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Report of the Working Group to Review Strategic Relations with Countries

The Regional Director has launched a new vision for the WHO European Region and a new direction that requires the Regional Office to evolve into a networking organization. To help shape this, she established an external group to carry out a review of the Regional Office's work with countries and to make recommendations for the future. The work carried out by the group included a review of documentation, meetings with high level delegations from seven countries, visits to 11 countries with country offices, and a review of the Regional Office. The group has summarized its findings and put forward a number of recommendations for consideration by the Regional Director.

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Introduction

1. The work of WHO is essentially divided between its normative activities and work with Member States. These tasks can be further categorized into six core functions (Annex 1.1).[1] While WHO's normative role is undisputed and relatively clearly defined, its role in countries has changed over time, in step with developments and changes that have taken place globally and within countries. The challenge for WHO is to foresee such changes and to adapt its work to changing circumstances, as well as continuously to strive for greater efficiencies and higher impact.

2. A changing Europe with new public health priorities and ongoing as well as emerging issues such as globalization, climate change and the impacts of economic crises all demand that WHO takes stock and assesses the way it works with countries. In the European Region, WHO will need to strengthen the strategic role that it plays in supporting ministries of health to build capacity in health policy-making and health systems development.

3. WHO's country offices (COs), to be found mainly in the central and eastern parts of the Region, are important elements in country relations. Over the years, COs have played a key role in WHO's relations with Member States and they have provided important links and fostered close relations with ministries of health in their countries. Their advocacy role has been crucial to support appropriate national policy-making and decision-making processes. However, the roles and responsibilities of these COs have gradually evolved over the years from political to administrative and lately also to technical. This evolution resulted in a strengthening of technical support in COs, and a corresponding reduction in technical strength at the Regional Office. The type of support required to meet Member States' public health needs today must be reviewed and delivered in the most effective manner.

4. The recently elected Regional Director has launched a new vision for the WHO European Region and a new direction that requires the Regional Office to evolve into a networking organization. This means that COs will have to revisit their responsibilities to ensure that they operate as integral elements of the Regional Office, while providing high-quality support to countries. Other adjustments may be necessary in the way in which COs interact at various levels – political, strategic and technical. Ongoing and emerging priorities in public health in Europe, determined by changing lifestyles, the impact of globalization and the economic situation, together with a new direction and new priorities are important elements that must influence future strategies.

5. In order to shape these strategies, the Regional Director decided to establish an external **Working Group to Review Strategic Relations with Countries (RWG)**. The main objective of the group is to study how WHO has operated in the European Region till now. It will establish how effective these mechanisms have been, what outputs they have generated and what impacts they have had in the countries. In the light of its findings, the Working Group will advise the Regional Director on what changes may be necessary to improve the support that the Regional Office provides to countries. The

[1] All annexes to this paper are contained in background document EUR/RC60/SC(2)/BD2.

review will include an assessment of the way in which the Regional Office has supported country work, and it will offer recommendations on how to improve this work in the future. The terms of reference of the RWG are contained in Annex 1.2.

6. The Regional Director appointed nine members of the RWG (listed in the terms of reference) in March 2010, and the work undertaken was conducted during the period April to November 2010. This report presents the findings and recommendations of the RWG.

Methodology

7. This review has applied a mix of methods:

8. A *documentary review* was done to study the essential background documents on earlier work with countries. These included both policy and strategy documents issued from the Regional Office, as well as guidelines and administrative circulars. Country-specific documents, including bilateral collaborative agreements (BCAs) and country reports, were also studied to provide a clear picture of the interactions between the Regional Office, the COs and national authorities.

9. The RWG carried out *country visits* to 11 countries with WHO COs. The countries visited are listed in Annex 2.1. Country visits were conducted by two members of the RWG in such a way that each member visited 2–3 countries. A structured interview guide (Annex 2.2) was used to elicit consistent and comparable information. The visiting team prepared a report on each visit, and a summary report (Annex 2.3) was compiled based on all country reports.

10. *Interviews with country delegations* were done in connection with two major events, the World Health Assembly and the Regional Committee for Europe's September 2010 session. Two RWG members normally did these interviews and a short interview guide was used. The RWG met a total of seven country delegations, usually headed by the Minister of Health or a high-ranking ministry official.

11. A formal *review of the Regional Office's functions* was conducted by three members of the RWG. This review focused on relevant documents and interviews with most senior staff from both technical and administrative units.

12. *Four RWG meetings* were held (in Copenhagen (twice), Geneva and Andorra) to plan the work, review progress, analyse findings and formulate its recommendations. The work was coordinated with the simultaneous review of the Geographically Dispersed Offices (GDO) through joint meetings, consultations between the Chairs and sharing of draft reports.

13. The second meeting of the RWG was held in parallel with a retreat of *all heads of country offices* (HCOs) in the European Region. One day was dedicated to a joint meeting where HCOs debated prepared agendas with the RWG members. The purpose was to solicit the opinion of country staff around key issues related to the CO functions.

14. The *Regional Office served as secretariat* to the RWG. This task was undertaken by the unit responsible for Strategic Relations with Countries (SRC) in Copenhagen. Dr Marie-Andree Romisch, Director, –Department of Country Focus, WHO headquarters, provided valuable input to the entire process and participated in several meetings with RWG members.

15. The RWG Chair presented an interim report in June 2010 and a final report in November 2010 to the Standing Committee of the Regional Committee.

16. Specific briefing sessions with the Regional Director were held in connection with each RWG meeting.

WHO's work in countries in the European Region

17. The European Region of WHO is vast. It stretches from the Pacific to the Atlantic and from the Mediterranean to the Barents Sea. It comprises 53 Member States with an estimated population of 890 million people.

18. WHO/Europe supports the 53 Member States in the WHO European Region in developing and sustaining their national health policies, health systems and public health programmes; working to identify, prevent and overcome potential threats to health; advocating public health; and anticipating future challenges.

19. Its work is a two-way exchange, gathering best expertise from key partners in national and international institutions, and analysing data and research findings to propose evidence-based public health and health system interventions. This enables WHO/Europe to inform and advise countries on the most effective ways to improve the health of their populations.

20. The role of WHO/Europe is to provide tailored support to countries through technical programmes addressing a wide range of public health issues. These programmes work together, covering areas including disease prevention and control, response to public health emergencies, environmental health, health determinants and health systems.

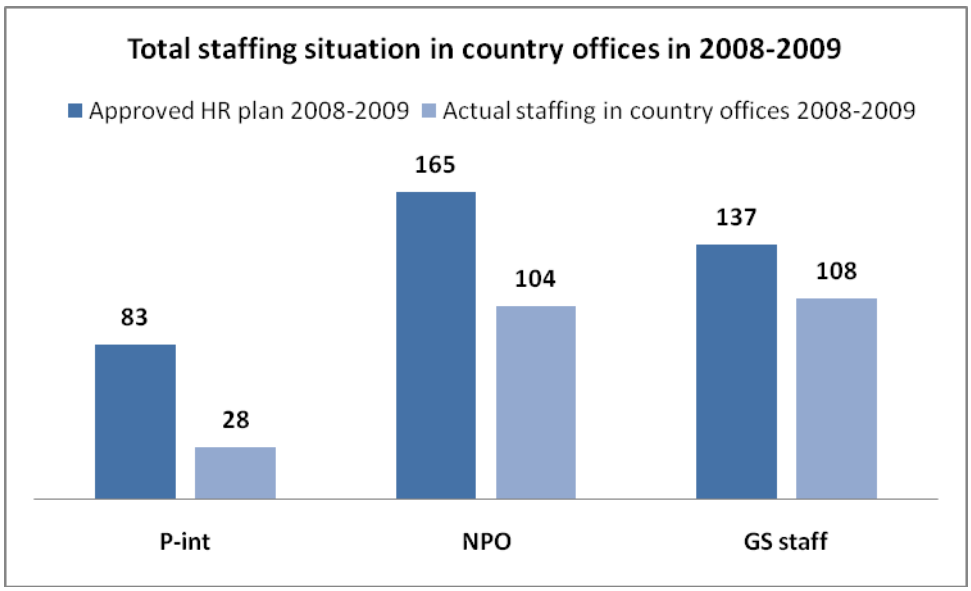
21. The Regional Office is located in Copenhagen, Denmark. It has a staff strength of 267. There are COs in 29 Member States (Annex 3.1), in addition to WHO offices in Pristina and in Brussels. The latter coordinate relations with the European Union. The work with countries without resident staff is coordinated from the Regional Office. There are geographically dispersed offices (now called centres of excellence) in Barcelona, Rome, Bonn, Venice, Athens and Brussels.

22. The Regional Office houses the Regional Director and her senior management, as well as technical and administrative divisions. The organizational chart of the Regional Office is given in Annex 3.2. The staff strength of the technical divisions varies considerably. The divisions develop standards and guidelines on technical issues, provide technical support to countries and organize intercountry activities (ICP).

23. Each CO is headed by a WHO representative (WR, international post) or HCO (national post). There are no differences in the terms of reference for the functions of the CO. The post description of WRs and HCOs is contained in Annex 3.3. The staff strength of each office varies considerably, from one professional officer and one support staff to a number of international and national technical staff and a number of support staff. There are eight large COs with the staff strength greater than ten. An overview of the core staff (HCO, administrative officer and support staff) composition is presented in Annex 3.4. It shows that the number of core staff varies on average from 2 to 10. The staff strength and budget implications by country are shown in Annex 3.5.

24. Figure 3.1 presents the total number of encumbered posts in COs in the Region and the division between international and national staff. It shows that there were 385 posts planned in countries and approved in the HR plan 2008–2009 but only 240 of them were filled as of the end of 2009. The breakdown by country is included in Annex 3.6.

Fig. 3.1 Total staffing in country offices as of 31 December 2009 and comparison to the approved HR plan 2008–2009



25. Member States and WHO develop biennial collaborative agreements (BCA) each biennium. The Minister of Health and the Regional Director normally sign these. The BCA outlines the major priorities and strategies for collaboration between the government and WHO for the following two years, corresponding to the WHO budget cycle. The standard template for a BCA is included in Annex 3.7.

26. The budgeting process in WHO is complex. Annex 3.8 presents the originally signed “aspirational” BCA budgets and progression of planned costs through the biennium. BCA budgets are the resources needed to achieve the country-specific expected results as planned before the biennium starts. In the course of the biennium, depending on the country-specific situation, the necessary response to major global developments (such as the H1N1 pandemic) and the availability of financial and human resources, budget figures are adjusted in the country work plans; these are so-called

planned costs. Available resources (or the working budget) are the actual funding effectively allocated for country use.

27. The total regional budget for the biennium 2008–2009 was US$ 274 million, of which US$ 148 million (54%) was allocated to countries and US$ 125 million (46%) was allocated to the Regional Office (including GDOs). The budget figures are presented in Table 3.1. This table reflects how, in the course of the biennium, the planned costs were re-adjusted as compared to the programme budget figures, based on the availability of funds and implementation. As a result, at the end of the 2008–2009 biennium the Regional Office's planned costs were higher than originally envisaged in the programme budget, while the countries' planned costs were ~30% lower. The rate of implementation of the available resources was relatively high for both countries and the Regional Office.

Table 3.1 Countries/Regional Office split of approved Programme Budget (PB), Planned cost, Available resources and Implementation for 2008–2009

	Countries				Regional Office*			
SO	Approved PB	Planned cost	Available resources	Implemented	Approved PB	Planned cost	Available resources	Implemented
01	17,955,000	8,907,076	15,132,870	13,031,292	11,970,000	15,505,193	15,039,341	13,043,906
02	21,556,000	7,702,525	15,055,732	12,479,421	14,370,000	13,609,850	12,185,135	10,594,921
03	9,943,000	8,316,517	4,385,759	3,637,412	5,966,000	6,277,160	6,150,100	4,426,429
04	9,269,000	9,160,991	4,512,276	4,143,672	5,149,000	4,861,670	3,170,626	2,831,602
05	12,947,000	12,744,664	10,106,050	8,799,939	7,967,000	7,829,931	2,192,953	1,810,580
06	5,209,000	3,944,537	5,223,203	4,791,377	4,750,000	5,130,119	5,983,834	4,778,033
07	2,490,000	1,104,970	1,595,451	1,512,673	3,485,000	4,531,818	5,143,779	2,652,294
08	10,471,000	2,988,296	6,225,470	4,489,630	7,480,000	12,328,161	14,594,859	12,509,663
09	2,888,000	2,580,692	1,910,957	1,131,339	3,087,000	2,898,661	1,979,309	1,716,283
10	29,039,000	23,841,918	12,486,716	9,587,427	19,528,000	20,862,975	25,439,117	19,947,605
11	4,481,000	1,996,183	2,339,039	1,952,360	2,490,000	1,495,696	1,973,125	1,684,200
12	10,136,000	9,936,927	10,764,432	10,725,425	15,205,000	14,803,857	14,346,887	14,194,829
13	12,465,000	9,417,954	10,333,016	10,332,232	24,467,000	26,047,452	27,285,322	26,733,127
TOTAL	**148,849,000**	**102,643,250**	**100,070,971**	**86,614,199**	**125,914,000**	**136,182,543**	**135,484,387**	**116,923,472**
% of Total	54%	43%	42%	43%	46%	57%	58%	57%

*Regional Office share includes all intercountry activities and cost of intercountry staff (Regional Office and geographically dispersed offices)

28. The Regional Office supports country work in various ways. Under the supervision of the Director, Programme Management (DPM), the technical units provide technical expertise, guidelines and standards to countries via the COs. In collaboration with the COs, they develop biennial work plans and budgets for their respective technical areas. However, the HCOs are the work plan coordinators. In theory, no changes to the plans can be introduced without consultation with the HCO. The delegation of authority for the HCO is defined as indicated in Annex 3.9.

29. The SRC unit is responsible for overall strategic country developments, including Country Cooperation Strategies (CCS) and BCAs. It also helps coordinate the country work. A detailed draft description of the function of this unit is presented in Annex 3.10. These functions are under development and may change.

30. The Regional Office takes responsibility for procurement to country programmes in a centralized manner, with little authority for local procurement by COs. Legal

support, such as with contracts and formal agreements with donors, is likewise provided from Copenhagen.

Review findings

31. This section describes the findings of the RWG based on the desk review, visits and interviews.

Desk review

32. RWG members were given access to all documents within the Regional Office, but concentrated on those that related to country work and COs.

33. These revealed that WHO/Europe had continuously tried to align its work with country needs and national health plans. The goal of WHO's country presence was to enable the entire organization to develop a two-way collaboration, by supporting a country in reaching its national health goals, contributing to global and regional public health action and drawing on the country's experience in building a body of public health knowledge that can benefit the rest of the world.

34. The reports showed that the structure of the Regional Office was clear. The managerial and reporting lines were well defined, as were the reporting procedures, types, structure and format. There were guidelines and procedures for country work, including roles and responsibilities, based on recommendations made at the Third Global Meeting of WHO Representatives and Liaison Officers in November 2003.

35. However, what appeared to be lacking was the use of reporting back from countries, and no interventions appeared to have been developed based on reports received from countries. There was some evidence of the use of CO reports in the biennial reports of the Regional Director, but not regular evaluation of the work of COs by local partners or the Regional Office. On the other hand, the reporting back was onerous, with frequent detailed reports.

36. The country strategy from 2000 was clearly important for the Regional Office, and the documents showed the evolution of that strategy with periodic reviews, followed by new guidelines, policy and memoranda, but these reviews and developments did not appear to be based on the feedback and analysis of COs.

37. The full report of the desk review is included as Annex 4.1.

Interviews and country visits

38. There were meetings with high-level delegations from seven countries during the 2010 World Health Assembly and Regional Committee session and visits to 11 countries. All the visits were to countries with COs. The interviews were with countries mostly in the EU, most of whom did not have a CO.

39. In about half the countries, there were many positive comments about WHO staff, and in particular their technical skills. There was genuine respect for the standards, input and impact they made. In other countries, the contribution to programmes in particular was welcomed, but appreciation was more muted, and in a small number there was concern about the lack of impact and visibility of the CO staff.

40. In a few countries, the CO appeared to make a genuine impact on health policy and health reform. In these countries, the WR or HCO worked well with the ministry of health (MOH), and there were comments from other United Nations agencies about the close relationship, which was not always the case for other agencies. However, in one country, there was criticism from the other agencies that WHO did not make the most of its close relationship to have more impact. The reasons for the lack of influence on policy, strategy or health service reform in other countries varied. In most, it appeared to be the lack of senior staff or staff with the right experience. In one country, the WR was beginning to make an impact but felt the lack of strategic skills among his staff. In some countries the political situation made such work harder, even when there was an experienced WR. This was especially the case when ministers changed on a frequent basis. However, in general, those COs that were headed by an international member of staff appeared to have the most impact.

41. Other positive comments were about the coordination of different agencies by WHO and the support in seeking funding from donors. The rapid support in emergencies was clearly valued. However, where support to programmes was the predominant work, concern was sometimes expressed by other agencies and institutes that the balance of work was wrong, and they expressed the need for more strategic and policy influence. The lack of skills in some areas was also mentioned, including that of noncommunicable diseases (NCD), as well as what was seen as WHO bureaucracy slowing things down.

