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A country strategy for the WHO Regional Office for Europe

Equitable improvement in the level of health is the ultimate goal of the World Health Organization (WHO). WHO's country structures play an important role in attainment of this objective. The WHO Regional Director for Europe brought together an external working group (RWGCo) to review the Regional Office's strategic relations with countries. RWGCo prepared an extensive report and presented it to the Regional Director (the report is available to the Regional Committee as background document EUR/RC61/BD/1). The Regional Director would like to thank the members of the Group for their valuable work and inputs.

This paper presents the Regional Director's views on the recommendations of the Group and her vision of the Regional Office's country strategy. It first provides a brief overview of developments in the WHO European Region before going on to outline the country strategy that is envisaged for today's context.

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Introduction – From past to present

1. In Europe, the period from the establishment of WHO in 1948 through to the early 1990s witnessed intense political competition between the country blocks involved in the Cold War. With a few exceptions, the European Region's health indicators ranked higher than those of the rest of the world, and its health care systems were stable and sustainable. The Regional Office's biggest challenge at the time was to avoid political mis-steps that could upset sensitive balances. In addition to this consideration, a major function of the Regional Office was to generate academic and technical knowledge, policies and tools that were exchanged between countries – the "intercountry" way of working. With the exception of an office of a WHO representative in Turkey, the Regional Office did not have any country presence. At the time, the WHO European Region was made up of 32 Member States.

2. The 1990s witnessed significant political changes in the European Region. The fall of the Berlin Wall in 1989 and the subsequent reunification of Germany in 1990 were remarkable milestones that were followed by a process of systematic disintegration in the economic, social and political spheres, resulting in the abolition of the Soviet Federal Government and the independence of the republics that had made up the Union of Soviet Socialist Republics at the end of 1991. By 1995, the number of Member States in the WHO European Region had increased to 50.

3. The political and economic difficulties in the countries of central and eastern Europe and the former Soviet Union had a detrimental effect on the social determinants of health. The disintegration of the social fabric, high unemployment, a sharp decline in purchasing power, shortages of commodities such as vaccines, medicines and other consumables, and changing behaviour patterns, particularly related to alcohol, tobacco and nutrition, led to a higher incidence of communicable and noncommunicable diseases, which in turn led to higher mortality rates.

4. The Regional Office acted very fast to respond to the health and health care system challenges outlined above, and the "Eurohealth programme for intensified cooperation with central and eastern Europe and the newly independent states" was adopted by decision of the Regional Committee in 1990, in order to develop and scale up activities in CCEE and NIS. At that time, about two thirds of the Regional Office's activities were directed towards CCEE/NIS.

5. A Country Health Department was established for the first time at the WHO Regional Office for Europe, for the purpose of carrying out the Eurohealth programme. Countries were assigned to "desks" that each consisted of a professional staff member and a few administrative personnel. Liaison Offices, each with a national professional officer and an administrative staff member, were established in each country of central and eastern Europe. The task of these offices was to form an interface between the country where they were situated and the WHO Regional Office.

6. Despite working with a limited budget, much was accomplished: the Regional Office's technical work was channelled to the target countries through the infrastructure created by the Eurohealth programme. During these years, the Regional Office continued to support and strengthen the "intercountry" mode of working, providing technical assistance, including policy support, normative functions and monitoring health trends that "fed" the networks and infrastructures created by the Eurohealth programme.

7. After 2000, the Regional Office began to change its way of working with countries, under the motto of "Matching services to needs". There were several components to this change.

- Policy development and technical “intercountry” work which, until then, had been at the forefront of the Regional Office’s programme, was matched by more “country-specific” work. The main focus of the Regional Office was to direct its activities to meeting the specific needs of each country, thereby giving individual consideration to each country.
- The Regional Office paid more attention to the concerns of the international organizations which were expressing an interest in health areas and adjusted its activities accordingly.
- When working with the Regional Office, Member States decided on their own needs, their own pace and their own preferences for participation in different programmes.
- There was a major decentralization of functions and responsibilities, resulting in responsibilities for technical programmes being transferred to the country offices. It was decided that the Liaison Offices would coordinate the delivery of work in the country and the allocation of funds to the work, and they were also made responsible for negotiating contracts at country level. They also autonomously assessed and decided on what type of collaboration to pursue with other organizations.
- In serving the Member States, the Regional Office employed, as temporary advisers, public health specialists who had participated in public health reforms in their own countries. Disseminating case studies was considered to be the main way of ensuring the exchange of information and of demonstrating that the advice and recommendations provided by the Regional Office were practicable and realistic.
- The Regional Office moved towards being more responsive to the concerns and queries raised by its Member States, either by mobilizing staff to respond directly or by facilitating contact with other sources of expertise, both within and outside the Organization.
- In order to support the new strategic approaches in the services offered by the Regional Office, a new organizational structure was adopted. Specific technical programmes were abolished and were replaced by generalist, cross-cutting programmes. The technical programmes were asked to orient the technical assistance they provided, as well as the activities they carried out, around either the health system functions or the country groups, whereas previously the emphasis had been on the various branches and functions of public health.

