REGIONAL COMMITTEE

Provisional Agenda item 9.1

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# JOINT EVALUATION OF A SPECIFIC INTERCOUNTRY PROGRAMME – MULTI-DISEASE SURVEILLANCE AND RESPONSE

The Regional Committee had, at its 55th session, selected the supplementary intercountry programme (ICP II) "Multi-disease surveillance and response, including health hazards, risk behaviour surveillance, through intercountry and interregional collaboration, and use of regional mechanisms like ASEAN, SAARC, Mekong Basin Project, and Intercountry Cooperation in Health Development" for in-depth evaluation in 2003 and reporting to the 56th session of the Regional Committee.

The evaluation of this supplementary intercountry programme was undertaken in India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand by joint teams comprising representatives from (a) Member Countries – high-level officials familiar with the programmes, (b) experts of WHO collaborating centres and (c) staff from the Regional Office and WHO headquarters. The country visits, lasting three to four working days each, took place during April/May 2003. Each team interviewed officials and staff involved in programme implementation in the ministries of health and/or other focal ministries, and the WHO country office. The teams reviewed relevant WHO and country documents.

The teams assessed the intercountry programme in terms of the appropriateness of the mechanisms and approaches; adequacy of the resources; relevance, efficiency, effectiveness, complementarity, sustainability and replicability. Supplementing the analysis of the programmes and lessons learnt, recommendations were made with regard to: (a) understanding of the supplementary intercountry programme's purpose and objectives by the national officials and WHO country and Regional Office staff; (b) involvement of national programme managers and WHO country office in programme planning; and (c) the scope, approaches and mechanisms employed in programme delivery.

Based on the teams' analysis in respect of each country, a report was prepared by the evaluation team members and the Regional Office. This is now being submitted to the Regional Committee, through the 40th CCPDM, for its consideration.

# JOINT IN-DEPTH EVALUATION OF SUPPLEMENTARY INTERCOUNTRY PROGRAMME (ICP II) "MULTI-DISEASE SURVEILLANCE AND RESPONSE INCLUDING HEALTH HAZARDS, RISK BEHAVIOUR SURVEILLANCE, THROUGH INTERCOUNTRY AND INTERREGIONAL COLLABORATION, AND USE OF REGIONAL MECHANISMS LIKE ASEAN, SAARC, MEKONG BASIN PROJECT AND INTERCOUNTRY COOPERATION IN HEALTH DEVELOPMENT"

**SEAR EVALUATIONS 2002-2003**

**CONTENTS**

## ABBREVIATIONS AND ACRONYMS USED

| | | |
|---|---|---|
| AFP | – | Acute flaccid paralysis |
| ASEAN | – | Association of South-East Asian Nations |
| BBIN | – | Bangladesh, Bhutan, India and Nepal |
| BCT | – | Blood safety and clinical technology |
| CCPDM | – | Consultative Committee for Programme Development and Management |
| CPC | – | Communicable disease prevention, eradication and control |
| CSR | – | Communicable disease surveillance and response |
| EB | – | Executive Board |
| FETP | – | Field Epidemiology Training Programme |
| HIV | – | Human immuno-deficiency virus |
| HLTF | – | High-Level Task Force |
| ICP | – | Intercountry Collaborative Programme |
| MAL | – | Malaria |
| MBDS | – | Mekong Basin Disease Surveillance Project |
| MOH | – | Ministry of Health |
| MOU | – | Memorandum of Understanding |
| NCD | – | Noncommunicable disease |
| NGO | – | Nongovernmental organization |
| RC | – | Regional Committee |
| SAARC | – | South Asian Association for Regional Cooperation |
| SARS | – | Severe acute respiratory syndrome |
| TB | – | Tuberculosis |
| TUB | – | Tuberculosis |
| UNDP | – | United Nations Development Programme |
| UNICEF | – | United Nations Children's Fund |
| USAID | – | US Agency for International Development |
| WHA | – | World Health Assembly |
| WHO | – | World Health Organization |
| WPRO | – | WHO Western Pacific Regional Office |

## 1. BACKGROUND

The 54th session of the Regional Committee, in September 2001, recommended that joint evaluations of the supplementary intercountry programme - with representatives from the Member States, staff from the Regional Office and WHO country offices and a representative from outside the Region – should continue within the overall context of WHO's evaluation framework. The evaluation plays a fundamental role in strengthening dialogue among countries, Regional Office and WHO headquarters; serves to increase participation of the Member Countries in the continued development of the intercountry programme; and provides an in-depth assessment of a specific programme/content area addressed through the Supplementary ICP mechanism.