42. For the countries in the EU or candidate countries, the presence of WHO was still valued, although with rising health standards and EU investment, some recognized that change might be necessary, either in the size of presence or the type of input.

43. The situation in the Russia Federation appeared to be more mixed, as the country receives support from WHO but also contributes to the Organization and has many collaborating centres.

Key areas of work

44. Most countries included the following in their list of work, although their real contribution varied as above:

- new legislation and health policy;
- health service reform, including stewardship, finance, performance, capacity and workforce.

45. All countries were involved in programme work; common areas were:

- improving maternal and child health services, including immunization;
- mental health services;

- other specific health services, such as pharmaceuticals and blood safety;
- the International Health Regulations, including surveillance and preparing for emergencies;
- communicable diseases, including tuberculosis and HIV/AIDS;
- food safety
- NCD, including tobacco, nutrition and road safety; and
- environmental health, including climate change.

Type of support provided

46. Where there was an impact at national level, the inputs included:

- leadership;
- advice on policies and strategies;
- input to or comments on documents (a number of countries mentioned the 'quality control' role of WHO in policy documents, or bringing a wider understanding from experience in other countries);
- bringing key parties together, including through workshops;
- working across government;
- advice to funding agencies, such as the World Bank.

47. At a more programmatic level, support included:

- training;
- running conferences or workshops;
- advice on guidelines and protocols (a number of countries mentioned working towards WHO standards and norms and using WHO guidelines);
- technical advice;
- coordination;
- funding for national experts to attend WHO functions within the Region.

48. In some situations, WHO staff brought in support from GDOs or other outside experts. Access to wider expertise was mentioned as a particular benefit in some places.

49. A few people commented that they would like more access to WHO guidelines and policy documents. Although they were on the Organization's web site, people in countries were not always aware of new documents, nor how they applied to them. In many countries, there was a request for more of these to be in Russian, as health policy-makers and professionals had not mastered English.

Biennial collaborative agreements

50. The BCA is generally considered a useful instrument for WHO-country collaboration, although with several shortcomings. The budget provided for in the agreement was regarded as usually misleading, causing expectations that are not met when budget amounts are subsequently reduced. The instrument is not considered flexible enough by several countries.

51. The process of preparing the BCA is usually confined to negotiations between the MOH and WHO. No other government agencies are involved, and even interaction with the MOH is limited in some countries. Several partners proposed a more open process and a wider access to the BCA in order to align other partners' inputs to the BCA.

52. There were BCAs in some of the EU countries, and others indicated that they would wish one.

Coordination within WHO

53. This is the area where most frustrations were expressed. WHO is seen as a very bureaucratic institution, which is slow and complicated to work with.

54. There is a pervasive concern across most COs that administrative procedures cause the largest impediments to country operations. This is particularly so in human resources management (e.g. recruitment of short-term consultants takes six months on average) but the obstacles are also prominent in financial administration and in procurement. Provision of legal assistance is also considered a major problem by several COs. The Organization's global management system (GSM) has, so far, made operations in COs even more cumbersome and slow.

55. The summary report of all visits and interviews is included as Annex 2.4.

Review of the Regional Office

56. There were 16 interviews with 27 people. They were asked how programmes could support country work and what kind of country arrangement would be appropriate.

57. There was consensus over some points. Some kind of country presence and a collaborative framework are necessary, although not always with a country office; there needs to be a balanced approach between country and intercountry work, and some kind of subregional arrangement would help coordination. The administrative capacity of COs needs strengthening, limited resources are spread thinly and the quality of COs relates both to capacity and the quality of work.

58. There was less agreement about the mandate of the COs, what the subregional arrangements might be, the balance of staff in the COs and the structure of the Regional Office for country work.

59. It was agreed that more communication and public relations work on COs was needed; Regional Office staff needed to have a better understanding about countries; country work should be assessed from a cost-efficiency perspective, and the role of WHO in countries needed to be clear.

60. The report of the Regional Office review is included as Annex 4.2

General conclusions

61. The Introduction to this paper sets out the changes across the European Region, many of which reflect global changes. WHO and its Member States need to adapt their work to meet those changes. The review has also identified some areas for improvement in the infrastructure, skills and organization across the Region that must be addressed if WHO and its Member States are to improve the health of the population. However, it should also be recognized that WHO funding is unlikely to increase, and may decrease, particularly with the current financial pressure affecting countries., It will therefore be important to ensure that WHO funding is used to best effect, and if some areas need strengthening, others may need to be reduced.

62. The main focus of WHO's work with countries should be to support them in setting norms and standards; developing effective health policy; strengthening health and health care systems, including public health institutes; building local capacity to implement change and sustain improvements and monitoring health. The aim should always be for countries to drive the work to achieve improvements, supported by WHO.

63. This in turn requires a change in the range of skills and the roles of the Regional Office and COs. However, to maintain countries' confidence in WHO, such changes will need to be phased, to enable key areas such as the technical capacity of the Regional Office and alternative approaches such as subregional arrangements to be developed. Such changes should not preclude significant improvements in CO performance through radical changes to the administrative functions of the Regional Office. WHO should also be seen as working as one organization, so that all countries continue to enjoy the support of WHO whatever the arrangements.

Recommendations

The Regional Office

- **The Regional Office should shift from a process/activity approach to one more focused on content and results, less on outputs and more on outcomes.**
- **There needs to be an increase in the key skills in or available to the Regional Office.**
- **There need to be major improvements in the administrative and support functions of the Regional Office.**
- **Communication, both within WHO and externally, needs improvement.**

64. There should be greater emphasis on technical skills that reflect more accurately the health needs of the Region, particularly in NCD such as diabetes, cardiovascular disease, cancer, mental health, asthma and osteoporosis. Attention should also be paid to health policy and developments in health systems. For them to be used effectively across the Region, people with these skills should be based within the Regional Office, in subregional arrangements or in ways so that they can be called on as needed.

65. Improvements should be made at the Regional Office, particularly in support services such as human resources, finance and information technology, to reduce the frustrations felt in COs. These departments should develop a 'service culture', where they recognize that their role is ensure that technical and CO staff are able to fulfil their roles through effective and timely systems. This in turn should reduce the need for such staff in COs and the development of parallel systems which grow up when staff are not confident in central ones. A better understanding of GSM is needed.

66. There should be a continuing improvement in communication across the Region, to reinforce integrated working. Communication should be recognized as central to the Organization, not an added luxury. This is as much about understanding and attitude as systems.

67. If WHO/Europe wants to address the general public as its target audience, it needs to work through national media outlets and use local languages. Country or subregional arrangements would need to be assigned clear roles in communications. It is possible that smaller offices would not have a communications function at all, while bigger offices would assume this function entirely.

68. New sources of funding may need to be raised for communications, advocacy and related training projects. A roster of consultants should be created to enable WHO/Europe to react quickly to emergencies and provide communications support to COs or subregional offices on an ad hoc basis (e.g. ahead of visits by the Regional Director and major conferences).

Working with countries

- **WHO should have a relationship with all Member States, but there are a range of arrangements that should be established depending on the needs of each country.**

69. WHO/Europe should develop close cooperation with all countries and ensure a WHO presence. In the new Guide to WHO Country Cooperation Strategies, this is defined as:

> "WHO presence in countries with or without a country office is the platform for effective engagement with countries for supporting national health policies, strategies and plans. It refers to the work of the Secretariat as a whole, in that country."

70. This presence might be in the form of a named member of staff in the Regional Office, a liaison officer, a subregional arrangement or a Country Office.

71. The level of support for a country should be assessed using a set of criteria based on:

- its health status in comparison with other countries in the Region, and the rate of improvement;
- the level of development of health systems and services;
- political stability and support for health system development;
- economic status and capacity for development of health systems.

Country offices

72. Currently, there are 29 COs. Using the above criteria, an assessment should be made of the need for these to continue.

73. For those countries that have not reached that level of stability in the health system, the CO should continue. However, there should be change in the skill base, and in particular the HCO should be a senior person, with leadership skills and sufficient experience to work at ministerial level. Over a period of time, the appointees to these posts should be experienced international staff that have been through the Assessment Centre and included on the register as being eligible to apply. This is in line with WHO policy. This policy needs to be explained to Member States, as they do not always find recruitment procedures transparent. Such staff should be given appropriate delegated authority. Within COs, there should be less emphasis on technical skills; rather these should be Region-wide, mainly but not exclusively in the Regional Office. There should be more use of short-term appointments, rather than a large staff complement. However, for this to be effective, there need to be simpler arrangements for recruitment.

74. For those countries where there is stable development of their health systems, withdrawal of the CO should be considered. However, before that happens, alternative arrangements should be in place, including improvements in the technical skills available at the Regional Office. Alternative arrangements might include a nominated person for that country in the Regional Office, or a subregional arrangement. Across the Region, but especially in those countries that are now members of or candidates for membership of the European Union, there should be support to access EU resources and networks. For a period, a co-financing agreement with the country might be appropriate, with a gradually decreasing share from WHO, possibly with the involvement of schools of public health.

Subregional arrangements

75. Subregional arrangements should be considered, but feasibility studies should be carried out. Such arrangements should not be at the expense of strengthening the Regional Office. They should provide technical skills and promote networks in a particular part of the Region with common health problems. They might also draw on local experts, such as Russian-speakers in the east of the Region.

76. Across both the Regional Office and countries, deployment of staff will depend on resources. Costs should be kept at a minimum to allow a shift in resources to improve

areas such as NCD. Incentives should be sought to encourage staff movement, to enable them to gain a range of experience.

Networks

77. In some situations, subregional arrangements may not be appropriate or feasible, but networks of common interest or common programmes, whether geographical or among countries with similar problems, should be encouraged and facilitated.

Biennial Collaborative Agreements or Country Cooperation Strategies

78. If successful, the CCS pilot should be rolled out across the Region, but all agreements should be based on clear principles.

79. In most countries there is a BCA. However, there is a pilot programme to work on a CCS in some countries. This should be continued, and if successful a programme to move to these across the Region should be developed. This would bring WHO/Europe in line with other regions.

80. In the meantime, the principles set out in the guidance on the CCS should be applied, namely:

- ownership of the development process by the country;
- alignment with national priorities and strengthening national systems;
- harmonization with the work of sister United Nations agencies;
- collaboration as a two-way process.

81. Whichever process is used, a multisectoral approach should be adopted.

Review

- **The RWG recommends that the new strategy should be reviewed no later than 2015.**

82. The RWG puts forward these recommendations to support the development of a new country strategy for WHO/Europe to be presented to the Regional Committee. The RWG recommends that a review period should be included in that strategy.

Annex 1.1. Core functions of WHO applied at country level

The 11th General Programme of Work (GPW) has defined six core functions built on WHO's mandate and an analysis of its comparative advantage. How they apply in each country is to be determined by the Country Cooperation Strategy.

- ***Providing leadership on matters critical to health and engaging in partnerships where joint action is needed***. At country level, WHO acts as broker on high level policy issues and leads or remains active to harmonize the efforts of all development partners and helps align their work with national priorities.
- ***Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge***. WHO builds Member States' capacity in generating and disseminating knowledge, as well as in applying the knowledge gained from appropriate health research that will bring in health improvement.
- ***Setting norms and standards, and promoting and monitoring their implementation.*** WHO supports Member States in application of global/regional norms and standards to different contexts and settings and also brings country realities and perspectives into the setting of norms and standards.
- ***Articulating ethical and evidence-based policy options***. WHO provides Member States with reviews of policy options to consider in different settings. WHO gathers global evidence and facilitates its adaptation for country work, and suggests Government and civil society what is feasible in different socio-economic contexts.
- ***Providing technical support, catalysing change, and building sustainable institutional capacity.*** WHO provides high quality strategically sustainable policy advice and technical support in response to national needs; catalyses change with clear direction; and supports in building institutional capacity focusing on strengthening key institutions for implementing health policy.
- ***Monitoring the health situation and assessing health needs.*** WHO helps ministries of health link with other national statistical institutions, for collecting, analysing and disseminating health information; supports monitoring of the health situation; and builds national capacities for surveillance and response and mapping of public health risks.

Annex 1.2. Terms of Reference for the Working Group to Review Work of WHO Regional Office in the Countries (RWGCo)

Background

A changing Europe with new public health priorities and ongoing, as well as emerging issues such as globalization, climate change and the impacts of an economic crises, all demand that the Regional Office evaluates the way it works with countries. WHO Europe may need to strengthen the strategic role it plays in supporting Ministries of Health to build capacity in health policy. The role of health diplomacy needs to be elaborated further.

An important element in country relations are the country offices (COs) that can be found mainly in the central and eastern part of the region. Over the years, COs have played a key role in WHO Euro country relations and they have provided important links through close relations with ministries of health in their countries. Their advocacy role has been crucial to ensuring appropriate national policy-making and decision-making processes. However, the roles and responsibilities of these COs have gradually evolved over the years from political to administrative and lately also technical. The type of role required by the public health needs of the member states today needs to be identified and delivered in the most effective manner

Another element is the new vision for the WHO Regional Office and the new direction that requires WHO Euro to evolve into a networked organization. This means that COs will have to revisit their responsibilities to ensure that they operate as integral elements of the WHO Regional Office. Other adjustments may be necessary in the way the COs interact on various levels - including political, strategic and technical.

Main Objectives

With the increased presence of strategic partners like the European Commission as well as IGOs, and donor organizations in the countries, as well as many new players from sectors other than health, WHO COs need to have a clear identity and role in the countries they serve and possibly to be more proactive is safeguarding health.

For this purpose a Working Group to Review work of WHO Euro in Countries will be set up. The main objective of the group is to develop new strategies for WHO Euro's collaboration with countries and to recommend ways of implementing such changes. At present WHO Euro has only two CCS one with Romania and one with Kyrgyzstan. Otherwise WHO Euro works through Biennial Collaborative Agreements. The preparation of Country Cooperation Strategies in a prioritized manner is likely to be an important step forward. This should also be an important issue for the working group to explore with the aim of developing a plan for CCS developments, if found appropriate.

The Working Group should also look at how effective WHO Country work has been. The group should study the impacts the impacts that COs have in the countries and whether they all have added value. The options for sub-regionalisation of COs should be

specifically studied in order to be assessed and included in the report. Part of this evaluation will include studying the functions and responsibilities of COs in the WHO European Region and how they can be improved. With regards to the functionality of COs themselves, the following aspects (and possibly more) should be included: 1) line of reporting, 2) levels of authority, 3) staffing patterns, 4) planning and budgeting, 5) organization and modalities of RO support.

Process

83. An evaluation of WHO's work in the countries will assess the input of WHO in the country and the added value of WHOs work. More specifically it will look at how far WHO has managed to influence the strategic developments of the country. With regards to the role played by WHO in coordinating and implementing technical assistance, evaluation of how successful WHO has been in supporting the country vis a vis the other organizations.

In order to ensure a broad range of different countries are studied, it is suggested that a desk review of around 12 countries takes place through :

(a) Questionnaires and interviews - carried out over teleconference or videoconference.

(b) Country visits - Preferably the first visit should be done by the entire group to one country – e.g. Russia or Turkey to align schedules and modalities for each visit. After this country visits could be done by individual members alone or two and two together. Since members may have limited time for travel only one – to two countries per category can be visited (total app. 12 visits).

(c) A visit to PAHO to compare and discuss sub-regional structures in that region should be considered.

84. In preparation for this desk review, all available documentation, including available BCAs, CCS's or related papers will be provided to the members of the working group. An overview of each country office staff and workplans for 2010/11 should also be available. A list of websites of relevance should be prepared – e.g. EURO country web sites with BCAs.

85. An internal working group will be set up to ensure information and documents are always provided in a timely manner should be available to all members

86. Once all experts have accepted to join the working group to review WHO country work, a list of short CVs for each review team member will be put together.

87. Considerations should also be given to include one senior regional staff (EMRO or former DRD EMRO, now in HQ) in one meeting of the RWG.

88. At least one member of the Review Group should have access to EURO intranet.

89. The members of the working group will work mainly over emails or video or teleconference, but will meet together and with RD to discuss findings at least once

during the first few months. Regular reporting back to the RD on progress achieved should be done through the Chairperson of the group or any other member as decided by themselves.

The Working Group will prepare a report for RD which will include recommendations for action, through which they will provide advice to the Regional Director on what changes may be necessary to improve the support provided by WHO Euro to countries. This report may provide input for the drafting of the Country Strategy to be presented to RC 61. Full discussion and endorsement of the new Country Strategy will take place during a specific session to be held at RC 61

Countries to be reviewed

The countries to be reviewed should be representative of diverse geographic and political parts of the WHO European Region. As a minimum it is recommended that these countries could include

a. Baltic countries e.g. Latvia

b. Balkan countries including Albania,

c. Caucasian and non-EU Eastern Europe

d. Central Asian countries such as Tajikistan, Kyrgyzstan and Turkmentistan

e. New EU Member States such as Hungary and Poland,

f. Turkey and the Russian Federation as countries with a large population and significant subregional influence

As indicated above, a visit to the PAHO Regional Office will also take place to see how this functions with a subset of big country offices as well as small ones

Outputs and timeframe (to be reviewed further)

A first outline of the methodology and assignment of countries and time frames discussed with Chairperson	14 - 16 April 2010
Countries assigned to experts	By end April 2010
A meeting of group on results of work	End May 2010
Report to RD with recommendations for RD review and decision	15th June 2010
Discussion with HCO at staff retreat	25 – 26 June 2010
Discussion with SCRC at RC 60	September 2010

Draft and finalize the Country Strategy for RC 61 based on recommendations of Working Group (**October 2010 to May 2011)**

Discuss with MS in RC 61 **(September 2011)**

Implementation of new organization **(Jan 2012)**

Composition of the Working Group

The Working Group will be made up of a number of experts as listed below, assisted by a representative of the RD and an internal group of WHO staff who will provide additional assistance by feeding the external evaluation with the proper documentation required.

