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# STRENGTHENING TECHNICAL AND ECONOMIC SUPPORT TO COUNTRIES FACING ECONOMIC CONSTRAINTS (INCLUDING LEAST DEVELOPED COUNTRIES)

## Report by the Director-General

Resolutions WHA43.17 and WHA44.24 drew attention to the problems being encountered by countries experiencing serious economic constraints, in particular the least developed countries, and requested the Director-General to take adequate measures to strengthen support to such countries. This document reports on measures taken so far and indicates the further action required.

The report begins with a description of the new initiative to intensify WHO's cooperation with countries in greatest need, in close partnership with development agencies. It then looks at the first achievements observed at country level, made possible by an improved response from both WHO and development agencies. The various activities are listed by countries in the Annex to the report. Special attention is paid to activities in the area of health economics.

In the light of the first lessons learned, the report ends with a mention of the issues considered to require particular attention, namely: establishing a WHO leadership role in the area of health sector reforms; strengthening collaboration with other development agencies; strengthening WHO expertise in strategic development areas; and providing adequate administrative support to ensure effective, timely and sustainable delivery of WHO intensified cooperation with the poorest countries.

At its eighty-ninth session (January 1992) the Executive Board reviewed and noted the report, which is now submitted in accordance with resolution WHA44.24 for consideration by the Health Assembly.

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## I. INTRODUCTION

1. The Forty-fourth World Health Assembly, in resolution WHA44.24, called upon the Director-General, *inter alia*, "to continue and intensify, in liaison with the organizations concerned of the United Nations system, including the United Nations Conference on Trade and Development, the efforts to provide support for the countries that need it most - with due priority for the least developed countries - in strengthening their health systems and in identifying resources and new approaches to health in the current social and economic context". In the same resolution the Director-General was requested to report to the Forty-fifth World Health Assembly on the measures taken. This document provides that report and indicates the further action required. Resolution WHA44.24 also made reference to resolution WHA43.17, which drew attention to the problems being encountered by countries experiencing serious economic constraints, and to the Paris Declaration adopted on 14 September 1990 at the close of the Second United Nations Conference on the Least Developed Countries.

2. These resolutions reflected growing concern at the deteriorating health situation in many developing countries, and the difficulties being encountered in implementing effective primary health care in the countries in greatest need, and amongst the most vulnerable groups. The figures speak for themselves. Amongst these countries, the average life expectancy is often less than 50 years, the infant mortality rate is in many cases more than 100 per 1000 live births, population growth is more than 2.7% per annum and a large proportion of the population, particularly women, is illiterate. Access to health services is limited. Even these figures hide major differences between countries and within countries, where many regions are in a considerably worse situation.

3. The problems which impede effective implementation of primary health care in the developing countries fall into two main categories. On the one hand, there is undoubtedly an absolute lack of financial resources, with generally poor economic performance, often aggravated by other factors such as natural, and sometimes man-made, disasters. However, no less important are such factors as widespread weaknesses in the organization and management of health services, poor health information systems, lack of intersectoral cooperation, and weak and ineffective coordination of both internal and external resource inputs. To this must be added a lack of skills in the area of health economics, with resultant deficiencies in the rationalization of health care financing and loss of opportunities for harnessing additional national resources.

## II. RESPONSE BY WHO

4. To address these difficulties, WHO has undertaken a new initiative to intensify its cooperation with countries and peoples in greatest need, i.e. not only countries formally recognized as being among the least developed. A country-by-country approach is used, involving close collaboration among all levels of the Organization as well as efforts to develop active partnerships with other multilateral development and financial agencies and the development agencies of the industrialized countries. Inherent in the approach is the need for national authorities to take a fresh and realistic look at health priorities and at available as well as potential resources. Governments must be prepared to recast their national health plans in the light of today's grim economic realities. For its part, WHO is committing itself to making more efficient use of its technical and financial resources and to mobilizing additional ones to meet the countries' priority needs.

5. The outcome of this process will naturally vary from country to country. However, in most cases, it can be expected to lead to the formulation of better integrated, well-coordinated and more realistic national health development plans that take account of the availability of human and financial resources.

