REPORT OF THE SECOND GLOBAL MEETING OF WHO REPRESENTATIVES AND LIAISON OFFICERS

Geneva 26 to 30 March 2001

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I. BACKGROUND

The second global meeting of WHO Representatives and Liaison Officers was opened by the Director-General (Annex I, Opening and Annex II, Closing Remarks of the Director-General). The meeting brought together 135 WHO Representatives and Liaison Officers from all six regions with WHO's top management from both headquarters and the regional offices. Eight Heads of Offices of Emergency and Humanitarian Action also attended the meeting (see Annex III, List of Participants)

The main objectives of the meeting were:

- to strengthen "esprit de corps" of WRs' as a group
- to follow up the recommendations of the First Global Meeting of WHO Representatives and Liaison Officers held from 22 to 26 February, 1999;
- to encourage the sharing of WR/LO experiences at country level and encourage common problem solving;
- to facilitate interregional cooperation and an exchange of information on common issues;
- to update and inform WRs/LOs on new initiatives and corporate programmes to encourage proactive leadership at country level.

II. ORGANIZATION OF MEETING

The meeting was conducted through plenary sessions, working groups and technical dialogues. Plenary sessions were on Global and Organizational Developments and the Effect on the Work of WHO Representatives and Liaison Officers, Cooperation with Countries, Disaster Preparedness and Response, Mental Health and Health Systems Development. Working groups also met to further the discussions on Cooperation with Countries and Disaster Preparedness and Response. In addition, eight technical dialogues took place in parallel sessions with WRs/LOs choosing the ones they would attend. The technical dialogues focused on the following issues: communicable diseases activities at country level, essential medicines, making pregnancy safer, the Enhancing Health Performance Initiative, HIV/AIDS, transforming primary health care to address the challenges of chronic conditions, the negotiation process on the Tobacco Convention, and the Global Alliance on Vaccines and Immunization (GAVI). Following a brief introduction to each session, WHO Representatives and Liaison Officers were given the lead in presenting their experiences and in discussing their work at country level.

A poster and video display was organized to give participants and members of the Organization a personal insight into the workings of the country offices.

On the first day the meeting addressed some of the broad issues related to WHO's work at country level (Section III, Sub-sections A-D). On the second day the discussions were more focused on WHO's management processes and how they are implemented at country level, and on country cooperation strategies (Section IV). The mornings of the third and fourth days were devoted to three technical dialogues in plenary, while the afternoons were for optional technical dialogues (Sections V-VII). The meeting drew its conclusions and consolidated its views on the morning of the fifth day (Section VIII) (see Annotated Agenda, Annex IV).

III. GLOBAL AND ORGANIZATIONAL DEVELOPMENT AND THE EFFECT ON THE WORK OF WHO REPRESENTATIVES AND LIAISON OFFICERS

Role and functions of the country teams in response to global health initiatives and challenges

Participants were asked to give their views on the effects of global and organizational developments, as well as collaboration with other partners, the spread of HIV/AIDS, and disasters and emergencies on the work of WHO Representatives and Liaison Officers.

The meeting stressed the importance of increasing WHO's visible presence in the field. To achieve that, WHO Representatives and Liaison Officers had to be given the means and support to fulfil their role as credible and respected advocates of WHO's new emphases. They therefore had to be more involved in discussions with national authorities. Participants felt that the role of country offices was not accepted widely and a change of culture to a "country first culture" was needed.

Many of the activities that WHO Representatives and Liaison Officers were now having to undertake, such as prioritizing work and programme activities and building new partnerships, placed a strain on the capacity of country offices, particularly in small countries. Country teams were increasingly having to become more specialized in order to deal with priority areas such as HIV/AIDS and TB, as well as resource mobilization. A possible solution was to recruit specialist National Professional Officers, although care had to be taken not to rob Ministries of Health of their human resources capacity. Economists and demographers were also being enlisted to assist country teams.

Participants suggested that there should be a clearer definition of strategic focuses, for example, roll back malaria, DOTS and the safer pregnancy initiative, and that more emphasis should be placed on technical support to country teams.

There was a strong feeling that there should be more delegation of authority and decentralization of operations to allow a better and more sensitive response to countries' needs. In countries lacking stability and accessibility, greater flexibility would permit WHO Representatives and Liaison Officers to re-allocate resources to where they were most needed.