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Dr Litvinov
(contact details to be inserted)

WR as representative of a WHO country office

Mr Arun Nanda and Dr Lucianne Licari as RD Representatives

Dr Muhammend Jama
(request will be made at WHA)

Dr Marie Andree Romisch- Diouf
(WHO HQ to be informed and asked to act as a control and supporting group)

Annex 2.1. RWGCo Country visits (19 May 2010)

TURKEY	Bjorn Melgaard Marion Caspers-Merk **16–18 JUNE**		28TH JUNE–30 JULY
RUSSIAN FEDERATION		Tatul Hakobyan Marion Caspers-Merk Vladimir Gusmari **24 JULY–31 JULY**	12–18 JULY, 1–20 AUGUST
SERBIA		Tilek Meimanaliev Serguei Litvinov **10–13 JULY**	14–20 JULY 5–23 AUGUST
LATVIA	Tatul Hakobyan Michaly Kokeny **20–23 JUNE**		28 JUNE–30 JULY
ROMANIA		Serguei Litvinov Serdar Savas **27–30 JULY**	9-27 AUGUST
ALBANIA		Tilek Meimanaliev Pat Troop **21 – 23 JULY**	15-31 AUGUST
HUNGARY	Vladimir Gusmari Serdar Savas **12 – 15 JULY**		11 JUNE 19 JULY – 6 AUG 16-20 AUG
UKRAINE	Tatul Hakobyan Michaly Kokeny **17 JUNE – 19 JUNE**		9 JULY - 23 AUGUST
TAJIKISTAN	Pending due to polio outbreak		AVAILABLE

Annex 2.2. WHO Euro Country Offices Review
Structured Interview

Introduction

The following sections set out suggested areas for discussion on the Country Offices, the details of which will vary for different countries and representatives. The aim is to guide the discussion with different representatives, reflecting varying perspectives, rather than provide an exhaustive list of questions. Although it is in sections, the intention is to ensure key areas are covered, as inevitably, responses in early sections may cover questions in later sections.

The questions are drawn from the comments received and the various policy and review documents setting out the roles of Country Offices, and in particular the shift from specific technical issues and single programmes towards policy support and a more integrated way of working.

The paper on the 'Terms of Reference for Desk Officers in the Country Policies and Systems Unit, Division of Country Support' in particular describes the relationship between WHO Euro headquarters and Country Offices and countries. This is reflected in Section 4.

In Section 5, for some countries, the European Union will be important. In a review of the relationships between Member States and the European Centre for Disease Control (ECDC), an apparent lack of coordination with WHO was mentioned several times. On the other hand, there was appreciation of the support from the ECDC.

The questions are of a general nature, and may need to be supplemented from the specific agreements with the individual country.

In the 2006/07 Review of the Regional Office, there were three specific examples of support for countries that were at an early stage. It would be helpful to assess if they have been implemented or sustained:

- Albania – emergency medical services
- Armenia – support in strengthening the national capacity for health system performance assessment
- Azerbaijan – reproductive health

Country Offices Review
Structured Interview

Section 1. Background Information required for interview

(*to be provided by Regional Office)*

- Key points from Bilateral Collaborative Agreement or Country Cooperation Strategy
- Details of Country Office
    - Staffing
    - Structure
    - Budget
- Particular programmes being pursued by WHO Euro

Section 2. Questions to WHO Country office

- What is the rationale for current structure and staffing?
- What are the difficulties that CO faces when working in the country?
    - What should be done to improve CO performance at country level?
- What are the current difficulties that CO faces when working with the Regional Office, and other COs in the Region?
    - What should be done to improve the Country work?
- Describe your role in the following areas
    - Liaison
    - Communication and correspondence
        - RO and Ministry of Health, direct or assigned
    - Support to BCA administration
        - Technical assistance and administrative support
    - Involvement in policy process, strategic planning and

implementation

- What instruments are being used to convey WHO strategies and recommendations
  - Presentations, conferences, seminars
- Promoting partnership in country and coordination and advocacy in health

- Are there any areas where NPO's feel that they are performing the tasks that should be performed by MOH officials (or any other country officials)? *(Sometimes NPOs are substituting the governmental officials in performing the tasks that usually should be carried out by them. This cases should be identified and eliminated)*
- Are the results of the implemented activities used as bases for future strategies? How information Is shared with other Country offices?
- Is the information flow within the country, within EURO region, within WHO adequate and prompt?
  - Any suggestions for improvement?

Section 3. Questions to Ministries of Health/Country delegations

Section 3.1. Expectation of Country Office

- What were the country's expectations from the collaboration with WHO CO and were these expectations met during the collaboration till now?
  - Are these expectations applicable solely to WHO CO, or they are similar with those that the country expects from other international organisations and agencies?
  - What in your opinion makes WHO different from other organizations?
- To what extent the BCA is reflecting the country needs and priorities?
- The BCA is more reflecting the country needs or WHO priorities?
- When working with WHO CO, is there a clear definition of roles, responsibilities and tasks of both sides (CO and MOH), and is it always clear what each side is expecting from the collaboration?

Section 3.2. Level of support from Country Office

What level of support has been received in key areas of development (substantial, minimal etc)

- Health policy
- Health systems
- Health services development
- Public health and health outcomes
- Capacity Development
- Information about and translation of global policies at country level
- Implementation of plans
- Specific programmes
- Technical areas, such as surveillance, information systems
- Improvement in evidence base, research development
- Support in specific events or outbreaks

- What is the unique role of CO in the country (if there is any),

  In other words what makes the WHO CO different from presence of other in-country international organisations, and what is the added value of CO presence for MoH?

  Could these benefits have been achieved without the Country Office presence, perhaps with direct support from WHO Euro, or another agency

Section 3.3. Type of Support received

- Policy advice
- Direct leadership of programmes
- Technical Skills
- Coordination of support
- Training

Is the staffing of WHO CO relevant and adequate (both in numbers of HR and in skills?

What was the adequacy, timeliness or appropriateness of support, including grades and technical skills of staff

Section 3.4. Coordination within WHO

How much support from/communication with

- Country Office
- WHO Euro
- WHO Geneva

Was this well coordinated, mutually supporting or were there areas of mixed communication or conflict

Section 3.5. Relationships with other agencies

- Have multiple international agencies been involved in health developments
    - If so – which agencies
- Is there a need to harmonise and streamline the support of international agencies in your country?
- What can be the role of WHO CO in promoting International Health Partnership?
- Were different agencies of more use than others
- Did the Country Office contribute to mobilisation of donors

Section 3.6. Future developments – potential ways of working

- Are there current gaps or new areas of support needed
- Does this require the presence of a Country Office
- Is there the potential for this to be provided on a sub-regional or network basis or from another agency

Section 4. Questions to International Organisations

- To what extent the work of different international organizations in country is harmonised?
- What is the specific role of WHO CO within the UN family in country?

Annex 2.3. Summary report on the visits to Country Offices

Introduction

This report summarizes the findings, conclusions and recommendations from the country visits undertaken by members of the Working Group to review work of WHO regional office in the countries (RWGCo).

The group visited 11 countries in the region, selected on the basis of geographic location, health situation and WHO role in the country. The country reports have been summarized based on the structure in a questionnaire used as guide for the country visits. Patricia Troop and Bjorn Melgaard prepared this summary.

Country offices

The staff strength and budgets of the Country Offices (CO) vary considerably. The biggest office has 38 staff (Russia) while the smallest has 2 staff (Latvia). The average is 14 and 3 offices visited had 3 staff or less.

The total biennial budget varies similarly from 9 Mill (the Ukraine figure in the report needs to be checked) to 0.4 Mill USD. One office (Russia) relies exclusively on voluntary contributions while budgets of the remainder are a mix of assessed and voluntary contributions.

Benefits to Country

We heard very positive comments about WHO staff, and in particular their technical skills, in about half the countries. We heard genuine respect for the standards, input and impact they made. In other countries, the contribution to programmes in particular was welcomed, but was more muted, and in a small number, there was concern about the lack of impact and visibility of the staff in the Country Office (CO).

In a few countries, the CO appeared to make a genuine impact on health policy and health reform. In these countries, the WR or Head of Office worked well with the Ministry of Health (MOH), and there were comments from other UN agencies about the close relationship, which was not always the case for other agencies. However, in one country, there was criticism from the other agencies that WHO did not make the most of its close relationship to have more impact. The reasons for the lack of influence on policy, strategy or health service reform in other countries varied. In most, it appeared to be the lack of senior staff or staff with the right experience. In one country, the WR was beginning to make an impact, but felt the lack of strategic skills amongst his staff. In some countries the political situation made such work harder, even when there was an experienced WR. This was especially thee case when Ministers changed on a frequent basis. However, in general, those COs which were headed by and international member of staff appeared to have the most impact.

In most countries, the contribution to programmes was particularly valued, in some countries very positively, with genuine recognition of the skills of WHO. Other positive comments were about the coordination of different agencies by WHO and the support in

seeking funding from donors. The rapid support in emergencies was clearly valued. However, where support to programmes was the predominant work, concern was sometimes expressed by other agencies and institutes that the balance of work was wrong, and they expressed the need for more strategic and policy influence. The lack of skills in some areas was also mentioned, including that of non-communicable diseases (NCD), as well as what was seen as WHO bureaucracy slowing things down.

Several countries were now in the EU or were candidate or aspiring countries. The presence of the WHO was still valued, although with rising health standards and EU investment, some recognised that change might be necessary, either in the size of presence or the type of input.

The situation in Russia appeared more mixed, as they receive support from WHO but also contribute, and have many collaborating centres.

Key areas of work

Most countries included the following in their list of work, although their real contribution varied as above

- New legislation and health policy
- Health service reform, to include stewardship, finance, performance, capacity and workforce

All countries were involved in programme work, common ones were: -

- Improving Maternal and Child Health Services, including immunisation
- Mental health services
- Other specific health services, such as pharmaceuticals, blood safety
- International Health Regulations, including surveillance and preparing for emergencies
- Communicable diseases, including TB and HIV/AIDS
- Food safety
- Noncommunicable diseases, including tobacco, nutrition, road safety
- Environmental health, including climate change

Type of support provided

Where there was an impact at national level, the inputs included

- Leadership
- Advice on policies and strategies
- Input to or comments on documents; a number of countries mentioned the ‘quality control’ role of WHO in policy documents, or bringing a wider understanding from experience in other countries
- Bringing key parties together, including through workshops

- Working across government
- Advice to funding agencies, such as the World Bank

At more programme level support included

- Training
- Running conferences or workshops
- Advice on guidelines and protocols; a number mentioned working towards WHO standards and norms and using WHO guidelines
- Technical advice
- Coordination
- Funding for national experts to attend WHO functions within in the Region

In some situations, WHO staff brought in support from GDOs or other outside experts. Access to wider expertise was mentioned as a particular benefit in some places.

A few people commented that they would like more access to WHO guidelines and policy documents. Although they were on the website, the country people were not always aware of new documents, nor how they applied to them. In Central Asia, there was a request for more of these to be in Russian, as the health policy makers and professionals had poor English.

BCA

The BCA is generally considered a useful instrument for the WHO- Country collaboration, though with several shortcomings.

The budget provided in the agreement is usually misleading, causing expectations that are not met when budget amounts subsequently are reduced. The shift from BCA budgets to planned cost to actually available funds creates confusion in some MOHs.

The instrument is not considered flexible enough by several countries, though no specificities were provided in terms of areas that could be made more flexible.

The process of preparing the BCA is usually confined to negotiations between MOH and WHO. No other government agencies are involved and even the MOH interaction is limited in some countries.

Several partners proposed a more open process and a wider access to the BCA in order to align other partner inputs to the BCA.

Coordination within WHO

This is the area where most frustrations were expressed.

There is a pervasive concern across most COs that administrative procedures cause the largest impediments to country operations. The problems are massive in HR management (e.g. recruitment of short-term consultants take 6 months on average) but

the obstacles are also prominent in financial administration and in procurement. Provisions of legal assistance is also considered a major problem by several COs. The GSM has – so far – made operations in COs even more cumbersome and slow.

WHO is seen as very bureaucratic institution, which is slow and complicated to work with.

The technical support to countries from RO varies in quality and speed. Some technical units are responsive, quick and relevant others are slow and inadequate. The most problematic area mentioned by most COs is NCD.

The relationship with the GDOs differs considerably across CO's and GDOs. The office in Rome is mostly considered responsive, though one office mentioned that they mainly ask for information but provide nothing in return. Bonn is also mentioned with positive notes. The evaluation of the Barcelona office is mixed while no office visited mentioned relations with Venice.

One office has been without resident HCO for several years, which has damaged WHO's image considerably and basically left WHO without involvement in a major health system reform.

Several CO staff expressed their frustrations over the lack of trust shown by some RO units. (" It is as if we do not exist").

Relationship with other agencies

Most offices have good relations with the UN family – where it is present. In a number of countries other UN agencies are withdrawing or reducing presence and WHO should consider similar actions. In others, WHO –as a specialized agency – is seen as very valuable even in the absence of other UN partners.

The relations to bilateral donors and development banks vary considerably from one country to the other. For example, in one country WB is strongly engaged in health systems reform without any engagement with WHO. In others excellent partnerships exist between bilateral partners such as EU and USAIDS. WHO leverage funds, participate in projects funded by donors and is seen as a valuable partner.

Most agencies see WHO norms and guidelines as gold standards that they use and support.

The role of WHO as a conduit for fund raising varies likewise from country to country. Though few mentioned the role in relation to the Global Fund it was the impression that WHO play a key role in helping preparing applications and fulfilling reporting requirements.

Future development

Many countries mentioned the need for WHO to focus more on health policy and health systems issues and to concentrate its work in these areas. This would include contacts to

institutions outside MOH such as other Ministries with relevance to health, parliamentary committees for health and other stakeholders.

A special feature is that several countries are becoming donor countries and provide increasing development assistance to other countries (e.g. Turkey, Russia, Romania). WHO will have to change its role in such countries in order to facilitate such assistance and relate to national agencies that are responsible for such support.

Recommendations

The recommendations from the visits fell into two types, generally applicable and country specific. However, similar country specific recommendations were mentioned in several reports and so are included here as general recommendations.

