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A country strategy for the WHO Regional Office for Europe 2012–2014





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Equitable improvement in the level of health is the World Health Organization's ultimate goal. WHO's work with, for and in countries plays an important role in attainment of this objective.

The WHO Regional Director for Europe brought together an external working group to review strategic relations with countries. The Working Group prepared an extensive report and presented it to the Regional Director. That report was made available to the Regional Committee last year as a 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 vision of the Regional Office's country strategy, together with her views on the recommendations of the Working Group. 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.

Preliminary drafts of this document were discussed at three meetings of representatives from countries across the Region.

This paper takes into consideration the ongoing WHO reform process and aligns itself with its provisions.

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Abbreviations

AC	assessed contributions
AMS	Activity Management System
BCA	biennial collaborative agreement
CARNET	central Asian republics health network
CCEE	countries of central and eastern Europe
CCS	country cooperation strategy
CINDI	Countrywide Integrated Noncommunicable Disease Intervention
CIS	Commonwealth of Independent States
DG SANCO	European Commission's Directorate-General for Health and Consumers
EPHO	essential public health operation
EU	European Union
GDO	geographically dispersed office
GSM	WHO's global management system
HCP	Healthy Cities project
HFA	Health for All
HIA	health impact assessment
HIV/AIDS	human immunodeficiency virus/acquired immunodeficiency syndrome
HoCO	head of country office
NC	national counterpart
ND	Northern Dimension
NDPHS	Northern Dimension Partnership in Public Health and Social Well-being
NFP	national (technical) focal point
NIS	newly independent states of the former Soviet Union
NPO	national professional officer
OS	other sources
RB	regular budget
RHN	Regions for Health Network
RWGCo	External Working Group to review WHO/Europe's work with countries
SEEHN	South-eastern Europe Health Network
SRC	Strategic Relations with Countries
SWAps	sector-wide approaches
TB	tuberculosis
UNDAF	United Nations Development Assistance Framework
UNMIK	United Nations Interim Administration Mission in Kosovo
VC	voluntary contribution
WHO	World Health Organization
WR	internationally recruited WHO representative

Executive summary

Today, the European Region is one of the most diverse and dynamic of WHO's regions. With a total population of almost 900 million people in 53 Member States that have different economies, political systems, levels of health and cultures, the WHO European Region needs a new country strategy. Increasing problems such as unemployment and poverty, cuts in public spending that threaten health and an ageing population are only a few reasons why the WHO Regional Office for Europe needs to adjust the way it works for, in and with its Member States, in order for WHO to have a beneficial impact in all countries.

In this challenging and exciting era, WHO is already discussing how best to reform the way the Organization operates, in order to increase its effectiveness at all levels, but particularly at country level. The WHO reform process calls for WHO's country presence to be more closely aligned with each country's needs, priorities and capacity to respond.

In the WHO European Region, the existing country strategy has been in place for over a decade, during which time the policy environment has changed rapidly, and with it the priorities and needs of the Member States. The present interim country strategy intends to address this change by proposing how the Organization can maximize its resources, avoiding unrealistic burdens. The main direction is to make WHO/Europe's work in countries more efficient by taking the Member States' own capacities into consideration and sharing their experiences more effectively through the WHO country offices, where they exist, supported by the technical knowledge of the WHO Regional Office for Europe and WHO headquarters. The new country strategy sets out the values and principles of working **for and in** but also **with** countries. The Regional Office's main policy approach is to secure greater participation of Member States and more transparency in decision-making – so more specific actions will be developed as the result of further consultation. Progress in the WHO reform process is already being carefully followed and will be taken into consideration on a continuous basis.

Also new to the interim strategy is the way in which the Regional Office will work with European Member States at regional, subregional and national levels:

- At the regional level, the strategy describes how the Regional Office brings together the input from its technical programmes and geographically dispersed offices (GDOs), as well as from WHO collaborating centres, to ensure an evidence-based approach to addressing health needs in countries.
- At the subregional level, the approach is mainly one that results from working with natural alliances of Member States and making use of the opportunities that exist for countries to share knowledge, experience and resources.
- At the national level, it is WHO's country offices (where they exist) that are the implementers and facilitators of technical assistance at country level, under the strategic direction of the Regional Office. The interim strategy therefore explains how they are being further strengthened by ensuring that the countries' priorities and capacities are better addressed through strengthened core and project staffing, with increased emphasis on the competencies, skills and training required. The interim country strategy also suggests new ways of working with countries that do not have country offices, which will be discussed bilaterally with the Member States concerned.

These approaches will be reinforced by key strategic directions for the next two years, which include: (i) analysis of existing challenges, opportunities, and capacity; (ii) mobilizing existing policies and strategies approved by global and regional governing bodies; (iii) cross-country learning and learning from diversity; (iv) development of tools and guidelines; (v) effective utilization of academic, research and national public health institutions including WHO

collaborating centres; and (vi) monitoring and evaluating the impact of the interim strategy, and reporting back to the Regional Committee by 2014.

A framework for action is necessary, to ensure that the work with, in and for countries is documented. The strategy therefore highlight the new procedures that are being put in place by the Regional Office to better frame its work in country, intercountry and multicountry modes. Specific reference is made to existing biennial collaborative agreements (BCAs) and the development of country cooperation strategies (CCSs) in all Member States in the Region.

Introduction – From past to present

1. Following the establishment of the World Health Organization (WHO) in 1948, the Regional Office for Europe was set up in 1952. In these early stages, only Turkey had a WHO Representative Office, whereas in other countries WHO's presence was felt through the development of norms, standards and guidelines, publications and collaboration on various, mainly vertical programmes. Through these, WHO established the value of an "intercountry" way of working.

2. In 1985 the then 32 Member States in the European Region agreed on their first common policy for health, "Health for All" (HFA), which has since been updated at regular intervals *(1)*. The 1990s witnessed significant political changes in the WHO European Region, as a result of which the number of Member States in the Region gradually increased to 53.

3. The political and economic upheavals faced by the countries of central and eastern Europe (CCEE) and the newly independent states of the former Soviet Union (NIS) had a serious 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 and morbidity rates.

4. The Regional Office acted rapidly to respond to these challenges. The "Eurohealth programme for intensified cooperation with central and eastern Europe and the newly independent states" was approved by the Regional Committee in 1990, in order to develop and scale up activities in this part of the Region (2). About two thirds of the Regional Office's activities were directed towards these countries.

5. To facilitate implementation of this programme, a country health department was established. Countries were assigned to "desks", each consisting of a professional staff member and a number of 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 these countries and the WHO Regional Office.

6. Despite working with a very limited budget, much was accomplished – as the Eurohealth evaluation showed – and the Regional Office's technical work was channelled to the target countries through the infrastructure created by the Eurohealth programme. This infrastructure still exists, though it has been further developed in the subsequent decade. During these years the Regional Office, while further strengthening its intercountry mode of working, continued to provide technical support (including policy advice) to Member States, introduced the monitoring of health trends and helped countries to turn the results of normative work into national policies and guidelines.

