WHO at country level—a little impact, no strategy

Fiona Godlee

This is the fourth in a series examining the role of the World Health Organisation, its current problems, and its future prospects.

The acid test of WHO's effect on the world's health is its impact at country level. Unless it has an impact there, all of its declarations, its debates at the World Health Assembly, its conferences, its pamphlets, its political manouvering in Geneva and the regions, all of these come to nothing. Working as it does through national governments, WHO insists that it has no role in directly managing or delivering health care. Judging WHO's impact in individual countries is therefore difficult—its approaches are largely indirect, and initiatives may take years to bear fruit. But from the meagre resources that WHO makes available at country level it is clear why its country operations are criticised as the weakest link in an already weak chain of influence from its headquarters in Geneva to the people in its member states. Poorly funded, undertrained, and with no clear strategy to follow, its staff at country level stand little chance of making an impact.

More harm than good?

It may seem harsh to suggest that WHO's impact on countries may be not just minimal but negative. Such a suggestion is, however, widely acknowledged. The phrase is "donor robbery." By this people mean that WHO—and other international agencies—rob countries of precious expertise. Skilled and effective professionals are in short supply in some areas and are therefore snapped up by the international organisations. The professionals themselves are attracted by what are, by local standards, huge salaries. In WHO's case this means that specialists in public health are recruited from district government service and posted to WHO's regional offices where, say some to whom this has happened, they sit with little to do and much less direct influence on people's health than they had when employed to work directly at local level. One way around this, which Save the Children is beginning to use, is to pay people for staying where they are, the aim being to keep effective people working where they can be effective.

The implementation gap

WHO's aims are in the best tradition of sustainable intervention—to help countries to build up their own health care infrastructure and professional expertise. As laid down in its constitution, WHO works through national ministries of health. The arrangement has its advantages. Because of it, WHO is accepted in all member countries and avoids the charge of neocolonial interventionalism. But it also combines with WHO's financial woes to create what commentators are calling WHO's "implementation gap." WHO has neither the mandate nor the means to implement its own programmes. It is entirely dependent on the receptiveness and effectiveness of national ministries of health.

In some regions this leaves WHO all but powerless to act. In Africa, for example, where WHO faces its severest challenges, many governments cannot deliver health care in line with WHO policies. They do not represent their people at local level and lack the necessary health infrastructure for delivering local health care. Since WHO has neither sufficient influence to democratise Africa nor money to develop its infrastructure, its only effective strategy would be to bypass national governments and implement its policies at local level. This is something that WHO in its current form cannot do.

Country representatives

WHO denies that it has a problem with implementation and it points to its country representatives as proof of its local impact. These representatives are unique in the United Nations in giving WHO a direct presence within the health ministries of recipient member states. Directly employed by WHO, their role is to act as a link between the health ministry and WHO's regional office and to liaise with other agencies. They advise the minister on health policy and management in line with WHO's strategy and field requests from local health professionals for technical advice and assistance.

The model is good. Sadly, however, the reality is not. A recent report from the Danish overseas development organisation, Danida, concluded that, although the system of country representatives was well designed, country offices were inadequately resourced and therefore limited in what they could achieve.[1]

My conversations with aid workers and doctors who have worked alongside WHO corroborate this conclusion: some WHO representatives hold down several other jobs to supplement their salaries, leaving them little time for WHO; representatives are rarely seen outside the capital city; rapid turnover of staff in the ministries as governments change and reshuffle means that representatives, and staff in the regional office, must spend much of their time educating new incumbents about WHO's role and aims; and being situated in the ministry of health, traditionally one of the ministries with the lowest status, means that WHO representatives have little impact on other factors that influence health, such as employment, education, and housing.

Given these circumstances, much depends on each representative's motivation and abilities. Some are known to be extremely effective, coordinating not only WHO's activities but those of other aid agencies, but in general they have a reputation for being reactive, ineffective, and of little use to local health workers. A doctor working for a British based aid organisation told me that he made a point of calling on the WHO representative in each country he visited, but that in most cases this resulted in "lots of bluster and rhetoric but not a lot of action."

Political appointees

As Dr Lobe Monekosso, outgoing regional director for Africa, told me, WHO's system for selecting representatives is not designed to seek out energetic and skilled people. Member states put forward candidates for appointment by the regional director, and the post is often seen as a reward for doctors who

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have worked for their national governments in some other capacity. As a result, the typical country representative is looking forward more to comfortable retirement than to radical action on WHO's behalf. Local health workers see them largely as political appointees.

