should be taking the lead in ensuring that there is agency understanding and agreement on the format of such analyses. Failure to do this will isolate WHO from the increasingly important discussion now taking place on the importance of investment in the social sectors.

The need for sectoral analysis has recently become more apparent to PAHO/WHO. In response to a mandate of the Ibero American Presidents, PAHO/WHO has prepared a Regional Plan for Investment in the Environment and Health. This Plan, presented to the 36th Meeting of the PAHO Directing Council<sup>(28)</sup> identified the specific investments that needed to be made in the health and environment sector(s).

Any efforts to determine such needs should be based on a careful analysis of the sector. The logic of this is even more apparent when it is realized that many agencies were and will be investing in the sector, given the strong orientation of many multilateral funding institutions towards strengthening the social sectors. PAHO/WHO has advanced somewhat in trying to identify some common framework for sectoral analysis that might respond to the needs of both the country and potential donor agencies. Particularly, progress has been made in defining methodologies for sector analysis in water and sanitation.<sup>(29)</sup>

Is flexibility in services a part of the WHO mandate? Absolutely. It is taken for granted that the health situation is in a state of continuous epidemiological, economic, financial and political change. This view is reaffirmed in the Draft Ninth General Program of Work:

- Changing conditions underline the need for WHO to secure the full involvement of all government agencies, including Planning and Finance Ministries, as well as authorities in the environment and education sectors and the nongovernmental bodies opening up lines of communication with these sectors and strengthening relations with Ministries of Health as leaders in health development.

The mandate for change has always been part of the WHO constitution and program. The principle is not in question but rather that appropriate change may not occur if sector

planning is weak, if priorities are not based on national development criteria, and if the agents of change such as national health leaders and the WHO Country Offices, are not trained or prepared to offer guidance in sector planning. The country studies confirm an appropriate colloquial phrase that *the devil is in the details*.

WHO strategy needs to take account of professional and sectoral progress in its Member States. The Country Studies demonstrate the increasing strength of professional skills and organization available in such countries as India, Indonesia, Mexico and the Philippines. Formal programs for technical cooperation among developing countries characterize professional depth. Country needs for technical cooperation change from traditional professional advice to management, planning, research promotion, efficiencies in health economics; areas which call for shift in the mix of professional skills and training within WHO and its Member Countries.

If WHO is perceived to have decreasing direct accountability for the large volume of externally supported projects at the country level, and if there a perception of a shortage of sector planners and pertinent disciplines in comparison with the availability among development donors, are there significant compensating areas for the WHO role in technical cooperation at the country level? At all levels, there should be no decrease of outstanding professional services in consultation on technical issues, organization of training, dissemination of information, research promotion and resource mobilization. But this should in no way be seen as a compensation for the lack of skills that now must be present or available in the Organization as a whole.

The review of supply and demand factors included in the 16 country studies indicate that important and unique WHO functions prevail in the functions of monitoring, continuity, resource mobilization, sector planning and management. The recommendations offered are not those of radical change but those of encouragement to fully apply the authority and flexibility of WHO to the continuously evolving parameters of technical cooperation.

These points are no less applicable to nongovernmental organizations, including foundations, universities and research institutions. The studies indicate increasing efforts by government to set up coordination meetings with NGOs to discuss national priorities and program needs. The difficulties in arranging information exchange are large. Where governments recognize the contributing role of NGOs in medical, public health or research and where there is a clear policy to encourage participation, there is reason to expect greater NGOs participation. There are examples, outside of the 16 studies, which describe active technical cooperation between a government Ministry of Health and NGOs. Donor-sponsored NGOs are particularly cooperative.

The study highlights again the difficulty in coordinating the various inputs into the sector and only hints at mechanisms that might be effective. The experience in PAHO has shown that for collaboration to be effective it first must be driven by the expressed wish of the Governments to achieve it. It must focus on specific plans and programs set out with enough detail that agencies can adapt their technical cooperation onto a nationally constructed template. A critical

role for WHO, which it probably alone can play, is to assist in the development of that template and itself be disciplined enough to fit its own technical cooperation onto it and deliberately strengthen the Ministry of Health in its coordinating function.

