WHO at country level

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WHO’s activities at country level have earned the organisation both criticism and praise. The organisation’s technical publications are esteemed as authoritative guidelines for disease control. Successful disease-control programmes and contributions to health research have heightened WHO’s reputation. The organisation has also provided the focus for evolution of important ideas, such as primary health care and the relevance of equity and other ethical issues. But WHO has been criticised for not adapting rapidly and logically to changes in the health field. With increasing national capacity in the more advanced developing countries, and with the involvement of new participants in the health sphere, the organisation needs to reassess its role at country level. My recommendation is that WHO improves its analytical capacity so that its programmes take into consideration the health needs of the country, its national capacity, and the contributions from other external agencies.

Since its establishment half a century ago, WHO has made indelible marks on the health services of most countries. WHO’s impact has been greatest in developing countries in which the founding of the organisation coincided with the transition from colonial rule. The newly independent nations generally maintained some links with their former colonial powers, but increasingly turned to other external agencies for guidance and support. In its first decades, WHO had a dominant role as the most significant external agency in the health sector; the organisation provided technical assistance and covered a wide range of activities, including training of health personnel, development of national programmes, the building and strengthening of national institutions, and direct involvement in the operation of health programmes.

WHO’s performance has been closely scrutinised in recent years. Although some of this scrutiny has been related to the increasing concern about the efficiency of the United Nations (UN) system as a whole, specific criticisms have been levelled at the quality of WHO’s leadership and the effectiveness of its programmes. There is also concern that WHO’s strength lies mainly in supporting traditional programmes for disease control, and that the organisation is not equipped to respond to the current needs of the more advanced developing countries.

Much of this criticism has come from developed nations through their medical and popular press, and from donor agencies that provide the bulk of extrabudgetary funds. The response from developing countries has been mixed. In some, WHO is still regarded as a credible adviser and an effective partner in health development. In others, many believe that WHO’s role has been downgraded, and that other external agencies—such as the World Bank and bilateral donors—have replaced WHO as the most influential agency in the health sector.

WHO’s programmes have evolved over the past five decades. After starting with a strong emphasis on disease-control programmes, it built up its involvement in the development of health services. In its review of WHO’s performance at country level, this paper examines critically two elements of the organisation’s activities: disease control and the development of health services.

Disease-control programmes

WHO’s reputation was originally built on its effective interventions in disease control—the yaws campaign being a typical example. Yaws control was a fortunate choice for the establishment of WHO’s credibility in the endemic countries. This highly visible disease—typically presenting as disfiguring lesions on the face—disappeared within a few days of patients receiving a single injection of penicillin. The dramatic success of the yaws campaign portrayed WHO as highly effective at deploying modern tools to control endemic diseases.

The yaws programme was a forerunner of WHO’s involvement in the control of other diseases (panel). The success of many of these programmes and their popularity with national governments established disease control as one of the most important features of WHO’s activity at country level. WHO’s contributions to disease control take many forms, ranging from the reproduction and distribution of technical information to direct involvement on the ground of WHO staff in implementing projects.

Criticisms of WHO’s involvement in disease-control programmes

The target diseases selected by global and regional bodies do not necessarily tally with national priorities. Vertical-control programmes distract national Ministries of Health from the more important task of broadly developing their health services. Integration into the general health services of disease-control programmes that were developed as vertical and externally aided is often difficult. Limited national resources are sometimes diverted into new initiatives as international agencies shift their interests from one priority concern to another. Instead of devolution of responsibility to national institutions and personnel, external support continues longer than is necessary.
Some disease-control programmes supported by WHO