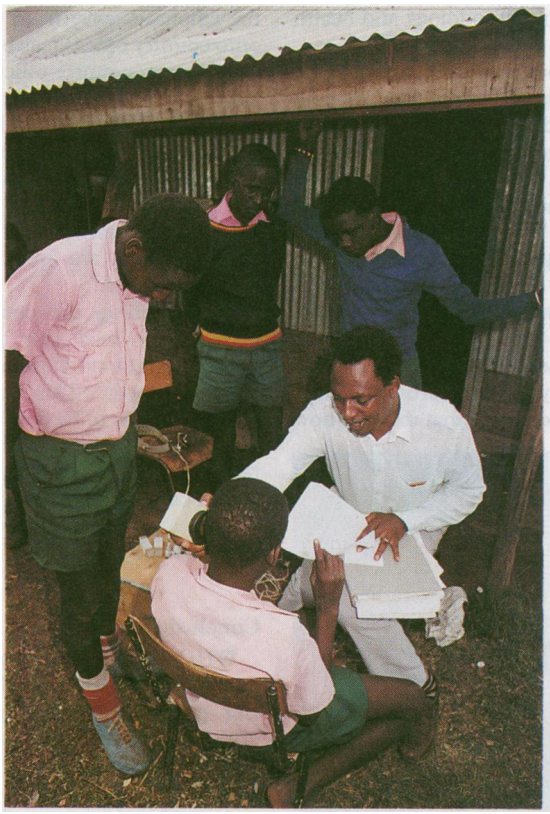
Nor does WHO's system encourage its representatives to exercise their initiative. They are well paid by the standards of doctors in the developing world. Their contracts are almost routinely renewed as long as they remain in favour with their regional directors. Once out of favour they can be posted to one of the region's less desirable capitals. The threat of such action is usually enough to encourage conformity.

Representatives can, however, exert their own political pull: if out of favour with the regional director they can and do go to their own governments for support. Ministers of health can then put pressure on the regional director who, being dependent on them for re-election, is likely to oblige. The power balance is therefore equal, but in both cases WHO gets the bad end of the bargain; the system discourages regional directors from sacking ineffective representatives while discouraging those who might be effective from sticking their necks out.

Untrained and hampered by bureaucracy

Political appointments and slack accountability are aggravated by poor training. According to a report from the Health Policy Unit of the London School of Hygiene and Tropical Medicine, health workers in the developing world often find that WHO representatives are unable to give much in the way of technical assistance.[2] Many find that Unicef's country office staff are better informed. WHO's representatives are given no structured training, while Unicef's country staff rotate regularly with staff in Unicef's regional offices and its headquarters in New York. They also tend to be younger than WHO's representatives, more enthusiastic, and vocationally trained.

The Health Policy Unit's report also found that WHO representatives were hampered by bureaucratic and remote regional offices.[2] Staff working on country programmes in the Western Pacific region told me that WHO headquarters responded to their requests for help by offering to send out advisers, but the regional office in Manila refused to let the advisers come. By contrast, Unicef's 138 field offices have a large degree of autonomy and, although staff complain that there is too much interference from headquarters, they are able to support local initiatives without referring each request back to regional office or headquarters. WHO's current financial crisis has much to do with its reputation for cautious bureaucratic responses to countries' needs. Donors who want things done quickly tend increasingly to use non-governmental organisations such as Oxfam, Save the Children, and Action Aid.



ROB COUSINS/PANOS

Health workers often find that WHO representatives are unable to give much in the way of technical assistance

Comparison with Unicef highlights another problem faced by WHO's country staff—lack of money. WHO's annual budget for India is $7·5m compared with Unicef's $100m. This is an important factor in WHO's implementation gap. Staff in some countries are unable to pay for vehicles to do field trips, a fact which may explain their reputation for never leaving the capital cities. Meanwhile, health workers in the field say that WHO's lack of available funds makes a mockery of its attempts to influence health at country level. A doctor working in Nepal told me that WHO staff would sit in on meetings but that nobody listened to what they had to say. "All they could do was write reports and hand out advice," he said. "They had no money to support specific projects so most people just ignored them."

