

The regions-too much power, too little effect

Fiona Godlee

WHO's regional offices make it structurally one of the most decentralised of all United Nations agencies. But at what cost and to what effect? This article argues that too often the regions give only the illusion of decentralisation while wresting power from WHO's governing body and prolonging the time taken for resources to reach the point of need.

The World Health Organisation's division of the world into six regions is an accident of history rather than the result of design. When the organisation was founded in 1948 two regional public health bodies already existed: the International Sanitary Bureau in Washington and the Conseil Sanitaire Maritime et Quarantenaire in Alexandria. Both were incorporated into WHO's constitution and to some extent dictated the design of the four other regional offices. The bureau in Washington was particularly responsible for the degree of autonomy enjoyed by the current regional directors. Now called the Pan American Health Organisation, it agreed to serve as WHO's regional office for the Americas only on condition that it maintained its autonomy. It remains the most independent of the six regional offices and functions almost completely without reference to Geneva.

The regional structure allows WHO to claim to be one of the most decentralised of the United Nations agencies, an important weapon when the United Nations stands accused of being out of touch with life beyond Geneva and New York. Staff say that the division into regions allows WHO's actions to be more flexible and relevant to the needs of individual countries. But the regions have come under increasing criticism both from within and outside WHO, the main charges being that they are inefficient and bureaucratic, that they duplicate expertise available at the headquarters in Geneva, and that they are too bound up in regional politics. What, critics ask, does

the world get for \$250m a year? In this article I will examine the criticisms and consider whether, as many commentators suggest, the regions' activities should be reduced, their autonomy curtailed, and their responsibilities devolved to WHO's country offices.

How the regions work

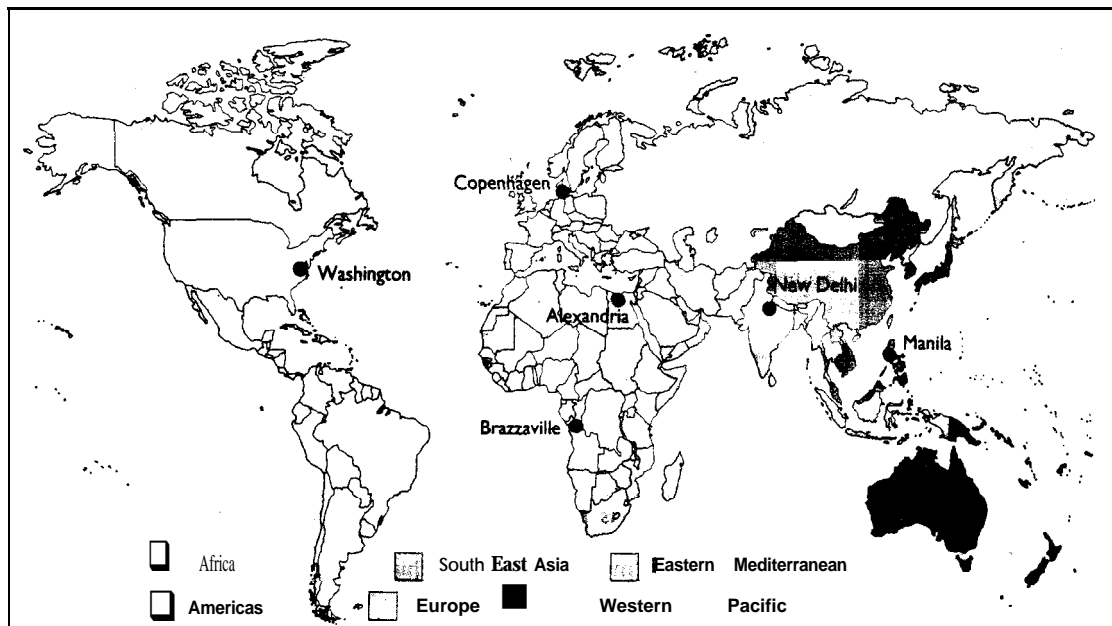
Each region consists of a regional committee, made up of delegates from the ministries of health of the region's member states. This committee meets twice a year at the regional headquarters, to decide on regional policy and to review progress, and every five years it elects or re-elects a regional director. The regional committee is also responsible for drawing up the biennial budget proposal for the region, which is submitted to Geneva for incorporation into the global budget. The allocation of money to each region is decided partly on the region's needs and population, but WHO's overall budget has been frozen in real terms for the past 13 years, so allocation is now based largely on historical precedent.