6. Health economic analysis is an important part of the initiative, in that identifying and assessing economically feasible options for the financing, delivery and administration of health services will become one of the principal components of WHO's work. This does not mean that WHO will advocate particular policy instruments, such as compulsory health insurance or voluntary health insurance, or user charges in any particular form. Rather, WHO's concern is to cooperate in identifying feasible changes in the organization, financing and delivery of health care that have a beneficial effect on overall health status.

7. As far as partnership with development agencies is concerned, WHO's actions are based on a desire to link the Organization's technical know-how with the resources which the agencies are committing to each country. In the absence of such linkage, the action will have limited impact. There are many possible ways in

which WHO and development agencies can work together in countries. However, the element which is common to all of them is the central position of the national authorities. The following are examples of successful approaches used so far:

- WHO supports planning and implementation of activities to be funded by a development agency;
- WHO provides staff or consultants to participate in the planning, implementation, monitoring or evaluation of activities undertaken under bilateral agreements between countries and development agencies;
- WHO provides technical information to national authorities and development agencies in countries as a basis for planning bilateral support and as a means of ensuring proper coordination of external support, with such information sometimes including well-analysed, up-to-date details of the country's health status, health system development and macroeconomic situation, as well as methods and guidance for designing particular technical interventions;
- WHO participates in orientation and training of the staff and consultants of development agencies prior to their deployment in countries.

## III. SITUATION REPORT

### Cooperation with countries

8. To date, the initiative of intensified WHO cooperation has involved some 20 countries, following requests from the governments. New requests have been received from a further 10 countries and preparatory discussions are being arranged with the regional offices concerned in order to ensure a well-coordinated response.

### The approach to support

9. The initiative is based on the principle of support to each country according to its needs. This calls for flexibility and pragmatism, with responses designed to achieve both short- and long-term objectives. The cooperation has two important features intended to address issues that have usually received inadequate attention in past international efforts. The first is an extensive review of the economic factors influencing opportunities for better health, and the second is the establishment by each country of a policy framework in which to pursue its health development efforts, including the mobilization of international support.

10. Flexibility must not invite confusion. Thus it has been necessary to establish a certain methodology in order to ensure consistency and facilitate good coordination of WHO's inputs from the office of the WHO representative, the regional office and headquarters. The main steps are as follows:

- country information analysis in the country and preliminary consultations among all agencies concerned;
- policy dialogue with the government, during a first mission in which all levels of WHO are represented;
- formulation of a joint WHO/country "agenda for action" which focuses on the country's priority health development needs;
- further technical and financial support for implementation of the agenda through workshops, seminars and/or studies if necessary;
- formulation of specific projects and mobilization of resources for them;
- support to the government in donor coordination and aid management;
- implementation and concomitant evaluation of the agreed activities.

### WHO's response to country needs in practice

11. The following section is intended to address the question "What has WHO done to meet country needs?". A brief summary of the action taken since the initiative commenced in 1989 is presented in the Annex. By the very nature of the initiative, the number of participating countries as well as WHO's capacity to respond have been gradually increasing. Thus some countries, such as Guinea and Guinea-Bissau, have been involved from the initial stages whilst others, such as Bangladesh, Benin, Mongolia and Togo, are recent additions to the list.

12. As can be seen from the Annex, the approach used has been different in each country. For example, as a result of recommendations made during the first mission in some countries, such as Nepal, Sudan and Yemen, the ministry of health, in collaboration with other ministries, has set up multisectoral task forces to make a comprehensive review of national priorities and resources (human and financial) in the health sector. This exercise has led not only to the production of a national policy document and the development of specific project proposals, but has also strengthened the capacity of the ministry of health in planning and priority-setting and in intersectoral relations with the ministries responsible for finance and national planning. In other countries, such as Benin, Lao People's Democratic Republic and Viet Nam, the initial mission actually helped the government to identify priorities. Subsequently, the ministry of health, with WHO support, has proceeded to establish specific task forces for different purposes such as health financing in Viet Nam, health planning and human resource development in Lao People's Democratic Republic, and human resource development in Djibouti and in Guinea.

13. The timing of the initial participation in the initiative is often a critical factor. Where possible, this has been arranged to provide support to the ministry of health in the preparation of health sector plans within the national development planning cycle, as in Bhutan. This ensures that the arguments for the priorities of the health sector are cogently presented - both within the national framework, and with respect to international development assistance.