Many of the conclusions of this study that has been limited to health are similar to those reached by Berg in his excellent wide ranging analysis of technical cooperation in Africa.<sup>(30)</sup> He points out the growing dissatisfaction with many aspects of technical cooperation which has been singularly ineffective in *the achievement of greater self reliance in recipient countries by building institutions and strengthening local capacities in national economic management*. He identified major sources of ineffectiveness as follows:

- weaknesses in design, implementation, and supervision of technical cooperation projects;
- excessive reliance on one model of delivery for technical assistance--the resident expatriate-counterpart model, which has failed as an instrument for capacity building;
- the donor--or supply-driven nature of technical cooperation, which has led to excessive use, inefficient allocation, weak local ownership, and hence limited commitment; and
- poor incentives and working conditions in recipient country public sectors, which lead to low local staff job motivation and high turnover, creating a Teflon-like work environment in which capacity-building and institutional-development efforts fail to take hold.

Of particular interest to us was his comment from a report on the evaluation of technical cooperation in health:

- in health, the most striking successes of technical cooperation have been in *functional* or *campaign* approaches, such as the complete elimination of smallpox or the development of oral rehydration techniques to combat diarrhea in infants.

The most attractive of the remedial measures to this study are the strengthening of the local management of technical cooperation and the call for comprehensive programming. The latter is absolutely critical and essential for optimum use of technical cooperation always with the proviso that governments - Ministries of Health, are seen to be the key stakeholders in the process.

In the final analysis, the usefulness of any studies of technical cooperation will turn upon the benefits they bring to both, those who give and those who receive, but ultimately the real benefit is to the people served by governments. In the case of the health sector, technical cooperation will increasingly be seen as another one of the means to strengthen its position as a critical part of a country's development.

As Dr. Macedo, the former Director of the Pan American Health Organization put it:<sup>(31)</sup>

... the current decade will be a critical period of revision of development values and strategies in most countries of the Region. The health sector can and should contribute to this revision.. The health sector has a compelling duty to learn how economic policies influence the health of the population and to fight to ensure that *impact on health* is viewed as a yardstick against which development strategies must be measured.

## 6. Recommendations

Recommendations in this study, directed primarily to the WHO Organization, suggest approaches to more effective application of existing policies on technical cooperation as **the primary organizational product**. Six proposed recommendations may apply equally to Member States of the WHO, to official and non-governmental international organizations and to private and voluntary institutions.

This paper does not propose radical change in the approach to technical cooperation. It calls for radically new effort. The official policies of bilateral, multilateral banks and the UN system, including the WHO, are sufficiently supportive and flexible to permit continued strengthening of technical cooperation. The gap between policy pronouncement at Headquarters levels and application by Member States (or cooperating host countries) determines the effectiveness of policy. The following *Recommendations* offer suggestions for major components of technical cooperation, which may require strengthening to facilitate more universal understanding and acceptance of this form of work.

As the unique advocate for world health, WHO is aware that advocacy is more than a public relations effort. In a highly competitive development environment, each sector (agriculture, industry, education, defense) is equally intent on resource mobilization and sector improvement. Advocacy implies supporting the capability of the health sector at country level to compete for resources at the national and international level.

*Since technical cooperation is stated to be one of the two main functions of WHO, the recommendations are stated in terms of WHO actions that are already authorized but require added emphasis.* As noted, however, the recommendations, while directed towards the WHO system, may find echo in all international official and nongovernmental organizations with program interest in the health sector.

### *Conceptualization*

With the objective of improving the design, quality and effectiveness of technical cooperation strategy at the country level, and in view of the multiple national and external factors which influence the outcome of technical cooperation, WHO should encourage the convergence of technical cooperation concepts and definitions for application by Member States, WHO professional staff, and collaborating international organizations. There should be clarity about what Member States can expect from the WHO Secretariat regarding technical cooperation, and similar clarity about the identity of the dimension and content of technical

cooperation from other actors within the health field, be they other countries or multilateral or bilateral agencies.

### *Review and Study In-Depth*

In order to provide greater specificity to design, strategy and application of technical cooperation at the country level, WHO should convene a series of discussions (or seminars) among representatives of participating organizations including, for example, WHO Headquarters and Regional Offices, World Bank, selected bilateral donor organizations, selected developing country donor organizations, and representative private and voluntary organizations.

