

Evaluation of WHO's work with Collaborating Centres

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Acronyms and Abbreviations

ADG	Assistant Director-General
AFRO	WHO Regional Office for Africa
AMRO	WHO Regional Office for the Americas (cf. PAHO)
APW	Agreement for Performance of Work
CC	Collaborating Centre
DG	Director-General
DGO	Director-General's Office
DPM	Director of Programme Management
EB	Executive Board
eCC	Electronic Collaborating Centres
EMRO	WHO Regional Office for the Eastern Mediterranean
EQ	Evaluation Question
EURO	WHO Regional Office for Europe
FENSA	Framework of Engagement with Non-State Actors
GFP	Global Focal Point
GPW	General Programme of Work
HQ	WHO Headquarters
PAHO	Pan-American Health Organization
PMDS	Performance Management and Development System
RFP	Regional Focal Point
RO	Responsible Officer
SDG	Sustainable Development Goal
SEARO	WHO Regional Office for South-East Asia
TC	Technical Counterpart
ToR	Terms of Reference
WHO	World Health Organization
WPRO	WHO Regional Office for the Western Pacific

Executive Summary

WHO collaborating centres (CCs) have been in place since the founding of the World Health Organization (WHO), with the first WHO CC having been designated in 1948. WHO CCs are a mechanism of cooperation in which relevant institutions are recognized by WHO as assisting the Organization in implementing its mandated work by: supporting the achievement of WHO's planned strategic objectives at the regional and global levels; enhancing the scientific validity of its global health work; and developing and strengthening institutional capacity in countries and regions.¹ The main functions of CCs include:

- collection, collation and dissemination of information;
- standardization of terminology and nomenclature of technology, diagnostic, therapeutic and prophylactic substances, and of methods and procedures;
- development of evidence-based technical guidance tools and resource materials;
- provision of reference substances and services;
- participation in collaborative research developed under WHO's leadership;
- training, including research training;
- coordination of joint activities;
- capacity building work at country level; and
- provision of monitoring, preparedness and response services to deal with disease outbreaks and public health emergencies.²

WHO's work with CCs is intended to benefit both parties. Through this work, WHO stands to gain access to leading institutions worldwide and the institutional capacity to support its work. In turn, institutions designated as CCs stand to gain visibility and recognition by national authorities, as well as greater attention from the public for the health issues on which they work.

It has been 12 years since the last evaluation of WHO's work with CCs was carried out in 2007. Recommendations from the 2007 evaluation addressed a wide range of issues, from putting in place or updating internal policies to guide the work with CCs at all levels of the Organization, to changing administrative procedures for designating and redesignating CCs, and developing a clear and common shared vision of the strategic role of CCs. Since that evaluation, WHO has undertaken efforts to make its work with CCs more strategic, in part by discontinuing the designation of CCs that are inactive or ineffective. There are currently 822 CCs across the six WHO regions.

The present evaluation aimed to: (i) examine the relevance, effectiveness and efficiency of the programmatic contributions of CCs to the achievement of WHO objectives, (ii) identify lessons learned, and (iii) make recommendations to inform future policy and decision-making. The evaluation was framed around four key questions, namely:

- a. To what extent is the work carried out by the CCs aligned with the relevant General Programmes of Work (GPW) and their outputs/outcomes?
- b. To what extent does the work of CCs contribute to the delivery of WHO's results?
- c. How efficiently did WHO manage its relations with CCs?
- d. What are the main lessons learned and the strategic recommendations for the way forward?

The evaluation findings presented in this report are organized according to the four evaluation questions.