7. After 2000, the Regional Office introduced a new strategy, "Matching services to needs" *(3)*, which put more emphasis on the country-specific way of working and was driven by country priorities in its bilateral collaboration. Considerable decentralization took place, both in technical and administrative areas. Country offices were further strengthened, and they were supported by a "country help desk" at the Regional Office, based in the Regional Director's office. While attention was focused on countries most in need of support, work continued with western and northern European countries through the established networks and intercountry programmes, and specifically through the "Futures Fora". Launched in 2001, the Futures Fora

aimed to provide an impartial environment where top-level decision-makers could share their experience of tackling concrete policy issues and working out possible solutions *(4)*. The technical programmes at the Regional Office and in its GDOs continued to support countries on request.

And today …

8. Today, the European Region is one of the most diverse and dynamic of WHO's regions. Its 53 Member States have a total population of almost 900 million, with diverse economies, political systems, levels of health and cultures. Unfortunately, unemployment and poverty have increased during the financial crisis, which continues to occupy the agenda of most Member States. Cuts in public spending threaten health, and the full consequences of the economic crisis will continue to play out over several years. The most prominent demographic characteristic of the Region is its ageing population.

9. In this situation, considerable budget increases for the Regional Office cannot be expected. On the other hand, the political and economic empowerment of certain Member States means that they now not only stand on their own feet but are also able to offer support to other countries in the Region. In addition, the WHO European Region is fortunate in being home to many of the most prestigious academic, research and public health institutions in the world, making a large expertise available.

10. The state of health in the WHO European Region has been improving overall, but not as rapidly as it could or should. In some cases it is getting worse, especially in respect of a widening health gap between social groups and the growth of child poverty. There are still extreme pockets of ill health and poverty that need to be urgently addressed and large, correctable variations in health status between and within all countries.

11. A detailed description of the public health situation in the Region is contained in the forthcoming publication, *The European health report 2012*.

WHO reform and its relationship to the new country strategy

12. In this challenging and exciting era, WHO is already considering how best to reform the way the Organization operates in order to ensure a healthy future. This includes increasing WHO's effectiveness at country level. WHO's country presence will be further aligned with each country's capacity, needs and priorities. The WHO Regional Office for Europe is closely involved in this reform process, ensuring that operational improvements are both appropriate for the specificities of the Region and in line with those proposed at global level.

13. The reform process will naturally take some time to reach completion. In the meantime, especially since the economic crisis has hit the European Region particularly hard, it is urgently necessary that support to countries is as effective and efficient as possible. In this situation, it is considered appropriate to establish an interim country strategy for the next two years only, thereby allowing the Region to move quickly ahead in creating a beneficial WHO impact in *all* Member States. This will also help WHO/Europe to make best use of its resources and of WHO's comparative advantage, and to test new ways of working. Progress will be evaluated and reported back to Regional Committee in 2014, by which time the WHO reform process will have been completed. Also by then the new European health policy framework, Health 2020, will be in implementation mode and it will be timely to assess the progress made in countries

since 2012 and to check that WHO's way of working in the European Region is still in harmony with the approach of the global reform. A longer-term country strategy will then be developed.

Why a new country strategy at this time?

14. So why a new country strategy? The existing strategy has been in place for over a decade, and in the meantime the policy environment has changed rapidly. In the current economic environment, it is time to assess how the Organization can maximize its resources, avoiding unrealistic burdens. It is also time to redress the balance of previous years, so that while countries in particular need of support continue to receive this in an appropriate way, *all* countries across the WHO European Region receive support as and when they need it.

15. Building on the work of the previous decades, the WHO reform initiatives are integrated into the new country strategy for *all* Member States in this diverse European Region. It aims to make WHO's work in countries more efficient, by taking into consideration the capacity of the Member States and sharing their experiences more effectively. All countries are encouraged to collaborate in and contribute to this joint venture to improve health and reduce inequities in health in Europe.

16. The work of WHO in the European countries will be guided by the Regional Office (through intercountry, multicountry and country-specific operations), with extensive technical input from the evidence collated and produced by the GDOs, WHO collaborating centres and other networks. Work in the countries will draw on the vast capacity and knowledge of the Regional Office, backed up as necessary by WHO headquarters. The WHO country offices will continue to play a significant role in the work in all the 29 countries where they exist.

17. It should be clear that this is not an action plan. It does not go into the details of who exactly does what, or when and how; that will be dealt with later. What it intends to do is to set out the values, principles and new approaches of working *for*, *in* and *with* countries, along with the main strategic directions for next two years. Strategic planning is not a finite process, and it cannot be carried out without the close collaboration of all stakeholders. Therefore as discussions continue through the WHO reform process and, as consensus is slowly reached on the overall strategic directions, the WHO Regional Office for Europe will continue to consult with European countries and make adjustments around specific priorities and issues as agreed in a transparent manner. In the meantime, the work outlined in this interim country strategy will proceed, with further strengthening of the institutional framework, training and capacity-building of staff and in Member States, exchanges of information and good practice, and the development of country cooperation strategies in those Member States who have expressed a willingness to have them.

A new country strategy for the WHO Regional Office for Europe

Underlying values and main objectives of the new country strategy

18. The new country strategy is based, first and foremost, on the common values enshrined in the WHO Constitution and is bound by clear principles for action. These include the following: (i) that the country strategy contributes to improved health outcomes, reduced health gaps and strengthened health systems, for the continuous improvement of population health and the reduction of inequities in Europe; (ii) that all Member States are able to benefit from and/or contribute to WHO country work, each in ways appropriate to its needs and assets, and are supported in making use of existing and emerging evidence and knowledge as part of their national decision-making process; (iii) that optimum use is made of the limited resources

available in the Regional Office and in countries, including time, funding, knowledge and personnel; (iv) that the diversity of the Region becomes a resource for learning and developing alternative ways of meeting the challenges and taking advantage of the opportunities, and that efficient and effective sharing of know-how and information is facilitated, (v) that the way of working is proactive, forward-looking and adaptive, ensuring that emerging challenges and opportunities are quickly picked up; and (vi) that the mechanisms, functions, structures and staffing are in place to reach the objectives of the Organization's work with and for countries, by closer integration of country, intercountry and multicountry work to ensure their mutual enhancement.

19. The mode of operations is based on learning from the experience of the past, when there was a somewhat artificial separation of country, intercountry and multicountry work. The new country strategy aims to reinforce the intercountry way of working and to take advantage of multicountry initiatives, so that a much more effective sharing of knowledge and experience can be achieved. This is over and above the traditional country-specific mode that was so strongly emphasized in the last country strategy. Further strengthening of the country-specific mode will continue through a clear strategic direction from the Regional Office that builds on the evidence-based work that is developed through the intercountry and multicountry approaches. In this time of economic crisis, it is expected that this change in the way of working with Member States and making better use of all types of resources at all levels of the Organization and in the Member States is also a move in the right direction that will be more cost-effective and result-oriented.

Strategic directions to achieve these objectives

Analysis of existing challenges, opportunities and capacity

20. In order to go forward, the Member States and the Regional Office need to be fully aware of the existing situation and possible opportunities and challenges in the next few years, and to bring together the main sources of knowledge. Six main sources of information will be used to analyse the challenges and opportunities for country work. These include: (i) the analysis made of recent Regional Committee resolutions and agreements; (ii) the HFA database and other databases, as well as country information collected by technical programmes at the Regional Office, its GDOs and country offices; (iii) information from networks such as Healthy Cities, Regions for Health, Health-Promoting Schools and other types of intercountry collaboration; (iv) the work of subregional networks (the South-Eastern Europe Health Network, Baltic countries, Nordic countries, European Union (EU) countries, etc.); (v) information from WHO collaborating centres and interested research institutions; (vi) analyses carried out by countries themselves. A regular review of information from these sources will inform the discussion with countries regarding challenges, possible opportunities as well as priorities, and the review will be kept up to date. This will include the possibility of partnerships, also with other organizations.