The meeting considered that, given the increasing scope of the work of country offices, the role of WHO Representatives and Liaison Officers should be strengthened in line with those of other agencies. However, strategies for strengthening country

teams should take account of country size and, therefore, the possibility of setting up sub-national offices in very large countries.

Participants felt that there should be an opportunity to review the effects of the new initiatives.

Developing the capacity of country teams

Having explored the changing challenges and the shifting environment of operating, the meeting discussed how country teams could be provided with the capacity to respond.

Stronger vertical links between HQ, regional offices and country offices would improve communications and country teams should be included in initial deliberations on policies and strategies. Information and publications also needed to be more country focused and, where possible, summarized for ease of translation; websites could also be further utilized with clear and summarized updates on technical issues. There was also a need for clearer guidance on different strategies, adapted to the needs of different countries. It was also felt that capacity-building should be integrated into WHO's Country Cooperation Strategy (CCS).

Participants emphasized the need to establish a well-defined career structure with recruitment of high-calibre national and international personnel, as well as a performance assessment procedure and a timetable for implementation. A strong management structure would also assist WHO Representatives and Liaison Officers to carry out their functions effectively.

Other suggestions included the use of distance learning, the rotation and secondment of staff, including interregional transfers of WHO Representatives and Liaison Officers, exchange of information between country offices and the use of UN volunteers.

Capacity at country level could also be enhanced by broadening the health perspective to involve other sectors (cross-cutting), as in the case of road traffic accidents.

Specific challenges of working with other development partners

The meeting was invited to discuss the specific challenges of working with other development partners, in particular, the United Nations Agencies, World Bank and bilateral partners, with a view to reviewing WHO's working relations with multilateral and bilateral partners.

Participants emphasized the need for guidelines to clarify relationships with donor partners. There was concern, too, that increasing decentralization of donor partners' operations meant that global policies were not always taken into account, therefore strong leadership was required at country level.

Membership of UNDG enabled WHO to contribute health aspects to UN planning and increased its credibility with governments. It was also useful in establishing a collective identity and common goals and in the sharing of information. WHO's acknowledged technical capacity meant that it should be accepted as the leader in

health by the other UN agencies. Collaboration with nongovernmental organizations and civil society could also enhance WHO's influence over health policy.

Participants emphasized the need to clarify UNDAF's function and WHO's role in it. It was considered to be very rigid and theme group meetings were time consuming; in addition, some agencies were perceived as lacking real commitment to it. It was also important for WHO to be represented at the same level as the other UN agencies.

Collaboration with the World Bank had been positive in some areas, for example, blood safety, but there had been little progress in defining a common approach to health systems development. There was also a conflict of interest between the funding priorities of some countries and those of the World Bank. The role of the World Bank planning instruments, the Comprehensive Development Framework (CDF) and the Poverty Reduction Strategy Papers (PRSP) needed to be more clearly defined.

WHO Financial Systems and Information Technology

Financial systems

The revised Financial Regulations and Rules were now in effect. The revisions reflected that WHO operated within the framework of a single strategic budget composed of all sources of funds. The major difference from the previous Regulations and Rules was a greater emphasis on the relationship between authority, responsibility and accountability.

A further important change for countries was that contributions might now be paid in local currencies subject to approval by the Director-General. It was expected that this provision would facilitate payment by countries that had difficulty allocating US dollars to meet their assessments which were denominated in US dollars. Care had to be exercised in this area since, unfortunately, devaluation would have an adverse effect on the value of local currencies.

In some countries the UN rate of exchange was unrealistic compared with some rates available locally. However, the UN had to use the official rate of the country. In circumstances such as those obtaining in the Democratic Republic of the Congo, WHO was working through the UN to try to secure a more favourable rate.

Travel

WHO's duty travel policy had been revised, and following implementation, a review of the new policy was under way to evaluate the implementation. The changes made by WHO were consistent with those taking place throughout the United Nations system. The aim of the new travel policy was to ensure maximum cost-effectiveness and savings had already resulted from a combination of the new per diem policy and negotiated air fares for many frequently travelled routes.

Participants pointed out that the cheapest fares were not always in the best interest of WHO in terms of the health and efficiency of staff members. There was also a feeling that WRs/LOs should be empowered to handle their own travel arrangements locally.