Nearly a third of WHO's 4500 staff are based in the six regional offices (figure)-in Alexandria (Eastern Mediterranean region), Brazzaville (African region), Copenhagen (European region), Manila (Western Pacific region), New Delhi (South East Asian region), and Washington (the Americas). As well as the regional directors and their administrative, secretarial, and support staff, the offices have staff working on WHO's special programmes based in Geneva, such as the programmes for immunisation and maternal and child health. These officers work with their counterparts in Geneva to implement the programmes at regional and national level.

The regional offices have their impact on member countries through WHO's country representatives. These are appointed by the regional director and



This is the third in a series examining the role of the World Health Organisation, its current problems, and its future prospects.



Regional offices and areas

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installed in the ministry of health in each recipient member state. Their role is to advise and support the ministry in planning and managing national health programmes.

Through their contact with national health ministers (represented on the regional committees) and with country representatives, regional offices are expected to formulate policies and set priorities that are both relevant to the member states in their region and in line with WHO policy. They also compile data on a range of health indicators collected by individual countries as part of the Health for All initiative. From the viewpoint of recipient countries, the regional offices are intended as a resource, providing information to health professionals in the region and technical support for governments, either by arranging visits from WHO staff or external consultants or by funding training fellowships and workshops.

A recipe for corruption

The autonomy enjoyed by the regions has for a long time been portrayed as one of WHO's major strengths. It is increasingly being seen, however, as an important structural flaw. Critics say that it not only risks producing seven different WHOs, each directed by the whims of its constituents, but encourages political manipulation and abuse of power.

The potential for regional directors (and the directors general) to abuse their power resides largely in WHO's staffing contracts. Staff who join the organisation agree in their contracts to be posted around the world at the discretion of the management. Meanwhile employees from developing countries receive salaries that are 4-10 times what their own countries could pay. These two factors combine to create what Dr Jonathan Mann calls a recipe for corruption. Dr Mann, former director of WHO's global programme on AIDS and now director of the International Center at Harvard School of Public Health, said, "The regional director has potentially unlimited power of granting and taking away jobs and money. If someone at the regional office or a country representative opposes him, he can send that person to the remotest corner of his domain." A current WHO employee agreed. "To remain in post one has simply to do what the director asks, and the financial inducements, one might even say pressures, to do this are enormous."

Unchecked power of the regions

Two structures should act to check the regional director's power: the regional committee and the executive board. Neither, however, is effective. The delegates on the regional committees are political appointees, either ministers of health or their representatives. In regions where governments undergo frequent change and reshuffle there is a high turnover of delegates, which reduces the committees' effectiveness. Also, in some regions delegates may be unwilling to cross their regional director because of the impact he could have on their careers. Dr Mann gave me an illustration of this. "Health ministers would ask our programme not to send money through their regional office," he said. "But they wouldn't tell the regional director, and at official meetings they would criticise us for not going through the regional office. Why? Because when they stop being health ministers they will look to the regional director for jobs and consultancies."

The regional directors' powers are checked to some extent by their reliance for election (and re-election) on gaining (and maintaining) support from their regional committees. But, as in other parts of the United

tendency for the most politically active candidate, rather than the most able, to get the job. According to a recent report from the Danish aid organisation Danida, the system encourages regional directors to devote too much of their time and energy to regional politics.'

