Partnerships: The WHO approach to collaborative innovation

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An early model of partnerships in health

The Second World Health Assembly (1949) laid down the policy that WHO should not consider the establishment, under its own auspices, of research institutions. Instead, it was considered that research in the field of health is best advanced by coordinating and making use of existing institutions.
Two main types of partnerships

• WHO Collaborating Centre (WHOCC)
• Multi-stakeholder partnerships

• Definition: the WHOCCs are institutions designated by the Director-General to carry out activities in support of the Organization's programmes at the country, regional and global levels
Roles and incentives

• Role: to provide strategic support to WHO to meet two main needs:
  - implementing WHO’s mandated work and programme objectives, and
  - developing and strengthening institutional capacity in countries and regions

• For the WHOCCs
  – gain enhanced visibility and recognition by national authorities, calling public attention to the health issues on which they work;
  – obtain improved opportunities to exchange information and develop technical cooperation with other institutions, in particular, at international level, and to mobilize additional and sometimes important resources from funding partners

• For WHO
  – gain access to top centres worldwide and their institutional capacity to ensure the scientific validity of global health work.
  – exercise leadership through these global networks in shaping the international health agenda
What are WHO Collaborating Centres?

Most of these institutions are universities, research laboratories, parts of scientific academies or MoH, and hospitals.
Currently there are 930 WHOCCs in 99 Member States
Number of WHO collaborating centers by Region

- EU: 38%
- AM: 22%
- WP: 21%
- SE: 9%
- EM: 6%
- AF: 3%
WHO Collaborating Centers by country

- Switzerland: 2%
- Netherlands: 2%
- Brazil: 2%
- Russian Federation: 2%
- Canada: 3%
- Italy: 3%
- France: 3%
- Thailand: 4%
- Japan: 4%
- Germany: 4%
- India: 4%
- Australia: 5%
- United States of America: 11%
- China: 8%
- United Kingdom of Great Britain: 7%
- Other Countries: 43%
Number of Collaborating Centers by Subject

- No Subject: 34%
- Other Subjects: 50%
- Oral health: 2%
- Viral diseases other than those: 2%
- Reproductive health (excluding): 2%
- Health systems research & development: 3%
- Zoonoses: 3%
- Nursing: 4%
- Health promotion & education: 4%
- Occupational health: 4%
- Mental health & neurosciences: 4%
Old way of working

• Historically, the WHOCCs worked in isolation from one another, on one-to-one relationships with WHO

• That way of working started to change in the early 90s with WHO coordinating activities involving several centres as well as some centres developing joint activities among themselves
In January 2000 the Executive Board encouraged WHO CCs to develop working relations with other centres by setting up or joining collaborative networks with WHO’s support.
As of 2007 several networks of WHOCCs established, mostly organized around a common technical area of work

- WHO CCs for Occupational Health
- Global Network of WHO CCs for Nursing & Midwifery Development
- Global Environment Monitoring System - Food Contamination Monitoring and Assessment Programme (GEMS/Food)
- Global Network of WHO CCs working on Communicable Diseases
- Network of WHO CCs for Tobacco Control
- WHO CCs for Radiation / REMPAN network
- WHO CCs for International Classifications
- WHO CCs for Traditional Medicine
- WHO CCs for Injuries and Violence Prevention
- WHO CCs for Health Promotion
In comparison with the former way of working, the networks of WHOCCs have shown the following benefits:

- Better alignment with WHO's programmes;

- Activities with a greater global application and impact;

- Coordination of activities requires less time to WHO;

- New opportunities for the centres beyond their agreed work with WHO, new synergies. Improved motivation for the centres.
Eradicating polio in WPR

Polio Cases and OPV3 Coverage -- Western Pacific Region 1974-2004
As threats to global public health mount, stronger collaboration in surveillance and reporting needed

**Threats to global public health security:**
- Smallpox
- Poliomyelitis caused by a wild-type poliovirus
- Human influenza caused by a new virus subtype (e.g. avian flu)
- SARS

**Diseases of documented, but not inevitable, international impact, e.g.:**
- Cholera
- Pneumonic plague
- Yellow fever
- Viral haemorrhagic fevers (Ebola, Lassa and Marburg)
- West Nile fever

**Drug resistance in existing threats:**
- Tuberculosis
- Diarrhoeal diseases
- Hospital-acquired infections
- Malaria
- Meningitis
- Respiratory tract infections
- Sexually transmitted infections
- HIV/AIDS

**Selected emerging and re-emerging infectious diseases:**
1996–2004

[Map of global health threats]
Other infectious disease outbreaks have incurred massive economic costs to countries

This economic cost is particularly difficult for poorer countries to bear

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Excludes economic impact of human sickness and death.

Date source: (8)
Global Outbreak Alert and Response network (GOARN)
HINARI

- 111 partners
- 4,200 journals
- 2,800 institutions

- 108 countries
- $2.5m / subscription
- $7bn value
Sharing eHealth IP4D (SHIPD)

Vision

To support Healthcare in the development world by sharing eHealth Intellectual Property

Statement of intent put forward by WHO & NHS Connecting for Health (CfH) in 2005

To identify and use areas of IP produced by NHS CfH in concert with other initiatives being undertaken by WHO

DSS - diagnosis

Case management tool
ICT4HRH – the next big partnership area

Countries with a critical shortage of health service providers (doctors, nurses and midwives)

Distribution of health workers by level of health expenditure and burden of disease, by WHO Region

% of global burden of disease

% of global workforce

South-East Asia
Africa
Western Pacific
Eastern Mediterranean
Europe
Americas
Encouraging experiments from eLearning

- Brazil – 324,000 nurse auxiliaries trained in 4 yrs.
- Kenya – 22,000 RNs to be produced
- Seychelles – first cohort of graduate nurses, without traditional nursing school
- Courseware – largely available
**MDG Target 18:** In cooperation with industry, make available the benefits of technology, especially information and communications.

Multi-stakeholder collaboration (government, academia, industry, civil society, etc.) will help bring the transformative powers of eHealth to improve global health.
THANK YOU

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