<table>
<thead>
<tr>
<th>Disease</th>
<th>Action</th>
<th>Outcome</th>
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<tr>
<td>Yaws</td>
<td>Late 1940s: WHO used mobile teams to deliver selective targeted chemotherapy with penicillin</td>
<td>Successful control of disease in endemic countries</td>
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<tr>
<td>Malaria</td>
<td>WHO programme for global eradication</td>
<td>Malaria eliminated from large areas of sub-tropics, but global eradication a failure</td>
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<tr>
<td>Smallpox</td>
<td>WHO initiative for global eradication</td>
<td>Global eradication certified in 1980</td>
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<tr>
<td>Leprosy</td>
<td>Multiple-drug therapy adopted in 1985; resources mobilised from public and private sources</td>
<td>Substantial reduction in prevalence of active cases</td>
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<tr>
<td>Chagas disease</td>
<td>Regional control programmes based on application of new control measures</td>
<td>Transmission reduced or eliminated in endemic countries</td>
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<tr>
<td>Onchocerciasis</td>
<td>West-African programme cosponsored with other agencies</td>
<td>Highly successful in original 7 countries and in extension area (a) Progressive control achieved</td>
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<tr>
<td>Poliomyelitis</td>
<td>Programme led by WHO/PAHO eliminated infection from western hemisphere; global eradication programme launched</td>
<td>Lessons learnt from success in Americas applied in other regions</td>
</tr>
<tr>
<td>Guinea worm</td>
<td>Private agency (Global 2000) as key leader; WHO gives moral support</td>
<td>Good progress towards goal of global eradication (b)</td>
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Praise of WHO’s involvement in disease-control programmes

WHO has been involved in research to develop new technologies: in collaboration with pharmaceutical companies and networks of national scientists, the organisation has helped develop several products, such as anti-malarial drugs (mefloquine, artemisin products), multiple drug therapy for leprosy, ivermectin for treatment of onchocerciasis and lymphatic filariasis, and vector control measures (insecticidal paint and fumigant canisters for control of vectors of Chagas’ disease).

By convening scientists and specialists worldwide in expert committees, scientific groups, and other technical bodies, WHO produces and distributes authoritative “state of the art” technical papers, monographs, and manuals for disease control.

WHO’s technical publications are highly regarded as authoritative and useful guidelines on disease control. Up-to-date information is available by radio, on the Internet, and through an e-mail response service (outbreaks@who.ch).

WHO promotes exploration of innovative practical approaches to disease control—in particular, methods that can be applied in developing countries (eg, control of diarrhoeal diseases).

WHO has an advantage in tackling difficulties that require inter-country intervention, since it provides a neutral platform for coordination of disease control in neighbouring countries. The Onchocerciasis Control Programme initially involved vector control on the Volta river basin that runs through seven countries. Because the vector Simulium damnosum has a flight range of several hundred km, local control in any individual country would have been ineffective.³

Cost-effectiveness of malaria research by major funding bodies

Development of health services

In its early years, WHO’s support concentrated on the development of health services in developing countries. Newly independent states had a tendency to build large tertiary institutions with running costs that distorted the national health budget.⁴ In some cases, the running of one tertiary hospital in the state capital took up more than half the national health budget. WHO’s advocacy promoted the development of basic health facilities aimed at providing rudimentary services to the whole population, with particular focus on: development of peripheral health institutions to provide coverage of health care at community level; and support for the training of health-care workers to complement services provided by health professionals. These ideas were consolidated at the historic Alma Ata conference in 1978 that WHO cosponsored with the United Nations Children’s Fund (UNICEF).⁵ This conference set the global agenda for health development, based on equity, with the goal, “Health for all by the year 2000.” The period after the Alma Ata conference saw significant changes in the organisation of health services of both developing and developed countries, with greater attention paid to primary health care.

In the past two decades in particular, however, important changes have occurred in WHO’s privileged position at country level: the national capacity of countries has increased, thereby diminishing or even eliminating the need for external experts and advisers on the basic elements of health services; new agents have arisen in the health field, including the private sector on the national scene, and the increasing involvement of external agencies, multilateral and bilateral; and concerns have mounted about WHO’s capacity to meet the needs of member states in the altered policy environment that has evolved in the past 20 years.