The second potential check on regional autonomy, the executive board, is equally ineffective. The board, which is the executive arm of WHO's governing body, the World Health Assembly, is made up of health experts from 31 member states, with member states taking turns to nominate representatives in a three yearly rotation. In terms of their own countries' political hierarchies, the delegates on the executive board are usually junior to the delegates on the regional committees. In theory the regions report to the board. In practice, however, the regions have the upper hand. The delegates are not WHO employees, and so the World Health Assembly and director general hold little direct influence over them. But the regional director in their country's influence over them. But the regional director in their country's region is in a strong position to influence their careers.

"The regional director is much more important than the director general in the lives of executive board members," said a European diplomat in Geneva. "He can manipulate them out of a job." The unchecked power of the regions is, he said, "a big problem that has yet to be talked about, let alone tackled."

The director general, Dr Hiroshi Nakajima, is known to be in favour of limiting the powers of the regional directors. Their autonomy grew during the 1980s under the directorship of Dr Halfden Mahler but was tempered by Dr Mahler's strong personality and the respect in which he was held by individual regional directors. Dr Nakajima lacks Dr Mahler's charisma and communication skills and has the added disadvantage of having come up from within the regional directors' ranks. This reduces their willingness to take direction from him. Diplomats in Geneva comment on the unequal interaction between the director general and the regional directors. "It is clear that they feel they have the edge over him," said one. "They are in control."

Expense, bureaucracy, duplication, and delay

The unequal balance of power between the regions and headquarters would matter little if the regional offices were obviously effective. But their impact is far from clear. To many, including staff in Geneva, they simply represent unnecessary expense and bureaucracy. The six regions received over two thirds of WHO's regular budget in 1992-3; the rest was spent in Geneva (table). The proportion of the regional budget devolved to country level ranged from an impressive 78% in South East Asia to only 6% in Europe. The African region, which is perhaps WHO's greatest testing ground, spent nearly half of its \$135m budget at its regional office in Brazzaville as well as two thirds of the \$112m it received for special programmes such as AIDS and immunisation. In the Americas, where the regional office has additional layers of administration, less than half of the 1992-3 budget reached member states (figure).

WHO argues that this is a misleading interpretation of regional spending. Its funds are not intended for implementing health care within countries, it says, and the variation in the amount reaching countries relates to the different demands being made on each regional office. "The regional office acts like the hub of a wheel, for networking and exchanging ideas and information," said one staff member in Geneva. "Spending on the regional office benefits countries

| Region | States (n=186) | Population (millions) | at birth (high/low) | (high/low) (US\$ 000) | 1992-3 (US\$ million) | Of total WHO budget | % Spent at country level | \$ Spent per capita |
|-----------------------|----------------|-----------------------|---------------------|-----------------------|-----------------------|---------------------|--------------------------|---------------------|
| World | 186 | 5000 | 77/53 | 22410/890 | 1200 | 18.0 | 55.5 | 0.25 |
| Americas | 45 | 500 | 71/48 | 6330/1180 | 87 | 11.8 | 47.7 | 0.10 |
| South-East Asia | 11 | 1350 | 69/51 | 7820/400 | 73 | 10.0 | 78.0 | 0.06 |
| Eastern Mediterranean | 22 | 400 | 79/50 | 26930/1220 | 63 | 8.6 | 59.0 | 0.18 |
| Western Pacific | 23 | 1500 | 78/69 | 33610/1050 | 46 | 6.2 | 5.9 | 0.04 |
| Europe | 50 | 850 | | | | | | 0.05 |
| All regions | | | | | 477 | 65.0 | 56.0 | |
| WHO Headquarters | | | | | 258 | 35.1 | | |

what is best in the world in terms of research and public health. Most of WHO's money goes on salaries, meetings, and publications, and this is to be expected given the design and role of the organisation."