As the first phase of evaluation of WHO collaborative programme in 2002–2003, a general evaluation of the overall ICP II programme was conducted in 2002 and the outcome reported to the 55th session of the Regional Committee. The Committee, while endorsing the recommendations of the evaluation, selected the content area "Multi-disease surveillance and response, including health hazards, risk behavior surveillance, through intercountry and interregional collaboration and use of regional mechanisms like ASEAN, SAARC, Mekong Basin Project, and Intercountry Cooperation in Health Development" for in-depth evaluation in 2003 (Phase II). The results of evaluation were to be submitted to the Regional Director for his consideration, and on his approval, forwarded to the 56th session of the Regional Committee in September 2003.

## 2. OBJECTIVES AND FOCUS OF THE EVALUATION

### 2.1 General Objectives

The purpose of the evaluation was to critically evaluate the selected programme for 2002–2003, assessing whether the objectives of the ICP II programme were achieved and whether it:

- benefited several Member Countries with a catalytic or multiplier effect;
- developed regional or multi-country partnerships, regional institutional capacity–building and networking;
- facilitated technical cooperation through advocacy and influence on policy; and
- helped mobilize further resources to address critical problems in the programme area.

The joint evaluation was also to identify areas in intercountry collaboration and whether the expected contributions, strategies, approaches and mechanisms needed to be reoriented in future biennia to meet the collective needs of the countries of the SEA Region.

### 2.2 Specific Objectives

The specific objectives of the evaluation were to determine whether the selected ICP II:

- proved relevant and adequate in the context of: the regional public health problems, health policies and priorities; Organization–wide WHO goals and objectives, global expected results; and recommendations and resolutions of governing bodies and relevant global and regional forums (WHA, EB, RC, CCPDM, Health Ministers Meeting, Health Secretaries Meeting, etc.);
- effectively complemented the WHO country programmes;
- has been effectively and efficiently managed at country and Regional Office levels; and
- has been sustainable and replicable.

## 3. METHODOLOGY

### 3.1 Selection of Specific Programme Areas for Evaluation, Countries to be visited and Composition of the Evaluation Team

The Regional Director's selection of the programme area evaluated was based upon the criteria suggested by the 53rd session of the Regional Committee and the first meeting of the High–Level Task Force (HLTF). The selection was undertaken with a view to identifying programmes that are representative of the overall intercountry programme and which illustrate characteristics common to all intercountry programmes. This permits the evaluator to draw lessons and develop recommendations that would benefit all intercountry programmes as a whole, as well as the specific programme evaluated. Accordingly, the 55th session of the Regional Committee selected this programme for the joint in-depth evaluation.

The selection of countries to be visited was based on the extent to which the specific ICP activities were targeted to those countries. India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand were eventually selected for the evaluation.

As suggested by the High-Level Task Force on Intercountry Collaboration, six joint teams were selected, comprising (a) either the focal point for the programme or high-level officials familiar with the programme from selected countries[1], (b) expert from WHO collaborating centres in the SEA Region, (c) WHO country office staff in countries visited as part of the evaluation team, (d) the Regional Office staff, and (e) expert in the programme area selected for evaluation from outside the Region, one from AFRO[2] and/or another from WHO headquarters. The members of the teams included:

***Country experts nominated by Member States on the invitation of RD:***

- Dr Rinchen Chophel, Joint Director, Health Care Division, Health Department, Government of Bhutan
- Dr Ajith Fonseka, Director, International Health, Ministry of Health, Sri Lanka

[1] Nepal, selected as one of the six countries to nominate a national expert for the joint evaluation, could not provide him/her due to active involvement of most of the health officials in SARS screening.
[2] WHO AFRO could not provide an expert staff on disease surveillance due to prior commitments within that Region

- Prof. (Dr) Md. Mahfuzur Rahman, Department of Community Medicine, National Institute of Preventive and Social Medicine (NIPSOM), Bangladesh
- Dr U Hla Pe, Deputy Director-General, Medical Care, Department of Health, Myanmar
- Mr Ahmed Salih, Director, International Health, Ministry of Health, Maldives