National capacity

There is wide diversity in the level of sophistication of health services in developing countries, and in the national capacity to organise and manage these services. Mortality statistics—mortality rates of children aged less than 5 years, for example—vary in developing countries
from less than 50 per 1000 in the more advanced countries to over 250 per 1000 in the least developed countries. There are substantial regional variations (figure). Economic indices also show great diversity of gross national product (GNP)—over US$2000 per person in the more affluent developing countries to around $100 per person in the least developed.

The more advanced developing countries have outgrown the need for WHO’s traditional programmes in support of basic health-service components. These countries no longer require external help to organise and manage their immunisation programmes, to run their training institutions, or to deal with major endemic and epidemic diseases within their borders. However, they may need assistance in designing and operating new projects (such as national health-insurance schemes), in dealing with environmental-health difficulties in rapidly growing urban centres, and in coping with the challenges of the new epidemiological profile that is increasingly dominated by cancers, cardiovascular diseases, and other chronic diseases.1

Although developing countries now have the ability to manage their own health services, Ministries of Health are generally perceived as weak compared with other government departments. Ministers of Health usually have little influence within the administration. The top management, moreover, is often unstable. For example, a recent study of 12 developing countries showed a rapid turnover of senior management in the Ministries of Health. Within a 10-year period, there were four to 11 Ministers of Health, four to 12 professional Heads (“Directors of Medical Services”), and three to nine Heads of Administration (“Permanent Secretaries” or “Secretaries for Health”).1 Ministries of Health may also have difficulty in transforming goals that are agreed at the World Health Assembly into national programmes. This is particularly true of sensitive issues, such as equity in health. In some countries, the Ministry of Health is able to buttress its position by citing the authority of WHO in support of proposed changes in national policies and strategies.

New agents in the health sector
Nationally, a variety of operators have become active in many developing countries, thereby ending the public sector’s dominant role as chief provider of health services. These new providers include social-security departments, non-profit organisations, as well as the profit-making private sector; the growth of the latter is diminishing the role of Ministries of Health as providers of health care. Since WHO’s official contact at country level is the Ministry of Health, the organisation’s influence on the national health scene depends on the degree of cooperation between the public and private sectors.

External agencies
Other international agencies have increased their involvement in health. UNICEF, through its child-survival programme, provides massive input into the health sector, often in collaboration with WHO. Other UN agencies, such as the UNAIDS project; the UN Children’s Fund for Population Action, the International Labour Organisation, and the Food and Agricultural Organisation, have programmes relevant to specific aspects of the health sector. A major development has been the recent expansion of the World Bank’s interest in health; through its lending programme, the Bank has become the largest source of external finance for the health sector.1 Many developing countries now want to promote more efficient and cost-effective health programmes. This has placed the Bank at the centre of the major changes taking place in the health sector, particularly with regard to reform.

Generally, these external agencies operate independently of one another, but some attempts at coordination and collaboration have been made. UNICEF and WHO have established mechanisms of collaboration as the Task Force for Child Survival. WHO also on occasion carries out health programmes on behalf of other external agencies. A more ambitious attempt at collaboration between agencies is the UNAIDS project; six US agencies jointly manage this programme for the Global Control of HIV/AIDS Epidemic.

Several bilateral donor agencies support health programmes as part of their development assistance. The bilateral programmes vary substantially in content, duration, and interaction with other external agencies. Some programmes focus narrowly on the specific interest of the donor country (eg, family planning). A movement is underway, however, to achieve more effective coordination of external aid through sector-wide expenditure planning. The idea is to develop a sector-wide programme, based on national priorities and funded from national resources supplemented by donor aid. All participating donors subscribe to the national plan and contribute their donation to a common pool.

Concerns over WHO’s capacity and leadership
Until a decade ago, WHO was widely held in high regard, and frequently exempted from general criticisms of the
UN system. During the past decade, criticism of WHO has grown, and more questions are being asked about its effectiveness. The resignation of the external auditor has also raised doubts about the transparency of WHO’s financial management.