14. In all participating countries, emphasis has been placed on the need for the ministry of health to work very closely with the ministries of finance and planning for two closely related reasons, the first being to ensure that health sector planning is carried out in the light of harsh economic realities and the second to reduce the isolation of the health sector.

15. In some African countries, such as Chad, Guinea and Guinea-Bissau, the initial emphasis was on external resource mobilization, with more emphasis being given to technical cooperation at a later stage. The initial approach in Central African Republic, Ghana, Mozambique, Nepal, Sudan and Yemen focused on supporting the national health planning process. In other countries, such as Bolivia, Ghana, Guatemala, Guinea-Bissau, Lao People's Democratic Republic, and Mozambique, support has been given to designated districts, on the understanding that this conforms to national policy that promotes integrated district health systems development.

16. In most of the countries, strengthening of planning and managerial capacity to ensure sustainable health development and coordination of resources mobilized for the health sector has been a central issue. The existence of round-table mechanisms to achieve optimum use of internal resources and mobilization of external resources for health has played a catalytic role in strengthening national capabilities for health analysis in national health planning, or for review of the national health budget, and in promoting external coordination. This has been the case in Bhutan, Central African Republic, Chad, Ghana, Guinea, Guinea-Bissau and Mongolia.

## Activities within WHO

### Headquarters level

17. A reflection of WHO's commitment to this initiative has been the Director-General's decision to reallocate 2% of the 1992-1993 regular budget for global and interregional activities to support priority programme activities in countries in greatest need. This will make some US$ 4.6 million available for use in integrated disease control, improvement of nutrition and environmental conditions, and strengthening of health systems.

18. An interprogramme task force on WHO's intensified cooperation with countries and peoples in greatest need was established in February 1991 to improve information exchange and coordination between programmes and thereby respond more effectively to countries' demands and provide technical back-up to regional offices as and when required. At the same time, it has monitoring responsibilities and advises the Director-General.

19. Country desk officers have been appointed at headquarters in a coordinated way involving staff from many offices. They act as focal points, stimulating information exchange, coordination and follow-up of activities for countries.

20. Technical back-up has been provided to countries in close liaison with regional offices, in such fields as health planning, macro- and microeconomic analysis, and health systems analysis. New partnership mechanisms with development agencies have been developed.

### Regional level

21. Coordination between headquarters programmes and the regions has been greatly improved through the appointment of a high-level official as focal point for this initiative in the regional offices. Various mechanisms have been promoted to ensure information and decision sharing: joint missions, regular review meetings, planning and monitoring of coordinated country support including policy dialogue with countries, meetings with delegations at the World Health Assembly, and review of WHO country programme budgets.

22. Areas that have been identified by the regional offices as the most important for improving their country support capacity and to which efforts have been mainly directed are: development of country profiles, planning and management, health economics and financing, communication and information, integrated programme development, and coordination with development agencies. Close interaction with headquarters has been ensured, particularly in respect of country support for analysis of health economics and financing policies.

23. The Regional Office for Africa has further facilitated this coordination through the production of a regional strategy document, whereby the key coordination role is given to the WHO representatives at country level. Active efforts to coordinate the initiative with the African health development policy and strategy framework together with ongoing plans to strengthen the operational capacity of the WHO representatives' offices has considerably enhanced activities in the African Region.

24. Integration of planned intensified cooperation with a country into the regional managerial framework for country programme development, now systematically undertaken in the Regions of Africa and the Americas, has helped considerably to harmonize overall support to a country. Utilization of the WHO country programme management mechanism helps to avoid parallelism in the use of resources made available to a country, whether from WHO or from other external sources, thus ensuring optimum deployment of such resources in activities targeted to respond to country needs. As a result of WHO internal coordination efforts, development agencies have increased their cooperation with WHO to support countries, especially in the African, South-East Asia and Western Pacific Regions.

### Country level

25. Following the recognition that WHO representatives' offices must be strengthened to enable them to play their essential role effectively, various measures are being promoted or developed, e.g. specific briefing for WHO representatives at the Regional Offices for Africa, South-East Asia and the Western Pacific, the creation of country support teams for countries in the African Region (including experts in management, information, health economics and environment) and the secondment to WHO representatives' offices of experts from Belgium, France, Netherlands and Sweden.