***Expert from WHO Collaborating Centre:***

- Dr Somsak Wattanasri, Senior Expert in Preventive Medicine, Division of Epidemiology, Ministry of Public Health, Thailand

***WHO country office staff:***

- Dr Russell M. Brooks, Senior Health Planner, WRO Indonesia
- Dr Myo Paing, NPO, WRO Myanmar
- Dr Anton Fric, Epidemiologist, WRO Nepal
- Dr Lokky Wai, Management Officer, WRO Sri Lanka
- Mr Narintr Tima, NPO, WRO Thailand
- Dr Sampath K. Krishnan, NPO, WRO India

***Experts in the programme from WHO/HQ:***

- Dr Giuseppe Masala, PHO–CCO/SDE, and
- Dr Maria Santamaria, MO–CCO

***WHO Regional Office staff:***

- Dr T. Walia, HSD
- Dr P.T. Jayawickramarajah, Coordinator, SHS
- Dr Deoraj Caussy, OEH
- Dr J.M. Luna, CAH, and
- Dr S. Puri, PDO

### 3.2 Process

Building upon the “Framework for the Evaluation of Priority Supplementary Intercountry Programme 2002–2003 (SEA/PDM/HLTF/Meet.3/5)”, an evaluation protocol was developed. The protocol, along with background documentation on supplementary intercountry programmes 2000–2001 and 2002 2003, formed the basis for evaluation.

The joint evaluation teams consisting of one member each from countries, WHO collaborating centre, WHO country office, Regional Office and WHO headquarters visited each of the selected countries. The country visits lasting five working days took place from 14 April – 30 May 2003. Each team interviewed officials and staff involved in programme implementation in the Ministry of Health and other focal ministries, ASEAN, SAARC, Mekong Basin Disease Surveillance Project (MBDS), agencies/partners, and the WHO country office. The individual teams reviewed relevant WHO and country documents.

The Regional Office prepared a draft summary report incorporating individual country analysis of all the evaluation teams. The team members from the countries, together with the Regional Advisers, reviewed the draft at a meeting held on 19–20 June 2003 and prepared the final report which will be submitted to the Regional Director for his consideration and submission to the 56th session of the Regional Committee.

Dr Than Sein, Director, Department of Evidence and Information for Policy, provided overall guidance in the evaluation and preparation of the draft evaluation report.

## 4. ANALYSIS OF THE PROGRAMME

It is worth noting that the planned period of implementation of the ICP II programme extends over the two–year period of the current biennium and the evaluation was conducted approximately two–thirds through the biennium. It was understood that many of the expected contributions would not have been achieved. Therefore, emphasis was given to the managerial process and results achieved so far rather than the overall outcome or impact of the programme.

It must be emphasized that the focus of the evaluation was only on one ICP II programme. Though it was difficult attempting to isolate the ICP II component from other factors affecting the WHO collaborative programme, the evaluation did not attempt to cover the countries' own programme in this area nor the joint country/WHO efforts supported through the WHO collaborative programme or WHO country budget.

### 4.1 Description of the Programme

The national surveillance systems too often are built on independent control programmes without appropriate coordination. This leads to duplication and surveillance gaps and thus is not cost-effective. The increasing resistance of micro-organisms to drugs undermines the available therapy, and reduces effective response, thus significantly increasing the cost of health care. Specialized surveillance systems are important, especially where surveillance is complex and has specific information needs such as surveillance of risk factors and behaviour. Despite the variety of information requirements, many data elements collected in surveillance are very similar and the data source is often the same individual or facility.

With weak infrastructure and limited resources, the countries of the Region cannot sustain surveillance of an increasing number of communicable diseases, including drug resistance monitoring, risk behaviour surveillance and surveillance of occupational diseases. It was necessary, therefore, to focus on multi-disease surveillance using an integrated approach. Strengthening intercountry and inter-regional collaboration, use of regional mechanisms such as ASEAN and Mekong Basin Project and further development of

collaboration with SAARC were considered essential for the integrated multi-disease surveillance approach.