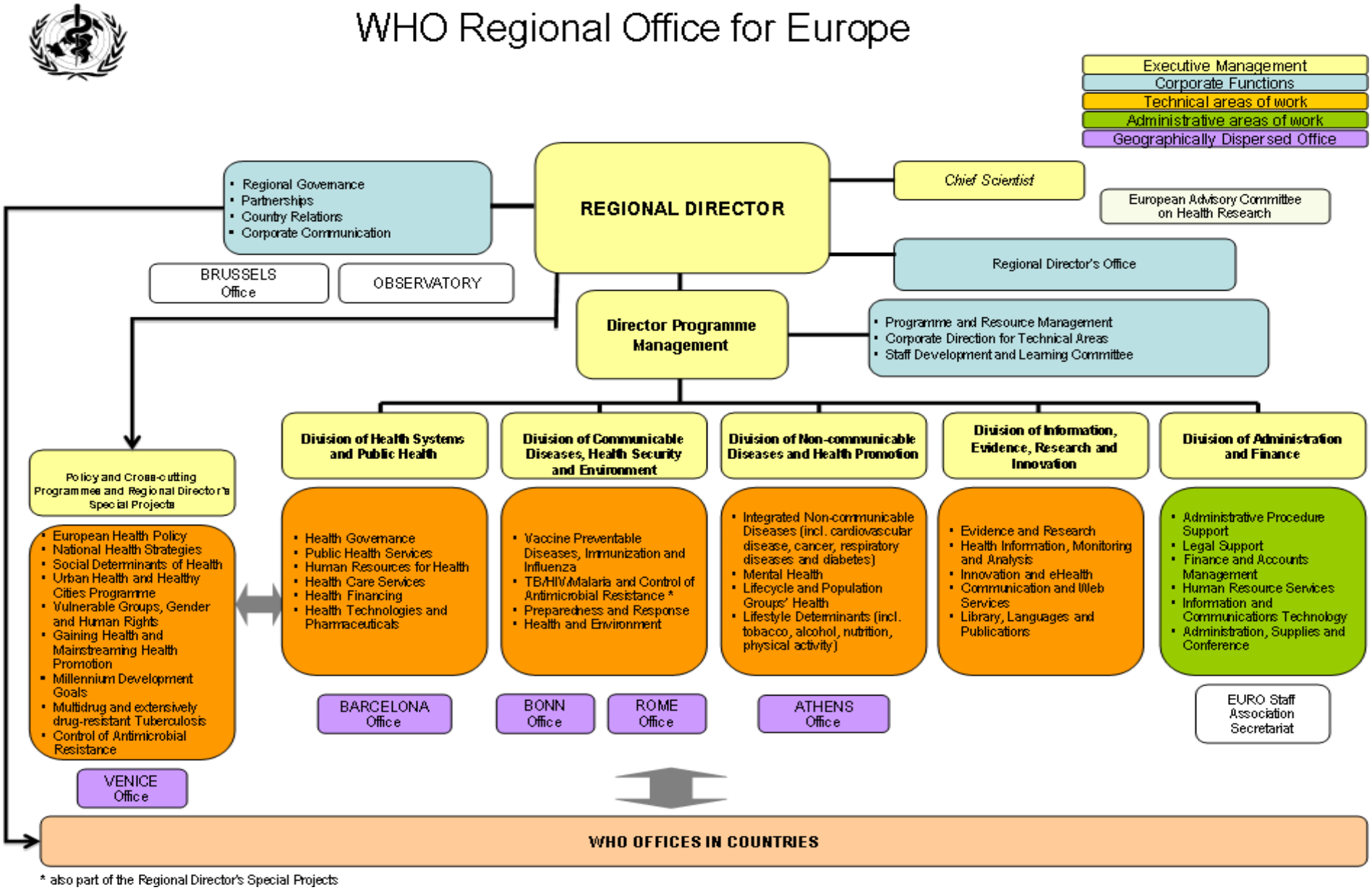
- All visitors recommended the continuation of the CO in the countries they visited in the short-term. However, for some countries, there were comments about changes in the future level of support, or the move to sub-regional offices or liaison officers (see below). This was particularly relevant to small country offices in several EU countries.
- Sub-regional offices could be considered in some parts of the region, those mentioned were in the Baltic area, in Budapest, Russia and Turkey. This might then impact on the level of input to an individual country. However it was also pointed out that in some parts the political situation made cooperation amongst some countries difficult.
- The links to the EU need to be clarified, and the future WHO input to countries reaching EU standards need to be considered.
- The experience of the BCA process and structure varied, but there were a number of recommendations for improvement, around the time of development and the budgetary procedures.
- Country Offices need senior staff able to work at Ministry level, with leadership and managerial competences, able to be proactive and with appropriate skills in health policy and health service reform. *(In Kazakhstan The CO has suffered from the long absence of a permanent WR. Appointment to this post should be a high priority).*
- COs need to increase focus in health policy and health systems reform and in particular financing; and in non-communicable disease. They should, therefore, have more access to wider skills in this area. Some of these should be from strengthening technical units within the RO, or a number of COs suggested a regional roster of experts from which they could draw.
- Technical Units should pay more attention to the speed of response to COs and work in a more coordinated way. An analysis of the strength and weaknesses in TU responses to country needs is required to strengthen country work.
- The RO should show greater understanding of the difficult political situations under which some COs work and adjust their expectations.
- EURO should work on the attitude of regional and country staff towards building more trust and team spirit across the organization expectations.

- A high priority should be paid to reducing the bottlenecks in HR and finance functions and reviewing delegation powers to senior CO staff.
- Country office staff should be regularly updated on staff movements in RO.
- Regional Advisors should visit countries on a regular basis
- EURO should play a more active role in strengthening inter-country collaboration
- The WHO role in countries that are increasing their development assistance should be reviewed and changes made to facilitate this assistance.
- EURO should become more involved in the ‘One UN’ pilot to ensure effective WHO input to the thinking

Annex 3.1. Member States with country offices

NN	Countries
1	Albania
2	Armenia
3	Azerbaijan
4	Belarus
5	Bosnia and Herzegovina
6	Bulgaria
7	Croatia
8	Czech Republic
9	Estonia
10	Georgia
11	Hungary
12	Kazakhstan
13	Kyrgyzstan
14	Latvia
15	Lithuania
16	Montenegro
17	Moldova, Republic of
18	Poland
19	Romania
20	Russian Federation
21	Serbia
22	Slovakia
23	Slovenia
24	The Former Yugoslav Republic of Macedonia
25	Tajikistan
26	Turkey
27	Turkmenistan
28	Ukraine
29	Uzbekistan

Annex 3.2. WHO/EURO organigram



* also part of the Regional Director's Special Projects

Annex 3.3. Terms of Reference for Head of Country Office

WHO OMS

WORLD HEALTH ORGANIZATION • ORGANISATION MONDIALE DE LA SANTÉ

Vacancy Notice No: EURO/09/FT216

Title: Head of Country Office / WHO Representative (GEO, KAZ, MDA)

Grade: P5

Contract type: Fixed-term appointment

Duration of contract: Two years

Date: 14 April 2009

Deadline for application : 14 May 2009

Duty Station: Multiple duty stations

Organization unit: EURO Europe Regional Office (EU/RGO) /
EU/RDO Office of Regional Director (EU/RDO)
Operations In Countries

OBJECTIVES OF THE PROGRAMME :
The goal of WHO's country presence is to enable the entire Organization to develop a two-way collaboration by supporting a country in reaching its national health goals and contributing to global and regional public health action, and to draw on the experience of the country in building a body of public health knowledge that can benefit the rest of the world. Under the leadership of the Heads of WHO Country Offices and supported by all levels of the Organization, the WHO country office is the centre of the Secretariat's mechanism for delivering its technical cooperation.

Description of duties:
As representative of the Director General and the Regional Director/Deputy Regional Director, the Head of WHO Country Office manages WHO core functions at country level and provides leadership in the following key functional areas: Advocacy, Partnership and Representation, Policy Development and Technical Cooperation, and Administration and Management.

1. Advocacy, Partnership and Representation

- Act as an upstream policy adviser to the government by promoting an effective health dimension to social, economic, environmental and development policy through dialogue with senior government officials from the Ministry of Health and other relevant ministries and local governments, bi-lateral and multi-lateral agencies, UN organisations and other partners and advocate health as an integral part of national development and aid cooperation.
- Provide health authorities with assessments of broad political trends at the global and regional level and their implications on national health programmes.
- Keep national authorities regularly informed of resolutions of the governing bodies on health priorities, enable the country to contribute to the work of WHO and gain maximum benefit from its membership.
- Facilitate dialogue between national authorities, the donor community and other development and cooperation partners on policies and act as a convener/broker for the development and/ or strengthening of networks with government, institutions, non-governmental organizations, professional associations, the external partners and other health actors to mobilize support and resources for priority health needs.
- Promote coordination amongst health development partners under the leadership of the Ministry of Health (MOH) in line with the Paris Declaration on Aid effectiveness.
- Lead the public health agenda within the UN country team and ensure that the UNDAF reflects the national health situation and priorities and that the needs for cooperation and coherent assistance are addressed by the UN System.
- Promote WHO activities and information on global health trends through the national public information media.

- Foster and inform the contribution made by the country towards WHO in developing the global and regional public health agendas and actions.

2. Policy Development and Technical Cooperation

- Catalyse policy development through informed social and health policy options and technical cooperation in ways that stimulate action and help to build sustainable national health systems and capacity in the health sector.
- Facilitate the development or update of the Country strategic health needs report and priorities for WHO collaboration with the participation of the Regional Office (RO) and Headquarters (HQ), ensuring its alignment with national priorities and harmonization with health development partners; co-ordinate the CCS management and implementation process of country programme based on CCS, within the MTSP framework.
- Mobilize expertise from all levels of the Organization (RO and HQ) to provide appropriate and coherent technical and programmatic support to the country based on the CCS strategic agenda.
- Perform and keep an updated situational analysis and assessment of health needs and resources; suggest and support appropriate interventions, by providing evidence-based information to national authorities, and facilitating the planning, implementation and evaluation of national health policies and systems, plans and programmes.
- Contribute to global health policy and global and regional strategy formulation and the development of norms and standards.
- Provide technical support in building national capacities for health and health systems including for disaster preparedness and response.

3. Management and Administration

- Ensure implementation of the WHO strategic objectives in the country, as outlined in the Biennial Collaborative Agreement (BCA).
- Ensure full accountability for the delivery of country expected results committed in the biennial plans.
- Ensure the optimal use of the financial, technical, logistic and human resources of the WHO country office to produce maximum impact through planning, directing and managing efficiently and effectively, including the application of policy and operational guidance from the Global and Regional levels (Resolutions of World Health Assembly, Executive Board and Regional Committee; General Programme of Work, Expert Committee Reports; Staff Regulations, Staff Rules, WHO Manual, Directives of the Director-General and Regional Director; EURO's country strategy; Biennial Collaborative Agreement with the Country; Country Strategic Health Needs and Priorities for WHO collaboration).
- Promote team work and harmonious staff relations; apply various methods and resources for development of staff competencies and skills, in accordance with requirements identified through CCS.
- Develop and monitor the Country Office (CO) and staff work plans.
- Serve as a member of the UN security management team. Follow/apply guidance to ensure the safety and security of personnel employed by WHO at the duty station and their eligible dependants and for the implementation of the security plan.
- Establish contingency and business continuity plans and ensure that all staff is knowledgeable and trained accordingly. Ensure that the country office and its operations are MOSS compliant.

REQUIRED QUALIFICATIONS

Education:
Advanced university degree in health systems, health-related or social sciences with a post-graduate qualification in public health or health systems field.

Skills:

- Knowledge of WHO and/or UN programmes and policies;
- Proven skills in strategic planning, organization, coordination and management;
- Proven skills in providing leadership in a complex environment;
- Skills in teamworking as both leader of a team (WHO) and as a member (UN Country team).
- Ability to communicate in a clear and effective way.

Competencies: see WHO Global Competencies model at http://www.who.int/employment/competencies/en/

- Promoting WHO's position in health leadership;
- Building and promoting partnerships across the Organization and beyond;
- Ensuring the effective use of resources;
- Respecting and promoting individual and cultural differences;
- Promoting innovation and organizational learning;
- Producing high-quality results and workable solutions that meet client needs.

Experience:
Progressively responsible experience at a senior level, in particular in managing complex health programmes/health systems at both national, preferably in developing countries, and international levels. Must include at least two years working experience in an Inter-Governmental organization - preferably in WHO, or another UN system organization - or in an international Non-Governmental organization.

Languages:
Very good knowledge of the English language with working knowledge of any other WHO/EURO official language (French, Russian or German).

Knowledge of other European languages an asset.

Additional Information:
Similar positions at the same grade may be filled using this vacancy notice.

WHO has an on-line recruitment system, therefore **ONLY** applications submitted on-line at www.who.int/employment/en will be accepted.

All on-line applications are automatically acknowledged. If you do not receive an e-mail within 24 hours confirming receipt of your application, you should verify your on-line profile. In case of repeated difficulties, contact by e-mail HrsRecruitment@euro.who.int indicating the vacancy **title and number** in the subject line.

A written test may be part of the initial short-listing procedure which does not preclude a written test or presentation prior to final interview.

Annual salary: (Net of tax)
USD 75,432 at single rate
USD 81,197 with primary dependants

Online applications are strongly encouraged to enable WHO to store your profile in a permanent database. Please visit WHO's e-Recruitment website at: www.who.int/employment. The system provides instructions for online application procedures.

All applicants are encouraged to apply online as soon as possible after the vacancy has been posted and well before the deadline stated in the vacancy announcement.

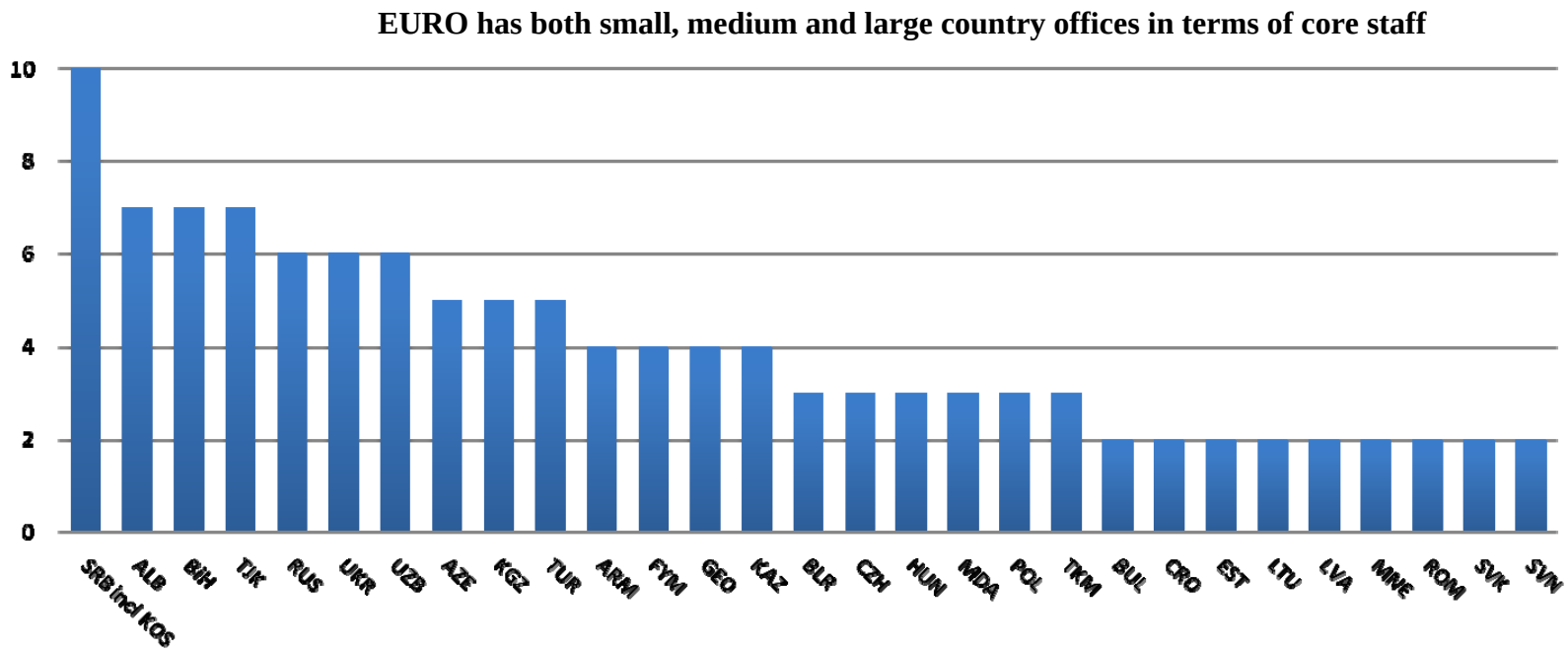
Applications from women and from nationals of non- and under-represented member states are particularly encouraged.

Any appointment/extension of appointment is subject to WHO Staff Regulations, Staff Rules and Manual. Only candidates under serious consideration will be contacted.

Currently accepting applications

WHO has a smoke-free environment and does not recruit smokers or other tobacco users.