21. In carrying out this analysis, countries will be asked not only what support they need but also what contribution they could offer to make to WHO's work with, for and in countries. In some cases, such contributions may be financial or organizational, such as offering to form subgroups to investigate specific issues. In other cases, they might relate to improving the overall WHO database by submitting timely information, providing interesting case studies, or acting as pilots for new ways of working or as peer-reviewers, "buddies" or "twins" for other countries, regions or cities. A mapping of institutional and expert capacity in countries that could be offered for the benefit of other countries or regions will be further explored, to allow pilot projects to be drawn up on such capacity, either on a country-by-country or a multicountry/subregional basis. As the WHO Regional Office for Europe moves towards the

development of country cooperation strategies, this information is central to such agreements and will allow for more effective mapping and sharing of such resources.

Mobilizing existing policies and strategies approved by global and regional governing bodies

22. Over the years, Members States have discussed and agreed to a plethora of policies and strategies to improve health and well-being at both global and regional levels. These represent a wealth of knowledge and experience to be implemented at the country level. The Regional Office's main aim is to support 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 provision of technical programmes, interventions and capacity-building. The priorities of WHO's work in countries will reflect the decisions taken by its global and regional governing bodies, as well as country-specific priorities. It will be at the crossroads of these two approaches, and in line with the regional perspective on the programme budget.

23. As mentioned above, a new European health policy framework – Health 2020 – is being presented to the Member States at the sixty-second session of the WHO Regional Committee for Europe. Following numerous consultations, there are clear indications of a growing consensus around certain issues in the new policy, including: (i) the vital importance of health and well-being as a driver of socioeconomic development, and the need for action to reduce health gaps; (ii) the essential role of the new arrangements for governance for health through a whole-of-government and whole-of-society approach; (iii) the need to ensure the involvement of all stakeholders in finding solutions to improve health and health systems in countries; and (iv) the essential role of the health sector, not only in providing access to patient-centred care and effective public health functions, but also as leaders and capacity-builders in the collaboration with multiple sectors and stakeholders.

24. The Regional Office's work on strengthening health systems, as reflected in the Tallinn Charter that was adopted in 2009, which places emphasis on improving the quality of health care and health systems, including health financing arrangements that promote health, has been further developed. Additional efforts have started to ensure that the essential public health operations (EPHOs) are being effectively implemented in all countries (according to their national laws), including disease surveillance, as well as primary prevention and health promotion. Tools to analyse weaknesses in the system and policies to invigorate them have been developed and will continue to be shared with all countries in the Region.

25. 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 environmental agreements where WHO has some clear responsibility (the Protocol on Water and Health to the 1992 Convention on the Protection and Use of Transboundary Watercourses and International Lakes, the Convention on Long-range Transboundary Air Pollution). WHO also achieves much progress through "soft law" such as declarations and charters adopted at ministerial conferences, as well as strategies and action plans that are endorsed at global and regional governing body meetings and further supported by the adoption of accompanying resolutions. The so-called "soft law" commitments are of course voluntary, but some countries have achieved a positive impact on health through their implementation. A recently completed analysis of key decisions made by the Organization's governing bodies will continue to guide and inform the use of such instruments in the future.

26. 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, firstly to ensure that such tools are brought to their attention, and second to assist them in making use of them. The Regional Office's web site will be further enhanced for this purpose. A communications strategy is currently being developed, to allow the Regional Office to take fuller advantage of modern communications practices, technologies and marketplaces.

Cross-country learning and learning from diversity

27. Multicountry and/or subregional networks of Member States in the WHO European Region have come together through natural alliances based on areas of mutual interest and needs. These will become more relevant in WHO's work in countries. Such multicountry learning may not necessarily be confined to a group of countries that share geographical or sociopolitical similarities, but could also focus on a particular area of interest. For example, one country has expressed interest in sharing its experience in the fields of tobacco control and of emergencies and humanitarian aid with a wider group of Member States; another is interested in helping to build capacity around addressing tuberculosis (TB) and HIV/AIDS. Such proposals are mainly acted on using the resources and funding of the Member State in question.

28. In order to further promote cross-country learning, the Regional Office can play a facilitating role in the formation of such subgroups, as well as in their work, as is already the case in several instances. It can and will facilitate and encourage the use of existing resources in a country to support other countries in tackling issues of priority for public health, and it will promote initiatives taken by Member States to share such experiences directly with others, if they are in line with WHO's values and principles. It is therefore envisaged to further map such available capacity for the benefit of the Region or parts of the Region or for interregional collaboration.

29. Networks such as Healthy Cities, the Regions for Health Network and Health-Promoting Schools are in effect natural laboratories for testing different ways of meeting challenges and taking advantage of opportunities. These "settings" networks are already collaborating on vital issues such as formulating public health reports, developing policies to tackle the social determinants of inequalities in health, and developing capacity for and implementing health impact assessment (HIA). Some of the participants in these networks are world-wide pioneers in their area of interest, but the knowledge and tools they produce are not always widely known, even in their own countries. WHO will help to ensure further dissemination and sharing of the knowledge of these intercountry networks with all Member States.

Tools and guidelines

30. Most of the technical programmes and networks have produced and are using various tools and guidelines. An inventory will be made of all such tools and guidelines, to bring them together in a "one-stop shop". Equally importantly, experts in countries who have used such tools will be asked if they would be willing to share their experience of how such tools did or did not work, and to advise prospective users on how they can be implemented in practice.

Effective utilization of WHO collaborating centres and national academic, research and public health institutions

31. There is great potential for the Regional Office to increase its capacity by making better use of WHO collaborating centres. Currently these centres respond to ad hoc requests for evidence or research from the Regional Office. However, ways of making better and more regular use of the WHO collaborating centres are being explored, as they can contribute to evidence-based policy-making in a more regularized manner. They can also be useful in helping to absorb and make use of new research findings, and to forge closer links with universities and research institutes in general. By 2014, links to specific networks of public health schools,

public health institutes and universities will also be strengthened, and effective ways of working with them will be identified and used, to encourage research, knowledge-sharing and training in areas of particular interest in Europe.

Monitoring and evaluating the impact

32. In the past, not enough attempts were made to evaluate the impact of WHO's work with, for and in countries. Discussions will be held to propose how this can be remedied in such a way that it is not a burdensome process, but that there is clear feedback on the value and outcomes of WHO's work in countries and suggestions for further improvements. The process of evaluation will be developed within the Regional Office and will take into account the need to be simple and not burdensome for the Member States involved. As a first step, simple feedback on country satisfaction with and perceived value of WHO support could be called for, moving later to measuring outcomes which, by the nature of the work, cannot be attributed to WHO alone. This will also inform the development of a longer-term country strategy beyond 2014.

Putting the country strategy into place

33. With the main principles and objectives for working "for, in and with countries" outlined in the interim country strategy, implementation will require greater participation of Member States and more transparency in decision-making through the development of more specific actions. In doing so, progress in the WHO reform process will be carefully followed and taken into consideration on a continuous basis.