Under the ICP programme selected for evaluation, technical support is being provided to the countries on establishing regional mechanisms for multi-disease surveillance and surveillance of risk factors, and strengthening capacity for multi-disease surveillance and response.

### 4.2 Status of Implementation of the Programme

By the time evaluation was concluded, of the planned 2 products with 9 and 12 activities, respectively, to achieve both the expected contributions of the supplementary intercountry programme, most of the activities were either conducted or being undertaken. As of 20 June 2003, from the biennial allotment of US$ 291 000, the programme commitment reached 100 per cent (95 per cent obligation + 5 per cent earmarking) with 85 per cent disbursement of the total resources.

Apart from the continued technical support being extended, among others the major activities completed include, development of a “Regional Strategic Plan for Integrated Disease Surveillance 2002–2010”; and “Establishment of a South-East Asia Regional Network for Noncommunicable Disease Surveillance”, which resulted in the development of the “Draft Regional Strategy for NCD Surveillance”.

The programme has been supporting the countries in developing skills in epidemiology and outbreak response through 2 years, 3 months, 4 weeks (for paramedics), and especially designed 10–day and 5–day Field Epidemiology Training Programme (FETP) for different categories of health personnel. Through ICP the training modules were also developed for the institutions conducting 10 and 5–day FETP.

Other activities under different stages of development include: strengthening laboratories, including public health laboratories; establishing a network of laboratories in four countries; preparing guidelines on integrated surveillance of occupational and environmental diseases; designing a database system for priority communicable diseases to publish SEAR quarterly ‘Multi-Disease Surveillance Bulletin’; developing database for vector-borne diseases; analysing present linkages of intercountry and inter-regional collaboration mechanisms (ASEAN, SAARC, Mekong Basin Network) to recommend support for multi-disease surveillance and response.

### 4.3 Have the Mechanisms and Approaches Adopted by the Programme Proved Appropriate?

The overall approach adopted by the programme appeared to be appropriate. It defined correctly the problems and developed expected contribution, product and activities that address problems in an optimal manner recognizing the role and limitations in implementing ICP II for multi-disease surveillance and response for both communicable and noncommunicable diseases.

To increase the usefulness of ICP, active and meaningful participation of the countries were needed in developing the regional strategies. The intercountry programme adopted an

approach of focusing on regional consultation, which brought together the Member countries to develop strategies based on country-based practices. It includes the development of the regional strategic plan for integrated disease surveillance, 2002-2010, the draft regional strategic plan for noncommunicable diseases, sustainable databases for NCDs and their risk factors, etc.

Though the approach adopted by the programme has been appropriate, there is a need to develop awareness and understanding about the concept of ICP as well as integrated multi-disease surveillance among the officials of most of the countries. Several factors can contribute to this situation:

- The decisions on the ICP mechanism and broad planning were taken by an HLTF representing senior officials of MoH and there appeared to be no appropriate dissemination of information to programme managers or relevant people, thereby limiting its understanding, ownership and translation into activities.
- There had been inadequate involvement of national officials at the operational level and the WHO country office in the planning and implementation of ICP affecting its outcome, especially in finding appropriate incorporation in health sector plans and strategies.

### 4.4 Has the Programme Proved Relevant?

It is observed that the programme was relevant in terms of regional health priorities, the WHO corporate strategy and the recommendations and resolutions of the governing bodies at the relevant global and regional forums. In particular, the following aspects were highlighted:

- The development of the “Regional Strategic Plan for Integrated Disease Surveillance 2002–2010”; and “Establishment of a South-East Asia Regional Network for Non-communicable Disease Surveillance”, resulted in the development of the “Draft Regional Strategy for NCD Surveillance” and provided policy guidelines to the countries to develop their national plans for integrated disease surveillance programme.

- With regard to national capacity building, the training of different categories of health personnel in the field of epidemiology and outbreak response, specially designed Field Epidemiology Training Programme (FETP) is of strategic value not only in terms of benefit to the trainees, but also institutional development at the national level.

- Strengthening of laboratories for disease surveillance through transfer of technical know-how and to some extent supplying relevant chemicals and equipment.

- Further provision of technical support during the SARS epidemic has contributed towards the rapid response to disease outbreaks.