8. Today, the European Region is one of the most diverse and dynamic of WHO’s regions. It spans 53 Member States has a total population of almost 900 million, and encompasses diverse economies, political systems, health levels and cultures. Unemployment has increased in Europe during the financial crisis, the aftermath of which continues to occupy the agenda of most Member States. It seems that the full consequences of the economic crisis will continue to play out over several years. The percentage of overseas development assistance (ODA) dedicated to health, in spite of the rise in poverty levels in the European Region, is a clear indication that one should not expect considerable budget increases for the Regional Office. On the other hand, the political and economic empowerment of certain Member States has led to the emergence of new donor countries in the Region. The most prominent demographic characteristic of the Region is its ageing population.

9. Member States are already suffering from a very high and ever-increasing burden of noncommunicable diseases (85% of the overall burden of disease), particularly in the form of cardiovascular diseases, cancer, diabetes, respiratory diseases and mental health problems. Obesity is a Region-wide epidemic. While there has been some improvement, alcohol, tobacco and drug use still poses challenges.

10. Communicable diseases, whether ongoing or emerging, continue to be a challenge for the Region and it is surveillance, control and prevention measures, if well instituted in countries,

that keep them at bay. When health systems break down, the Region faces outbreaks and pandemics. This was seen particularly with the importation of wild poliovirus into the central Asian republics, which underlined the need to sustain the Region's polio-free status and to achieve the elimination of measles and rubella and of malaria by 2015. The Region is contributing greatly to the global burden of tuberculosis, especially through cases of multidrug resistance. The European Region is the only region with increasing numbers of HIV cases. Strengthening health security, pandemic influenza preparedness and ensuring Member States' compliance with the International Health Regulation (2005) are among the important tasks for the Region. Antimicrobial resistance also impacts on the control and prevention of communicable diseases and has become a real problem for many countries.

11. Migration from outside, between and within the countries in the Region is an issue that requires more attention, since it highlights challenges to the health of the migrating individual and to the weak health systems of the country of origin, as well as raising new health challenges for the recipient country. Migrants' health is made more complex by the detrimental impact of the social determinants of health and the major role they play in heightening inequities, including poverty, among the most vulnerable population groups.

Aims of the Regional Office's Country Strategy

12. The challenges outlined above are spread across all the countries in the European Region, at different levels and to different degrees. Despite this diversity, all Member States share WHO's values and all need the support and assistance of the WHO Regional Office for Europe, which must continue to be relevant to every Member State in the diverse European Region, to support them in finding the best solutions to the common problems and to work with every one of them, although through different modalities. The Regional Office should have a flexible yet effective approach to collaboration with all European Member States.

13. The WHO Country Strategy takes a holistic approach: all that WHO does is specifically work for, in and with countries. Therefore the challenge is how to find the best way to channel the knowledge from every part of the Organization to the countries in the most effective way, to build capacity and to support policy-makers in making use of the knowledge and evidence that exists as part of the national decision-making process.

14. The main aim of the new country strategy is therefore to ensure that the mechanisms, functions, structures and staffing are in place to reach the above objectives in the Organization's work with countries, for the continuous improvement of population health and reduction of inequities.