34. As recommended by the External Working Group set up to review strategic relations with countries (RWGCo), the Regional Office should be in regular contact with each and every country in the European Region (see document EUR/RC61/BD/1 for the full report of the RWGCo). Until now, some countries' cooperation with the Regional Office has been limited to participation in sessions of WHO's governing bodies, technical meetings and conferences, and collaboration in intercountry programmes and networks. However, there is a need for constant and up-to-date liaison with each and every country, and while this is achieved through country offices in Member States where they are present, a mechanism must be identified to ensure the same effective and timely liaison for countries without a country office.

Working with all Member States at European regional level

35. At the regional level, WHO/Europe's work will continue to be visible mainly through the governing bodies and intercountry programmes and the effective use of publications, standards, guidelines, tools and information. 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. Since the Member States' active involvement in the Organization's governing bodies is very important in shaping the outputs of WHO, this work will be encouraged and facilitated by briefings, preparatory meetings and background documents, as well as by coordination meetings during sessions of the governing bodies. Better use will be made of the opportunities afforded by sessions of the Regional Committee to share knowledge of WHO's work with countries.

36. A new structure, the European Health Policy Forum of High-Level Government Officials, was established in 2010 to facilitate strategic discussions and provide a good opportunity for the Regional Office to work with European Member States in driving policy and ensuring implementation of effective action throughout the Region. This Forum played an important role in the formulation of Health 2020 and has met twice a year, maintaining contact through electronic exchanges on a protected web site in between meetings. The Forum is now being evaluated and the results will be presented to the Regional Committee at the present session. If the evaluation proves to be positive and it is decided to continue with this process, all countries will be encouraged to participate actively in its discussions.

37. Work with countries will continue in a country-specific mode but an intercountry approach, as well as a subregional/multicountry one, will be strengthened wherever necessary and feasible, with more emphasis on the two latter components than in previous years. What will change under the new country strategy is that intercountry work will be linked to the six strategic directions outlined above (see paragraphs 20–32), in order to give impetus to working with, for and in countries. Particularly in countries without a physical WHO presence, the brief analysis of challenges and opportunities will be vital for pinpointing where countries could make better use of the tools and guidelines already available, whether it would be appropriate for them to join existing intercountry activities, and how they might actively participate in tackling ongoing or emerging health challenges.

38. Any country may request direct support from the Regional Office's technical programmes for policy development and organization of conferences, consultations, workshops and training programmes. For example, comments from WHO on draft policy documents have been one means of support that has been appreciated in a number of countries. The improved organization and categorization of tools, methodologies and guidelines, etc., including those developed by the various networks, will make these more easily accessible to all countries, whether or not they participate in a particular network or collaborate with a particular technical programme. The presence of a WHO staff member or expert for closer liaison especially at a crucial point in partnership-building can be helpful, and greater efforts will be made to ensure that countries are aware of which WHO staff member to approach for which issue. The Regional Office will meanwhile continue to do all it can to provide all countries with rapid access to examples of country policy documents and relevant case studies.

39. Finally, in order to ensure that the Ministry of Health is informed of all possible collaboration between WHO and their country, it is suggested that use be made of modern technology by establishing electronic platforms through which communication between WHO and a country may be passed.

Working with Member States at subregional level

40. Although multicountry groups and settings-based networks do not operate in exactly the same way, they have much in common and sometimes overlap. The WHO European Region is enriched by a number of subregional country groupings, and many countries in the Region are involved in more than one group. Certain subregional groupings of countries have a long history and can be extremely formal. The **European Union (EU)** is the largest group (including 27 countries) and has a supranational character. Work with the Member States that belong to the EU needs to take account of the relationship that many of them have with the European Commission, as part of their full membership of the EU. At the sixtieth session of the WHO Regional Committee for Europe in Moscow in 2010, WHO/Europe and the Commission's Directorate-General for Health and Consumers (DG SANCO) signed a joint declaration, in order to invigorate policy dialogue and technical cooperation.

41. The country strategy will continue to promote the strategic partnership with the European Commission at regional level, translating the areas of cooperation into work at national level, thereby ensuring further policy coherence for health. WHO/Europe has also established a coordination mechanism to support Member States in preparation for and during their presidencies of the EU Council in relation to their health policy agendas. The Regional Office will continue to adjust its way of working with EU member countries by recognizing the specificities of this Union. How the Regional Office implements its country work, in collaboration with the European Commission, is relevant to the Member States and may also be beneficial to both organizations. Through a continued strategic partnership at regional level (as well as at country level), the Regional Office will continue to promote the sharing of information and agreement on common tools and instruments and data sets, so that synergies will be created and overlap between the two organizations will be avoided.

42. Another subregional grouping is the **Commonwealth of Independent States (CIS)**. The wealth of experience of this group of countries is enormous and should be systematically tapped. The Member States in this part of WHO's European Region feel they have a lot to share and are looking for opportunities to do so. They have expressed appreciation for the way in which they are increasingly involved in coordination meetings in preparation for important events such as governing body meetings. However, there is need for the CIS countries to come together more often as a subregional group to discuss themes and health issues of common interest. The Regional Office will continue to make every effort to promote this.

43. The CIS countries feel that WHO documentation centres are much appreciated by the countries where they are located, and they ask for them to be revitalized or made better use of, especially for the promotion of research, information and case studies in the subregion. The CIS countries also believe that the country strategy should ensure further promotion of their ongoing work. Some country offices could undertake translation of selected Russian documentation into foreign languages and disseminate it back to other European Member States. The cross-fertilization and transfer of information between different subregional groupings will thereby be further strengthened.

44. Other subregional groupings of Member States include the Nordic countries, which have a long history of working closely together. The **Nordic Council**, formed in 1952, has elected members from Denmark, Finland, Iceland, Norway, Sweden, the Faroe Islands, Greenland and Åland. The **Nordic Council of Ministers** has a secretariat of almost one hundred people, coming from all the Nordic countries. These countries cooperate on practically all aspects of economic, social and cultural development. Their cooperation on social and health affairs is based on the joint values that underpin the Nordic welfare model. The Nordic School of Public Health and the Nordic Centre for Welfare support their work, as does the Nordic Medico-Statistical Committee (NOMESCO).

45. The **Northern Dimension (ND)** is an instrument of cooperation between four equal partners: the EU, Iceland, Norway and the Russian Federation. Geographically the ND covers the north-west of the Russian Federation, the Baltic Sea and the Arctic regions. Its aim is to support stability, welfare and sustainable development by means of practical cooperation. Such cooperation takes place through partnerships, particularly those related to the environment and the Northern Dimension Partnership in Public Health and Social Well-being (NDPHS). Canada, France, Germany, Poland, the Russian Federation, the Baltic states, all the Nordic countries, the European Commission, WHO and other United Nations organizations participate in the NDPHS. More recently, a network of universities and the Northern Dimension Business Council have been established. The ND's operations are based on joint funding. Every effort will be made to take such opportunities where Member States gather to promote the work and technical guidance of the WHO Regional Office for Europe, working not only for these groupings but with these groups of countries to the benefit of the WHO European Region.