- In India, ICP II was used for enlisting the assistance of an external international plague expert from Russia during the plague outbreak in Himachal Pradesh in February 2002 and also in developing the plague manual. It was also used for

providing expert assistance from India to diagnose scrub typhus (another emerging disease) in Maldives during the same year.

- Similarly, the work done by various technical institutions (e.g. Centre for anti-microbial resistance monitoring in food-borne pathogens in Thailand), towards the implementation of operational research projects allows the development of tools and know-how at national and regional levels. These are activities that are fully relevant, and for which the vision of ICP II has been instrumental.

Ministries of health of the countries evaluated took some notable initiatives in integrating their disease surveillance, mainly in communicable diseases and to a limited level for NCDs. It is also quite obvious that without additional resources, there is a substantial risk of sliding backwards, if not stagnating. The surveillance systems for malaria, TB, HIV, measles and AFP for polio continue to remain separate vertical programmes, posing limitations to the efforts made for integration. Making the WHO country offices more responsible and provision of further support through WHO country programmes towards maturation of the integration process could prevent it.

There is a definite need for WHO to play a central coordinating role since there are numerous collaborating partners in the area of disease surveillance, each pursuing its own areas of priority. Several activities related to multi-disease surveillance and response are being implemented under bilateral or multilateral arrangements (WHO, UNDP, UNICEF) with shared or third party funding; and/or through mechanisms, such as ASEAN and Mekong Basin Disease Surveillance (MBDS) Project with internal and/or external funding, e.g. Rockefeller foundation, Norway, Japan.

The Ministries of Health of Thailand, Myanmar, Cambodia, China, Laos, and Vietnam signed two MoUs within the framework of both the MBDS and the ASEAN during the second and last quarter of 2001 valid for two and five years, respectively. The Mekong River Basin Project aims at strengthening national and sub-regional capabilities in disease surveillance and outbreak response to five priority diseases (DH/DHF, malaria, severe diarrhoea including cholera, vaccine-preventable diseases, and outbreak of diseases with sub-regional significance), in order that they can be rapidly and effectively controlled. The ASEAN focuses on HIV/AIDS prevention and control; and specifically on the implementation of a joint action programme on reducing HIV vulnerability among the mobile population.

The MBDS Project is more related to diseases surveillance and response, while ASEAN remained as a broader framework for policy development, not directly linked to project implementation. The scope of cooperation includes system development, institutional strengthening, human resources development, information exchange, joint outbreak response and other joint activities. It illustrates the flexibility of action that countries have as these are not bound by a specific mechanism, country or region but by common specific health concerns.

Countries of the WHO South-East Asia Region, the Western-Pacific Region and ASEAN have to address multi-disease surveillance and response in the perspective of cross-border collaboration and multi-country initiatives. Because of the characteristics of the populations living in border areas (e.g. migrant, rural, with difficult access to public health services) and their impact on community health, ICP II has become of special interest to these countries. The MBDS project addresses issues related to drug-resistant malaria with a

view to improving malaria control for boosting economic and social change. Countries participating in this project are supported partially by the European Commission with the Regional Malaria Control Programme and the inter-regional cooperation of WHO - through the South East Asia and the Western Pacific Regional Offices - providing technical and financial support.

- WHO assistance to its Member Countries during the current SARS outbreak continued by the ICP mechanism serves as a source for readily available support for quick response to sudden outbreaks, emergencies and disasters.
- The ICP programme has been under the process of analysing the present linkages of the existing intercountry and inter-regional mechanisms for enhancing collaboration with the above projects, including also the NGOs, private sector, and other civil society groups to support the integrated multi-disease surveillance and response systems.
- It is worth considering designating a focal point in WHO country offices to undertake responsibilities to follow up on disease surveillance activities and stimulating closer coordination among different stakeholders/partners to undertake more focused initiatives.

### 4.5 Has the Programme Proved Adequate?

Adequacy is viewed in terms of whether the allocated resources are sufficient to achieve the planned outcomes as well as whether attention has been given to an appropriate definition of the problem and to designing programmes that address the problems optimally.

In general, the programmes adequately defined the problems and designed relevant outcomes, products and activities; though there were some limitations as noted in the discussion on the “Appropriateness of the mechanisms and approaches.” The number of programme areas supported through the supplementary intercountry programme increased from ten in 2000–2001 to fourteen in 2002–2003, though the budget allocation remained constant.