Because WHO has had to operate a non-growth budget in the past 10 years, it has been forced to economise through cuts in programmes and staffing levels. The organisation must, therefore, examine its own functions in an urgent and critical way, and identify the most relevant activities in which it has an advantage. WHO should aim to adjust its structures and mechanisms to enable it to carry out its functions in support of world health.

UN agencies, including WHO, are often accused of inefficiency and waste. In the absence of formal comparisons between the cost-effectiveness of WHO and other multilateral and bilateral agencies, such accusations are usually based on anecdotal cases. One report on malaria research published by the Unit for Policy Research in Science and Medicine, provides some comparative data. The authors “examined funding inputs to malaria research internationally as well as published outputs and broader outcomes . . . .” (table). Although these data must be interpreted with care, they do not support the view that WHO was less efficient in its funding of malaria research than the other agencies.

From the viewpoint of the US tax payer, moreover, investment in malaria research through WHO was seven times more cost-effective than through the bilateral agency, USAID (United States Agency for International Development), as judged by the number of publications per million US dollars spent. To carry out similar independent and external evaluations of the performance of WHO and other agencies would help replace subjective ideas with more dispassionate assessments.

The way forward
Clearly, WHO cannot afford to continue carrying out its functions in the manner of “business as usual”. Instead, the organisation needs to review its mechanisms and programmes with awareness of the important changes that have taken place within its member states and in the environment in which it operates. Some of the proposed solutions are well-considered, but others are simplistic. For example, some commentators see the reform of WHO primarily in terms of reducing the running costs of the various UN agencies through the introduction of economies and cuts in programmes. Others call for a redefinition of WHO’s mandate in the light of the broader involvement of other UN and bilateral agencies in the health sector. One suggestion is for WHO to concentrate exclusively on setting standards—the so-called “normative functions”—and to leave direct involvement in technical matters—known as “technical cooperation”—to other agencies. To eliminate the involvement of WHO in providing technical services to countries would erode the credibility of the organisation’s advice and its technical publications.

Although bilateral agencies have much larger resources than WHO, and can call on expertise from their own institutions, their involvement with developing countries has been inconsistent. Bilateral agencies select favourite countries and regions, and often restrict their support to items of their own agenda rather than of national priority. To improve WHO’s performance at country level, there must be changes in the way that WHO designs and implements its programmes, in the response to WHO of national authorities, and in the attitude and conduct of other external agencies.

Modification of WHO’s country programmes
The relations between WHO and individual member states have evolved over time and have often been shaped by historical precedents. A 1997 study of the organisation’s performance at country level highlighted some of the anomalies that resulted from this process: WHO’s expenditure in each country did not seem to match the national need—some of the poorest and least developed countries received the smallest input from WHO’s resources; the organisation’s programmes included activities that could have been carried out effectively by national bodies or other external agencies; and the profile of expertise in WHO’s country and regional offices was inconsistent with national requirements, particularly in the more advanced developing countries. The investigators in the 1997 study recommend a new approach to the definition of WHO’s work at country level. They propose that WHO and member states adopt a new concept—“the essential presence”—as a logical framework for the shaping of WHO’s relation with each country. By “essential” the investigators mean that the mechanism should be necessary and sufficient to achieve the desired goals. The concept of the essential presence is applicable to all member states, but the nature of the “presence” would vary according to the country’s needs, its capacity, and on the performance of other external agencies. In the least developed countries, WHO could maintain a large office that is staffed and equipped to respond to the many needs of the member state. This new concept would entail a logical and systematic grading of WHO’s physical presence—ranging from the large office to support a developing country that has limited capacity, to a functional presence in a developed country where national institutions can effectively interact with the organisation. WHO’s physical presence would diminish over time as the country acquired increasing capability, and as its specific needs changed. The new concept is proposed as a flexible mechanism to enable WHO to expand its activities in some countries and to contract them in others, based on objective analyses of local situations. This forward-looking concept makes capacity-strengthening and self-reliance the goals of WHO’s presence in developing countries. At the same time, essential presence suggests that WHO should intensify its interaction with developed countries through their Ministries of Health as well as through national institutions—some of which should be designated as collaborating centres.