46. Another successful subregional grouping was initiated by the leaders of the **Balkan countries**, who now come together on an annual basis to pursue common goals and ideals. The South-eastern Europe Health Network, a subregional gathering of ministers of health, meets regularly to discuss national projects that serve the subregional gathering of Member States through regional centres. In the past, projects related to specific health issues have also been established, such as the Balkan Primary Health Care Project supported by the Canadian International Development Agency.

47. The **South-eastern Europe Health Network (SEEHN)** came into existence following the establishment of the Stability Pact for South-eastern Europe in 1999 as a conflict prevention and reconstruction process in the region; a health component was added in 2001. It comprises representatives of ministries of health from nine countries (Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Montenegro, the Republic of Moldova, Romania, Serbia and the former Yugoslav Republic of Macedonia), ten donor countries and five international organizations, including WHO. The WHO Regional Office for Europe has provided political, managerial and technical support to the network from the beginning. Decisions are made by consensus through regular meetings every six months, and the presidency of the network rotates on a six-monthly basis. The SEEHN enjoys funding from a broad number of countries, the EU and other organizations.

48. The Regional Office will continue to make efforts to promote this way of working through subregional mechanisms at both political and technical levels, where countries naturally align around each other or around the recognized leadership of one particular country. One example involves tobacco control, as well as emergencies and humanitarian aid, where countries have requested assistance from Turkey, and the Member State has willingly provided resources in order to help them achieve similar positive results in these areas of health.

49. The WHO **Regions for Health Network (RHN)**, established in 1992, today comprises 29 regions in 18 countries. The RHN was unique in that it started “from the bottom up”, i.e. the 11 founding regions asked WHO to establish a network of regions to promote health through intersectoral action and to tackle inequalities in health. The RHN is largely self-financing and includes fees from members. The importance of the level of regions has been recognized by the EU, which has set up the Committee of the Regions. For countries such as Germany, Spain and Switzerland, the level of the regions is particularly important. It is probable that, in line with the WHO Regional Director for Europe’s vision of closer collaboration with the EU, strong links could be made to the Committee of the Regions. A steering committee of participating regions and WHO decides on the issues to be given priority in the RHN. Thanks to their continuing and long-term collaboration, colleagues from the regions maintain strong links and are able to offer each other support, both through agreed projects and on an informal basis.

50. The **Healthy Cities project (HCP)** has become a global movement. In the European Region, over 100 cities have been or are being designated as healthy cities; hundreds more are associated through their national networks. The HCP is largely self-funding and includes fees from members. From its inception, the project was designed to promote the values of HFA and the HFA policy at city level. Together the participating cities decide on the issues that they will focus on over the next five years. Subgroups have also been set up to concentrate on specific issues in which at least 15 cities have expressed an interest. One of those cities takes the lead in pushing the group forward, so their results can then be shared throughout the network. In 1998, a “multicity” group was formed: the Baltic Region Healthy Cities Association. In addition to its clear WHO character, the Association links to the EU Strategy for the Baltic Sea Region and to the NDPHS, taking part in their meetings and developing new projects.

51. **Interregional networking** will clearly become a more important component of the WHO Regional Office for Europe’s work. There is much to learn from other WHO regions. The

Regional Office will keep a close watch on their developments, both in country work and otherwise, in order to learn from their experience. In an attempt to ensure coherence within WHO itself, closer collaboration between WHO's regional offices will be promoted.

52. More importantly, relevant country offices will also be encouraged to share their experiences across WHO regions, in an attempt to expand the dissemination of information on positive health developments in the Member States. The country office in Turkey, for instance, is perfectly positioned to bridge the gap between the European and Eastern Mediterranean regions of WHO, and this is possible owing to the good relations that the Member State itself has with its neighbouring countries. Other relevant examples could be identified and used in the future, such as between the country office in Kyrgyzstan and China.

53. Further interregional collaboration is being developed with other regions. Particular attention will also be paid to possible initiatives from WHO headquarters to bring together the WHO regions for mutual learning and collaboration and to promote the global spirit of the Organization.

Working with Member States at national level

WHO collaboration with Member States with country offices

54. Over the years, country offices have played a key role in the Regional Office's country relations. 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. Country offices have also been important for ensuring continuity in the development and implementation of health policies and plans, despite changes in governments. In several Member States there is and will continue to be a physical WHO presence in the country. However, the Regional Office is constantly reviewing the need for its country presence and adapting the level of its presence accordingly.

55. When the RWGCo reviewed all the country offices in 2010 and explored the need for their continued presence, the feedback they received from countries regarding the value of the country offices was unanimous. Member States consider these offices to be an asset and they would like them to continue, even at the expense of a cost-sharing arrangement. The RWGCo also recommended that there should be a country presence in each and every country, and not only in the 29 countries where they currently exist. The RWGCo did warn that, with the passage of time since their establishment, the staffing and funding of some offices may not be as cost–effective as it should be. Hence, cost-sharing arrangements with governments were encouraged. Moreover, the technical expertise in the country office does not always match the actual needs of the country. RWGCo therefore indicated that the nature of this country presence will differ in each country, as it should be based on the country's needs and capacities as well as on the Regional Office's capacities and resources. The WHO Regional Office for Europe will therefore maintain its country offices for as long as the Member States consider them useful, but this issue will be kept on the agenda and addressed at regular intervals.

56. At present, WHO has country offices in 29 European Member States, mainly in central and eastern Europe, south-east Europe, the CIS and central Asia. The explanation for setting up these country offices is historical, as outlined in paragraphs 2–7 above. Country offices fall into two categories: a country office led by an internationally recruited WHO representative (WR); and a country office led by a nationally recruited national professional officer (NPO). In the latter case, the country office can be either medium-sized, because of the technical assistance still required by the country, or a smaller country cooperation office for advocacy and liaison.

57. Country offices led by **NPOs** are found in Armenia, Azerbaijan, Bosnia and Herzegovina, Belarus, Bulgaria, Croatia, Czech Republic, Estonia, Georgia, Hungary, Kyrgyzstan, Latvia, Lithuania, Montenegro, Poland, Romania, Slovakia, Slovenia, the former Yugoslav Republic of Macedonia, and Turkmenistan. Knowledge of the country's settings and cultural traditions, as well as of the 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. Country offices' understanding of the local setting is important for making technical programmes more aware of the specific needs in the countries.

58. In the case of Kazakhstan, the Republic of Moldova, the Russian Federation, Serbia, Tajikistan, Turkey, Uzbekistan and, most recently, Ukraine, the heads of country office (HoCOs) are international staff, i.e. **WRs**. Annex 1 contains a list of WRs and NPOs.

59. The functions of the two types of offices are similar, except in policy development, where internationally recruited staff are more accepted in some countries.[1] Country offices 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), and in advocating for health and promoting new initiatives and approaches such as working on 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, WHO's country offices will continue to be the face of the Organization in advocating for coherence in addressing health priorities.

60. The type of country office depends on the specific local situation, the size of the country and its complexity or stability, as well as its capacity. The need for different types of country office is therefore expected to continue over the next few years. In 2011, criteria determining the type of country office needed by the Member State were elaborated based on indicators and HFA data. These include the level of national health indicators, health system and service coverage, the country's economic situation and its population. More importantly, the criteria used were aligned with those discussed in the WHO reform process, but they will be periodically reassessed. If, as a result, the criteria and indicators change, and a 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 areas considered to be a priority for the Region.