Policies and strategies that underpin the Regional Office's Country Strategy

15. WHO is a multilateral, intergovernmental organization where all decisions on policies, strategies and programmes are taken by the Member States; these are the decisions that the Organization is expected to implement and be accountable for. The resolutions of the Organization's governing bodies (the World Health Assembly, the Executive Board and the Regional Committee) aim to improve population health and they call on the constituent parts of those bodies, the Member States as well as the Organization, to implement their provisions. The relevance of these joint decisions must be translated from a global level to a regional one, but undoubtedly, it is the country level that is the most important element of the work done by the organization. The WHO Regional Office's main aim is to support the countries in addressing

their country-specific strategic developments, not only by providing norms and standards but also through evidence-based (informed) development of health policy, strategies and health systems, as well as through the delivery of technical programmes, interventions and capacity–building measures.

16. At regional level, the main policy tool that will drive country work and effective cooperation with countries will be the new European health policy – Health 2020. This policy is to be presented to the Regional Committee at its sixty-first session and endorsed at its sixty-second session, and it will be the foundation of all the Regional Office's work in the Member States. Countries will benefit from this policy framework, as it will provide a more coherent approach to health and health equity. Achieving health and well-being has to be an overall objective of government policies, thus ensuring a whole-of-government approach and horizontal governance of health. Strong high-level political commitment is required, and the success of such policies will depend on the managerial and technical tools needed to implement them and on the built-in capacities of the countries. A whole-of-society approach is also relevant and will ensure the involvement of all stakeholders, including the private sector and the "expert patient", in finding solutions to improve health systems in countries

17. Health 2020, which is currently work in progress, will be the policy framework that the Regional Office will promote in Member States. The work of the Regional Office will be located in this context and against this background. The priorities for intercountry work will be to decrease inequities in the European Region, augment health status, increase the effectiveness and efficiency of health systems, manage noncommunicable diseases, control communicable diseases, ensure disaster preparedness and response, and promote environment and health.

18. The Regional Office's work on strengthening health systems, on the other hand, will be based on the approach adopted at the WHO European Ministerial Conference held in Tallinn, Estonia in June 2008. Strengthening health systems – a flagship product of the Regional Office – guided by the Tallinn Charter and the follow-up work done since it was adopted, will continue to be important in driving country specific work. Along with a sharper focus on reducing health inequities, governments must develop rational long-term, comprehensive and intersectoral public health policies as an adjunct to strengthening health systems. Hence, the main emphasis of WHO's work in countries in the future will be both on the quality of health care and on public health functions such as surveillance, primary prevention and health promotion. Tools to analyse weaknesses in the system and policies to invigorate them will be developed and shared with all countries in the Region. No differences in economic development, political system, or location can change the requirements for the development and implementation of health policies and health systems. In this respect, the mechanisms of public health development are generic.

19. Other tools that help to provide direction to WHO's work in countries include the commitments made by Member States; these comprise "hard" law such as the International Health Regulations (2005) and the Framework Convention on Tobacco Control, multilateral agreements such as the multilateral environmental agreements where WHO has some clear responsibility (the Protocol on Water and Health, the Convention on Long-Range Transboundary Air Pollution) and "soft law" such as declarations and charters adopted at ministerial conferences, as well as strategies and action plans that are endorsed at governance meetings and further supported by the endorsement of accompanying resolutions. Finally, guidance developed through WHO's normative work, as well as evidence-based policies and tools, are relevant to all Member States in the WHO European Region, and the Regional Office will strengthen the support it provides to the Member States to assist them in adhering to them.

Main directions of the Regional Office's new Country Strategy

20. The Regional Office has a clear role to play in supporting European Member States within this framework. It has the responsibility to adopt the most effective approaches to reach its goals, in keeping with WHO's values, while bearing in mind the current features of the European Region and accepting that there will not be a significant increase in the funds available to the Regional Office. Within this context, the Regional Office's Country Strategy is formulated around how it will work for countries, in countries, and with countries.

The Regional Office's work for all countries

21. The Regional Office takes a holistic approach to its work with countries: it considers that the Organization's vast knowledge base is relevant to countries and that its Country Strategy should therefore support Member States in obtaining access to this and translating it into national decisions whenever relevant. The starting point for the Regional Office's country work and for elaborating the priorities for bilateral collaboration is therefore an analysis of the recent decisions of the Organization's governing bodies.

22. In line with this thinking, all the Regional Office's activities that are either a result of "intercountry" work or of different networks working together for health can be called work "for all countries"; this constitutes the sum total of work done, regardless of country. WHO's normative and standard-setting functions, the development of health policy frameworks and management tools, the generation of knowledge and gathering of evidence and information, and the transformation of research-based academic knowledge into information that is ready for use in countries can all be considered under this heading. In the upcoming budget periods, a multi-tiered approach will be adopted to increase the Regional Office's intercountry work, as well as its budget.