Knowing, not doing

There is a saying in international aid circles that WHO knows everything and does nothing while Unicef knows nothing and does everything. (The United Nations Development Programme comes off worst: they say it knows nothing and does nothing.) This distinction between WHO and Unicef is a real and important one. "Unicef does not set policy," said Professor L M Nath, dean of the All India Institute in Delhi. "It's HIV programme is only condoms."

WHO insists that this is part of the design. It says that Unicef is about direct action, which tends to be shorter term, while WHO is about indirect advocacy with long term goals. But this seems like making a virtue out of necessity. Lack of money means that WHO has no choice but to rely on other agencies to implement its policies. Faced with shrinking resources, the last resort for staff in WHO is to maintain a sort of moral high ground. "We are very happy to work with Unicef," said Dr N K Shah, WHO's country representative in India, "so long as they follow our technical guidance."

He who pays the piper

Because of its limited funds, however, WHO is in no position to dictate terms. "The agency with the money determines what happens," said a doctor working for a British based aid organisation. The joint WHO/Unicef immunisation programme illustrates how WHO suffers as a result. WHO's immunisation policy was designed to integrate immunisation programmes into each country's health care network rather than simply adding on a free standing immunisation programme requiring high levels of investment, the idea being to invest in training and monitoring as part of the wider goal of developing primary health care services. As interpreted by Unicef, however, this ideal has been distorted. Instead of a gradual and sustainable build up of local capacity, Unicef set out to "get the job done"

and satisfy its donors. It set itself the target of immunising all children before 1990 and injected large amounts of donor capital and external manpower into the programme. As will be shown in a subsequent article, this intervention has not proved sustainable in the long term and has done nothing to increase local capacity.

Lack of strategy

Given its lack of funds, it would seem vital that WHO should have a coherent strategy for spending at country level. The report from Danida finds little evidence of this.[1] Resources that might be used to develop strategically planned and integrated national programmes are used instead for "ad hoc financing of fellowships, study tours, workshops, local cost subsidies, and miscellaneous supplies and equipment." According to the report, WHO's country and regional offices lack the analytical skill and political will to properly assess countries' needs. On the basis of a study of WHO's activities in four recipient countries—Kenya, Nepal, Sudan, and Thailand—the report concludes that WHO has failed to exploit one of its main advantages over other agencies: namely, that it has centrally secured funds from membership fees that do not need to be linked to specific programmes. WHO's failure to take the lead in assisting integrated primary health care has, it says, led to WHO being marginalised in the donor community at country level, where it is used mainly as a source of technical advice and occasional finance.

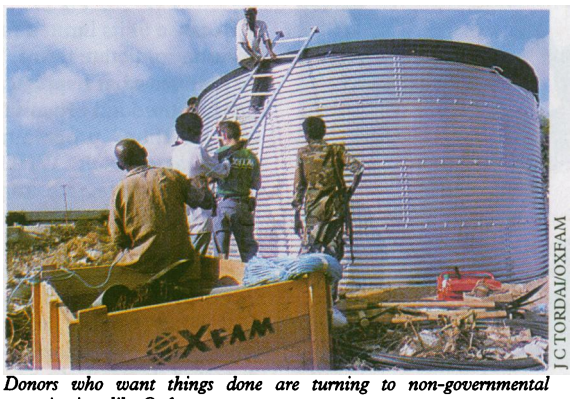
Out of date advice

The type of advice WHO is offering may be partly to blame. The world has changed since WHO was founded in 1947. Thanks partly to WHO's own efforts, many countries in the developing world have now established a cadre of technical experts in fields that have been WHO's teaching platform for 40 years—tropical diseases, disease prevention, and primary care. What these countries need now, say commentators, is expertise in research methodology and health systems management.

Research experience, especially in epidemiology, is vital, said one former regional employee, to help countries counteract the tendency common among all international agencies to generalise inappropriately from one country to another. "Too often, what looked like a good idea in one place is quickly generalised across the board," she said. "The most practical help WHO could provide in many countries would be help with basic methodology, so people can learn to put together decent grant applications to get local research funded."

"Many of the people inside WHO have been giving out the same advice for 25 years or more," she said. "They are not willing to acknowledge that they are now relatively obsolete—it's not an easy thing for anyone to acknowledge. But things have changed out there and countries' needs have changed."