61. The staffing of the Regional Office's country offices was also reviewed in 2011, with the aim of ensuring the right technical level of country staff/experts required to deal with country-specific issues. The emphasis is on ensuring more uniformity of staffing profiles within the country offices, by having a similar core presence and administrative capacity in each country office, but allowing for a technical skill mix that is more tailor-made to the country than was the case until the end of 2011. A "*core presence*" of staff has been defined as the minimum staff presence to secure an effective liaison function at country level, and an "*essential presence*" is defined as the minimum staff necessary for country office functions to be implemented. These vary according to the size of the country office as defined by WHO headquarters.

[1] WR-led country offices support policy development, provide strategic advice on health system strengthening, ensure technical cooperation and coordination, are responsible for information-gathering, advocacy and communication, and ensure representation and partnership. NPO-led country offices provide health leadership, especially in emergencies, ensure technical cooperation and coordination of country-specific work, are responsible for information-gathering, advocacy and communication, and ensure representation and partnership.

62. With regards to professional development and skills, all HoCOs and WRs are highly trained in management, policy formulation and in facilitating technical assistance with reforming national processes. This is important, as they ensure that the intercountry work delivered by the Regional Office through its technical programmes and networks is successfully transmitted to countries. They will be encouraged to participate in well-established networks and interest groups when these meet their health development challenges. There is a need to increase the attention focused on 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. This, together with the right level of managerial decentralization and an adjusted delegation of authority, will ensure that HoCOs and WRs play a stronger diplomatic and political role. To this end, all country office staff will continue to 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 are already being offered as priorities of their training.

63. Since country offices are particularly important in those Member States that are facing difficult political problems or which require the most assistance in health system reforms, they are now receiving further and more effective administrative and managerial support from the Regional Office, coordinated by a central team called "Strategic Relations with Countries (SRC)", which is situated in the office of the Regional Director. SRC has recently been restructured and downsized in order to serve a dual function a) providing strategic advice to the technical divisions at all times as the central point where country information and intelligence is collated, thereby ensuring more effective coordination of those country activities that are implemented by the Regional Office; and b) serving as the main liaison point for strategic and policy issues with those countries that do not have a country office.

WHO collaboration with countries that do not have a country office

64. Consultations with the Member States that do not have a country office have clearly indicated that their needs are different and go beyond the activities mentioned above. Suggestions by the Member States for the Regional Office to consider include: (i) to assist with strengthening the leadership role of the ministry of health in its intersectoral collaboration with other ministries (known as the "stewardship" function); (ii) to identify opportunities for twinning of countries to facilitate the exchange of experiences; (iii) to provide support and evidence for key national events; (iv) to discuss priority issues such as health budgets or the development of national health policies; or (v) simply to be involved in discussions on strategic directions, such as preparations for health-related activities under a country's Presidency of the EU Council.

65. These Member States also feel that WHO could play a key role in bringing countries together around common public health priorities, to share good practices, exchange research and information, mobilize twinning and also carry out high-level missions, as well as helping them to mobilize their assistance to those most in need. All this should be clearly captured in the CCS that is to be developed for every Member State in the WHO European Region. All in all, it is clear that Member States can be more strongly supported by or contribute to the Regional Office's intercountry or multicountry work, including that of the networks.

66. However, the nature of WHO's "presence" in these Member States still needs to be further explored and strengthened. Different alternatives are suggested here, as well as a combination of these alternatives. A "country presence" could be in the form of a regular contact point or desk officer who would ensure a constant flow of information to and from the country's Ministry of Health. Another option would be to assign a WHO staff member at the Regional Office as the dedicated focal point or desk officer for the country. This person would act as a WR/liaison officer for the country (this is the approach taken at the WHO Regional

Office for the Americas). Another alternative could be to ask the Ministry of Health to nominate and appoint a national counterpart (NC) in the country, to ensure that this person is best positioned to secure adequate collaboration between WHO and the Member State (see Annex 4). The NC would be responsible for ensuring the exchange and dissemination of information between the Regional Office and the Ministry of Health and its institutions, particularly about developments in the country and hence its needs, priorities and also assets, especially in relation to innovative interventions for health. This would enable further discussions to be held on opportunities for support by the Regional Office or for the country to support intercountry work or an individual Member State.

67. Whichever alternative is considered to be appropriate for a particular country, much greater efforts need to be made to ensure that all countries are aware of the contact person for specific issues, either in the Regional Office or in the Member State. It has been suggested that the contact details of all technical staff should be made available to Member States, together with a list of institutions and focal points used by the Regional Office's technical programmes. As mentioned above, better use can be made of the Regional Office's web site, so that all countries are fully aware of ongoing activities. Modern technology could also provide an electronic platform to ensure not only that important messages reach the appropriate decision-maker but also that the person designated as the main focal point for WHO/country collaboration is fully aware of the various links.

WHO collaboration with Member States from the Regional Office

68. Technical support will be given to country offices by the Regional Office, which will use its technical capacity in Copenhagen, supported by a highly integrated set of GDOs that provide evidence and information for policy-making and by WHO collaborating centres. The Regional Office will also tap into other expertise available in the Region and elsewhere, for example by making use of existing knowledge hubs in the countries or by employing external consultants who are trained in the priorities, principles and values of WHO. The latter will be chosen from a roster of carefully selected experts who are interested in devoting part of their time to work 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. How this can be successfully accomplished will be further discussed, and the advice of Member States will be sought. It is important to state here that 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.

69. Technical programmes in the Regional Office will pay particular attention to improving the timeliness of their response to countries' requests for support or even to be more proactive in their approaches. As described in paragraph 63 above, the SRC team in the Regional Director's office, as the point of coordination between technical units and country offices, will be instrumental for this purpose. SRC leads the elaboration of country-specific workplans and helps to monitor progress in implementing them. SRC will also be responsible for providing strategic advice to the technical divisions at all times and, as a central point of country information and intelligence, can ensure more effective coordination of those country activities that are implemented by the Regional Office. Ensuring timely support by the technical programmes for dealing with incoming requests from countries will take place with the assistance of strategic desk officers in the SRC team, who are responsible for ensuring more coordination between the country offices and the technical divisions.

70. 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 and 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 country's health status are achieved.

71. 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 from the vast number of networks, experts and consultants associated with the Regional Office, will also be used to maximum benefit. This also means that WHO's technical 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 and 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. NCs nominated by ministries of health will be the first point of contact with the Organization on strategic issues and will be encouraged 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.

Framing the work of WHO with Member States – CCSs and BCAs

72. The work of the Regional Office in countries is driven by standardized policies, procedures and tools that are not necessarily known to the counterparts in Member States with whom the WHO Secretariat works. So far, the **BCA** has been the main tool through which the Regional Office has delivered technical assistance to most countries in the Region. Until now, BCAs have for many years provided some Member States with seed money around country priorities. This "contract" between the Regional Office and the country has the added value of specifying the priorities and expected outcome(s) during a biennium. A description of the financial contributions provided to Member States through "in-kind" technical support in countries over the past three biennia is presented in Annex 2. BCAs or other forms of framework agreements are found in 32 countries to date.