23. In accomplishing this task, the Regional Office will use its technical capacity at the Regional Office, together with the capacity at its Geographically Dispersed Offices (GDOs) and WHO collaborating centres, as well as the expertise available in the Region and elsewhere (in line with the functions spelled out in the paper on the strategic coherence of the work of the Regional Office[1]). However, wherever there is production on behalf of the Regional Office, responsibility for setting the policy direction and ensuring the quality of outputs lies with the Regional Head Office.

The Regional Office's work in countries – the institutional framework

24. The Regional Office's work in the countries will also include all the above elements: full consideration will be given to the governing bodies' decisions, and all intercountry, multicountry and subregional modes of operation will be fully exploited to maximize the use of limited resources.

25. The Regional Office's work in countries is delivered through various mechanisms. The main emphasis is on providing:

- support to the country to develop national policies and plans for strengthening its health system;

[1] Document EUR/RC61/16.

- support to the country through organizing national debates, for example on adopting the provisions of the Framework Convention on Tobacco Control or the alcohol policy, and assistance with capacity-building, for instance in connection with the International Health Regulations (2005);
- and last but not least, ensuring country-specific support as and when required, where resources and regional priorities allow.

26. The mechanisms vary but in general, WHO provides support through the:

- involvement of the country in all the Regional Office's intercountry activities and networks;
- involvement and support of institutes and technical experts in countries with the development of evidence-based programmes and networks;
- organization of conferences, consultations, workshops and training programmes.

27. The Biennial Collaborative Agreement (BCA) will continue to be the "contract" between the Regional Office and the country, specifying the expected outcome(s) during a biennium. Work with countries will continue to include both a country-specific element and an intercountry approach, but there will be more emphasis on the latter than in previous years. The Regional Office will develop Country Cooperation Strategies (CCSs) in five countries of the Region on a pilot basis, in order to align with the procedures used by other WHO regional offices. Depending on the result, this pilot scheme will be extended to all the other Member States in the European Region. The CCS forms an agreement of work between the Member State (i.e. the Ministry of Health, and other sectors, partners and stakeholders at country level) and the Regional Office. The CCS is drawn up for six years, but annexing the BCA to the CCS will allow a more flexible approach to negotiating the outcomes and outputs listed under the CCS priorities on a biennial basis.

28. Moving towards the development of CCS will not only ensure that WHO functions as "one organization" (since other regions already use and implement CCs); true to WHO's values and principles, the CCS will also provide a highly participatory approach that reaches out to a broader set of health actors in the country, involving them in diagnosis of the country's needs. This will undoubtedly create ownership of and commitment to what needs to be done at country level, across the whole of society. The process ensures clear leadership by the health authorities, empowering them to lead discussions with all partners and sectors, resulting in a clear overview of the main determinants of health at country level and identification of health needs and priorities. Each CCS is also informed by clearly defined public health indicators; these are particularly useful to flag up health issues and are important for ensuring further negotiation and endorsement of a "road map" of technical activities at national level with the Ministry of Health.

29. More strategic dialogue and hence engagement with the Member States will be sought at every opportunity and every level, thereby ensuring that collaboration is not simply reactive but is carefully discussed, negotiated and then delivered in a more comprehensive and coordinated manner. Country work must be not only timely – reacting immediately to needs (emergencies, public health crises) as soon as they are known – but also effective in preventing the causes of ill health through addressing the social determinants of health, lifestyle approaches and health promotion, as well as result-oriented in such a way that noticeable improvements in the country's health status are achieved.

30. While the strategic direction, guidance and coordination of work in the Member States will come from the Regional Office in Copenhagen, input from the country offices, GDOS and WHO collaborating centres, as well as the vast number of networks, experts and consultants associated with the Regional Office, will also be used to maximum benefit. This means that

WHO's counterparts in countries will have to be reviewed and constantly updated, to ensure that the Organization works with all the relevant institutions and experts, both in the health sector as well as in other sectors. An effort will be made in the coming months to review the list of networks and technical counterparts in the countries, in order to work more closely and on a more regular basis with them. National counterparts will be expected to coordinate and liaise with technical counterparts and networks, to avoid duplication of efforts at country level. This will also include close collaboration with national public health institutes.