Resource mobilization and Programme Support Costs (PSC)

Between 1998 and 2000 the level of extrabudgetary contributions had risen by over 100%, therefore the 13% handling charge was not necessarily a disincentive. Donors were well disposed towards WHO because it offered technical assurance and quality. Moreover, private institutions charged more than 13%, so the charge might be considered as representing good value. In emergency situations the rate was only 6% and there should be no need to apply for it retrospectively.

PSC earnings in the last biennium had amounted to US$ 80 million and they therefore represented an important part of WHO's overall budget.

Although other UN agencies, for example, UNICEF, had a lower handling charge, they retained all the interest from extrabudgetary funding, whereas WHO applied most of the interest it received to programme activities.

WHO had to have some form of agreement with donors on how their money was being spent, otherwise donor expectations might not be met. However, there was a need to review agreements and ways of making money available more quickly at country level. Proposals for a more transparent allocation of PSC were under discussion with Executive and Regional Directors.

Information Technology (IT)

The Global Private Network (GPN) consisted of private channels linking the regional offices with HQ. Most country offices now had internet access, however, security considerations had restricted intranet access. That was now under review and all country offices would have access by mid-2001. The current debate focused on how to fund increased country connectivity.

IV. COOPERATION WITH COUNTRIES

Overall Management Framework and Programme Budget 2002-2003

The overall managerial framework consisted of a set of key elements, focused on the work and responsibilities of the Secretariat, and providing a unified programme framework for "One WHO". A major difference from past practice was a clearer focus on selected priorities, as evidenced in the 2002-2003 Programme Budget (PB) by a shift of resources to the current 11 priorities. The 2002-2003 PB also marked a change from resource-based to results-based budgeting.

Country Cooperation Strategies (CCSs)

The Country Cooperation Strategy (CCS) constituted a country-specific, medium-term (3-5 years) framework for WHO cooperation in and with the country concerned, highlighting both *what* WHO would do and *how* it would do it (areas of work and functions). It represented a sound balance between country needs, the activities of other development partners, and WHO's own global and regional directions. The intention was not only to articulate WHO's strategic agenda in each country, but also to put into practice new ways of working and to foster strategic thinking within the Organization. Hence, both the process and the product were important. Collective

findings from CCSs would feed into other managerial and organiz processes, for example the General Programme of Work 2006-20(

Country offices had found the CCS process intensive but worthwl briefing of staff, holistic rather than vertical approaches, and impr performance. The CCS document had been useful in presenting a WHO's role and priorities to Ministries of Health and partner orgi agendas developed in pilot CCSs envisaged greater selectivity, wi on "upstream" functions, and on partnership, coordination, health systems development. Experience to date suggested that success i strategic visions for WHO at country level would require changes budgets and operations, including more timely and flexible suppo to country offices and appropriate recruitment and training.

The meeting found that the CCS had great potential in providing l within WHO and a strategic approach to WHO's work at country bridge between WHO's global priorities and countries' needs and benefit countries by helping establish consensus on the strategy, a contributions to be made by all in-country and external partners ir health needs.

The CCS would enable WHO to participate better in wider Comn Assessment/United Nations Development Framework (CCA/UNI Work was in hand to institutionalize the CCS to secure compleme WHO managerial processes and to ensure that CCS findings influ working throughout the Organization. The meeting recognized th consequences for regional and Geneva offices in responding bette needs, as well as for budgets at all levels.

V. TECHNICAL DIALOGUE ON DISASTER PREPAI RESPONSE

WHO's country offices had an undeniable comparative advantage public health and local public health systems in the face of the ofi competing influence of external assistance. Therefore, country of given greater authority and technical and administrative support t fulfil their critical role.

Participants also recommended that WHO should take a stand on the arms trade and sanctions. WHO had both the mandate and te act as an advocate for and to protect the health of populations in c irrespective of political considerations.

WHO had precise responsibilities and unique assets for building i for disaster reduction. The protection of national capacities acros health sector should begin with analyses of risk and vulnerability. was therefore a priority for national partners as well as WHO staf undertaken on the basis of an evaluation of needs and lessons lea

It was essential for WHO to assume a more active role in mobiliz resources for public health in humanitarian action and to limit the

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