Some WHO staff disagree. "Regional offices vary in their efficiency," said one programme director. "In general, though, there is lots of activity and talk, but it is not at all clear what they achieve. Most of them could run on half the staff without losing much effectiveness." Dr Hussein Abdul-Razzaq Gezairy, regional director for the Eastern Mediterranean, agrees. "The problem at the moment is that there are lots of staff around with not enough to do because expenditure on implementation has been cut but staff numbers and salaries have stayed the same," he said. Dr Lobe Monekosso, regional director for Africa, acknowledged the fact that the regional offices duplicate expertise available in Geneva and went further to suggest that WHO did not always need to employ experts directly. "You need a core of highly trained

staff in Geneva whose role it is to draw on expertise that is available elsewhere. The institutions already exist-like the communicable diseases centres in Atlanta [in the United States] and Colindale [in Britain]. We don't have to recreate them."

The fact that resources often have to pass through the regional offices often delays them from reaching the point of need. As already quoted, Dr Jonathan Mann, said that some countries would specifically ask his staff to send money directly to them rather than going through the regional offices in order to speed the distribution process.

I asked Dr Marc Danzon, director of country health development at the European regional office, about this. He said that special programmes in Geneva do sometimes bypass the regional offices and deal directly with countries, but that the regional offices do what they can to prevent this. "We try all the time to collaborate with our counterparts in Geneva. But some of the new countries in Europe don't understand the system. They sometimes call Geneva directly for help." Programme staff in Geneva say, however, that they feel justified in bypassing the regional offices because of donors' demands for more effective management and accountability. Perhaps the most concrete sign of this trend is the decision that the reformulated multiagency global programme on AIDS will act directly from Geneva to individual countries.

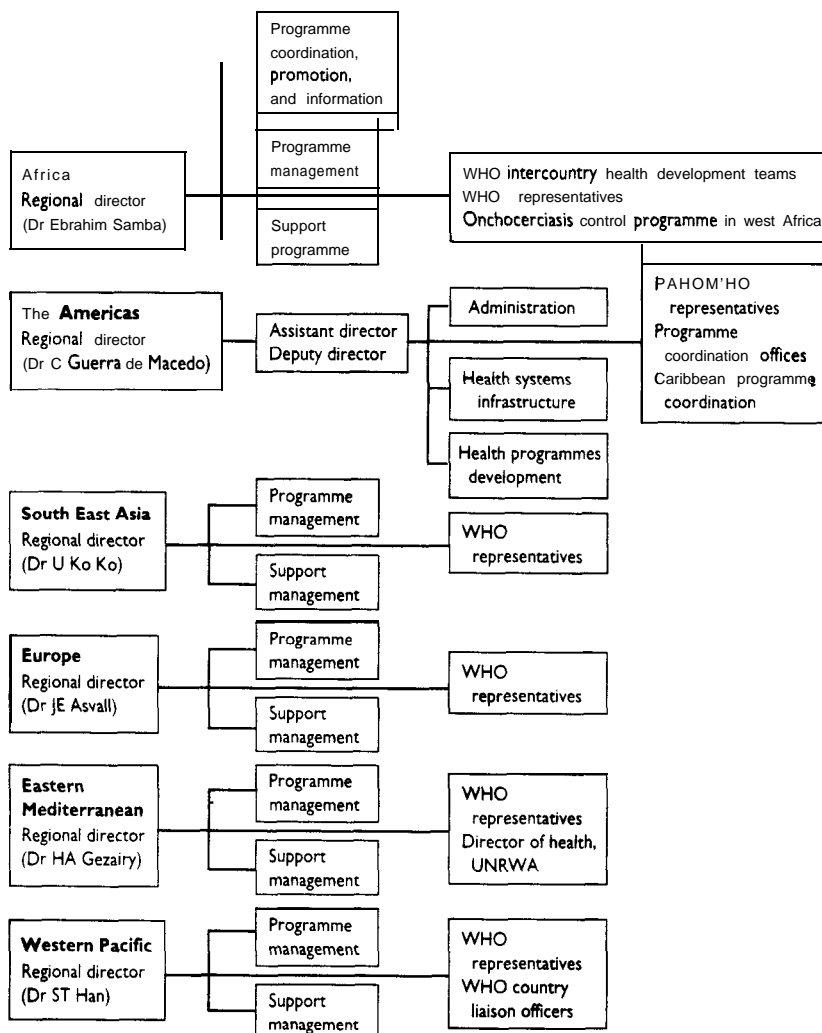
Another reason for bypassing the regional offices, according to diplomats in Geneva, relates to the degree of autonomy allowed to the regional directors. In theory, the regional budget is allocated in line with WHO's broad strategies. In practice, however, the allocation can follow the hobby horse of the regional director or of the health minister of one of the more powerful countries in the region. Special programmes in Geneva may therefore be thwarted in their efforts to get regions to act on their behalf at the country level if the regional leaders have other priorities in mind.