31. To support this process, as recommended by the External Working Group to review WHO/Europe's work with countries (RWGCo), the Regional Office must be present in each and every country in the European Region. An important element of the Regional Office's work in countries is the existence of country offices (COs), which are found mainly in the central and eastern parts of the Region. Over the years, COs have played a key role in the Regional Office's country relations, ensuring important links through close relations with ministries of health. Their role in advocating for health and in facilitating and coordinating technical assistance to the country has been crucial and has resulted in more evidence-based policy-making and decision-making processes at national level. COs have also been important for ensuring continuity in the development and implementation of health policies and plans, despite changes in governments. They continue to be an important and live interface between health policy needs at national level and the technical knowledge available in the Regional Office. Their understanding of the local setting is important for making technical programmes more aware of the specific needs in the countries.

32. Most COs are led by national professional officers (NPOs), who have been effective and appreciated in most countries because of their good work, their commitment and the close relations they have established with national counterparts in the countries' ministries. In the case of Albania, Kazakhstan, the Republic of Moldova, the Russian Federation, Serbia, Tajikistan, Turkey, Uzbekistan and, most recently, Ukraine, the heads of country offices (HCOs) are international staff. All HCOs are highly trained in management, in policy formulation and in facilitating technical assistance with reforming national processes.

33. Knowledge of the country's settings and cultural traditions as well as of its social, economic and political situation, is key to ensuring targeted action, and this comes from a strategic presence in countries where feasible, as well as from a good ongoing relationship with policy-makers in ministries of health. COs will continue to be crucially important for providing this guidance and intelligence, but new ways will be used to ensure that all countries benefit from all the knowledge and possibilities that WHO can offer, and that these same advantages are made available to countries that have no CO or BCA.

34. WHO's presence in countries can take different forms in the different parts of the Region. At present, WHO has country offices in 29 out of the 53 Member States in the European Region. These country offices are mainly in central and eastern Europe and central Asia. At the request of the Regional Director, the RWGCo reviewed all the offices and explored the need for their continued presence. The feedback from the countries was unanimous: they consider these offices to be an asset and they would like them to continue, even at the expense of a cost-sharing arrangement. While the RWGCo recommended that there should be a CO in each country, the nature of this presence will undoubtedly differ in each country, as it should be based on the country's needs and the Regional Office's capacities. In the countries without a BCA or a CO, mechanisms for more active and efficient collaboration must be put in place and the various options that exist must be further explored.

35. It is possible to identify three different types of country presence: a country office led by a WHO representative (WR), a country office led by an NPO and a country cooperation office. Most of their functions would be the same, but there are some differences; for example, the head

of a WR's Office will be mandated to lead on health policy development and health system strengthening and will therefore be specifically selected for this position based on these criteria. At the same time country offices led by WRs are established in countries of the European Region that meet some specific criteria, such as: large country, complex situation, extensive country cooperation, unstable situation, large or multiple country-specific projects requiring health leadership and coordination.

- Country office led by a **WHO Representative** (WR): Within this office, an international senior public health expert is supported by a few national/international professional officers and administrative staff. The WR's responsibilities will cover four main areas: (i) policy development, provision of strategic advice on health system strengthening, (ii) technical cooperation and coordination, (iii) information gathering, advocacy and communication; (iv) representation and partnership; (v) health leadership, coordination and communication in health emergencies; (vi) administration and management of staff in the office, including technical and project-specific staff; and (vii) contributing to the United Nations Country Team (UNCT) within the United Nations Development Assistance Framework (UNDAF) for reforming the United Nations system.
- Country office led by a **National Professional Officer** ((NPO): Within this office, a senior national professional is supported by administrative staff. The NPO's responsibilities will cover: (i) information-gathering, advocacy and communication; (ii) representation i.e. to be the interface between the Regional Office and the government of the country, and coordination between the Regional Office and national counterparts, (iii) partnership with sister United Nations agencies and other partners at country level; (iv) health leadership, coordination and communication in health emergencies; and (v) administration and management of country-specific work.
- **WHO presence in countries without a BCA or country office**: This needs to be further explored and strengthened. There are different alternatives here, as well as a combination of these alternatives. One option is to assign a WHO staff member as the dedicated focal point/desk officer at the Regional Office. This person would act as a WR/liaison officer for the country. (This is the approach that the WHO Regional Office for the Americas takes.) Another alternative could be to establish a Country Cooperation Office in the country. This office would be set up in consultation with the relevant Member State to ensure that it is the best positioned to ensure adequate external relations between WHO and the Member State. Such an office would be responsible for ensuring the exchange and dissemination of information between the Regional Office and the Ministry of Health, particularly about developments in the country and hence its needs and priorities; this would enable further discussions to be held on opportunities for WHO/Europe support. In countries that host a GDO, it is expected that the GDO can also play this role. Official relations between the country and WHO would continue to be carried out through the agreed mechanism, supported by the international relations department at the Ministry of Health.