Annex 3.4. Overview of CO core staff



Average No of core staff per CO is 4
9 offices with 2 core staff (BUL, CRO, EST, LTU, LVA, MNE, ROM, SVK, SVN)
10 offices with 3-4 core staff (ARM, BLR, CZH, GEO, HUN, KAZ, MDA, MKD, POL, TKM)
10 offices with 5-10 core staff (AZE, ALB, BiH, KGZ, RUS, SRB incl. KOS, TJK, TUR, UKR, UZB)

Annex 3.5. CO staff strength and budget implications

Out of 29 Country offices, 8 have no other presence than core

	CORE STAFF		TECHNICAL STAFF	
Country Office	No of staff	Cost of staff	No of staff	Cost of staff
ALB	7	$732,000	11	$1,316,000
ARM	4	$210,000	4	$312,000
AZE	6	$314,000	5	$636,000
BiH	7	$742,000	1	$106,000
BLR	3	$136,000	2	$136,000
BUL	2	$182,000		
CRO	2	$272,000		
CZH	3	$348,000		
EST	2	$234,000	1	$120,000
FYM	4	$386,000	3	$372,000
GEO	4	$238,000	7	$1,050,000
HUN	2	$310,000	1	$146,000
KAZ	4	$186,000	4	$421,000
KGZ	5	$192,000	4	$224,000
LTU	2	$152,000		
LVA	2	$146,000		$5,740
MDA	3	$93,000	3	$210,000
MNE	2	$155,000		
POL	3	$390,000	1	$308,500
ROM	2	$190,000	1	$122,000
RUS	6	$1,288,000	25	$3,966,000
SRB	10	$1,286,000	6	$1,056,000
SVK	2	$324,000		
SVN	2	$208,000		
TJK	7	$890,000	10	$1,162,000
TKM	3	$120,000		
TUR	5	$1,206,000	1	$310,000
UKR	6	$600,000	17	$1,984,000
UZB	6	$494,000	14	$1,304,000
Grand Total	116	$12,024,000	121	$ 15,267,240

Annex 3.6. Staffing situation in country offices in 2008-2009

Staffing situation in country offices in 2008-2009: approved HR plan vs. actual staffing

Table 3.1	Approved HR plan 2008-2009				Actual staffing in country offices 2008-2009							
					as of 31 December 2008				as of 31 December 2009			
	P-int	NPO	GS staff	TOTAL	P-int	NPO	GS staff	TOTAL	P-int	NPO	GS staff	TOTAL
ALB	5	6	13	24	1	3	9	13	3	5	9	17
ARM	2	6	5	13		5	3	8		5	3	8
AZE	2	7	5	14		6	5	11		6	5	11
BiH	3	4	6	13	1	2	5	8	1	2	4	7
BLR	1	5	2	8		3	2	5		3	2	5
BUL	1	2	2	5		1	1	2		1	1	2
CRO	1	2	1	4		1	1	2		1	1	2
CZH	1	2	1	4		1	2	3		2	1	3
EST		3	1	4		2	1	3		1	1	2
FYM	2	5	4	11		4	3	7		4	3	7
GEO	3	6	6	15	1	5	5	11	1	5	4	10
HUN		3	1	4		2	1	3		2	2	4
KAZ	4	6	4	14	1	2	4	7		3	5	8
KGZ	3	8	4	15	1	5	4	10	1	5	5	11
LTU	2	2	2	6		1	1	2		1	1	2
LVA	1	3	1	5		1	1	2		2	1	3
MDA	2	6	3	11		3	2	5		4	2	6
MNE	1	1	2	4		1	1	2		1	1	2
POL	4	2	2	8		3	1	4		3	3	6
ROM	1	4	1	6		2	1	3		2		2
RUS	13	22	20	55	7	14	16	37	6	12	13	31
SRB	6	8	9	23	1	4	7	12	3	5	8	16
SVK	1	2	1	4		1	1	2		1	1	2
SVN		2	1	3		1	1	2		1	1	2
TJK	7	13	10	30	6	7	7	20	6	5	7	18
TKM	1	4	2	7		1	2	3		1	2	3
TUR	7	5	5	17		3	4	7	1	2	3	6
UKR	5	16	13	34	3	12	11	26	3	12	10	25
UZB	4	10	10	24	3	7	8	18	3	7	9	19
TOTAL	**83**	**165**	**137**	**385**	**25**	**103**	**110**	**238**	**28**	**104**	**108**	**240**

Annex 3.7. BCA template

Biennial Collaborative Agreement
(BCA)

between

the Ministry of Health of XXX

and

the Regional Office for Europe
of the World Health Organization

2010/2011

Signed by:

For the Ministry of Health

_____ _____

Signature Date

_____ Minister of Health

Name **Title**

For the WHO Regional Office for Europe

_____ _____

Signature **Date**

_____ Regional Director

Name **Title**

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Introduction

Terms of Collaboration

PART 1. Medium-term priorities for collaboration for 2008-2013

PART 2. Biennial Collaborative Agreement for 2010–2011

1. Priorities
2. Budget
3. Commitments of WHO and of the Government
    1. Commitments of WHO
    2. Commitments of the Government

PART 3. Summary of expected results and products by priority areas

Introduction

This document constitutes the Biennial Collaborative Agreement (BCA) between the World Health Organization Regional Office for Europe and the Government for the biennium 2010–2011.

This 2010-11 BCA is part of a provisional Medium-term framework for collaboration between the WHO Regional Office for Europe and the Government for the six-year period 2008–2013, which corresponds to the period covered by the WHO Medium term strategic plan (MTSP 2008–2013).

Achieving the objectives of the current BCA is the responsibility of both the WHO Secretariat and the Government.

This framework for collaboration has been elaborated through successive steps of negotiation involving the national health authorities and WHO.

The medium term priorities for collaboration 2008-2013, as agreed by the national health authorities and WHO and specified in Part 1 of the 2008-09 BCA, were taken as the starting point for the process leading to the present document. The WHO Secretariat then formulated *priorities for collaboration* for 2010-11 with the national health authorities that also take into account the Organization's global priorities and policy directions, a strategic assessment of the country's needs and contributions in the country by other partners, as well as WHO's own capacities.

The document is structured as follows:

1. The first part sets out the *medium-term priorities and objectives for collaboration* for the six-year period 2008–2013, to be achieved through the joint efforts of the Government and WHO.
2. The second part focuses on the biennium 2010–2011. For each biennial priority, the WHO Secretariat has defined one or more *country expected results* (CER) to be achieved during 2010–2011. At the end of this section, there is a statement of the total estimated budget for the BCA.
3. The third part of the BCA is in the form of a table. Under each Priority is a table showing the associated country expected results, and next to each of these is the list of products (one or more) associated with the CER that will be delivered through the collaboration of the WHO Regional Office for Europe. Finally, reflecting the paper presented at the fifty-fifth session of the WHO regional Committee for Europe (document EUR/RC55/9 Rev.1, "Next phase of the WHO Regional Office for Europe's Country Strategy: Strengthening health systems"), each product is categorized according to one or more health system functions, i.e.:
    - Health policy and other stewardship and governance elements (ST)
    - Heath system financing function (FN)
    - Health system resource generation function (RG)
    - Health services delivery function (SD)

Terms of Collaboration

The *Medium-term priorities (part 1)* provide a provisional framework for collaboration for 2008–2013. The medium-term exercise is a rolling process, and the medium-term priorities may be revised every two years by mutual agreement, where prevailing circumstances indicate a need for change.

The Biennial Collaborative Agreement for 2010–2011, presented in part 2 and detailed in part 3, may be amended by mutual agreement in writing between the WHO Regional Office for Europe and the country as a result of, for instance, changes in the country's health situation, changes in the country capacity to implement the agreed activities, specific needs emerging during the biennium, or changes in the Regional Office's capacity to implement the agreed activities, or in the light of increased funding. Either party may initiate amendments.

After the *Biennial Collaborative Agreement* is signed, a detailed *country programme workplan* will be developed for the biennium. For each expected result, the workplan will specify the necessary details about activities or services, budgets, indicators of the objective of each CER (with baseline and target values), the WHO officer responsible, the country counterpart (where relevant), milestones and the implementation schedule. Implementation will start at the beginning of the biennium 2010–2011. Overall coordination and management of the country programme is the responsibility of the Head of the WHO Country Office.

WHO budget allocation for a biennium indicates estimated resources that will be used for achieving CERs predominantly at country level, coming from both the WHO assessed contributions and from any other source. The value of WHO staff input to the BCAs is not reflected in these estimates, and hence the figures greatly understate the real value of the support to be provided. The funds included in this BCA are the Organization's funds allocated for the Regional Office's cooperation with the country. Implementation of the country programme workplan is the only way to mobilize these funds.

It should also be noted that this Biennial Collaborative Agreement is open to further development and contributions from other sources, to supplement existing shared objectives or to introduce activities that have not been included at this stage owing to a lack of funding. In particular, the WHO Regional Office for Europe will facilitate coordination with WHO headquarters, in order to maximize the effectiveness of country interventions in the spirit of the "One WHO" principle.

PART 1. Medium-term priorities for collaboration for 2008-2013

The following priorities for collaboration have been selected in response to current public health concerns and ongoing national efforts to improve the performance of the health system. Setting medium-term priorities for 2008–2013 will facilitate the strategic orientation of collaboration.

1. PRIORITY 1:

- *Objective 1:*
- *Objective 2:*
- *Objective 3:*
- *Objective 4:*

PRIORITY 2: BUILDING UP THE CAPACITIES FOR ADDRESSING MAIN HEALTH PROBLEMS AND ACHIEVING EALTH GAINS IN IMPORTANT PUBLIC HEALTH AREAS

- *Objective 1:*
- *Objective 2:*
- *Objective 3:*
- *Objective 4:*

PART 2. Biennial Collaborative Agreement for 2010–2011

1. Priorities and Country Expected Results

PRIORITY 1:

-

PRIORITY 2:

-

2. Budget

The total estimated budget amounts to US$ XXX. WHO will continue to support the above priority areas with additional sources of funding, should they be made available. Such information will be presented as an annex to this agreement and will be updated on a continuous basis throughout the biennium to reflect indicative figures for such additional support.

3. Commitments of WHO and of the Government

1. Commitments of WHO

WHO agrees to provide, subject to the availability of funds and its rules and regulations, the above programme activities and inputs. Separate agreements will be concluded for any local cost subsidy or direct financial cooperation inputs at the time of execution.

2. Commitments of the Government

The Government shall provide all personnel, materials, supplies, equipment and local expenses necessary for the technical cooperation. The Government is encouraged to supplement funding for the above activities through fundraising.

PART 3. Summary of expected results and products by priority areas

Priority 1:

Country Expected Results	Products	Health System Functional Domain (stewardship – ST, finance – FN, resource generation – RG, service delivery – SD)			
		ST	FN	RG	SD

Priority 2:

Country Expected Results	Products	Health System Functional Domain (stewardship – ST, finance – FN, resource generation – RG, service delivery – SD)			
		ST	FN	RG	SD

Priority 3:

Country Expected Results	Products	Health System Functional Domain (stewardship – ST, finance – FN, resource generation – RG, service delivery – SD)			
		ST	FN	RG	SD

Management and coordination of BCA implementation

Country Expected Results	Products
Strengthened country programme coordination	***Recommendations on further strengthening of partnership and coordination with key stakeholders at country level, including UN common activities***
	WHO policies promoted at country level (including World Health Days)
	WHO country operations implemented as per workplan and adequate response provided to unforeseen country needs

LIST OF ABBREVIATIONS

General abbreviations

BCA – Biennial Collaborative Agreement
CER – Country Expected Result
FN – Health system financing function
HQ – World Health Organization headquarters
MTSP – WHO Medium Term Strategic Plan
RG – Health system resource generation function
SD – Health service delivery function
ST – Health policy and stewardship function
WHO-EURO – World Health Organization Regional Office for Europe

Technical abbreviations

MDG – Millennium Development Goals
PHC – Primary health care

Annex 3.8. BCA budgets

BCA 2008-09 Implementation Rate after end of biennium

Country	Amount of signed BCA, $000	Planned Cost as was in AMS after Feb09 review, $000	Planned Cost end bnm as in AMS ($000) PC	Planned Cost difference %	Working Budget (=available funds) as in AMS ($000)			Gap, $000 (PC-WB)	Gap % (PC-WB)/PC
					AC	VC	Total		
ALB	1,750	2,509	3,186	21%	96	1,997	2,093	1,093	**34%**
ARM	1,700	1,569	1,430	-10%	575	844	1,419	11	**1%**
AZE	2,200	1,368	1,534	11%	498	1,025	1,523	11	**1%**
BIH	1,600	1,461	969	-51%	328	764	1,092	-123	**-13%**
BLR	1,975	1,264	1,139	-11%	189	675	864	275	**24%**
BUL	700	343	223	-54%	95	60	155	68	**30%**
CRO	975	533	493	-8%	377	3	380	113	**23%**
CZH	500	206	180	-14%	114	21	135	45	**25%**
EST	400	312	372	16%	179	177	356	16	**4%**
FYM	1,375	730	647	-13%	222	421	643	4	**1%**
GEO	1,900	1,460	1,508	3%	279	1,087	1,366	142	**9%**
HUN	550	398	378	-5%	343	31	374	4	**1%**
KAZ	2,050	1,495	1,567	5%	373	1,184	1,557	10	**1%**
KGZ	2,793	2,485	2,510	1%	390	1,978	2,368	142	**6%**
LTU	450	470	423	-11%	69	280	349	74	**17%**
LVA	450	331	309	-7%	116	166	282	27	**9%**
MAT	250	106	93	-14%	57	27	84	9	**10%**
MDA	1,800	1,462	1,150	-27%	630	489	1,119	31	**3%**
MNE	750	220	195	-13%	112	69	181	14	**7%**
POL	1,585	897	940	5%	287	547	834	106	**11%**
ROM	1,050	1,043	885	-18%	216	336	552	333	**38%**
RUS	6,750	8,320	8,979	7%	150	6,826	6,976	2,003	**22%**
SRB	1,475	717	714	0%	197	402	599	115	**16%**
SVK	525	421	429	2%	308	75	383	46	**11%**
SVN	300	263	269	2%	134	135	269	0	**0%**
TJK	3,000	4,323	5,554	22%	464	4,565	5,029	525	**9%**
TKM	2,075	774	888	13%	463	365	828	60	**7%**
TUR	4,850	3,799	2,712	-40%	433	2,199	2,632	80	**3%**
UKR	3,800	2,089	3,827	45%	460	3,024	3,484	343	**9%**
UZB	4,100	2,640	1,922	-37%	606	870	1,476	446	**23%**
Totals:	**53,678**	**44,008**	**45,425**	**3.12%**	**8,760**	**30,642**	**39,402**	**6,023**	**14%**

Annex 3.9. Delegation of Authority

ANNEX I
Principles of delegation of authority to Heads of Country Offices

Further to the Programme Managers' meetings, the meetings of the DRD with the Heads of Country Offices, where the new rules for the financial management of country workplans to be put in place were discussed, and in line with the recommendations of the Global WR/HCO meeting, please find below the basic principles for operationalising the above as of 15 February 2008. DAF will provide further detailed financial instructions and administrative guidelines in the coming weeks, and the new rules will be accordingly incorporated into the EURO Handbook and made available on the intranet in the very near future.

The process of operational planning for Strategic Objectives (SO) is now being completed, including country work and intercountry work components. Once the country workplans have been approved, the Heads of the WHO Country Office (HCOs) will become the budget holders for all funds and activities related to their respective country workplans, including Biennial Collaborative Agreements (BCAs) and Country Office running costs.

The above means that:

- In the capacity of budget holder responsible for all activities in the country workplan, HCOs are being given the authority to manage resources in accordance with the workplan and their priority setting, following performance objectives linked to the effective and timely delivery of high-quality products. It is the responsibility of HCOs to ensure that high quality products and services are provided as planned, for which HCO will collaborate with all staff involved in the service production process.

- Whenever Other Sources (OS) are being committed for delivery of any specific activity and/or product, HCOs will bear in mind the contractual obligation of the respective Donor agreement.

- It will be the joint responsibility of HCOs and technical service production Divisions (DHP and DCS) to ensure mobilization of resources for the delivery of expected results. It will be the responsibility of HCOs to make contact with technical Units requesting them to fundraise for delivery of results in the area of their respective SO. Similarly, HCOs will also be expected to seek local opportunities for fundraising for such activities.

- Performance monitoring for both technical Units and Country Offices will be based on respective workplan delivery and key performance indicators, irrespective of budget holding responsibility.

- Based on such monitoring and in case of poor performance, measures may be considered to transfer the budget holder responsibility (from the Country Office or, more generally, from any other budget centre across the entire EURO) to a designated entity within the Regional Office without disturbing the implementation of work.

Annex 3.10. Description of SRC unit

April 2010

Regional Director's Cabinet
Strategic Relations with Member States in the WHO European Region

Overall vision of Strategic Relations with Member States

Strategic relations with all Member States in the WHO European Region are important to address the public health priorities identified by the WHO Regional Office within countries. Through Country Offices (COS), WHO Euro ensures tailor-made assistance is provided by bringing country realities and needs to the attention of the WHO Regional Office, while at the same time providing a liaison channel through which the technical assistance can be delivered, when and as appropriate.

To ensure improvement of public health within the Member States, country work of WHO Euro must be well coordinated. It needs to follow the policy directions set by RD, her cabinet and the executive committee (EXC), and it makes best use of the technical capacity available in the Technical Divisions, while taking into account the needs and capacities of the Member States. Till now, this coordination was the responsibility of Strategic Desk Officers (SDOs) who took responsibility for one or two Member States and carried out Country Health Needs Assessments over and above their normal technical duties. The Country Work Help Desk (CHD) was responsible for translating these needs into activities which were documented through Biannual Collaborative Agreements signed between WHO Regional Director and Minister of Health of the Member State

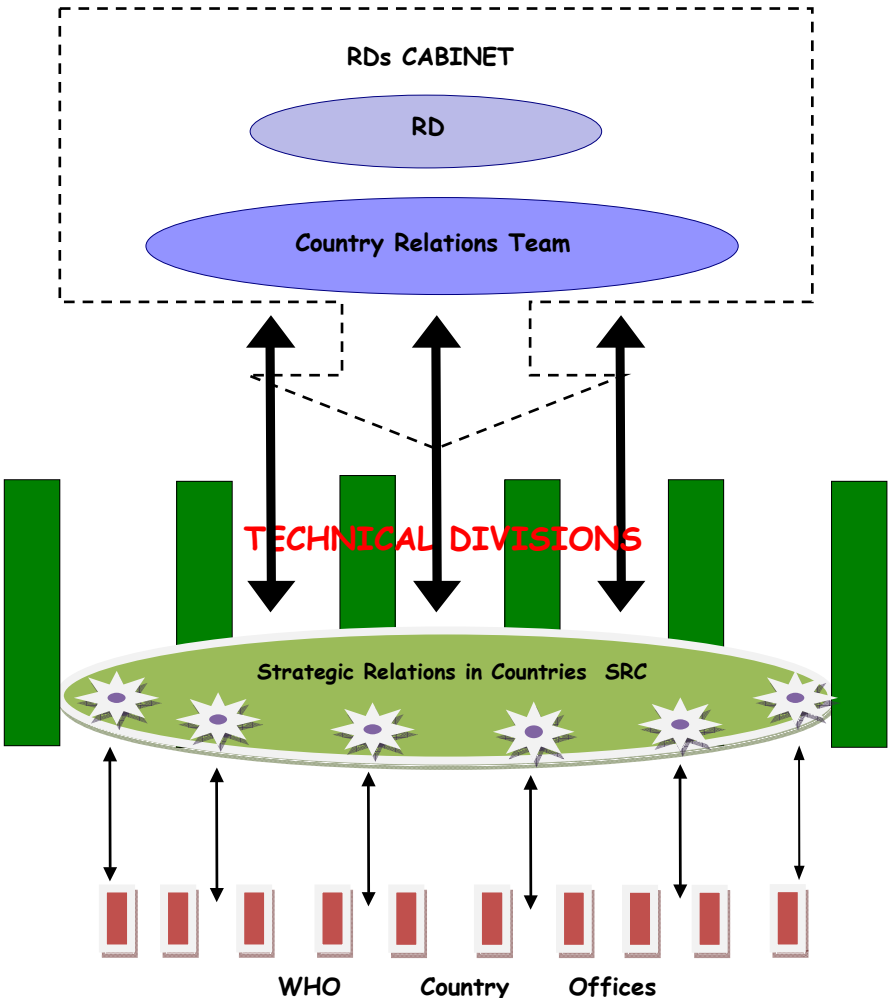
Structural reorganization of this overall planning procedure that results in effective public health improvements in countries is necessary. CHD functions need to align the country work provided by the Technical Divisions to the new visions and strategic directions of the Regional Office and this can only be done by more comprehensive and well-coordinated SDO functions within the Technical Divisions. Rather than having one SDO per Member State who assesses, plans, monitors and evaluates one Member State on a part time basis, it is proposed that full time SDOs become responsible for groups of Member States on a full time basis and align the needs of the Member States to the new Regional Office priorities on a daily basis. Moreover, by being placed within Technical Divisions, the SDOs take responsibility for that particular technical priority and can help to continuously assist Technical Divisions to plan, implement, coordinate, monitor and evaluate the country work required.