73. In other regions of WHO, the main tool used by Member States for cooperation with WHO is the **CCS**. Until now, the Regional Office for Europe has not developed CCSs with any of the 53 European Member States, since the BCA was the tool used and accepted as a bilateral agreement between WHO and the Member State, and it provided a good framework for action. Now, however, in the light of the WHO reform, the Regional Office is taking steps to move towards CCS development for all the 53 countries in the European Region and is already in the process of developing a CCS with Ireland, the Russian Federation, Switzerland and Turkey, while it is in discussions with Italy and the United Kingdom. In 2012, priority will be given to developing CCSs in all the non-BCA countries (all countries without country offices) where the country has expressed an interest in having a CCS. This will help to align more closely with the discussions and decisions taken as part of the WHO reform process.

74. Like the BCA, the CCS is a framework of action which documents: a) the needs and priorities identified by the country assessment and b) the cooperation of WHO with the Ministry of Health required to address these priorities. In the WHO European Region, the CCS will also give visibility to all the initiatives for health taken by the Member State at regional, international and global levels, by showcasing good practices, flagship initiatives and success stories, as well as national expertise (human resources as well as health institutions). Similar to the BCA, the CCS will provide a framework which incorporates the process of planning and implementing country-specific work; the appointment, role and responsibilities of national counterparts (NCs)

and national technical focal points (NFPs) (see Annex 4), as well as the WHO network of health institutions in the country and their roles and responsibilities. The CCS is not a legally binding document, unless the country chooses that it should be so. The Member State decides on the level of approval or endorsement or ratification of the CCS that it feels is most appropriate. Each CCS is therefore different, as it must be tailored to each country. Traditionally, it is a six-year plan, broken into two-year cycles, but successive versions may exist, as the most important feature of the CCS is that it is aligned on the country's planning process.

75. The BCA will continue to be an integral part of the CCS, so as not to lose the unique bilateral commitment between the WHO Regional Office and the Member State. This will ensure a more flexible approach, allowing for adjustments and negotiations on a biennial basis of the priorities, outputs and outcomes enlisted within the CCS. Progress in implementation of BCAs/CCSs will also be regularly reviewed using data from the Organization's global management system (GSM).

Resources

76. Providing technical assistance and support to countries requires resources. 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. In the meantime, 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 that are willing to share expertise and other resources to the benefit of other countries.

77. Member States will be encouraged to mobilize their own resources to assist other countries through multicountry approaches. Such multicountry approaches will be sought out and promoted by the Regional Office, as they have proven to be successful in the past. By working closely with Member States that are ready to invest human and financial resources in addressing health issues in which they have considerable experience and expertise, the Regional Office will achieve a more extensive and effective reach at country level.

78. 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

79. 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 this strategy. With the help of the governing bodies, the Regional Office Secretariat will do all it can to improve the health status of the Member States' populations.

80. The implementation and results of this country strategy will be reviewed by 2014, with a view to then developing a longer-term strategy, in full accordance with the WHO reform process.

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4. See for instance *Eleventh Futures Forum on the ethical governance of pandemic influenza preparedness*. Copenhagen, WHO Regional Office for Europe, 2008 (http://www.euro.who.int/__data/assets/pdf_file/0008/90557/E91310.pdf)

Glossary

Country-specific. A mode of operation used for outputs that are highly specific to the needs and circumstances of individual countries.

Desk officer. A Regional Office staff member responsible for relations with a country or group of countries.

Intercountry. A mode of operation used to address the common needs of countries through Region-wide approaches.

Multicountry. A mode of operation used when an output within an outcome is relevant to a limited number of countries.

National counterpart (NC). A contact person appointed/reconfirmed by the Ministry of Health as responsible for overall strategic cooperation with the Regional Office.

National Professional Officer (NPO). A nationally recruited WHO staff member leading a country office and providing health leadership, especially in emergencies, in addition to ensuring technical cooperation and coordination of country-specific work, being responsible for information-gathering, advocacy and communication, and ensuring representation and partnership.

National technical focal point (NFP). A person nominated by the Ministry of Health or equivalent and working in the Ministry or in an institution related to it, responsible for providing reviewed, updated and analysed country-specific data, disseminating best practice and information gained from WHO, and facilitating measures to address public health problems in a selected technical area.

WHO Representative (WR) An internationally recruited WHO staff member leading a country office and ensuring policy development and providing strategic advice on health system strengthening, in addition to ensuring technical cooperation and coordination of country-specific work, being responsible for information-gathering, advocacy and communication, and ensuring representation and partnership. A WHO Representative represents the Organization as a whole in the country (or a group of countries) of assignment. Internationally recruited heads of a WHO office are the representatives of the Director-General and of the regional director concerned.

Annex 1. WRs and NPOs in country offices

Country	Country Manager Post
Albania	WR (post vacant, being changed to NPO)
Armenia	NPO
Azerbaijan	NPO
Belarus	NPO
Bosnia and Herzegovina	NPO
Bulgaria	NPO
Croatia	NPO
Czech Republic	NPO
Estonia	NPO
Georgia	NPO
Hungary	NPO
Kazakhstan	WR
Kyrgyzstan	NPO
Latvia	NPO
Lithuania	NPO
Montenegro	NPO/Country Liaison Officer
Poland	NPO
Republic of Moldova	WR
Romania	NPO
Russian Federation	WR
Serbia	International Manager
Slovakia	NPO
Slovenia	NPO
Tajikistan	WR
The former Yugoslav Republic of Macedonia	NPO
Turkey	WR
Turkmenistan	NPO
Ukraine	WR
Uzbekistan	WR (post vacant, under selection)

The head of the WHO team attached to the United Nations Interim Administration Mission in Kosovo (UNMIK) is an NPO/Country Liaison Officer

Annex 2. Financial contributions provided to Member States through technical support in countries over the past three biennia (in $000)