Another former employee confirmed the impression that WHO has failed to update its message. "There is a fundamental mismatch between the skills available within WHO and the task it is now trying to perform," he said. "WHO has very little experience, for example, in health systems management, especially at regional level. That's the experience countries in the developing world need now."



J C TORDAI/OXFAM

Donors who want things done are turning to non-governmental organisations like Oxfam

Cambodia—showing how it could be done

One country programme shows what WHO can achieve at its best. WHO was one of the first agencies to move into Cambodia in 1992 after the downfall of Phnom Penh in 1992. At that time Cambodia was in a state of complete socioeconomic upheaval. It had no official nation status and was not a paid up member of the UN. Two years on, and on a budget of only $1m, WHO is credited with a major role in rebuilding Cambodia's shattered health system and restoring much international credibility to the country's government. The ingredients of this success are laid out in a report funded by the United Nations Development Programme.[3] They include in depth assessment of the country's immediate health needs; clear objectives—to help build local capacity, especially in health systems management and planning; a clear strategy—to mediate discussion between government, aid agencies, and health care workers; and high level leadership. Funded from special donations rather than from WHO's central budget, the project suffered little interference from the regional office in Manila.

STRENGTHENING THE COUNTRY OFFICES

WHO's experience in Cambodia carries lessons for the organisation as a whole. Its country offices need leadership and resources and then to be freed of unnecessary bureaucratic constraints. Until WHO restores donor confidence in its abilities, resources can only come from restructuring its priorities, and shifting the emphasis away from Geneva and the regions and onto country offices (see box on next page).

"A strong country office should be in control of the aid that comes in," said a former project director. "At the moment, donors' good intentions are lost in a flurry of uncoordinated activity, with different agencies offering different, often conflicting advice. The role of the country office should be to support the planning capacity of ministries of health and to make sure that WHO's efforts are integrated and appropriate to the country's needs."

Strengthening the country offices is the answer, according to most commentators, and is one of the main recommendations of a recent internal United Nations report.[4] This calls for more resources and responsibilities to be devolved from the regional offices as part of a move to reduce their involvement in regional politics and improve WHO's effectiveness within countries. As one regional director said, "If you want to influence people's health, you have got to do it close to them, not at a distance."

Conclusion

WHO's country operations are hampered by its mandate (to work through national health ministries). But given this restriction WHO could still vastly improve its effectiveness at the local level. WHO should shift resources away from Geneva and the regional offices into the countries themselves. Better resourced and better staffed country offices would be able to take on responsibilities devolved from the

Full menu still laid on in Geneva

WHO's response to financial reality has been ostrich-like. Far from prioritising its activities and concentrating its shrinking resources on the most pressing and potentially preventable health problems facing the world—tuberculosis, AIDS, malaria—WHO is set on expanding the list of conditions within its remit: what it calls the full menu approach.

WHO is trying to be all things to all people. Its programmes range over a bewildering array of conditions, from cancer prevention and treatment to dental health and psychology. Commentators say that WHO is getting bogged down in such things as the medical effects of nuclear war, developing essential drugs lists for circumpolar regions, and studying AIDS transmission in contact sports. Many of its initiatives seem to be mere gestures, such as its annual no smoking conference, while it makes no concerted stand against the growing influence of the tobacco industry in the developing world. Other initiatives merely duplicate the efforts of other agencies or national governments. Its statements on the need for life style changes, for example, are redundant in the United States, where people are inundated with similar advice from the scientific and popular press.

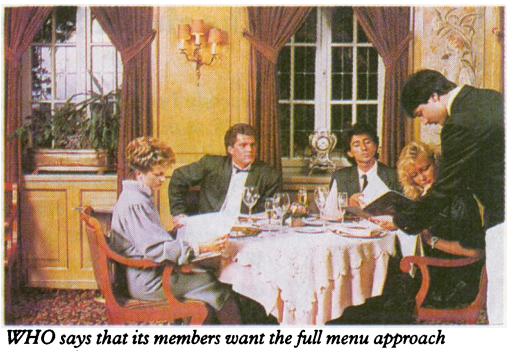
WHO is, say its critics, spending too much time dealing with public health problems of rich countries. In the process the pressing problems of public health faced by developing countries have been increasingly neglected.