36. The determination of what type of country office is assigned to each Member State will be made on the basis of objective criteria and agreement with Member States. These criteria will be selected from among factors that would pinpoint a host country's needs and capabilities, such as the level of national health indicators, the country's economic situation and its population. If, as a result of these changes, any country office needs to be downsized, a transition plan will be prepared, negotiated with the country and implemented. Resources made available from downsizing will be shifted to priority areas.

37. The staffing of WHO's country offices is already being reviewed and will continue over the coming months, with a view to ensuring the right level of technical expertise required to deal with country-specific issues, as well as a well trained set of core staff who will provide a constant base of support for these rotating experts. The emphasis is on ensuring more uniformity

in the level of staffing and a better skill mix than is currently the case. Simultaneously, the funding and the delegation of authority of heads of country offices will also be reviewed (delegation for country-specific activities will continue).

38. The country offices will be integral part of the Regional Office and they will work in close cooperation with, and under the guidance and supervision of, the Regional Office. They will ensure that the "intercountry work" delivered by the Regional Office is successfully transmitted to the countries within the context of Health 2020 and the approach for strengthening health systems. There is a need to increase the attention paid to health policy, health care reforms, public health functions and noncommunicable diseases, in addition to maintaining all efforts in health security, communicable diseases, and environment and health.

39. Technical support will be given to COs by the Regional Office, supported by a highly integrated set of GDOs that provide evidence and information for policy-making. For some areas of work, the Regional Office may need not only to make use of existing knowledge hubs in the countries but also to employ external consultants who are trained in WHO's priorities, principles and values. They will be chosen from a roster of carefully selected experts who are interested in working as WHO consultants. Other established and reliable networks will also be used. WHO envisages preparing a list of experts from Member States who are interested in working with it as consultants and whose performance has been shown to be reliable and useful.

40. Technical programmes will pay attention to countries' requests, in order to ensure a timely response to their needs. The team responsible for "Strategic Relations with Countries" (SRC) at the Regional Head Office will be instrumental for this purpose: it will lead the planning of country-specific workplans and also monitor the progress in implementing these plans. It will act as the point of coordination between technical units and COs. The role of the SRC programme will be to ensure (i) the proper flow of information; (ii) that cooperation is strategic and that opportunities are identified for this purpose; (iii) that Member States benefit from all the Regional Office's work in all areas, and (iv) in close collaboration with the country offices, that relationships are fulfilling and harmonious. COs will receive effective administrative and managerial support from the Regional Office, coordinated by SRC. SRC will also be responsible for providing strategic advice to the technical divisions at all times; as a central point of country information and intelligence, it can ensure more effective coordination of country activities implemented by the Regional Office, such as maintaining an overview of all the missions, major meetings and events planned in the countries. Through SRC, the Regional Office will ensure timely administrative support by establishing quality and time standards for processing incoming requests from countries.

41. COs have also been crucially important for integrating health into country development processes and into the work of partners at country level such as the United Nations Development Assistance Framework (UNDAF) and sector-wide approaches (SWAps), in advocating for health and in promoting new initiatives and approaches in areas such as the social determinants of health, human rights and gender equity. With new partners in health becoming more active at country level, such as the Global Fund on Tuberculosis, HIV/AIDS and Malaria, the World Bank and the European Centre for Disease Prevention And Control (ECDC), COs will continue to be the cornerstone of ensuring coherence in addressing health priorities at country level and providing strategic advice to ministers of health in driving ahead with WHO's global and regional policies. COs will also be more important in those Member States that face difficult political problems or that require the most assistance in health system reforms. All COs will be further integrated into the day-to-day work of the Regional Office. This will take place with the assistance of strategic desk officers in the SRC team, who are responsible for ensuring more coordination between the COs and the technical divisions.