## Donor response

26. During the last 18 months, WHO has arranged meetings to review overall collaboration with agencies and to present WHO's country approach to representatives of the governments of Belgium, Denmark, Finland, France, Germany, Italy, Japan, Netherlands, Norway, Spain, Sweden, United Kingdom, and United States of America. Visits were made to the Australian, Austrian and Swiss governments for this purpose.

27. Discussions also took place with the Commission of European Communities (CEC), the European Economic Community (EEC), the Organisation for Economic Co-operation and Development (OECD), the International Fund for Agricultural Development (IFAD), the International Monetary Fund (IMF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), and the World Bank, to encourage more joint activities to support specific countries. A meeting will take place with the Arab Gulf Programme for United Nations Development Organizations (AGFUND) early in 1992.

28. Working relationships between international organizations and government representatives have been established in most countries, based on national health plans. This is an important step as, for various reasons, the health sectors of some countries facing serious constraints were not included as priority targets by some of the largest agencies. In other cases, the external inputs were not appropriate for the priority needs of countries.

29. Development agencies have been involved to different degrees. In some cases, e.g. with Spain, only preliminary work is being done, while in others, e.g. with Finland, France and Japan, joint planning and missions to countries are taking place to determine areas for joint support, in agreement with governments. Italy and Japan provided funds through WHO for multilateral support, and Italy recently decided that its support to selected WHO programmes should also be used, as a part of the intensified cooperation, in an integrated way. Multilateral and bilateral support is being received from Finland and France, including specific support for some countries through WHO. The Japan Shipbuilding Industry Foundation (JSIF) and the Belgian R.T. Holding have also provided funds to WHO for intensified cooperation. WHO has been influential in increasing bilateral support to some countries, such as Djibouti, Guinea, Guinea-Bissau, Mongolia, Mozambique and Zambia.

30. It is evident that variations of the approach have been appropriate in some countries. For example, initial missions were prepared and carried out jointly with the French Ministry of Foreign Affairs, to Bolivia, Lao People's Democratic Republic and Viet Nam. Where large health development contributions are envisaged, as with the World Bank in Bangladesh and the Finnish International Development Agency (FINNIDA) in Mozambique, steps may take the form of technical action on behalf of donors or in support of donor health project preparation or execution. WHO participated in a UNDP interagency mission for five-year programming in Malawi and Viet Nam, and is committed to pursue its involvement on a systematic basis. Similar interagency missions are planned in four countries with UNFPA and in six countries with the World Bank.

## IV. ECONOMICS AND HEALTH

### Economic component of health policies

31. Activities in the area of health economics are an important and integral part of the initiative, in recognition of the simple reality that the implementation of health policies requires an allocation of resources from the national economy. A better understanding of the links between health, health care and economic development has to be built up. Thus it is essential that economic analysis plays an increasing role in the development of health policies.

### Current activities in health economics

32. The need has become more pressing for decision-makers to design health policies that are compatible with recent macroeconomic realities. On the one hand, these macroeconomic constraints may call for specific health policy reforms, in areas such as health financing and cost-sharing. On the other hand, the health sector could enhance economic development through improvements in health status. This linkage also needs to be recognized when formulating health policies. Activities to address these issues initially comprised advisory work in countries, support in establishing ministry of health task forces in economics and financing, and the organization of seminars in the areas of macroeconomics and health policy reform. To date, Chad, Guinea, Malawi, Mozambique, Nepal, Poland and Viet Nam have been involved in these activities, and one intercountry consultation has been held. Seven additional countries have requested such support in 1992. In addition, Guinea and Viet Nam were supported in 1991 in developing models for cost analysis and cost-sharing of health services.

33. Another emerging need is for exchange of information between countries themselves, WHO and other international agencies. This, in itself, will promote links between economics and health. For this purpose, it is planned to hold an international conference on macroeconomics and the health sector in countries in greatest need in Geneva in June 1992. Topics to be discussed at the meeting will include health and economic growth, macroeconomic adjustment and health, modelling of linkages between the economy and the health sector, and health sector finance.