The result is the mobilization of appropriate technical assistance in a timely manner to the Member States most in need of that particular assistance

Overall institutional framework of Strategic Relations with Countries (SRC)

To be more effective, SDOs will work in small groups (so at least 3 staff in each division?within the Technical Division they serve. With the Directors of the Divisions as their first level supervisors, these teams of three persons each are responsible for liaising with the COs with which they have activities.

Interaction, regular coordination and flow of information between these divisional teams of SDOs is important to ensure appropriate country relations with all Member States of the WHO European Region. Hence these teams come together in a matrix fashion unit know as Strategic Relations with Countries (SRC) replacing the unit previously known as Country Work Help Desk (CHD). SRC is managed on a day to day basis by the Country Relations Team (CRC) in the Regional Director's Cabinet and the head of CRC is the second level superviser.



The diagram above describes this new structure of WHO-EURO

SRC will continue the work of the CHD i.e. it will continue to ensure support is provided by WHO EURO technical units to countries through capacity building, technical assistance and evidence based advice. However the main focus of the country work will be to assist countries to drive their own health actions, health policies and manage their own health systems. SRC will take on a more strategic function than originally performed by CHD by assuming the functions of the SDOs as full time responsibilities. The Terms of Reference of SRC are also broader as the strategic function goes beyond implementation of the EURO's work plans for

the biennium (i.e. the BCAs) and also includes country work and relations with EU Member States. To minimize the health divide between the western and eastern parts of the Region, Country Cooperation Strategies and Country Health Needs Assessments will be explored as ways of working throughout the region.

CRC will continue to ensure a two way and direct channel between the RD and the SDOs in the Divisions, who similarly maintain a two way channel with the COs. First level supervisors of SRC staff are the Divisional Directors while second level is Head of CRC

Mission statement of the Country Relations Team (CRC)

The Country Relations and Communication Team (CRC) works closely with the Member states in preventing and overcoming threats to health. The main objective is to advocate for improvements in public health, working with them to identify and prioritize the needs and capacities in a way that they is most appropriate to their needs, culture and capacities

Objectives of the Country Relations (CRC) team

The CRC team advises the Regional Office on its strategy for relations and cooperation with all 53 Member States. The main objectives of CRC are

- To develop a country relations strategy in line with the Regional Director's vision following up on the recommendations made by the Working Group reviewing WHO's work with countries (RWGCo). This strategy is to be presented to Regional Committee 61.
- To further build relations with EU Member States by proposing ways how WHO Euro can have added value in these countries.
- To regularly provide advice and support to the Regional Director on country relations, country emergencies and country needs.
- To oversee and managefor the activities of Strategic Relations with Countries Unit (SRC) and WHO Country Offices (COs).
- To work closely with the PAR team to ensure development of strategic partnerships at country level to the benefit of the WHO country offices and the Member States.
- To liaise with the Planning, Evaluation and Resource Mobilization Unit in identifying potential partnerships with donors and donor agencies
- To establish cross-divisional collaboration to support the effective country work in WHO Euro

Mission statement of the Strategic Relations with Countries Team (SRC)

Strategic Relations with Countries Team (SRC) as part of CRC, helps to ensure that the Member States can develop and sustain their own health policies, health systems and public health programmes by identifying needs and technical assistance that can ensure evidence based action by the Member States

Objectives of the Strategic Relations with Countries (SRC) team

The SRC team is responsible for the in-house coordination of country work and will apply the following instruments: Country Health Needs Assessments, Country Cooperation Strategies and Biannual Collaborative Agreements(BCA). Inside WHO EURO, SRC identifies the overall policy picture of each Member State through a strategic analysis of the health situation in the country and a needs appraisal. This may lead to a Country Cooperation Strategy that ensures drafting a plan of action for that particular Member State and that can be reflected in a BCAs.
It facilitates the provision of products and services by Technical Divisions in accordance with the needs and capacities of each Member State identified through SDOs.

The main objectives of SRC include:

- To facilitate, support and contribute to the coordination of all country activities undertaken by the technical units
- To support the WHO Regional Office for Europe in strengthening WHO Euro's existing relations with Member States by liaising regularly with the ministries of health directly or through country offices.
- To assist WHO Regional Office with the preparation and management of major special policy and technical events in the countries as required
- To ensure the quality and impact of the work of WHO EURO in the countries by ensuring consistency in WHO's vision and by eliminating overlaps and redundancies overlaps in the work of technical programmes in countries
- To ensure the development and support the implementation of the country cooperation strategies.

Staffing

A well staffed and resourced SRC team complemented by staff in CRC in RD's cabinet and staff in Country Offices will ensure implementation of the planned objectives.

CRC Team	
Grade	Title
P6	Head (ToR drafted – post to be established and advertised)
P3	Technical Officer EU countries (ToR to be adjusted – person to be moved from PCO but without post)
C4 /C5	Programme Assistant (Temporary Post exists but will expire in June. Person in place is in RDO and very good and should be kept to continue to assist this team)
SRC Team	
Grade	Title
FOR EACH DIVISION, the following will be required:	
P5	SDO (all four to be advertised – mainly to be filled by returning HCOs)
P2/3	Asst SDO (already exist in CHD)
C4/5	Two SDO assistants (one post exists and one to be shifted from PCO)

Annex 4.1. Draft report on the desk review

The desk review was conducted according to the methodology defined in Terms of reference (TOR) of the Working Group to Review Work of WHO Regional Office in the Countries (RWGCo) (*1, see numbered reference documents at the end of the report*). During the review it was found that all available documents can be grouped as those related to the country offices and operations, and those related to the development and implementation of country strategy. The extracted relevant information summary presented in Attachment 1(summary of country offices' related documents) and Attachment 2 (summary of country strategy related documents) as background information.

The review of country offices related documents revealed that WHO Euro continuously tried to align its work with country needs and National health plans. The goal of WHO's country presence is to enable the entire Organization to develop a two- way collaboration by supporting a country in reaching its national health goals and contributing to global and regional public health action, and to draw on the experience of the country in building a body of public health knowledge that can benefit the rest of the world. To ease reaching the stated goal, the countries of the region are grouped into functional groups. This grouping is flexible, recognises the diversity of the WHO Members states, and at the same time groups the countries according to the similarities, strengths and development phase and challenges. Currently there are 53 Member states in WHO region with 29 country offices (2, 3, 4, 5). The average size of country office is 11 staff members (varying from 43-Russia to 2- Bulgaria, Croatia, Czech Republic, Lithuania, Montenegro, Slovakia and Slovenia), the average budget size for BCA is 1,050,552 USD (varying from 7,410,000 USD – Russia to 120,000 USD - Turkmenistan) (6).

There are general guidelines of working with WHO country offices, which were developed based on recommendations made in 3rd Global Meeting of WHO representatives and Liaison officers in November 2003. The guidelines clearly define how the COs should work with the WHO EURO and country officials and aim to enhance coordination and communication in WHO to support Member states (9).

The roles and the responsibilities of Heads of country offices (HWCO) are well described in corresponding TOR, EURO's policy in Management in the WHO country offices and memorandum which was developed after adoption of new country strategy (7, 8, 11).

Also, the report of Heads of WHO Country Offices Survey was available for the review. According to the results of the survey, the HWCOs identified some areas, which need to be strengthened, to improve the work of HWCOs in general (12).

The definition of country offices' reporting types and periodicity exist and are presented in corresponding memorandum. This memorandum was developed in 2004, as reporting was an important area for improving the work of Division of Country support and the Regional director recognised reporting as one of 11 priorities of working with countries in following years. Besides the timeline and report types, the memorandum also defines the ownership, format and the structure of the reports (10).

However, no indication on review, analysis, interpretation of those reports presented by the countries and any respective interventions found, as appears that those reports provided high volume of information that could not be utilised by RO.

All structural and managerial changes that occur after adoption of the new country policy were defined in a EURO memorandum, which was distributed to all EURO staff. This memorandum defines the TORs for the Heads of Units in WHO EURO Regional Office and HWCOs, reporting lines in the new structure and management of Geographically Dispersed offices (GDOs) (11, 13). Along with that memorandum there is an administrative circular on budgetary and financial management of country work plans which was distributed to all staff of the region. This circular clearly defines the procedures for budgetary management, and the responsibilities of staff with regards to budget management (14).

The guidelines for WHO EURO country work and summary procedures also exist, and are well articulated (15, 16).

Overall, there are a number of guidelines, policies and memoranda that were developed by the regional office and distributed to staff, and clearly define how the country offices work should be organised across WHO EURO. However, the other side of the collaboration- the effectiveness of work of country offices is not evaluated, at least no indication of any such process was found in documents under review. The only documents that speak about the work in country are BCAs (available for the review). Yet, there are no documents which would present any problems reported by countries, any interventions developed based on reports from countries or any analysis of that reports.

Some results of country work might be found in biennial reports of Regional Director/s. These are descriptive reports, which describe the summary of preceding 2 years of the work of Regional office with countries, with examples from the countries and the implemented interventions and explaining how the work of WHO responded to the challenges or reached previously announced targets (17, 18, 19, 20).

The review of country strategy related documents showed the history of the development of Country strategy. A number of documents describe how and why new country strategy was developed after implementation of EUROHEALTH strategy in region (17, 21, 22). The review of these documents showed that the regional office was consistent in reaching the goal of WHO presence in the country, and always paid an attention to the problems/challenges identified during the reviews of implementation of the country strategy (22, 23, 24, 25, 26, 27, 28, 29). The review also revealed that adoption of the new country strategy was accompanied with development and distribution of a number of guidelines, administrative circulars and memoranda, which define structural changes, reporting lines, roles and responsibilities of staff concerned (10, 11, 13, 14, 15, 23).

Overall, the review of country strategy related documents revealed, that the regional office paid attention to coordination of the work in the region, to having an effective and workable country strategy, and put more emphasis on countries.

The current direction of country strategy could be defined as function based structure of WHO EURO, and country focused (also reflecting priority areas defined by WHO) strategy which aims to strengthen the health systems of the countries (25, 26).

In summary, the desk review of documents revealed, that there is a country strategy, which sets direction for work of WHO in and with countries, and there are guidelines and all relevant documentation which describe the roles and responsibilities of all participants of country work.

What is lacking the evidence of any feedback from countries on the work done, or examples of use of reports from country offices (the only small evidence can be noticed in biennial reports of regional director).

It was not clear from the reviewed documents if the local partners of WHO CO (Ministry of Health, UN agencies, NGOs, other partners) regularly evaluate the work of COs, the quality of assistance provided, and if at all this kind of evaluation was regularly requested from the countries (this is a usual procedure for quality assurance in general).

Human resources have been continuously deployed to COs.

There are 70 National professional officers in 29 country offices. Their biennial salary range is quite large, varying from 60,000 USD to 280,000 USD. He crude average biennial salary is 112,400 USD.

There are 25 Heads of country offices and 4 WHO representatives, with biennial salary ranging from 64,000 USD to 552,000 USD (HCO Russia, grade D1).

There are 101 administrative workers in 29 offices: drivers/clerks; program, administrative, financial, IT assistants; secretaries. Their biennial salary ranges from 16,000 USD to 332,000 USD (administrative officer in Russia, grade P3).

There are 5 program coordinators and 22 technical officers in 29 COs.

In general, the salary level depends on the grade. However, within the same grade the salary also varies. There were no documents for review explaining grading system and rationale for salary levels, and variations within the same grade. Based on review of provided documents it is difficult to assess the rationale for each CO size and effectiveness, efficiency of work done by them.

It is clear that by weakening the technical capacities of RO, more attempts have been made to strengthen COs' relaying on institution of NPOs, however no indication or evidence on justification of need for NPOs were found.

It is suggested that based on results of review of COs new country strategy has to address the issue of optimal balance of resources distribution across the region. This is the key issue as interests of all role players have to be considered.

References

1. Terms of reference, Working Group to Review Work of WHO Regional Office in the Countries
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3. Proposed function grouping of countries Nov 09
4. Revised working Groups 26April
5. Revised Proposed Groups 26April 1
6. Country offices info

7. EURO's policy in Management in the WHO country offices
8. ToR Head Country Office
9. Memo_10 July 2007_Guidelines for working with WHO CO
10. Memo_19 Nov 2004_Regular reporting from country offices
11. Memo_15 Feb 2008_Changes in Managerial lines in the WHO Regional office for Europe
12. Heads of WHO Country Offices Survey Report
13. DCS memo on Unit reorganization and working arrangements
14. Admin circular_26 March 2008_Budgetary and financial management of country work plans
15. 2003_WHO EURO Country work management system, Guidelines for country work
16. 2005_WHO EURO Summary Procedures for Country Work
17. EUR/RC52/4 Biennial report of RD 2000-2001
18. EUR/RC54/6 Biennial report of RD 2002-2003
19. EUR/RC56/4 Biennial report of RD 2004-2005
20. EUR/RC58/4 Biennial report of RD 2006-2007
21. EUR/RC50/4 External evaluation of EUROHEALTH programme
22. EUR/RC50/10 The WHO Regional Office for Europe's Country strategy "Matching services to new needs"
23. Terms of reference for the desk officers in the countries policies and systems unit, division of country support
24. EUR/RC53/10 Progress report on implementation of the WHO Regional Office for Europe's Country Strategy since 2000
25. Strategic directions for improving the coordination of the Regional Office's input in countries
26. EUR/RC55/9 Next phase of country strategy - strengthening health systems
27. EUR/RC54_Progress report on implementation of country strategy
28. WHO-Europe - Resolution EUR/RC55/R8
29. Implementation of the Regional Office's Country Strategy, 2004

Annex 4.2. Report of the Regional Office review

As part of the RWGCo, Working Group members, Drs Kökeny, Melgaard and Savas have undertaken 16 interviews with 27 people in the Regional Office of WHO/EURO in Copenhagen on 20-21 September 2010.

They were asked how programmes could support country work and what kind of country arrangement would be appropriate. Working Group members also questioned the technical capacity of the Regional Office from several perspectives.

There was consensus over some points:

RO should shift from an activity/process oriented approach to content/result oriented approach. The health gain is the ultimate objective and outcome for the organization and then equitable distribution of this should be the main concern. WHO should question all its activities from the perspective of 'effectivenes' and 'result orientation'. A style of management by the result should be considered to develop.

WHO/EURO should ensure a sort of country presence in each member state, based on the availability of resources. This presence might be in form of a liaison office with an NPO or representation of WHO by a national institution or a secondment from the member state or a country office or any other way. Solutions should be developed to reduce the costs to minimum level in order to shift resources to increase technical capacity of RO.

Sub-regional arrangements should be developed by grouping countries according to their geographical locations, health status, and health care systems. It may not be possible to put some of the Member States in to a specific group. For these cases special solutions need to be found, WHO/EURO may develop programmes to address the problems of these countries as groups by establishing and running networks on the priority need areas. There should be a network coordinator in one of the network countries.

The relationship of the Regional Office with the EU is important from several perspectives:

The 15 EU countries need WHO's policy development platform and promoting the basic values functions. Newly member states are in need of support to better adopt their policies in the chancing priorities in new environment. Accession countries have special needs to prepare their overall policies to be oriented towards health and also strengthen their health care policies and systems. Neighbouring countries to EU is also an issue for both WHO and EU to consider jointly to enlarge the health and safety issues in the region more effectively.