¹ A WHO CC refers to that part of an institution (e.g. university, research institute, hospital, academy, or government) that performs the agreed terms of reference and workplan with WHO – this in contrast to the other activities the institution performs outside the agreed terms of reference and workplan related to its relationship with WHO. See: WHO eManual, XV.5 Collaborating Centres

² WHO Manual XV.5: WHO Collaborating Centres

This evaluation applied a mixed-method approach that compiled evidence from several sources of qualitative and quantitative data, including: (a) a review of relevant documents; (b) face-to-face and virtual interviews, as well as focus group discussions, with 66 key stakeholders (i.e., WHO senior managers across the Organization, Responsible Officers (ROs), the Global Regional Focal Point (GFP) team and Regional Focal Points (RFPs) for CCs, Technical Counterparts (TCs), the Due Diligence and Non-State Actors team associated with the implementation of the Framework of Engagement with Non-State Actors (FENSA), and selected heads of CCs; and (c) two online surveys, one soliciting the perspectives of the heads of CCs (the survey had a 38% response rate, i.e., 314 out of 822 CCs) and another soliciting the views of WHO staff working directly with CCs, such as ROs and TCs (the survey had a 25% response rate, i.e., 96 out of 391 ROs/TCs). The evaluation covered CCs that were active during the biennium 2018-2019. Owing to a lack of robust monitoring data on the work of CCs, the evaluation relied primarily on the key informant interviews and the online surveys to answer the evaluation questions.

Evaluation findings

To what extent is the work carried out by CCs aligned to the relevant GPW and their outcomes / outputs?

Over the past 12 years, WHO has undertaken a range of actions in response to the recommendations of the previous evaluation, leading to improvements in the management of its relationship with CCs and to closer alignment of the work of CCs with WHO's priorities. For example, significant changes have been made to WHO's approach to working with CCs and the processes for designating and redesignating CCs through: a) the introduction and continued improvement of the Electronic Collaborating Centres (eCC), a web-based e-Work interface for initiating and managing these partnerships more efficiently; b) the improvement of guidelines for heads of CCs and WHO staff working with CCs; and c) the introduction of a due diligence process to ensure compliance with FENSA, a framework aimed at strengthening WHO's engagement with non-State actors such as NGOs, philanthropic foundations and academic institutions. Currently the approval process using the eCC provides opportunities to ensure alignment between the workplans of CCs and WHO priorities. Additionally, WHO guidelines for WHO and CC staff as well as the eManual provide details on how this alignment should take place. In recent years, these changes have led to a considerable reduction in the number of CCs, which has been achieved through the discontinuation of inactive, ineffective and less strategically aligned CCs and through concerted efforts to designate or redesignate only those CCs that can contribute to WHO's priorities. As a result, most of the work delivered by CCs is relevant to WHO's GPW and aligned with GPW outcomes and outputs.

Despite this progress, a number of outstanding gaps have hindered the ability of CCs to ensure continued relevance of their work to WHO's priorities. For example, despite the efforts to streamline the process of designating and redesignating CCs and make it more strategic, there are still several inactive or ineffective CCs, which may pose reputational risks for the Organization. Additionally, the previous evaluation highlighted the need for WHO to have strategic plans that serve as a reference point for selecting, designating and discontinuing CCs. However, WHO still lacks a comprehensive organization-wide strategic plan for working with CCs that includes specific actions at the global, regional, and technical programme area levels. While some of the departments have developed and implemented such plans with positive effects, others did not, mainly owing to the lack of engagement at the senior management level and the lack of resources to support implementation and monitoring.

The views of key stakeholders underscore the continued importance of these partnerships to the fulfilment of the GPW, even though the evaluation highlighted the need for further improvements. A majority of WHO staff who participated in the online survey consider CCs to be making a highly valuable contribution to the achievement of WHO's objectives. Many considered CCs as key partners, without which they would be unable to fulfil their WHO remit. This sentiment was particularly pronounced among

WHO staff who work with limited financial resources or in very small teams. There is also a good level of understanding among most, but not all, heads of CCs about how their work contributes to the delivery of WHO's priorities. Engaging key CC staff in discussions around WHO's strategic priorities could increase their understanding of WHO's priorities as presented in GPW13 and beyond.

At the same time, many CC and WHO staff have a limited understanding of the needs and requirements of the FENSA due diligence process. This presents challenges for both CC and WHO staff in knowing what is required through the process, and in understanding feedback on their designation proposals from the FENSA due diligence team. (A separate evaluation on the implementation of the FENSA was completed during the course of the present evaluation, and action on its recommendations should serve to reduce these awareness and knowledge gaps.³)

To what extent does the work of the CCs contribute to the delivery of WHO's results?