A first discussion could begin as a global review of key factors affecting supply, demand and negotiation of cooperative programs in health. The meeting could be convened in any location. The objective should be to elicit two outcomes:

- (a) to solicit an enlarged base of practical experience and opinion on the dynamics and support of technical cooperation, including the roles of international organizations;
- (b) to define the framework of additional study or research requirements. For example, future studies should include the number and type of all technical cooperation programs (country, regional and interregional) and factors affecting their progress. Issues of manpower trained in technical cooperation components such as resource mobilization should be included.

A second series of discussions might be convened at the country level, in agreement with the relevant WHO Regional Office and selected developing countries. In the form of a case study, discussions on-site with the Ministry of Health and its official and nongovernmental project or sector sponsors may prove more valuable to specificity and insight than global or regional reviews.

### *Some Key Prerequisites*

There can be no effective rationale for collaboration or cooperation among agencies in the absence of a national sector analysis and an **officially approved national plan** which serves as the basis for national priorities. Therefore, one of the key areas to which technical cooperation should be directed is the development of a consensus between WHO and its Member States on the essential components and methodology of sector analysis as a basis for a national health plan, as for example, the selection of program priorities on the basis of realistic economic, financial, and administrative requirements for goal accomplishment within a specified time frame.

A second prerequisite is that WHO develop and advocate at all its levels a common system of sector planning and programming which is based on financial and technical sustainability. The benefits in terms of communication and transparency of activities are obvious. Such a system will incorporate the rationale for stakeholder involvement and clear definition of results to be expected as a consequence of defined, costed program activities. This approach will be critical for any attempt to evaluate the effectiveness of national comprehensive technical cooperation for which responsibility and accountability is assumed.

### *Approaches to be Emphasized*

Although all aspects of technical cooperation may be intrinsically of equal merit, this study has highlighted the need for focus on the component of resource requirements and mobilization. Data from country studies is insufficient to make firm judgement on capacity of collaborating partners in studied countries to mobilize human, institutional and organizational resources for national priorities. There is need however for systematic attention to the mobilization of financial resources with special emphasis on training of both WHO and national staff. The intent should not be limited primarily to increase WHO extrabudgetary financing, but rather to encourage direct cooperation from a wide range of financing agencies. A specific measure of effectiveness in attracting resources should be the annual determinations of increase or decrease in flows to the sector.

### *Monitoring and Evaluation*

A system of monitoring and evaluating *all* major technical cooperation programs in health should be useful to national authorities and the efforts of WHO should be directed not only to schemes for monitoring and evaluating its technical cooperation with countries. Part of WHO's cooperation might be directed at assisting governments to identify and record all technical cooperation with emphasis on the expected results, activities and financing.

As a part of this monitoring, WHO might consider the preparation of a comprehensive NGOs Directory, given the increasingly important role being played by these organizations.

### *Research*

Although WHO is, by its mandate, the most appropriate body to initiate research on the global application of technical cooperation in health, there is a major need to strengthen staff capability for management of research agendas both within the Organization and in Member States. This capability assumes that selected staff are fully sensitive and professionally capable for supporting requesting countries not only in research for disease reduction but research in health policy, sector planning, financing of health systems, and overall system reform. Sustained recruitment and continuing training will be essential. While personnel of high calibre now exist

within the WHO system for research management, the numbers are far too small to compete with or marshal the professional capability which now resides in many of the world's universities and development-oriented institutions.

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## 9. *Glossary of Acronyms*

Acronym	Description
ADB	Asian Development Bank
ADH	Adolescent Health (WHO Program Classification)
AIDAB	Australian Development Assistance Bureau
AFDB	African Development Bank
AFRO	African Regional Office (WHO)
AIDS	Acquired Immunodeficiency Syndrome
AMPES	American Region Planning, Programming, Monitoring, and Evaluation System (PAHO)
AMRO	American Regional Office (PAHO/WHO)
A.M.U.	Arab Maghreb Union
ARI	Control of Acute Respiratory Infections (WHO Program Classification)
CABEI	Central American Bank for Economy Integration
C.A.R.	Central African Republic
CAREC	Caribbean Epidemiology Center (PAHO)
CDB	Caribbean Development Bank
CDD	Diarrheal Diseases (WHO Control Program Classification)
CERED	Demographic Research Center (Morocco)
CIDA	Canadian International Development Agency
CIS	Commonwealth of Independent States
CNSS	National Social Security Fund (Morocco)
CONACYT	National Council of Science and Technology
CRS	Catholic Relief Service
CRS	Creditor Reporting Systems