Calls for reform

A recent report highlights the problem of WHO's lack of control over its decentralised democracy. Presented this year by the United Nations Joint Inspection Unit, an internal body that examines the functioning of United Nations agencies, it concludes that "the decentralised structure of the World Health Organisation is currently handicapped by many problems [and] is not functioning as efficiently and effectively in the 1990s as it did in the early decades of its existence."

The report recommends several major changes:

- Regional committees should avoid becoming embroiled in politics and limit themselves to the discussion of technical and operational issues relating to health for all
- Members of the regional committees should be health professionals rather than politicians, in order to improve continuity within each country
- Regional committees should reduce the frequency



Organisation of WHO's regional offices. Regional directors report to the director general's office

Africa—a particular cause for concern

Africa is a fierce testing ground for any agency. With economic decline and escalating international debt combined with rising demands of population growth and AIDS, most countries in Africa are suffering what international aid workers call "an absolute resource lack." The World Bank considers an annual \$12 per head to be the minimum required for meeting basic needs; most countries in Africa spend less than \$5 per head. The countries most in need of assistance are also those with the weakest infrastructure and the poorest communications.

In addition to Africa's intrinsic problems, WHO in Africa has problems of its own. For a start, its office is located in Brazzaville in the Congo, which has been a virtual war zone for the past few years. The decision to site the office in Brazzaville was a political rather than a practical one, in response to demands that it be in a Francophone part of Africa. As a result of recent civil and political unrest the office has been closed for the past few months, and the regional director, Dr Lobe Monekosso, has had to decamp with some of his staff to his native Cameroon.

The unrest has prevented WHO's external auditor, Sir John Boume, from examining the finances of the regional office for the past two years. His report, in which he emphasised that he could give no account of Africa's spending of \$122m, assets of \$20m, and liabilities of \$21m, caused a furor at the annual meeting of WHO's governing body, the World Health Assembly, in May.

The unrest in Brazzaville has aggravated already poor communications between the region's 45 member states. According to one diplomat, it is easier for the regional office to get messages through to Geneva than to neighbouring countries. "The regional director works in extreme difficulty," he said. "Coordinating regional activities is almost impossible."

There are growing calls for the office to be moved to a more politically stable country. The Zimbabwean minister of health is known to have suggested his country as an alternative location. But such a move would mean writing off the tens of millions of dollars spent on the specially built complex outside Brazzaville, complete with housing for staff and technical equipment. Another suggestion is that the African regional office should be "atomised" into separate programmes, each based in the most appropriate or most functional country. This, however, would break away from the whole concept of regional offices and is not seriously contemplated.



ANENDEN/WHO

Dr Lobe Monekosso (above) has failed to secure a third term as regional director. The region has high hopes of his successor, Dr Ebrahim Samba (below)



PARKAS/WHO

Criticism of Brazzaville has not always been deserved, says Dr Gill Walt of the London School of Hygiene and Tropical Medicine. Africa was one of the earliest regions to produce an essential drugs list, at the end of the 1970s, several years before the Western Pacific and South East Asian regions. Yet the regional office was bypassed by the action programme on essential drugs based in Geneva, and donors tended to ignore its wishes. The programme's manager did not even visit Brazzaville until 1986, says Walt.