Country	2006–2007				2008–2009				2010–2011			
	Signed BCA	AMS Working Budget			Signed BCA	AMS Working Budget			Signed BCA	GSM Working Budget as of 19.07.2011		
		RB	OS	Total		RB	OS	Total		AC (RB)	VC (OS	Total
Albania	422	158	1 998	2 156	1 750	96	1 997	2 093	3 600	90	4 160	4 250
Armenia	570	426	754	1 180	1 700	575	844	1 419	1 265	270	532	802
Azerbaijan	640	356	227	583	2 200	498	1 025	1 523	1 640	172	595	767
Belarus	204	158	442	600	1 975	189	675	864	1 475	153	709	862
Bosnia & Herzegovina	463	417	1 709	2 126	1 600	328	764	1 092	1 190	202	117	319
Bulgaria	306	78	159	237	700	95	60	155	520	114	79	193
Croatia	336	147	25	172	975	377	3	380	725	146	244	390
Czech Republic	105	77	1	78	500	114	21	135	375	126	87	213
Estonia	153	65	141	206	400	179	177	356	300	151	169	320
Georgia	543	428	178	606	1 900	279	1 087	1 366	1 420	197	516	713
Hungary	89	90	1	91	550	343	31	374	410	139	153	292
Kazakhstan	340	181	266	447	2 050	373	1 184	1 557	1 860	143	1 472	1 615
Kyrgyzstan	1 150	453	1 900	2 353	2 793	390	1 978	2 368	2 080	385	2 908	3 293
Latvia	140	83	100	183	450	116	166	282	335	84	138	222
Lithuania	141	74	53	127	450	69	280	349	335	85	202	287
Malta	50	43	0	43	250	57	27	84	250	54	0	54
Montenegro *	0	17	10	27	750	112	69	181	560	113	162	275
Poland	141	115	19	134	1 585	287	547	834	1 180	95	311	406
Republic of Moldova	688	436	225	661	1 800	630	489	1 119	2 300	214	1 516	1 730
Romania	338	99	213	312	1 050	216	336	552	782	145	483	628
Russian Federation	9 986	405	10 252	10 657	6 750	150	6 826	6 976	4 800	57	5 602	5 659
Serbia*	304	69	224	293	1 475	197	402	599	1 099	180	217	397
Slovakia	94	74	10	84	525	308	75	383	390	114	86	200
Slovenia	55	49	0	49	300	134	135	269	225	63	104	167
Tajikistan	723	398	1 942	2 340	3	464	4 565	5 029	2 235	398	4 905	5 303
The former Yugoslav Republic of Macedonia	397	131	498	629	1 375	222	421	643	1 562	214	622	836
Turkey	456	304	3 728	4 032	4 850	433	2 199	2 632	3 615	388	2 767	3 155
Turkmenistan	222	154	158	312	2 075	463	365	828	1 545	329	521	850
Ukraine	1 550	162	4 036	4 198	3 800	460	3 024	3 484	3 772	185	1 898	2 083
Uzbekistan	630	379	742	1 121	4 100	606	870	1 476	3 089	257	1 579	1 836
Totals:	21 236	6 026	30 011	36 037	53 678	8 760	30 642	39 402	44 934	5 263	32 854	38 117

****Serbia and Montenegro split into two independent states in the middle of the 2006–2007 biennium**

Annex 3. BCAs and CCSs

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

	Countries identified to develop CCSs in 2012–2013
1.	Switzerland
2.	Turkey
3.	Russian Federation
4.	Italy
5.	Netherlands
6.	Norway
7.	Belgium (to be confirmed)
8.	United Kingdom (to be confirmed)
9.	Other non-BCA countries (subject to their agreement)

Annex 4. NCs and NFPs: Terms of reference

WHO is firmly committed to working for, in and with the Member States, as described in the new country strategy for the WHO Regional Office for Europe 2012–2014. Collaboration with countries is focused on mutually agreed priorities that reflect country needs and are matched with the Regional Office's capacity to deliver. In this context, the Regional Office is continuously trying to optimize the mechanisms of collaboration with Member States. The Regional Office has extensive experience of country work through the system of **National Counterparts (NCs) and National (Technical) Focal Points (NFPs).** Successful collaboration depends, to a large extent, on the commitment and efforts of national health authorities. It requires active involvement and fulfilment of commitments by all parties. While WHO staff have responsibility for appropriate, efficient and effective use of resources to deliver quality products, the role of the relevant national authorities is crucial in achieving planned outcomes.

A. National Counterpart (NC)

In the framework of the above, the work of the WHO National Counterpart will be subject to the following specifications:

Activities and tasks –The NC will act as a contact person for communication on strategic and technical issues between the WHO Regional Office for Europe and the Member State. He or she will present the Ministry of Health's views on collaboration with the Regional Office, providing overall support and coordination and performing specific technical tasks if necessary and when applicable to his/her competence; in other cases, he/she will involve experts with specific expertise. The NC's contribution to the process of collaboration with WHO will be recognized by the national government and/or national employer as an integral part of the NC's responsibilities at country level. To that end, clear discussions will be held at country level, to identify what is expected from him/her within the framework of mutual collaboration and what percentage of his/her time will be allocated to collaboration with WHO.

Appointment – Usually, at the beginning of the BCA planning process, each Ministry of Health or equivalent will be asked by the WHO Regional Office for Europe through an official letter to appoint/reconfirm the NC for all BCA-related activities or for overall strategic cooperation with the Regional Office. It is advisable that a single candidate be selected for the entire Organization, including WHO headquarters. Under normal circumstances, the duration of appointment will correspond to the biennial period. Prior to the beginning of each new biennium, the appointment should be reconfirmed or a new one mutually agreed upon. Should there be a need for a change of NC the national government will inform WHO in a timely manner through the country office (where applicable).

The list of NCs appointed by ministries of health is published on the Regional Office's internal web site.

B. National (Technical) Focal Point (NFP)

The precise type(s) of activities and tasks involved will depend on the nature of the technical job involved in each programme. But in general, the NFP would be expected to:

- provide reviewed, updated and analysed country-specific data;
- disseminate best practice and information gained from WHO through public presentations and participation in debates;
- facilitate addressing public health problems in selected technical area(s) through health systems strengthening;
- advocate for health policy, in particular in institutional circles, fora, etc.;

- support Region-wide and global developments through international WHO advisory bodies/mechanisms.

In addition, in countries with a BCA, the NFP will:

- contribute to the planning, implementation and monitoring of BCA activities within his/her area of responsibility;
- regularly interact with the Head of WHO Country Office (HoCO) as well as with the National Counterpart (NC) on technical activities undertaken within the framework of cooperation;
- participate in the monitoring and analysis of achieving specific country expected results.

Criteria for selection of the National (Technical) Focal Point

The NFP is also nominated by the Ministry of Health or equivalent, and should be a person working in the Ministry or in an institution related to it, which may or may not be officially designated as a WHO collaborating centre. While the Ministry of Health, or equivalent, will be responsible for the overall coordination of work with WHO, it is expected that the NFP will have:

- adequate technical competence in the area of collaboration;
- sufficient seniority, experience and adequate official status to facilitate effective communication at all levels, from senior political figures to health institutions within a particular programme/area of work;
- adequate links to the work of the national health system and the health policy development process; and
- be in a position to gain support from relevant national experts and institutions.

Good knowledge of English would be strongly preferable but it is not a condition for appointment of an NFP.

Appointment – Health ministries are asked to nominate NFPs whenever a related activity is taking place at intercountry level, multicountry level and national level. The NFP should ideally be the same throughout the biennium for the technical area. However, it is common practice that WHO technical programmes check to make sure there is no alternate proposed for any new technical activity that is planned to take place. There can be more than one NFP, as each one represents a particular technical area/programme of work. However, there can only be one NFP per area, and if necessary, he/she can then appoint/involve other national experts as needed, in consultation with the Ministry.

The WHO Regional Office will collate the list of NFPs appointed to liaise with its technical programmes and will share them with the WHO Representatives and HoCOs, as well as with the Strategic Relations with Countries (SRC) ream in the Regional Director’s Office. The names of the NFPs will also be forwarded to the NCs by SRC/HoCOs, to ensure closer collaboration at national level.

C. Lines of authority and accountability of NCs and NFPs

It is important to note that, in the context of joint activities (in which, by definition, the WHO Regional Office and the Ministry of Health make a joint effort towards common achievements), **the NC** represents the Ministry of Health.The NC may not be engaged in private bilateral negotiations with any other institution on behalf of WHO.

The **NFP**, on the other hand, will work in collaboration with the WHO staff responsible for the technical programme (at both country and regional levels) and closely coordinate all activities with the HoCO, as well as with the National Counterpart. Technical guidance for technical focal points is provided by the WHO staff (programme manager).