Indian J Med Res 147, January 2018, pp 11-13
DOI: 10.4103/ijmr.IJMR_118_18

Quick Response Code:

Perspective

Collaborating centres: Rediscovering an extended arm of World Health Organization

The idea of using national health research and training institutions for the common good of larger global community by the World Health Organization (WHO) is older than the world body itself. In the early days of the League of Nations, a few national laboratories were designated as reference centres for the standardization of biological products[1]. After the establishment of the WHO, more such reference centres such as the World Influenza Centre at the National Institute of Medical Research in London were designated as global facilities for epidemiological surveillance. The Department of Biological Standardization at Statens Serum Institut, Copenhagen, became the first WHO collaborating centre (CC) in 1948. The Second World Health Assembly in 1949 laid down the policy that WHO would not establish any international research institutions but would make use of existing national institutions[2]. By their very definition, such centres are supposed to form a part of an international collaborative network of WHO in support of its programme at various levels. In this sense, every CC is a global technical resource or an extended arm of WHO. The CCs are critical to the functioning of the global body as its technical work globally is handled by limited inhouse professionals leaving many areas of activity virtually uncovered. In effect, CCs may be the only technical resource of WHO in certain fields.

The CCs in the initial phase were focused on disease surveillance, epidemiological research and control of infectious diseases. The global programme of epidemiological surveillance of influenza is an example of pivotal role played by WHO CCs. In the South-East Asia (SEA) region, the effectiveness of this mechanism was demonstrated by the CC at the National Institute of Cholera and Enteric Diseases (Indian Council of Medical Research) in Kolkata in 1993 when antiserum developed for the diagnosis of a new strain of *Vibrio cholerae* was quickly distributed to countries where it was rapidly spreading[3].

Over the years, the horizon of collaboration expanded to include health policy, health economics, health systems development, health promotion and protection and disease control. In the 1990s, the research function of CCs grew rapidly, which led to substantial increase in their number. The research work done by some of these has had impact on health policies globally. For instance, research at the CC at Mahidol University (Nakhon Pathom, Thailand) on the genesis of resistance to antimalarial drugs helped shape the malaria response globally[4]. As per the WHO CC database, as of October 2016, there are 825 CCs located in 80 countries, with the majority in the European Region (286), the Americas (183) and the Western Pacific Region (191)[5]. In the SEA Region, there are 94 CCs across eight countries and three of these (Bhutan, Maldives and Timor- Leste) do not have any CC. The work of centres in this Region spans over 46 different fields and about 12 per cent of these are involved in research.

Strengthening CCs is critical for implementation of WHO's research agenda since four out of six core activities of the world body are linked directly or indirectly to research. One of the key ways to boost relevant health research would be to link CCs to recommendations emerging from Advisory Committee on Health Research (ACHR), a consultative mechanism that provides independent advice on health research to the Regional Director. This would make the work of both ACHR and executing partners such as CCs relevant and useful. ACHR recommendations are often wide-ranging and, at times, WHO finds it difficult to implement them due to limited resource availability.

Recalibrating collaborating centres for dynamic health landscapes

To remain relevant and effective, the work of CCs must be aligned with the changing health landscape,

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in general, and contemporary agenda as well as work programmes of WHO, in particular. While the importance of CCs in technical capacity building and research is well-recognized, it was felt in the early 1990s that their potential was not being fully utilized[6]. The CC framework could provide a cost-effective approach to develop and sustain capabilities, technical cooperation and conduct of appropriate research, particularly for programme areas constrained by limited or decreasing budgetary resources. The 50th World Health Assembly urged Member States to support and develop national centres of expertise so that they may meet the criteria to become WHO CCs. Creating such partnerships, the assembly felt, was necessary for WHO to exert global health leadership in the 21st century[7].