Observers say, however, that over the past 10 years WHO in Africa has lost further ground. Dr Monekosso, regional director since 1984 and recently deselected by the regional committee, failed to implement his three phase action plan for Africa and made little impression on the standard of country representatives in the region: the appointments are still more political than meritocratic, and the quality and impact of appointees remain low. According to one of his most outspoken critics, his failure to secure a third term in office also had much to do with his highhanded approach to employees and regional committee members. "We were concerned about the lack of influence the countries of Africa had over the management policies of the African regional office," said Dr Kalumba, Zambia's deputy minister for health and a member of WHO's executive board. "It appeared that the region believed it was a body bigger than its membership."

"What we need in Africa are three things," said Dr Kalumba. "revitalised leadership, accountability, and better partnership between the regional office and member countries." The region has high hopes of Dr Monekosso's successor, Dr Ebrahim Samba from the Gambia. Dr Samba leaves behind him the widely acclaimed onchocerciasis control programme in Burkino Faso and has a reputation for good management skills and integrity. "I have kept out of politics," Dr Samba told me. "I am a technician. People can judge me by what I have done. I turned the onchocerciasis programme around, and I will do the same for the region, though it won't be so easy. I was very lucky to have good staff. You need to select solid, good people and make sure that they are left to do the job."

Few doubt, however, that he has a Herculean task ahead of him. And most observers agree that without change in the organisation's structure, without clearer priorities and a more clearly defined role for the regional office, donors' confidence in WHO's work in Africa will be hard to restore.

of their meetings from two a year to one every other year, at which they could discuss the biennial budget. This would reduce the administrative costs of the regional committees

- Regional committees should report in a more structured way to the executive board
- Regional directors should be selected by the director general (after consultation with the regional committees and confirmation by the executive board) and should serve a maximum of two five year terms
- The regional directors' powers should be curtailed, with devolution of authority over country programmes to country representatives.

These changes would greatly reduce the power of the regional directors and committees. Selecting rather than electing the regional director would allow WHO to search beyond its own confines and should reduce the amount of politics involved. The European region has already gone some way down this path. Its regional committee has appointed a search group to seek out candidates in addition to those put forward by member states. On the basis of the group's recommendations, the committee then nominates an individual for appointment by the director general.

are up for discussion at the next World Health Assembly, but most people I spoke to were doubtful that WHO would succeed in implementing them across all six regions. Staff in Geneva think it highly unlikely that the Pan American Health Organisation will relinquish its political independence, and other regions are likely to use the American stand to resist coming into line. Since regional committee members also attend the World Health Assembly, there is, say diplomats in Geneva, little chance of them voting to reduce their own powers. Even if they should feel inclined to do so, the regional directors will be on hand to remind them of their responsibilities.

Conclusion

There are strong arguments against WHO's regional structure as it currently functions. It is bureaucratic and overpoliticised, it places too much power with too little accountability in the hands of a few people. The problems of the African regional office (box), in the face of the vast challenges confronting its 550 million constituents, are of particular cause for concern.

As might be expected, staff at the regional offices defend the regional structure. Dr Uton Muchtar Rafei, regional director for South East Asia, argues that other

that having regional offices reduces the time and money spent travelling to and **from** Geneva. Recently the independence of the offices has had the added benefit of insulating regional staff from the growing discontent in Geneva. WHO claims that the **decentralisation** allows fast, flexible, and relevant responses to the health needs of member states.

But the regions give only the illusion of **decentralisation**, while duplicating activities in headquarters and delaying resources and information getting to the point of need. WHO will be fully effective only if the regions are made properly accountable, both politically and financially, and if more of their responsibility is

responsibility.

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