34. It is reiterated that as the intensified cooperation activities continue and grow, progress will have to be made in the establishment and reinforcement of national teams that can identify and analyse the economic aspects of health sector issues, and to assist the decision-makers in designing appropriate health policies. Changes in countries' economic environment may also require a change in the type of technical cooperation provided by WHO and its initial choice of tools for economic analysis.

## Learning from experience

35. Learning from experience is widely recognized as an essential element of the socioeconomic development process. Unfortunately, this is not done sufficiently in a systematic way. With this in mind, the initiative has placed considerable emphasis on monitoring since its inception three years ago. As a result, a number of factors which are crucial to the successful initiation and development of the initiative in countries have been identified, as follows.

### Country commitment

36. Perhaps the most crucial factor for success is the level of involvement of the country itself. In this respect, the process usually starts only after a formal request has been received from the government. In such a way, countries are able to demonstrate full government backing and an understanding of the implications of the initiative. These include a commitment to provide relevant information as well as continuous involvement of senior officials in developing the plan for action and its subsequent implementation. This commitment is strengthened by the full involvement of government agencies, such as the finance and planning ministries in addition to the ministry of health. WHO's technical leadership role *vis-à-vis* not only the government but also external development agencies has to be strongly promoted, recognized and respected. It must be stressed that the cooperation process has been dependent to a large extent on stable political and other conditions within countries.

### Capacity of WHO representatives' offices

37. The WHO country representatives and their staff are responsible for explaining and promoting the initiative to government and other important national agencies involved in health development, as well as for supporting planning and implementation of the process of intensified WHO cooperation. This also requires coordination of all external contributions and not just those of WHO. Experience confirms that the success of the country-focused approach depends substantially on the capacity of the local office of the WHO representative. In this context, capacity is a function of the personality, training, skills and experience of the representative, as well as both the quality and quantity of the local technical and administrative support staff. Well-coordinated back-up from the global and regional levels of WHO is also essential, but can never be a substitute for WHO strength on the ground. A reflection of the increasing recognition of the key role of the WHO representative's office on the part of other development agencies is the fact that Belgium, France and Sweden have undertaken to provide technical experts to support the work of the WHO representatives in Benin, Guinea-Bissau, Malawi, Mozambique and Rwanda.

### First WHO mission to a country

38. One of the most important steps in the process of intensified cooperation is the first WHO mission to a country, which brings all levels of the Organization together at the place where their subsequent activities must achieve an impact, namely in the country itself. This provides an excellent opportunity to quickly and visibly demonstrate the Organization's response to the country's request for intensified cooperation, to determine the responsibility of each level in providing intensified cooperation, and to see how future communication and coordination are going to be maintained. Obviously this can be achieved only through a thorough examination of country needs and priorities. Experience has shown a need for increased WHO expertise in the areas of

organization and management of health systems, and strengthening of human resources for health development and macroeconomic analysis.

### Information needs

39. The continuous availability of relevant, up-to-date information on health status, health systems development and economic factors, specific to each country, is crucial to WHO's ability to support planning, implementation and monitoring of intensified cooperation. It is also crucially important in ensuring proper coordination of the inputs of external development agencies. So far, WHO's efforts in supporting the production and updating of country profiles has been well appreciated. However, more work is needed to determine how such information can be routinely obtained, collated, analysed, stored, communicated and updated. This is not only a technical matter but one that concerns the nature of WHO's role and responsibilities. Should WHO's efforts be strictly limited to helping countries to become competent and self-sufficient in undertaking this work or should the Organization also increase its capacity to maintain country-specific databases in order to fulfil its role in monitoring health development activities, identifying and responding to specific needs in countries and providing comprehensive technical guidance not only to governments but to all agencies involved in health development? Experience seems to indicate a need for a mixture of the two.

## V. STRENGTHENING OF WHO'S CAPACITY FOR INTENSIFIED COOPERATION

40. It seems clear that the number of countries requesting participation in the initiative of intensified cooperation with countries and peoples in greatest need will continue to increase. That is the logical implication of continuing economic stagnation and deterioration in many countries, predictably accompanied by increasing poverty and ill-health. At the same time, support to countries already involved will continue. Thus WHO's capacity must be further strengthened. In the light of experience to date, the following issues are believed to require particular attention.