Some corrective measures followed internal reviews of the CC mechanism resulting in discontinuation of inactive centres. The total number of CCs decreased from 1300 in 1998 to around 900 in 2006. Yet another internal review in 2007 concluded that CCs were too often ‘underutilized’ and frequently ‘insufficiently’ aligned with WHO agenda due to a lack of planning mechanisms to fully integrate them into WHO’s work as well as poor communication between WHO and CCs[8]. A case in point would be the eight Flagship Areas identified by the Regional Director of the SEA Region[9]. Of the 94 CCs in the Region, only 32 are directly working on these identified priorities of the regional office.

Pathway to re-engineer collaboration

The turn of the century saw mainstreaming of health-related targets in the Millennium Development Goals (MDGs) framework. WHO helped member countries in meeting their commitment through its activities such as setting prevention and treatment guidelines, and providing technical support. The health-related goals under Sustainable Development Goals (SDGs), which superseded MDGs in 2015, represent a paradigm shift to disease response. For instance, the goalpost for communicable diseases has been shifted from control to elimination. Several key MDG targets are also aligned with global and regional strategies of WHO for different diseases. Another reality is the reversal of trends relating to burden of disease between 1990 and 2010 from communicable diseases to non-communicable diseases. For countries in the midst of epidemiological transition, it means facing the challenge of double burden. Outbreaks of new viruses and pathogens also call for coordinated global response from governments, health ministries and WHO. In addition, funds available for health research and capacity building such as the Global Fund to Fight AIDS, Tuberculosis and Malaria are shrinking[10].

In view of all these factors, there is an urgent need to revitalize and optimally use the system of CCs. As a consequence of this new reality, the WHO has been engaged in finding ways to enhance the effectiveness of collaboration. Its regional offices are increasingly recognizing that effective collaboration requires new mechanisms that support regular communication, harmonized work plans and systematic evaluation. A meeting of CCs in the Western Pacific Region in 2014 recommended sharing of good practices in collaborative partnerships, including enhanced communication, consultative planning of work and strategic resource mobilization to improve outcomes[11]. To plug the communication gap between WHO and CCs, it was recommended that the work plan of CCs should be aligned with changing technical cooperation priorities of the WHO. The second such meeting of CCs in the Regional Office for the Western Pacific was held in November 2016.

The SEA Region organized a meeting of representatives of all the CCs in the Region in October 2016 to discuss ways of enhancing collaboration and partnership. A survey among CCs in the Region conducted before the meeting identified avenues and mechanisms for further collaboration and networking among CCs[4]. It pointed to the need for structured communication and coordination with WHO for implementation of the mandate and terms of reference. The Delhi meeting recommended that the process of the communication should be institutionalized in a manner such that dependence on individuals is reduced[4]. The coordinating office in the regional office needs to review the mechanisms, periodicity, content, context and recipients of communication between CCs and WHO in consultation with all parties concerned. It was recommended, to periodically review the Terms of References (ToRs) to clarify and ensure alignment with the WHO mandate and also refinement of monitoring and evaluation framework for CC activities to make them more transparent and quantifiable. Establishing platforms and mechanisms for dissemination and sharing of activities, achievements and good practices by CCs and WHO for networking and collaboration can go a long way. It was agreed that WHO would encourage CCs to form a regional network on common

themes to accelerate and enhance support to Member States in a more efficient manner.

Conclusions

The concept of having a string of CCs to support in implementation of the agenda of a UN body is unique to WHO and has stood the test of time over the past six decades. CCs have played a commendable role in pushing the agenda of WHO in control of infectious diseases, and improving maternal and child health. Many of these have become a great source of knowledge, technical help, research and emergency response. However, it is also being felt that the full potential of CCs is not being optimally used. These are not fully aligned to global and regional agenda of WHO, particularly in the context of SDGs, the need to promote universal health coverage (UHC) and agenda of ending major diseases by 2030. Regional offices of WHO are alive to the challenge and are geared to make full use of this valuable resource, based on the underlining philosophy that relationship between a CC and WHO is collaboration and not outsourcing.

***Financial support & sponsorship*:** None.

***Conflicts of Interest*:** None.

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Received January 17, 2018

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