Acronym	Description
DAC	Development Assistance Committee
DANIDA	Danish Development Agency
DBCS	District Blindness Control Societies (India)
DOH	Department of Health (Philippines)
D.P.R.	Democratic People's Republic of Korea
EEC	European Economic Community (Common Market)
EPI	Expanded Program on Immunization
EURO	Regional Office for Europe (WHO)
Ex-Im	Export-Import Bank (Jamaica)
FAC	Fonds d'Aide et de Coopération (France)
FAO	Food and Agriculture Organization of the United Nations (UN)
FP	Family Planning
GNP	Gross National Product
GOI	Government of Indonesia
GOJ	Government of Jamaica
GTZ	Agency for Technical Cooperation of the Federal Republic of Germany
HFA/2000	Health for All by the Year 2000
HIS	Health Information Systems
HIV	Human Immunodeficiency Virus
HPN	Health, Population, and Nutrition
HRP	Human Reproduction Research (WHO Program Classification)
IAEA	International Atomic Energy Agency
IARC	International Agency for Research on Cancer (WHO)
IAS	Inter-American System

Acronym	Description
IBRD	International Bank for Reconstruction and Development (World Bank) (UN)
ICC	Investment Coordinating Committee
ICO	Office of International Cooperation (WHO)
IDA	International Development Association
IDB	Inter-American Development Bank
IDF	Institutional Development Facility
IDRC	International Development and Research Center
IEC	Information, Education and Communication
IFC	International Finance Corporation
IMF	International Monetary Fund
IMR	Infant Mortality Rate
INAS	National Health Administration Institute (Morocco)
INAV	Institut National d'Agriculture et Veterinaire (Morocco)
INH	National Health Institute (Morocco)
INSERM	Institut National de la Santé et de la Recherche Médicale (France)
IPF	Indicative Planning Figure (UNDP)
IPM	Pasteur Institute in Morocco
ITEC	Indian Technical and Economic Cooperation Program
JICA	Japan International Cooperation Agency
MAE	Ministry of Foreign Affairs and Cooperation (Morocco)
MARA	Ministry of Agriculture and Agrarian Reform (Morocco)
MCH/FMP	Maternal and Child Health and Family Planning
MCH	Maternal and Child Health
MDT	Multi Drug Therapy

Acronym	Description
MHFW	Ministry of Health and Family Welfare (India)
MOH	Ministry of Health
MPH	Ministry of Public Health
MSP	Ministry of Public Health (Morocco)
MTPIP	Medium-term Public Investment Plan
MTTAP	Medium-term Technical Assistance Plan
NEDA	National Economic and Development Board
NGOs	Non Governmental Organizations
NID	National Immunization Days
NIS	Newly Independent States
NORAD	Norwegian Agency for Development
ODA	Official Development Assistance
ODF	Official Development Finance
OECD	Organization Economic Cooperation and Development
ONEP	National Drinking Water Office
OPEC	Organization of Petroleum Exporting Countries
PAHO	Pan American Health Organization
PHC	Primary Health Care
PHCD	Partnership for Community Health Development (Philippines)
PHDP	Philippines Health Development Project
PIOJ	Planning Institute of Jamaica
P.N.G.	Papua New Guinea
PVOs	Private Voluntary Organizations
RDCs	Regional Development Councils
RDP	Rehabilitation and Development Plan

Acronym	Description
SEARO	Regional Office for South-East Asia (WHO)
SDC	Social Development Committee
TA	Technical Assistance
TB	Tuberculosis
TC	Technical Cooperation
TCDC	Technical Cooperation Between and Among Developing Countries
TDR	Special Program for Research and Training in Tropical Diseases (UNDP/World Bank/WHO)
UFMR	Under five mortality rate
UN	United Nations
UNDP	United Nations Development Fund
UNDRO	Office of the United Nations Disaster Relief Coordinator (UN)
UNEP	United Nations Environmental Program (UN)
UNESCO	United Nations Educational Scientific and Cultural Organization (UN)
UNFPA	United Nations Population Fund (UN)
UNICEF	United Nations Children's Fund (UN)
USAID	United States Agency for International Development (USA)
VDMS	Visites Domicilières de Motivation Systématique (Morocco)
WFP	World Food Program (UN)
WHO	World Health Organization
WR	WHO Representative



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