### WHO leadership in the area of health sector reform

41. It is widely recognized by very poor countries that reform of their policies and structures is needed to allow them to use their national resources effectively in pursuit of the goal of health for all. This is seen as a natural consequence of reforms being undertaken in other sectors of the economy. Furthermore, many countries are being put under pressure to undertake such reforms as a condition for support from the development agencies of a number of the major industrialized countries. In this situation there is an urgent need to provide policy guidance to very poor countries, not only to plan structural adjustments within the health sector but to ensure, to the greatest extent possible, that the health of the most vulnerable groups of the population is protected in the short term whilst, in the longer term, the reforms do in fact give a stronger foundation for health development.

42. In order to fulfil its role in an effective manner, not only must WHO increase its capacity, as suggested under "Strengthening of WHO expertise" below, but must also ensure that country experiences are systematically analysed with a view to offering policy and strategic guidance on the reform process. This will require action on the part of WHO in adding an operational research element to the intensified cooperation with countries and also in establishing dialogue on the process of health sector reform both with governments and with representatives of development agencies.

### Collaboration with other development agencies

43. Earlier in this report, reference was made to the positive experiences of working with other development agencies in specific countries. As a result there is growing confidence amongst the donor community about WHO's ability to provide technical guidance in the planning and implementation of support programmes. This, in turn, offers possibilities for WHO to play a central role in coordination of the relatively large amounts of technical and financial support being provided to the poorest countries.

44. For WHO to be able to carry out such coordination, there is a need to further increase the support to the offices of the WHO representatives from both regional and global levels. Whilst part of this support should be directed towards strengthening the ability of the WHO representative's office to provide

country-specific, up-to-date analytical information about health development, there is also a need to review the role of the WHO representative in order to reflect this emphasis on coordination as well as to strengthen his or her personal skills in carrying out the tasks involved, including the ability to organize and influence meetings of development agencies. Whilst some WHO representatives are experienced in this type of work, many others require training and encouragement.

### Strengthening of WHO expertise

45. In general, very poor countries have particular needs with respect to technical cooperation for health development. These have to do not only with particular areas of expertise, but also with the way that the expertise is provided, i.e. the countries' limited possibility for absorbing technical support will often call for the provision of expertise over relatively long periods of time. Thus WHO's relatively restricted capacity in key areas such as organization of health systems, strengthening of human resources for health development and health economics is a serious constraint.

46. Whilst the obvious solution to this problem would be further recruitment of experts in these fields, the Organization's currently precarious financial situation makes it difficult to envisage any significant increase in staffing. Thus, whilst this option needs to be further considered, additional possibilities must be explored. These might include reorganization and training of selected, existing staff in ways that would permit them to extend their activities beyond their present roles and focus more on the key expertise areas; extension of WHO's experiences of building up working relationships with national institutions and individual experts in countries; and establishment of closer working relationships with other development agencies in specific countries so as to create a team of external expertise (possibly including secondment of experts, assignment of associate junior professionals and/or United Nations volunteers).

### Providing adequate administrative support

47. In this first phase of intensified cooperation, the Office of International Cooperation at WHO headquarters as well as the focal points in each regional office have undertaken the increasingly demanding task of organizing and coordinating the Organization's response to requests from countries to ensure that the cooperation is effective, timely and sustainable. As the number of participating countries increases, involving interaction not only with ministries of health but also with ministries of finance and planning, national nongovernmental organizations and the international and bilateral agencies working in each country, so does the necessity for strong administrative back-up. This is particularly important with respect to financial planning, allocation and accounting of the Organization's financial inputs for intensified cooperation, and also to the processing of short- and longer-term consultant services and so on. Special emphasis in the cooperative process is put on the need to respond quickly to country requests and opportunities.

48. It is expected that the preparatory work to be undertaken with respect to the programme of work for the 1994-1995 biennium and, more particularly, the Ninth General Programme of Work, will enable a more consistent and efficient allocation of managerial and administrative responsibilities to respond most adequately to countries and peoples in greatest need.