There needs to be a balanced approach between country and inter-country work. Inter-country work covers the policy development and normative functions as well as technical programmes. At this moment WHO/EURO need to increase its capacity especially on policy development and technical programmes on non communicable diseases and health care systems. RO need to mobilize financial or in kind contributions for its work in the countries. However it should be clear that WHO is not a donor agency but a technical organization to establish norms and standards and assist member states to develop policies.

WHO/EURO technical staff should work with and for countries. Therefore there should not be too many layers to contact the countries. Strategic relations with the countries are the responsibility of RD/DPM. Some liaison or coordination function with countries can be

established in the Regional Office, however any strategic function without technical content would serve only an increased bureaucracy and hampered technical cooperation.

The impression of WHO as an organization for ‘developing countries’ is wrong. Most industrialized and high income countries of the region need WHO as much as the least industrialized and low income countries.

The administrative capacity of country offices also needs strengthening, limited resources are spread thinly and the quality of country offices relates both to capacity and the quality of work. It is evident that the work of the office need more coordination horizontally (between technical programmes) and vertically (between Cos, RO and HQ).

It was agreed that more communication and PR at country level was needed. Regional Office should establish a professional capacity to communicate with the general public more directly. The role of WHO requires long term action within the countries, which may not fit the agenda of the governments of which maximum life span are 5 years. Therefore WHO should find the ways to carry its messages directly to the general public of the member states through different channels including NGOs, professional organizations, media etc.

Attachment 1. Background information on Country offices and country work

There are **53 Member states** in WHO region with **29 country offices.**

According to Country offices info (excel file) the biggest staff size is in Russia CO (43 staff members) and the smallest are Bulgaria, Croatia, Czech Republic, Lithuania, Montenegro, Slovakia and Slovenia (2 staff members). On average there are 11 staff members in country offices.

The biggest budget size has Russian CO (7,410,000 USD), the smallest-Turkmenistan(120,000 USD), average budget size is 1,050,552 USD .

The **goal of WHO's country presence** is to **enable the entire Organization to develop a two- way collaboration by supporting a country in reaching its national health goals and contributing to global and regional public health action, and to draw on the experience of the country in building a body of public health knowledge that can benefit the rest of the world.**

Under the leadership of the Heads of WHO Country Offices and supported by all levels of the Organization, the WHO country office is the centre of the Secretariat's mechanism for delivering its technical cooperation.

The **Head of WHO Country Office** manages WHO core functions at country level and provides leadership in the following key functional areas:

- Advocacy, Partnership and Representation,
- Policy Development and Technical Cooperation,
- Administration and Management.

According to the EURO memorandum on management of WHO offices in WHO EURO (April 2006) the mandate of HWCO consists in acting as

- The primary WHO **focal point** in relations with the local Government
- The WHO **spokesperson** in the country
- The **custodian** of all WHO resources in the country

In managerial terms the HWCO is responsible to protect the WHO image in the country, its relations with the authorities, sister agencies and other partners. She/he is also responsible for the security of all WHO staff and visitors and for the efficient use of WHO resources. Also, the HWCO is responsible for the facilitation of the implementation of all WHO programs in the region as approved by the Regional Office.

According to the **EURO memorandum on regular reporting from country offices (November 2004)** WHO COs should produce regular reports with specific unified format on implementation of BCA related operational plan. COs should assess the effectiveness, quality and efficiency of EURO's interventions in countries. This should not be a program-related technical judgment but a **managerial relevance assessment type of analysis**. The reporting is done through Country Help Desk, where there are 5 country operation support managers.

The **reporting types are the followings:**

- Urgent issues should be reported through phone calls or e-mails
- COs may also be required to report on specific issues on exceptional basis
- Besides the mentioned 2 types of reporting the COs should report to WHO EURO on a weekly, bi-monthly, annual and bi-annual basis. All these reports have the country-specific strategic document and workplan as their reference

According to **Admin circular on budgetary and financial management of country workplans (issued in 2008),** the main responsible for the management of CO budget is the HWCO. The circular with the **Memo on Managerial changes and delegation of authority** also defines the reporting lines and budget management guidelines across the region after adoption of the new country strategy.

According to **Terms of reference for the desk officers in the countries policies and systems unit, division of country support** till the Country strategy 2000, the WHO worked with the countries **with a "top-down", topic-related segmented approach.** After adoption of Country strategy in 2000, structural changes in WHO management were done, and EURO staff started to work in a coordinated way.

The new WHO-EURO structure has the following components and functions:

(a) **two Technical Support Divisions** should produce quality service packages for countries on the basis of evidence-based knowledge;

(b) **a Division of Information, Evidence and Communication** is expected to provide evidence-based, reliable information at the service of countries as well as of the entire EURO;

(c) **a Division of Administration and Finance** should provide the infrastructure for improved management and administration in order to better service Member States.

(d) the **Division of Country Support** has been set up to tailor EURO support to the needs and wants of countries/customers. DCS is thus the main responsible unit for "packaging" support to Member States. DCS is consequently also responsible for initially developing and implementing the Management Information System for Country Work.

In support to the mentioned changes DCS memo on Unit reorganization and working arrangements was prepared, which was describing the responsibilities of the heads of the new units and managerial arrangements across WHO EURO.

Memo_10 July 2007_Guidelines for working with WHO CO aims to promote coordination and communication across 3 levels of WHO in support of WHO at country level. It also describes how the invitations to participate to WHO events and meetings should be sent to government officials, to WHO CO staff, how the visits should be organized and arranged, etc.

There are also guidelines for country work **(Country Situation analysis, health needs, 2003),** which are defining how the country health needs should be evaluated, how the priority for interventions included in BCAs should be set, etc.

The survey of Heads of Country offices was carried out in 2009.

The purpose of the survey was to:

1. provide heads of WHO country offices (HWCO) an opportunity and a forum to share their experiences and perspectives on the organizational performance of WHO in the context of public health and humanitarian emergencies;
2. inform discussions at the 5th Global Meeting of Heads of WHO Country Offices, as well as subsequent analyses, aimed at identifying HWCO-driven priorities for capacity building and enhancement of specific aspects of organizational support during 2010-2011

The survey considered **four distinct areas:**
Part 1: HWCO Profile
Part 2: HWCO Roles and Responsibilities
Part 3: Country Office Capacities/Capabilities
Part 4: Organizational Support from Regional Offices and Headquarters

Response rate was 60%.

Part 1: HWCO Profile – This part focused on gathering data on the HWCO profile in relation to the management of public health and humanitarian emergency response.

- Over three-quarters of respondents (89%) **have already managed emergency situations**
- Approximately 85% of HWCOs **have received some kind of formal training** in outbreak/emergency management/epidemic response or participated in exercises
- HWCOs stressed the **importance of further training** as well as the need to have access to the same training as those they advice (technical teams and/or their government counterpart).

Part 2: HWCO Roles and Responsibilities – This part assessed the level of comfort HWCOs feel about their roles and responsibilities (R&R) in the management of public health and humanitarian emergencies.

- HWCOs (100% of respondents) view PH and HE emergency response as **part of their core functions.**
- Most have **established communication mechanisms** between their office and the IHR National Focal Point and Humanitarian or Resident Coordinator.
- ***Only 11% feel that WHO Country Offices are always able to meet the expectations of national authorities.***
- Several key areas exist in which many HWCOs **feel uncomfortable and express a need for support**
  - » *Coordination and negotiation* of activities with external stakeholders/ partners
  - » *Resource mobilization and management*
  - » *Mass media relations and communication*

Part 3: Country Office Capacities/Capabilities- This section of the survey sought feedback on *existing capacities/capabilities that are relevant to the management of emergencies with a view to identifying priorities for capacity building in 2010-2011.*

- Most HWCOs have the capacities listed in the survey and feel “confident” or “very confident” with them.

The examples of the capacities are the followings

1.Identify/Assess

- *Support national authorities to detect outbreaks and other acute public health emergencies in a timely fashion, including surveillance, investigation, monitoring, and reporting*
- *Support national authorities to prepare for emergency response*
- *Assess the risk of emergencies in accordance with WHO's mandate under the IHR*

2.Assist/Fill gaps

- *Support national authorities in epidemiological investigation of emergencies*
- *Facilitate the timely collection, storage, packaging and transport of clinical samples to an international reference laboratory*

3.Inform/Communicate

Manage and share information about emergencies in a timely and secure fashion etc.

- HWCO **do not believe, they can do it alone**.
- HWCOs rate key areas of priority for capacity building efforts in 2010-2011 in the following order:
    1. Identify/Assess.
    2. Inform/Communicate
    3. Co-ordinate.
    4. Assist/Fill gaps.

- HWCOs listed several **recurring factors** (positive and negative) influencing their level of confidence about capacities being investigated by survey

Key Positive Factors	***Key Negative Factors***
• strong national capacity and infrastructure • goodwill of national authorities • high integration with government counterparts • support from all levels of the Organization • adequate funds and human resources • increased/consolidated presence of WHO at country level • clarity on the implementation of the health cluster approach at country level	• fragmented national systems and mechanisms • heavy workload and conflicting priorities • lack of trained staff • lack of technical guidelines in appropriate languages • multiple and sometimes conflicting agendas among key partners

Part 4: Organizational support- This section sought feedback on the overall helpfulness of existing organizational support and services with a view to identifying potential areas for improvement.

- HWCOs place a **high value on organizational support**.
- Many respondents stressed the **importance of speaking a common language and unifying processes**.
- HWCOs identified **four key areas for improvement**:
    - Timeliness
    - Mobilizing and managing resources

  - Training
  - Contingency planning

- Suggest importance of **customizing process/adapting to local realities whenever possible**
- Survey created expectations for an **enhanced working relationship/increased organizational support.**

The **survey also identified several needs**,

- **Training should be provided to HWCOs**, on a **more consistent basis**, to ensure they have access to the same information and tools as their government counterparts and technical teams.
- **Capacity building is needed** to identify and assess PHE and HE emergencies as well as to inform and communicate about risk and emergencies with a variety of media, stakeholders and groups.
- Capacity assessment and building **efforts should be extended and offered to national authorities.**
- HWCOs value current levels of organizational support but **identified four key areas for improvement** *timeliness, mobilizing and managing resources, contingency planning and training.*

The work of WHO in the European Region, 2006–2007, Biennial report of the Regional Director

The Eleventh General Programme of Work lists WHO's six core functions:
1. providing leadership on matters critical to health and engaging in partnership where joint action is needed;
2. shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;
3. setting norms and standards, and promoting and monitoring their implementation;
4. articulating ethical and evidence-based policy options;
5. providing technical support, catalysing change and building sustainable institutional capacity
6. monitoring the health situation and assessing health trends.

The **WHO Regional Office for Europe,** with **690 staff**, has its headquarters in Copenhagen, Denmark, five geographically dispersed offices (in Barcelona, Spain; Bonn, Germany; Brussels, Belgium; and Rome and Venice, Italy) and **country offices in 29 Member States** across the Region. The dispersed offices perform technical functions at the service of the whole Region on specific technical matters.

Following the route chosen in 2000, the Regional Office has gradually adapted itself and its functions to better address the needs of individual Member States' health systems and to deliver at the country level- **the work become more country specific and country priority driven.**

The **mission** of the Regional Office is **"to support Member States in developing their own health policies, health systems and public health programmes; preventing and overcoming threats to health; anticipating future challenges; and advocating public health".**

Direct country presence is a critical factor in delivering WHO support, particularly in the **countries with higher disease burdens**. The Regional Office has continued acknowledging this factor and pursuing the development of a strong country presence.

The activities of Regional Office in countries are carried out through Operations in Countries unit. The Country Work Help Desk increased in both staff and operational capacity to provide managerial coordination and support between country offices and all other units and services of the Regional Office.

The Country Work Help Desk has ***three main functions***:
1. ensuring that country offices have all the necessary tools to support and facilitate implementation of BCAs at the country level;
2. supporting Regional Office management in many aspects of country and intercountry work, especially coordination and management; and
3. providing an important outreach to health programs, as well as the Division of Administration and Finance, in the daily life of the Office.

To enhance its strategic approach, **Regional office focused its country work on health systems,** acknowledging, that strong health systems are prerequisite for sustainable improvements in population's health.

Strengthening WHO country offices

Country offices ensure smooth implementation of BCA, which is agreed and aligned both with national health plan, and with WHO agenda and are based on 4 core functions of health systems. A review of the overall human resources situation in 2006–2007 identified some imbalances in terms of staff in countries, including the insufficient presence of international staff. The Regional Office has taken measures to correct these imbalances in 2008–2009.

Table 1. Redistribution of staff in countries, by category

Staff	Staff in 2006–2007 (%)				Revisions proposed for 2008–2009 (%)			
	IPOs[a]	NPOs[b]	GS[c]	Total	IPOs	NPOs	GS	Total
Non-country based	84	0	60	60	77	0	61	56
Country based	16	100	40	40	23	100	39	44
Total	100	100	100	100	100	100	100	100

[a] IPOs: international professional officers.
[b] NPOs: national professional officers.
[c] GS: general service staff.

The Regional Office carried out capacity-development activities to strengthen the effectiveness of country office staff. These included training in communications, human resources, general management and key health-related technical areas in the Region.

Besides these, the Regional Office assists Member States in their efforts to implement the IHR by providing technical advice. It pays particular attention to helping countries develop

core capacities for surveillance and response at all levels of public health services, as well as at designated points of entry (airports, ports and border crossings).

Regional office also developed internal strategic approaches to partnership development and a framework for resource mobilization to better harmonize donors' and partners' approaches in support of country work. Another objective was increasing the country focus in partnership building and development, to enable the WHO country offices to better support Member States through mechanisms and tools developed at the regional level. The move of many WHO country offices into United Nations premises ensured a better coordinated approach to country assistance within the United Nations family.

Further, staff from the country offices, building on their wide experience of working in partnerships in countries across the Region and with support from the Regional Office, have developed tools to identify, build, maintain and evaluate partnerships at the country level.

WHO has increasingly helped facilitate Member States' access to the available other donor funding, by providing technical assistance in different stages of proposal preparation (for example for GAVI Alliance- support to 6 countries- ARM, AZE, GEO, KYRG, TAJ, UZB).

Besides that, the area of support to countries included areas of communicable diseases, MCH, emergency preparedness, health workforce, etc.

Documents reviewed

1. Country offices info
2. Policy Paper on WHO Country Presence
3. Proposed grouping for the 5th HWCOs GM 15 Oct 09
4. Work of WHO in the European Region 2006-07
5. TOR Head Country office
6. Heads of WHO Country Offices Survey Report
7. summary 2010 report
8. 2003_WHOEURO Country Situation Analysis and Strategic Plans
9. Admin circular_26 March 2008_Budgetary and financial management of country workplans
10. Memo_15 Feb 2008_Managerial changes and delegation of authority
11. EURO memorandum on regular reporting from country offices (November 2004)
12. Country Situation analysis, health needs, 2003
13. Proposed function grouping of countries Nov09
14. Terms of reference for the desk officers in the countries policies and systems unit, division of country support
15. Memo_10 July 2007_Guidelines for working with WHO CO
16. Memo_5 April 2006_Management of country offices
17. Memo_19 Nov 2004_Regular reporting from country offices
18. EUR_RC58_4 Biennial report of RD 2006-2007
19. DCS memo on Unit reorganization and working arrangements

Attachment 2. Background information on development of country strategy

As described in The WHO Regional Office for Europe's Country strategy "Matching services to new needs", starting from 1990s Regional Office for Europe adopted EUROHEALTH program, with a purpose to offer the countries a common framework for tackling the main health problems they were facing. **EUROHEALTH** also emphasized the development of national policies for health for all and the broad outlines of health system reform.
In 2000, the external evaluation of EUROHALTH was carried out (EUR_RC50_4 External evaluation of EUROHEALTH programme). It concluded that the programme "has been successful in meeting its objectives given the limited resources at its disposal and the difficult political and economic situation in the countries concerned". However, the evaluation report also draws attention to a number of weaknesses. In particular, it stresses the need for better coordination of programmes within the Regional Office, in order to increase their effectiveness on the ground. **Dispersed action and a lack of quantitative strength** were mentioned in the evaluation **as critical weaknesses of WHO in delivering services to countries.**

Based on this, Regional committee approved a **new Country Strategy, "Matching services to new needs"**, in 2000, which was more focused on country work, particularly on health systems, and health financing, and emphasizes an orientation towards country work by considering all countries in their diversity. This process is described also in EUR_RC52_4 Biennial report of RD 2000-2001.

In practice, the Country Strategy 2000 has meant:
(a) introduction of the concept of Biennial Collaborative Agreements (BCAs) with countries of central and eastern Europe, covering all the resources used in countries;
(b) establishment of the "Futures Forum" program for Member States with which WHO has no formally signed BCAs (in essence, western European countries).

The concept of a single country office that functionally integrates all of the Regional Office's interests in each country was put into effect, so that all matters related to funding and human resources (whether permanent or temporary, and including humanitarian assistance and disease-specific project teams, etc.) become the full responsibility of the country office, under the auspices of the Division of Country Support at the Regional Office. This measure was fully implemented by the end of 2003.