Definition of WHO’s activities in each country
If the concept of essential presence were adopted, WHO would have to strengthen its analytical capacity to enable it to assess the needs of each country, its capacity, and the role of other agents—national and internal—in the health field. Indicators for assessment of a country’s needs include morbidity and mortality data, and more sophisticated measures of burden of disease by means of disability-adjusted life years (DALY) lost. National
capacity can be derived from economic indicators (such as GNP), literacy rates (particularly among the female population), access to health services, clean water, and effective sanitation.

WHO’s programmes in each country could be negotiated on a medium-term basis of 5–7 years. The agreement setting out the plan of action would outline the expected contributions from WHO and from the member state. The agreement would also include indicators that would be used to monitor performance and progress. To ensure efficient management, tools for the monitoring and assessment of WHO’s performance would be built into the programmes—a process that would include the involvement of independent external assessors when appropriate.

This “new look” of WHO at country level would be designed with much greater care than the present system. The aim would be to make rational judgments based on careful objective analyses of needs and opportunities.

Response of national authorities
Some of the limitations and failures of WHO’s programmes at country level result from intrinsic weaknesses in the management of the ministries of health in some of the host countries. Frequent changes in senior management lead to a lack of continuity in policy-making and poor understanding of how to work best with WHO. Member states should therefore address several issues: how to improve their participation in WHO’s governing bodies (the World Health Assembly, the Executive Board, the Regional Committees, and other committees) to ensure that the organisation takes notice of their needs and priorities; effective interaction with WHO at country level to assess WHO’s input and the appropriate matching response from the host country; optimisation of the value of WHO’s contributions through appropriate complementary national input—eg, maximum use of WHO fellowships by means of careful selection of candidates and placement of trainees on completion of their studies; and use of WHO’s expertise in the definition of a broad national health policy, thereby ensuring optimum use of both national and external sources.

Strategic alliances with other external agencies
WHO has been most successful when it has worked in collaboration with other agencies in cosponsoring and managing health programmes at country level. In some nations, external agencies work collaboratively and WHO is recognised as the credible leader whose task is to define health policies and strategies. New mechanisms are being developed to formalise this collaboration through sector-wide planning—to which all external agencies subscribe.

The other external agencies should also design their programmes to be complementary rather than competitive. The top management of UN and major donor agencies should reconcile their health-development policies as far as possible in order to facilitate collaboration by their staff at country level.

WHO has achieved its greatest successes when it has mobilised resources from—and worked in collaboration with—other UN and bilateral agencies, and with national institutions in both developed and developing countries. Some of these successes include: eradication of smallpox, which entailed a global network of reference laboratories, major inputs from bilateral agencies (USAID and others), and voluntary donations from some member states; the programme for elimination of poliomyelitis from the western hemisphere, which involved a network of upgraded national laboratories, resources from the individual member states in the region, as well as funds from Rotary International, which has adopted this programme as a global challenge; collaboration with Thailand, an advanced developing nation, to provide a range of services to countries in the region, including the training of over 500 WHO fellows each year, diagnostic and quality-control laboratory tests on behalf of surrounding member states, as well as workshops and seminars on such difficulties as the disposal of hospital wastes (of which Thai experience can benefit its neighbours); and collaboration with Mali, one of the poorer developing countries, in its provision of training in malaria research to neighbouring states. These examples illustrate the functioning of WHO as an intergovernmental membership organisation.

WHO’s operations have been influenced by the underlying philosophy that international health cooperation is of mutual benefit to participating countries, and that global cooperation through WHO is an effective mechanism for such collaboration. Thus, all member states contribute to the work of WHO through financial and other mechanisms; in turn, they derive benefits through their membership. This mutual reward is the real strength of WHO, and should form the basis of the recovery of its high status.

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References