The ICP is to be seen as “seed money” for triggering resources from national budgets and/or other development partners. But,

- The absence of complementary activities in the regular WHO country budget in some countries has limited effects in supporting the development of an integrated disease surveillance system.

The programme appeared to be over-ambitious, given the level of resources allocated. However, the funding has been adequate to carry out the activities necessary and to achieve expected products.

- Countries are currently in different stages of developing their national integrated disease surveillance plan in line with the WHO Guidelines for Multi-disease Surveillance, including updating of the WHO guidelines to suit the risk behaviour surveillance for NCD, justifying the adequacy of the ICP.

### 4.6 Has the Programme Effectively Complemented WHO Country Programmes?

All concerned interviewees were aware of the WHO country budget workplans. They refer to it and use it as a working tool. Furthermore, the team felt that the staff directly involved in ICP II activities participate in these without similar level of engagement; sometimes viewing these activities as adhoc or project–related, and therefore, losing the continuum and the strategic vision that ICP II has.

On comparison of the work plans at different country levels (CSR, CPC, HIV/AIDS, MAL, TUB, BCT) with the work plan ICP CSR 001-II, it was observed that the ICP II programme definitely complements – supports, enables, facilitates or reinforces without duplicating the rest of the WHO programmes at the country level.

However, there is a need to integrate ICP II activities with the WHO country budget. This integration would facilitate understanding of ICP II and allow monitoring by concerned parties. WHO plays a central role in supporting coordination since there are numerous collaborating partners in the area of disease surveillance, and sometimes with their own reporting systems i.e., surveillance systems of malaria and HIV/AIDS not having integrated in the national disease surveillance and response systems as yet.

In assuring that the responsible individuals involved in the development of the supplementary ICP programme, WHO country and Regional Office programmes reviewed the related work plans at the key decision points in their formulation and provided their counterparts with appropriate and timely input. At the completion of each phase, the Regional Office shared the supplementary ICP work plans with the WRs' offices and national counterparts to ensure that the ICP and country work plans were mutually supportive and avoided unnecessary overlap and duplication. Nonetheless, the input received was minimal, due to the following:

- Insufficient understanding regarding the purpose and objectives of ICP II on the part of national officials and WHO country office staff responsible for implementing the activities.
- The need for effectively synchronizing the parallel development of the work plans of supplementary intercountry programme, and WHO country and Regional Office programmes.
- At times, during implementation, complementarity was affected due to inadequate consultation in the reprogramming of ICP and country work plans.
- Though the Regional Office submitted the final supplementary ICP work plans to the Member States prior to the Regional Committee, some national officials at the operational level did not receive the plans.

### 4.7 Has the Programme Been Effectively and Efficiently Managed at Country and Regional Office Levels?

On evaluating the work plans of both ICP as well as country levels, it was observed that the individual expected contributions did contribute towards achieving the targets. There was

substantial progress towards achieving the targets of ICP at the country level in spite of the limited capacity or absence of a focal point to coordinate disease surveillance activities.

Comparing the share of the actual budget with the overall investment in multi-disease surveillance in various countries, it is impractical to evaluate this contribution, especially in actually alleviating regional and country health situations. However, the positive influence could be considered to be a significant contribution. At the same time,

- this could be seen in the context of successfully generated responses, attracted partners and mobilizing resources from national budgets, such as five–year plans and other development partners, e.g. USAID in India;
- the programme definitely works better through additional inputs, including of ICP for hiring of consultants, arrangements for intercountry resource persons, sharing of experiences/expertise, training, etc. These are inputs that make a significant difference.

The missions experienced varying national responses to the current SARS outbreak and viewed that the ministries of health were not able to capitalize on the presence of a large pool of FETP graduates in most of the countries (except Myanmar), which could have strengthened the national capacity to respond to such an outbreak through an effective surveillance mechanism.

In assessing efficiency, emphasis was placed on the actual versus planned use of budgets and changes in work plans with particular attention given to reasons for changes.

- In general, the supplementary ICP was implemented mostly within the given allocations.
- There were a few programme changes early in the second year of the biennium when it was found that some activities could not be achieved as planned.