After adopting the Country strategy, it was decided, that strengthened country offices need strengthened human resources. To support strengthening HR of COs 3 lines of actions were implemented:

- **shifting the necessary human resources from the Regional Office** in Copenhagen to the countries concerned;
- appointing **international heads of office**; and/or
- **upgrading the skills of existing staff**, especially liaison officers.

In parallel, the post of Liaison Officer and its legal status have been upgraded in 26 countries. The successful candidates have undergone a process of training designed to equip them with the necessary knowledge and skills. The entire process of recruitment and training was completed for all 26 countries by September 2003.

Accordingly, to implement the new strategy the Regional office was reorganized. **According to** Terms of reference for the desk officers in the countries policies and systems unit, division of country support WHO EURO has been working in countries with a "top-down", topic-related segmented approach. To respond to the needs of Country strategy 2000, new organisational structure of WHO EURO was developed. The decisive factor is that the **organizational reform of EURO is based on functions** (i.e. the contribution of different parts to the organisation as a whole) instead of on "thematic areas" or "issues", such as Infectious Diseases, Environmental Health, etc. The new WHO-EURO structure has the following components and functions:

(e) **two Technical Support Divisions** should produce quality service packages for countries on the basis of evidence-based knowledge;
(f) **Division of Information, Evidence and Communication** is expected to provide evidence-based, reliable information at the service of countries as well as of the entire EURO;
(g) **Division of Administration and Finance** should provide the infrastructure for improved management and administration in order to better service Member States.
(h) **Division of Country Support (DCS)** has been set up to tailor EURO support to the needs and wants of countries/customers. DCS is thus the main responsible unit for "packaging" support to Member States. DCS is consequently also responsible for initially developing and implementing the Management Information System for Country Work (but this will indeed have to be compatible with and eventually integrated in the global Information System of the entire WHO EURO).

The DCS division comprises two units:

- the "**Operations in Countries**" (OIC) unit, consisting in turn of (a) a series of Country Presence Offices and (b) the OIC Management Support Programme, known as "*Country Work Help Desk*". The OiC unit supports the implementation-related aspects of the collaboration between the Member State and EURO. The **Aim of this unit is thus to give consistent support to countries for them to maximise the support received from EURO** by means of their own health actions, health policies and health systems. In other words, the main Function of the OiC unit is to facilitate EURO work in each Member State, including the implementation of the Action Plan for the biennium (i.e. the BCAs and the Futures Fora activities).

- the "**Country Policies, Systems and Services**" unit (CPS), consisting of two functional clusters: (a) the "Health Policy" cluster and (b) the "Health Systems and Services" cluster. The **Aim of the CPS unit is to give consistent support to countries for them to develop their own policies and systems** in a way that is consistent with the principles and values promoted by WHO and suited to each Member State needs and circumstances.

Inside EURO the main function of the **CPS unit is to provide the overall policy picture of each Member State**, to be reflected in the Action Plan for collaboration between WHO and that particular country in the coming 2-3 BCAs. Functionally wise, the CPS unit has therefore a twofold role:

- outward looking, to ensure that support to countries is "pre-packaged" in terms of policies and systems in a way that fits the Member States needs and wants;

- inward looking, to strategically integrate country aspirations and request in the work of EURO so that EURO is able to refine its support to Member States.

Each person working in the above unit, be it in the Health Policy cluster or in the Health Systems and Services cluster would also be working as a "**desk officer" for one or a group of countries, thus providing a deeper insight in the policy and strategy developments at country level.**

In 2002, the Director-General announced the launch of the **"Country Focus Initiative" (CFI).** The aim of this initiative is for WHO to massively scale up its health and development work by improving its performance at country level.

The CFI focused on the following 3 areas:

- strengthening the role of WHO country offices;
- reaffirming the corporate strategy for the WHO Secretariat;
- responding to changing expectations of WHO

Throughout the period under review WHO RC acted in line with CFI, and Country strategy became a part of it. As a confirmation of this, a substantial amount of resources in the proposed programme budget for 2004–2005 were shifted to a strengthened country presence.

The implementation of the country strategy was reviewed in 2003, and a **Progress report on implementation of the WHO Regional Office for Europe's Country Strategy since 2000 (EUR_RC53_10)** was prepared (2003).

The work of RC till 2003 was focused on 3 main directions:

- **Programs with the Stability Pact countries of south-east Europe -** 7 Member States in south-east Europe (Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Romania, Serbia and Montenegro and The Former Yugoslav Republic of Macedonia) are **using health and social cohesion as the main vehicles to lasting stability, economic development and collaborative progress**. Project proposals were developed and implemented in those countries with support of governments France, Greece, Italy, Slovenia and Switzerland.
- **Strategies for rapid transition countries -** Strategies are being developed to support the so-called rapid transition countries (mostly those which are candidates for membership of the European Union (EU)) in **addressing their health needs, in order to optimize opportunities for health gain and health system improvements and to minimize possible negative developments.**
- **Futures forum series for non-BCA countries –**These are mostly western European countries. These forums are an opportunity to share their views and experience. Each Forum offers a vision and guidance in shaping the agenda for the future and serves as a network that provides and circulates information to its members and possibly to other Member States.

WHO supported Member states in the following sectors: strengthened international partnerships, providing tailored evidence that meets the needs of countries and their policy-makers, poverty reduction, resource mobilization, emergency and humanitarian assistance.

Overall, the **most important lesson learned** in recent months is that **it is possible to work in a new way in and with countries.** With political leadership, technical guidance and a substantial amount of modern management, **the Regional Office will strengthen its cooperation with countries during the remainder of this biennium (2003-2005) and the following one, in line with the European Country Strategy**.

However, there **are a number of challenges**. The strategic vision of a Regional Office oriented towards country work in the framework of the CFI needs to be fully articulated in the coming years.

This calls for:

- **a stronger resource base**, so that effective country offices are developed which are in close contact with national authorities and national as well as international stakeholders
- **more highly qualified staff in the field**. To this end, technical personnel will so far as possible be allocated close to where operations take place
- **strengthened staffing in terms of administrative and support personnel**, within the limits of available resources. The *process of appointing international heads of WHO country offices will be continued;*
- **strengthened managerial organization of WHO country offices**. To this end, the running of country offices will be subject to operational standardization, to better reflect the function-based structure adopted within the Regional Office, and job descriptions will be reviewed as part of this process;
- **refined mechanisms for development of coordination and partnership** with other United Nations agencies and international stakeholders at local level. Extensive use will be made of telecommunications, as financial resources permit;
- **further deepen the function-based reform of the Regional Office** at the service of its country orientation. This will be supplemented by further impetus to take forward coordination with WHO headquarters in the framework of the Country Focus Initiative

EUR_RC53_9 Strategic orientations of the Regional Office's work with geographically dispersed organizational entities, including WHO country offices (2003)
After 1990s 5 offices were opened in different countries focused on environment and health - Geographically Dispersed Offices (GDO).In 2000, the new Regional Director, taking into account the uncertainty of the situation with regard to the centers and the need for a policy for their development, asked Professor Silano to prepare a report on their situation.
The report revealed, that the centers are carrying out significant and indispensable work for the Regional Office, and that without them many useful activities would not exist. The report makes significant recommendations regarding the need to consolidate the existing GDOs, to clearly define their specific areas of activity, avoiding overlap with other Regional Office programmes, and to ensure that sufficient funding will be sustained. It also emphasizes **management issues** that in reality apply to the whole of the Regional Office with regard to the recruitment of staff, maintenance of scientific and technical competence and evaluation procedures. Finally, it raises the **issue of the specific relationship of the GDOs with the host countries and partners involved. Concern was expressed in the interviews about the coherence and consistency of the work carried out in Copenhagen and in the GDOs**.

The Silano report suggested

- consolidating GDOs, and clearly defining their specific areas of activity.

- in addition to their specific technical function, a broader function of coordination between the host country and the Regional Office could be located in the GDOs
- the work of GDOs and Regional office should be more aligned, and coordinated with each other and the hosting country.

It was decided, that GDOs will concentrate on stabilizing them and strengthening their links with the Office in Copenhagen, both administratively and programmatically. A special mechanism will be established to ensure and assess progress in this direction. The Regional Director will report to the Regional Committee on this issue in 2005.

In 2003 additional work has been carried out internally to look more broadly at the issue of the Regional Office's country presence. This work has consisted in an analysis of various WHO documents and policies. The review has also looked at the situation of WHO's country presence in the European Region; and, finally, a series of interviews have been conducted with representatives of Member States, members of the SCRC and staff members based both in and outside Copenhagen.

The **main results** regarding the 28 country offices were the following:

- There was a shared recognition of the **positive impact of the ongoing process for implementation of the Regional Office's Country Strategy**, including improved involvement at country level, definition of functions, training of staff and the way they are managed.
- The **liaison officers or heads of country offices** were described as **key elements** for assessing country needs and further developing the Regional Office's country presence as a service for the host country.
- Some comments were made about the need to achieve a "critical mass" and to reinforce technical capacity at country level, while **avoiding the creation of "mini regional offices**".
- A **lack of use and coordination of local institutions and experts, including collaborating centres and networks of counterparts**, was mentioned by some representatives of Member States.
- Interestingly, representatives of Member States with country offices (including countries in rapid transition, soon to be part of the European Union) were unanimous in acknowledging their usefulness, while the others expressed the opinion that although this was a good model for those Member States who had them, they could not see it as a solution for their own country.
- There were **diverse opinions and ideas about the Regional Office's future country presence in countries where there are no country offices**; this shows the need for more formalized thinking on the subject.

In 2003, during WHA, ***Country Focus Initiative***, endorsed by the World Health Assembly in 2002 was reaffirmed.

The **mandate of the country office according to CFI** can be summarized in terms of the following functions:

- managerial: coordinate and manage the implementation of WHO country programs, including the facilitation of relations with national counterparts;

- technical: identify the needs and opportunities for WHO support, facilitate technical interventions, disseminate WHO information;
- representational: represent WHO in the country and facilitate relations between WHO and the government.

The countries operate in line with BCAs. However, there were examples when there were no country offices, but the countries signed a BCA with WHO, and it was proposed, that this practice could be followed in future.

In addition to GDOs and country offices, the Regional Office's programmes are also present in Member States through different types of networks or institutions, such as

- *Collaborating centers* (474 WHO collaborating centres are located in the European Region, of which 112 have been designated by the Regional Office and 362 by WHO headquarters)
- *WHO documentation centers* (Regional Office also has formal agreements with 48 documentation centres in 38 countries of the European Region. These are involved in the dissemination of WHO products, although they are not officially WHO collaborating centres.)
- *technical focal points and networks of national counterparts* (the Regional Office has 47 different networks of national counterparts and focal points for many technical issues)
- *expert advisory panels* (At the end of 2001, WHO had 49 expert advisory panels, comprising 1337 national experts, of whom 433 were from the European Region)

Strategic directions for improving the coordination of the Regional Office's input in countries

Based on the findings mentioned above and as stated in the regional Country Strategy, **there is an evident need to strengthen coordination of the Regional Office's various inputs in each Member State in the Region**.

This requires *further development of the following ongoing processes*:
- assessment of the country's needs for WHO support
- coordination of all WHO activities in the country
- coordination of all types of WHO presence in the country
- dissemination of technical information and WHO documents.

The major orientations of this strategy will be the followings:

(a) **In countries where there is a country office** (28 at the moment), **the process of strengthening the capacities of that office will be continued**, under the guidance of the Regional Office's technical divisions. Country offices will also play to the full their role of coordinating all the other aspects of WHO's country presence.

(b) **In countries where there is a GDO** (four at the moment, with Italy having two), the **GDO will, in addition to its specialized technical mission, accommodate the function of liaising with the host country** under the responsibility and supervision of the Country Support division of the Regional Office. Within this new function, coordination of all of WHO's country presence will also be carried out through the GDOs.

(c) **In the countries where there is neither a country office nor a GDO**, a **collaborating centre could be selected jointly by the country and the Regional Office in order to serve as a WHO coordination centre**, linked to the Office's Country Support division. Its first new task would be to map WHO's existing country presence and liase with the institutions and individuals involved. The country's need for WHO activities would then be identified and an action plan drawn up, outlining the steps and actions to be taken to develop such cooperation.

In 2004 the implementation of Country strategy was reviewed (EUR_RC54_InfDoc2 Progress report on implementation of country strategy).

According to the report the **achievements of the implementation of the strategy are**

- Better coordination of activities at all-WHO level
- Strengthened country presence
- More competent staff at the service of Member States
- Country-specific strategies and workplans
- Enhanced relevance of the issues addressed for the Member States
- Improved partnership
- More transparent and accountable management

The following issues for further development were identified:

- **Country work performance indicators** should be developed (how to ensure that we have an impact by measuring what we need to measure in the field of country work).
- **Direct customer satisfaction** (how to ensure that we reliably measure whether the country feels it is now better serviced through a strengthened WHO presence as compared with before).
- **Sustainability** (how to ensure that the Regional Office's current initiatives remain in place in the coming years and add value to countries' continued efforts to improve their own health systems). The **efforts made by the Regional Office** to build new relationships with Member States **need to be translated into a more sustainable and systematic approach that results in a cultural change in the way in which the Office works in the service of Member States**, while helping countries to adapt their health systems to changing circumstances.

In 2005 the **summary of procedures for country** work was prepared. According to this summary

Main processes of WHO-EURO include

1. Assessing country health needs
2. Capturing country health priorities and preferences
3. Negotiating with countries
4. BCA implementation and follow-up
5. Performance evaluation including closure of BCA

PROCESS 1: Assessing country health needs

Activities	Tasks			
A. Identifying the required information	1. Identify information items and framework	2. Identify information sources		
B. Information gathering	1. Plan information collection	2. Gather internal data	3. Gather external data	
C. Performing the analysis	1. Apply standard needs assessment techniques	2. Adjust to WHO policies and strategies	3. Identify further information and research needs	4. Produce the country strategic health needs report

PROCESS 2: Capturing country health priorities and preferences

Activities	Tasks			
A. Formulating country priorities and preferences	1. Set up the process rules and time frames	2. Ensure proper process of discussion at country level	3. Ensure technical support to country stakeholders, on request	4. Ensure that all relevant stakeholders formulate their priorities
B Country priorities submitted	1. Analyse and treat the information	2. Check with the UN family and other stakeholders	3. Final checking with MoH of definitive priorities list	4. Report to DCS the country-suggested BCA

PROCESS 3: Negotiating with the country

Activities	Tasks			
A. Generating the preliminary BCA	1. Generate priorities for cooperation for the biennium	2. Adjust comments of Technical Units'	3. Weigh proposals according to WHO corporate priorities	4. Generate the 'negotiable BCA' (including draft outline work plan
B. Consultations and negotiations	1. Schedule meetings	2. Discuss with MoH		
C. Formalising commitments	1. Elaborate Final BCA and related documents after negotiations	2. Official signing of BCAs		

PROCESS 4: BCA implementation and follow -up

Activities	Tasks		
A. Operationalising the signed BCA	1 Adjust and elaborate further details on BCA workplan as per signed BCA	2. Make field-level adjustments (coping with incidentals)	
B. Implementing actions	2. Ensure implementation By EURO country representative	2. Ensure implementation By EURO non-country Presence	3. Ensure implementation by non-EURO stakeholders as per commitments made
C. Ensuring follow -up	1. Set up a framework for follow -up	2. Submit ongoing information	

PROCESS 5: Performance evaluation, including closure of the BCA

Activities	Tasks		
A. Ongoing BCA monitoring and evaluation	1. Set up evaluation objectives and standards per priority area	2. Perform continuous monitoring	3. Perform interim evaluation and make adjustments
B. Final BCA evaluation	1. Assess the overall BCA	2. Analyse overall deviations	3. Closure of the BCA
C. Recap: Ensuring transfer of lessons learnt	1. Prepare final BCA report	2. Discuss final BCA report with relevant units	

Also in 2005 **EUR_RC55_9 Next phase of country strategy - strengthening health systems, and WHO-Europe - Resolution EUR-RC55-R8** were prepared. The position paper and the resolution were a call for European countries to develop their own approaches, bringing together the key constituencies in strengthening health systems: country policy-makers, the major global programs and initiatives, funding agencies and European health system experts. The paper covers the scope, purpose and actions to be taken to develop this endeavor. It outlines specific areas where the Regional Office can support all countries in the Region in their efforts to strengthen their health systems.

Documents reviewed

1. Terms of reference for the desk officers in the countries policies and systems unit, division of country support
2. 2005_WHOEURO Summary Procedures for Country Work
3. Implementation of the Regional Office's Country Strategy, 2004
4. Strategic directions for improving the coordination of the Regional Office's input in countries
5. EUR_RC52_4 Biennial report of RD 2000-2001
6. EUR_RC53_9 Strategic orientation for RO work with GDOs and country offices
7. EUR_RC53_10 Progress report on implementation of country strategy
8. Memo_15 Feb 2008_Managerial changes and delegation of authority
9. EUR_RC50_10 WHO EURO country strategy Matching Services to New Needs
10. EUR_RC55_9 Next phase of country strategy - strengthening health systems
11. EUR_RC54_InfDoc2 Progress report on implementation of country strategy
12. EUR_RC50_4 External evaluation of EUROHEALTH programme
13. WHO-Europe - Resolution EUR-RC55-R8