42. All the staff will undergo further professional development that will help them to be better equipped for country work. Subjects such as health diplomacy, communication techniques and negotiation skills will be among the priorities of their training. The number of staff in COs will also be reviewed, to ensure a similar core presence and administrative capacity in each country office. This, together with the right level of managerial decentralization and an adjusted delegation of authority, will ensure that they play a stronger diplomatic and political role.

43. The work of the Regional Office in countries is driven by standardized policies, procedures and tools that are not necessarily known to the counterparts with whom WHO staff work. Many of these procedures will be revised as part of the implementation of the new Country Strategy. This will help to ensure effectiveness and transparency in the work of the Regional Office and will address issues such as (i) the process of planning and implementing country-specific work and the context in which the funding of BCAs/CCS is envisaged; (ii) the appointment, role and responsibilities of national counterparts and technical focal points; (iii) WHO's network of health institutions in the countries and their roles and responsibilities; and (iv) administrative procedures for country offices in order to ensure easier and faster solutions. This includes revision of committal documents such as agreements for performance of work (APWs) and payments to experts and national counterparts, as well as policies on travel by WHO staff to countries and employment of WHO temporary advisers and consultants.

44. As WHO is a technical agency, the emphasis will be on providing technical guidance and building capacity through intercountry, multicountry and bilateral mechanisms. Technical programmes will be more closely involved in planning country work, as well as in high-level political discussions and the provision of strategic advice to Member States. Where there is a natural alliance among Member States, the Regional Office will make use of subregional or multicountry approaches for providing technical expertise to more countries with similar backgrounds, challenges and needs. An advantage of such arrangements is that they make maximum use of the technical capacity and financial resources already available in the countries. Some technical areas are more conducive to multicountry cooperation, while others need more focused and targeted attention on a single country. The extensive experience of sister United Nations agencies will be taken into account here.

45. Providing technical assistance and support to countries requires resources. Efforts will be made to make best use of existing resources within the country itself, or even in neighbouring or other countries. Intercountry and multicountry work may be supported by resources provided by one or more lead countries willing to share expertise and other resources to the benefit of other countries. When resources are not available, resource mobilization will be key to ensuring funds for those priority areas of work that are decided on by the Organization's governing bodies or agreed with governments. This, however, will be part of the Organization's overall resource mobilization strategy.

The Regional Office's work with countries

46. WHO is governed by its Member States, and the Secretariat is committed to serving them and implementing the decisions they take in global and regional governing bodies. This means that representatives of Member States will have to be fully involved in the development of such policies to ensure subsequent ownership. A participatory approach and process is therefore required. Work done in interaction with Member States and their institutions and experts, as well as with existing European networks, is captured under this heading.

47. The European Health Policy Forum of High-Level Government Officials was established by the Regional Committee at its sixtieth session, and the first meeting took place in Andorra on 9–11 February 2011. Its role is to provide a high-level policy platform to debate significant

policy issues on the European health agenda. This forum will meet twice a year and in the meantime will maintain contact through electronic exchanges on a protected website. This forum will be reviewed and evaluated in 2012.

48. Moreover, Member States will be encouraged to mobilize their own resources to assist other countries through multicountry approaches. By having WHO work closely with Member States who are ready to invest human and financial resources in addressing health issues where they have considerable experience and expertise, this will result in a more extensive and effective "reach" of the Regional Office at country level.

49. These multicountry and/or subregional networks of Member States in the WHO European Region that have come together through a natural alliance based on areas of mutual interest and needs will become more relevant in WHO's work in countries. Examples include the South-Eastern Europe Health Network, the network of Nordic countries, the Baltic country network, and the Northern Dimension. In the past, there was also a health network among Central Asian Republics (CARNET). They are living examples of multicountry cooperation, where important policy issues are discussed. It is to be expected that more of these networks will be formed naturally, based on mutual interest. Nonetheless, the Regional Office can play a facilitating role in their formation and work. When and if necessary, some of the COs may play a supporting role for these networks.