ANNEX

# INTENSIFIED COOPERATION ACTIVITIES, BY COUNTRIES[1]

**Bangladesh (1991)**

- Design and implementation of 22 health projects within the Fourth Bangladesh Population and Health Project (total budget US$ 650 million)
- Health sector coordination
- Reorientation of the WHO country budget

**Bhutan (1990)**

- Development of a national human resources for health plan; a programme for improved quality control in water supply and sanitation; and an effective referral system to strengthen district health systems
- Preparation of a UNDP round-table meeting (scheduled for April 1992)

**Bolivia (1989)**

- Health economic and financing analysis
- Strengthening of the planning capacity of the Ministry of Health
- Development of the district health systems approach in one region
- Applied health research in one region through the Bolivian Institute for High-Altitude Biology

**Central African Republic (1990)**

- Development of a national health plan, based on district plans
- Strengthening of national capacity for resource mobilization, and preparation of a round-table meeting

**Chad (1989)**

- Health resources mobilization, including documentation of health sector analysis, and macroeconomic and health financing studies; organization of a national health consensus seminar; preparation of a UNDP round-table meeting (scheduled for June 1992)
- Development of human resources for health, including organization of a first academic year at the School of Medicine; improvement of management of paramedical professions; and formulation of policy on human resources, including nursing and midwifery (planned for 1992)
- Development of a national plan for water and sanitation for N'Djamena
- Production of health learning materials
- Cholera control through the Global Task Force on Cholera

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[1] Missions were carried out and plans of action drawn up for a number of other countries, including Guatemala, Haiti, Jamaica and Sudan, but cooperation with them has been relatively limited so far.

**Djibouti (1989)**

- Formulation of a national health development plan, including human resources policy
- Control of such diseases as tuberculosis in border areas and neighbouring countries
- Reorientation of the WHO country budget

**Ecuador (1989)**

- Development of the integrated family health and environmental health programme through the district health systems approach (SILOS)
- Cholera control through the Global Task Force on Cholera
- Development of a project for health improvement in the poorest urban communities, in conjunction with health insurance issues (planned for 1992)

**Ghana (1989)**

- Restructuring of the Ministry of Health
- Formulation of a national health development plan from community to district, regional and national level (planned for the end of 1992)
- District health system development

**Guinea (1989)**

- Development of a national health policy and plan
- Macroeconomic analysis and development of methodology for analysis of health expenditure
- Development of a policy on human resources for health, and hospital sector planning
- Formulation of a national plan for tuberculosis control
- Development of essential drugs policies and support for procurement
- Health resources coordination and mobilization

**Guinea-Bissau (1989)**

- Formulation of a national health document; a strategic health plan for three regions; a national malaria control plan; an epidemiological surveillance system; and a water and sanitation programme
- Economic analysis and financing studies, and setting up of cost-sharing mechanisms in one region
- Reinforcement of the WHO representative's office through assignment of a programme officer, and reorientation of WHO resources at country level
- Production of health learning materials
- Health resources coordination and preparation of a UNDP health review (scheduled for 1992)
- Strengthening of managerial and applied planning capacity of the Ministry of Health

Annex

**Lao People's Democratic Republic (1991)**

- Strengthening of managerial skills at provincial level

**Malawi (1990)**

- Cholera control through the Global Task Force on Cholera
- Strengthening of the Ministry of Health's capacity for planning and for economic analysis
- Elaboration of health and health-related components of the fifth programming cycle of UNDP

**Mongolia (1991)**

- Planning and procurement of essential drugs
- Health resources mobilization including preparation and presentation of proposals for health sector support to a round-table meeting

**Mozambique (1990)**

- Development of a new national health policy
- Preparation of a project proposal for 12 years' support to one province, to be funded by the Finnish International Development Agency (total budget about US$ 40 million)
- Formulation of a malaria control plan
- Design and implementation of a training programme for improving skills for case management at district and provincial hospital level

**Nepal (1989)**

- Health sector analysis, and resources study
- Strengthening of national capacity in health economics through an interministerial workshop on health economy/financing and applied studies on alternative forms of health financing
- Development of health information systems

**Viet Nam (1990)**

- Strengthening of the capacity of the Ministry of Health in planning and in health economic analysis and financing
- Campaign against blindness due to cataract
- Local production of BCG vaccine

**Yemen (1990)**

- Strengthening of national capacity in health economic analysis and in resources mobilization, including preparation of projects
- Development of a policy on human resources for health and of a health information system

- Provision of essential drugs, and establishment of norms
- Reorientation of the WHO country programme budget.

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