### 4.8 Has the Programme Been Sustainable and Replicable?

WHO needs to support ICP activities if these are to be continued. These play a catalytic role for health policy development, which is very well recognized by the health ministries concerned. Although the technologies proposed through ICP are suitable, its follow–up could be facilitated in managing the relevant health programmes.

The programmes generally have been designed in a manner that, over time, would enable the countries to sustain them after major financial, managerial and technical assistance has been terminated. That is, there is an emphasis on adapting technologies to be suitable to the Region and countries, making the programmes socio-culturally compatible, and developing local managerial and technical capacity. Nonetheless, it is too early to determine whether the programme will prove to be sustainable.

It is also worth taking into consideration that many intercountry initiatives such as SAARC (Bangladesh, Bhutan, India, Nepal, Pakistan, Maldives and Sri Lanka) and BBIN (Bangladesh, Bhutan, India and Nepal) along with ASEAN and MBDS mechanisms for HIV,

malaria, kala-azar and zoonotic diseases have already been made albeit on an informal basis as of now. They provide optimal opportunities for furthering the interest of WHO in strengthening not only the disease surveillance programme in those countries but also for more enhanced inter-country and inter-regional collaboration.

The decision of the 54th session of the Regional Committee that areas chosen for support through the supplementary ICP should continue for a minimum of two biennia was seen as increasing the probability of programme sustainability and achieving the desired programme goals. Nevertheless, to go along with regional strategies, such support should be for a longer duration. However, such expectations were tempered by the fact that the limited resources available for ICP II are spread over too many programme areas.

- Regarding the capacity of countries to replicate ICP processes and benefits in new locations after their effectiveness has been demonstrated, there seem to be limited expectations. The efforts of the countries are more through a multitude of donor resources, which pose questions of sustainability in the maturation of the efforts. The countries are likely to confront severe hurdles to scale up whatever they have initiated due to the limitations of adequate financial or technical resources (except Thailand and India).
- It is too early to observe the replicability of the programme, as it started from 2002.

## 5. LESSONS LEARNT AND RECOMMENDATIONS

Following lessons learnt and recommendations supplement those discussed in earlier sections:

### 5.1 Understanding of Purpose and Objectives of Supplementary ICPs

***Lessons Learnt***

There was a variation in the level of awareness and understanding of the present supplementary intercountry programme at the country level, both WHO country and field offices and the responsible departments in the Ministry of Health.

***Recommendations***

1. Conscious efforts need to be made to thoroughly brief national officials at the policy and technical/implementation levels as well as WHO country staff, on the purpose and objectives of ICP.

2. There is a need for an information package to WRs and their teams for briefing national counterparts on the strategic importance of supplementary ICP

### 5.2 Involvement of National Officials and WRs' Offices in Planning and Implementation

***Lessons Learnt***

The HLTF for Intercountry Collaboration has ensured meaningful participation of policy-level officials in the planning process of ICP II. The present evaluation still confirmed that this information did not trickle down to technical and operational levels. There appears to be no or little ownership of the ICP programme by the responsible counterparts at the national level.

***Recommendations***

1. Senior officials attending HLTF should organize in-country briefing on the outcome of their meeting to the responsible national staff at technical and operational levels.

2. The responsible technical officer of the Regional Office and WHO country office for the supplementary intercountry programme should ensure that the national counterparts at the operational level receive the relevant sections of the ICP II work plans, related to their areas of work, and be kept informed of programme changes, if any, in those areas.

### 5.3 Adequacy, Relevance and Continuity of ICP

***Lessons Learnt***

The absence of integrated planning within the country budget or failure to ensure continuous monitoring and follow-up of ICP II activities threatens this initiative. The support provided in terms of financial assistance through ICP II is nominal when compared to the national health budgets.

Many activities are being implemented naturally in a collaborative manner with neighbouring countries. Often, the umbrella of collaboration is decided by the collaboration antecedents and the availability of funding to maintain projects alive, e.g. HIV/AIDS and the ASEAN, or Malaria and the Mekong or Tuberculosis and SAARC. In this sense, ICP II activities are viewed in an *ad hoc* manner, and WHO will need to follow up ICP actively to get its strategic importance widely recognized.

***Recommendations***

1. WHO should consider focusing its support in fewer areas with a clear statement of the targets covering issues and interventions that are strategically important for each Member State/group of Member States.