50. Settings such as cities, schools, workplaces, hospitals, prisons, houses and other such venues have an impact on the health of populations. The Regional Office has accumulated experience regarding the settlements and settings where health is formed. This experience will once again be put to use, and networks such as "Schools for Health in Europe Network (SHE)", "Healthy Cities" and "Health-Promoting Hospitals" will be revitalized, while "Regions for Health" will be either revitalized or supported by WHO.

51. Linking similar organizations to each other and assisting them in setting agendas is a unique role for the Regional Office. Networks of patients' organizations and professional organizations will play an important role in facing the challenges of noncommunicable diseases. The countrywide integrated noncommunicable disease intervention (CINDI) programme is a good example of an issue-specific network.

Conclusion

52. The Regional Office will work *for countries, in countries* and *with countries*. Its chances of success are proportional to its ability to use European resources in an efficient and productive manner, based on objective criteria. The full support of the Organization's governing bodies is necessary for successful implementation of these strategies. With the help of the governing bodies, the Regional Office Secretariat will do all it can to increase the health status of the Member States' populations.

53. The implementation and results of this Country Strategy will be reviewed by 2015.

Annex: Main findings and recommendations made by the Working Group to Review the Work of the Regional Office in Countries

The Working Group to Review the Work of the Regional Office in Countries (RWGCo) found that the Regional Office's work with countries was well organized and that administration procedures and guidelines formed the basis of this work. There was intensive reporting from country offices back to the Regional Office, but this did not necessarily translate into action, mainly owing to the lack of use of the information provided. Also, as a result of a previous policy of strengthening technical capacity in country offices, there had been a corresponding weakening of technical capacity inside the Regional Head Office. This was particularly felt in some priority areas, such as noncommunicable diseases.

With regard to WHO's country offices, the RWGCo established that the COs had played a key role in delivering more country-specific technical assistance, and COs were generally appreciated by the countries. Their role in coordinating assistance provided by different agencies was important, particularly when rapid support was required such as in emergencies.

The RWGCo also noted that the impact which COs had in driving national policy- and decision-making was dependent on the skills of the staff and level of seniority, the most impact being achieved where international staff members led the COs. The increased focus on technical work in countries had resulted in a decrease in the COs' strategic and policy influence.

The main recommendations of the RWGCo, which were both general as well as country-specific in nature, included:

- COs should be continued in the shorter term. However, in some countries (such as those that are members of the European Union (EU)) where there are small country offices, the future level of support may need to change, moving towards subregional arrangements or liaison offices. The links to the EU need to be clarified, and WHO's future input to countries that meet EU standards needs to be considered. In EU member and candidate countries, the RWGCo also recommended changes in staff numbers in the COs, as well as in the type of assistance provided, since their main need was to address the EU's rising health standards and to be in line with the increasing EU investment.
- Subregional offices could be considered in some parts of the Region, such as the Baltic countries, Hungary, the Russian Federation and Turkey. This might impact on the level of input to an individual country, and particular attention should be paid to those parts of the Region where the political situation makes cooperation among some countries difficult.
- WHO's role in countries that are receiving increasing amounts of development assistance should be reviewed and changes made to facilitate this assistance. The Regional Office should also continue to become more involved in the "One UN" pilot scheme, to ensure effective WHO input into the thinking behind that initiative.
- COs need to have senior staff with leadership and managerial competencies, who are proactive, and who have the appropriate skills in promoting health policy and health service reform, thereby allowing stronger interaction at ministerial level. There is a need to review the delegation of authority given to senior CO staff.
- COs need to focus their work more sharply on health policy and health systems reform, particularly with regard to health system financing and noncommunicable diseases. However, it is important that technical units in the Regional Office are strengthened in order to provide this type of assistance, instead of the COs. An alternative solution could be to establish a regional roster of experts.

- The Regional Office should show greater understanding of the difficult political situations under which some COs work and adjust their expectations. Technical units should pay more attention to the speed with which they respond to COs' requests and work with them in a more coordinated manner. The Regional Office should update the COs regularly on relevant issues, and technical staff such as programme managers should visit the countries on a more regular basis. The Regional Office should also play a more active role in strengthening intercountry collaboration. Priority should be given to meeting the administrative needs of COs.
- The experience of the process and structure behind concluding biennial collaborative agreements (BCAs) is different in each country but needs to be improved, both in terms of the time taken to develop the document and with regard to budgetary procedures.