Too few funds in the right place

A recent report from two economists in America finds that WHO is not "seeking to apply resources to areas and activities where health needs are greatest."[5] Its authors argue that the interests of the major donors take precedence. Of the $107·8m budgeted for disease prevention and control, only $3·7m is allocated for diarrhoeal diseases and $2·5m for acute respiratory infections, while oral health, psychosocial health, and prevention and treatment of mental and neurological disorders are each allocated over $4m. Spending on individual countries shows similar anomalies. Ethiopia, one of the world's poorest countries, receives $0·07 per person, while Fiji, with more than 10 times the per capita income, has been allocated 46 times as much.

The authors of the report accuse WHO of irrelevance to the needs of the poorest countries. Most of WHO's 50 individual programmes were deemed of no relevance by African delegates at the recent budgetary assessment. Five programmes attracted three quarters of requests from African members for assistance and expertise, while nine were of no interest to African members and six were of interest to only two. "The poorest nations in WHO are interested in basic public health," say the authors, "and not in the more exotic forays of WHO into the public health issues of the modern industrialised West."

In defence of its position, WHO says that it must represent all of its members' concerns, that much of the toll of disease in the developing world is now caused by diseases of affluence such as diabetes and cancer, and that the organisation has to follow the policies set by the World Health Assembly; the full menu approach is what WHO's members want.



FOTEX/DREWA/REX

WHO says that its members want the full menu approach

Such an approach may be politically less uncomfortable than making difficult choices between programmes, but it is increasingly impractical. Spread so thin, WHO stands little chance of making an impact. Critics insist that it needs to look hard at what it can provide that others can't or aren't providing. It needs to examine where it can make the most difference with its limited resources. Its potential for influence is inevitably greater in developing countries, where WHO is often the only reliable source of information and advice, than in the developed world where national capacity is already well advanced.

Too many people in the wrong place

Shifting emphasis away from the rich world and onto the poor must be mirrored by a shift in resources. "WHO's problem," said Dr Lobe Monekosso, outgoing regional director for Africa, "is that it is a top heavy organisation with a large staff based in one of the world's most expensive cities."

Few people would disagree. More than a third of WHO's 4500 staff are based in Geneva. Another third are based in the six regional offices. This leaves fewer than a third of staff working in individual member countries, compared with Unicef's three quarters. The Geneva headquarters took up 35% of the biennial budget for 1992-3, an increase of 2% on the previous biennium. In the same period, spending on countries' health programmes fell by $28m, from $267m to $239m.

Commentators within and outside the organisation agree that WHO should move resources away from its headquarters and regional offices into the countries themselves. But resistance to change is evident at al levels. Successive directors general reiterate the rhetoric of decentralisation while strangthening and expanding the central structure. "No one likes to lose their empire," said Dr Monekosso.

Meanwhile, positions at headquarters are fiercely sought after, and delegations vigorously defend their quota of jobs. Salaries are up to 10 times those of national government jobs in developing countries, and once in Geneva no one wants to leave. "Whenever it is suggested that the headquarters are moved from Geneva, we always manage to vote it down," said one developing country representative.

regions and take a more direct part in implementing WHO's policies. This shift in resources needs to be coupled with a coherent strategy for spending at country level and a programme to recruit and train staff who are able to implement that strategy effectively. WHO needs to re-examine its priorities and its methods of working, to step down from its moral high ground and consider what is needed rather than what it can currently provide. Unless WHO takes action to restore donor confidence it will continue to descend in a vicious cycle of declining influence and declining funds.

Articles to appear after Christmas will examine WHO's fellowship programme, its disese specific programmes, and the impact and progress of Health for All. These will be followed by an interview with the organisation's director general, Dr Hiroshi Nakajima.

1 Danida. *Effectiveness of multilateral agencies at country level: WHO in Kenya, Nepal, Sudan, and Thailand.* Copenhagen: Danida, Ministry of Foreign Affairs, 1991.

2 Lee K, Walt G. What role for WHO in the 1990s? *Health Policy and Planning* 1992;7:387-90.

3 Lawson JS. *Strengthening health systems management: Cambodia.* Manila: WHO, 1994.

4 Daes EIA, Daoudy A. *Decentralisation of organisations within the United Nations system. Part three: the World Health Organisation. Report of the Joint Inspection Unit, General Assembly, official records, 48th session.* New York: United Nations, 1994. (Supplement No 34 (A/48/34).)

5 Tollison RD, Wagner RE. *Who benefits from WHO? The decline of the World Health Organisation.* London: Social Affairs Unit, 1993. (Publication No 53.)