2. There is a need to effectively synchronize the parallel development of supplementary intercountry programme, and WHO country and Regional Office work plans.

3. The Regional Office should actively work with the development partners in order to mobilize necessary funding for implementing the ICP II work-plan

4. Through the supplementary intercountry programme, the Regional Office and WHO country offices should strengthen their collaboration with the existing regional initiatives on disease surveillance. For example, SEARO could organize a back-to-back meeting with the senior officials' meeting of ASEAN or SAARC disease surveillance working groups or task forces.

## 5.4 Value of the Joint Evaluation Exercise

### *Lessons Learnt*

The joint evaluation of ICP demonstrates great value in this type of exercise that involves national focal point or high-level national officials familiar with the programmes and the Regional Office and WR Office staff. The advantages of such involvement clearly outweigh potential disadvantages in terms of possible reduced objectivity or credibility of the findings. The evaluation exercise increases their familiarity with the issues and problems confronting ICP and increases the likelihood of the evaluation findings being accepted and the necessary changes realized.

### *Recommendation*

The present system of joint evaluation, involving all levels of the Organization, national representatives and experts from WHO collaborating centres should continue.

# Annex

## PERSONS MET BY THE JOINT EVALUATION TEAMS

### Regional Office

1. Dr S. Puri, PDO
2. Dr M.V.H. Gunaratne, RA-CSR
3. Dr K.K. Datta, STP-Disease Surveillance
4. Dr Tej Walia, RA-HSD

### India

#### *WR Office*

1. Dr Sampath K Krishnan, NPO (CDS)
2. Dr Cherian Verghese, NPO (SCN)
3. Dr R Ravi Kumar, NPO (Malaria)

#### *Ministry of Health & Family Welfare, Delhi*

1. Ms Bhawani Thyagarajan, Joint Secretary (Health)
2. Dr Srinivas Tata, Deputy Secretary (Public Health)
3. Dr Rachel Jose, Dy DGHS (Ophthal) IDSP Cell
4. Dr Bachhani Dy DGHS (Ophthal) IDSP Cell
5. Dr Brij Bhushan, IDSP Cell

#### *National Institute of Communicable Diseases, Delhi*

1. Dr Shiv Lal, Addl DG & Director NICD
2. Dr S.K. Satpathy, Addl Director & Head Epidemiology Division
3. Dr Shashi Khare, Consultant & Head Microbiology Division
4. Dr A.C. Dhariwal, Jt. Director & Head Helminthology Division
5. Dr R.C. Sharma, Jt. Director Epidemiology Division
6. Mr P.K. Patanayak, Jt. Director Epidemiology Division
7. Mr G.R. Meena, Jt. Director Epidemiology Division
8. Dr Avdesh Kumar, Asst. Director Epidemiology Division
9. Dr Sudhir K. Jain, Dy. Director Epidemiology Division
10. Dr Sunil Gupta, Jt. Director Microbiology Division
11. Dr Manish Kakker, National Consultant (Microbiology) WR India

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1. Dr Narendra Arora, Additional Professor Paediatrics, AIIMS

#### *Directorate of Health Services, Tamil Nadu, Chennai*

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2. Dr VM Iqbal Sultan, Joint Director of Public Health & Prev Medicine (PHCs)
3. Dr KME Mohammed Esoof, Jt Director of Public Health & Prev Medicine (Inspections)
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5. Dr D Gurusamy, Joint Director of Public Health & Prev Medicine (VBDC)
6. Mr MC Rajendran, Chief Entomologist
7. Mr V Vasudevan, Deputy Director (DM)
8. Mr Ramalingam, Statistical Officer (Immunization)
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#### *National Institute of Epidemiology, Chennai*

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#### Madras Diabetes Research Foundation, Chennai

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2. Ms M Deepa, Research Nutritionist
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#### *Indian Council of Medical Research, Delhi*

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## Indonesia

### *WR Office*

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7. Dr Hla Pe, Deputy Director General, Medical Care, DoH
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16. Dr Kyu Myint, Regional Surveillance Officer, Rakhim State
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20. Mr U Soe Naung, Health Assistant, Sa-Ma Lauk, Regional Health Center
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5. Mr Tun Hla San, Treasurer, MRCS
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## Nepal

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## Sri Lanka

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