Both WHO staff and CC heads broadly felt that CCs contribute significantly to the delivery of WHO's results by undertaking important activities in the areas of: (a) provision of technical expertise; (b) capacity building; (c) research; (d) policy development; and (e) emergency response. CCs linked to WHO regional offices tend to focus more on direct technical assistance and capacity-building support to countries, while also improving WHO's access to high-quality technical expertise and research capabilities at this level. Those linked to the HQ technical programmes, by comparison, tend to work on issues that are global in nature, such as research, guidelines and policy development. These HQ-linked CCs are an effective mechanism for developing global thought leadership and increasing the evidence base for policy-making.

Indeed, WHO staff identified the development of global thought leadership and global communities of advocates for WHO's work as one of the key areas where the work of CCs have added the greatest value. Accessing global experts to engage in dialogue around policy or research ensures collaborative knowledge generation. CC experts supporting the work of WHO provide specific knowledge and expertise that WHO staff may not necessarily have. In this regard, several WHO staff felt that the large CC network has improved the quality and relevance of WHO's policy and research and development work. In addition, WHO's collaboration with CCs extends the Organization's scope of influence as it generates new advocacy opportunities through which WHO can position its policy work.

However, the potential of CCs to make a meaningful contribution at global level is curtailed by their unequal representation at the global level and across regions. Although the location of CCs is not of primary concern for WHO, as the CCs are expected to deliver outputs that are regional and global in nature, CCs located in low- and middle-income countries often face challenges related to low availability of resources, which can adversely affect their ability to fulfil their role as CCs. An analysis of the location of the 822 currently designated CCs, which are based in 99 countries across all six WHO regions, reveals that there is an imbalance in the geographic distribution of CCs in favour of high-income countries and specific regions. All told, fully one-third of all CCs are based in the European Region, while 24% are based in the Western Pacific Region, 22% in the Region of the Americas, 13% in the South-East Asia Region, 5% in the Eastern Mediterranean Region, and only 3% in the African Region. Furthermore, nearly 80% of all CCs are based in 22 countries, 13 of which are high-income countries. As a result, the potential of the CCs to achieve maximum effectiveness globally is limited by the unevenness in their global presence and reach.

CC heads expressed that what they most value in their relationship with WHO is the contribution that they make to global health outcomes by supporting WHO to fulfil its mandate. In addition, they highly valued the recognition that CCs gain through their formal relationship with WHO, as this helps CCs

³ [Initial evaluation of the Framework of Engagement with Non-State Actors: Report and Annexes](#). WHO, December 2019. (accessed on 8 May 2020)

improve their visibility and reputation vis-à-vis national authorities the broader public in their specific areas of work. They also noted that the relationship helped CCs gain access to broader global networks of CC institutions working in similar fields, thereby increasing their visibility at regional or global level. Increased involvement in policy-making processes was also identified as an important added value of the collaboration with WHO. Moreover, some institutions apply the learning and good practices that emerge from their role as CCs across other programmes, thereby improving the quality and consistency of the work delivered by their respective institutions more broadly.

Notwithstanding the aforementioned positive aspects of WHO's work with CCs, there are a number of areas in which WHO's work with CCs has been less effective. One of these areas relates to the monitoring of the work delivered by CCs. Stakeholders noted that internal processes for monitoring and reporting could be improved. In particular, the heads of CCs expressed that the feedback they receive from WHO staff on the annual reports that they submit does not meet expectations. Additionally, numerous stakeholders highlighted that there have been missed opportunities to assess the contribution of the work of CCs to WHO's results. Although this contribution is valued by WHO, opportunities for showcasing the work of CCs both within WHO and externally have been limited.

Interviews with WHO staff and heads of CCs also indicate that CCs often have workplans that are too broad and therefore difficult to implement within the designation period. Indeed, achieving the ambitious objectives in these workplans would require additional resources and capacities. Therefore, they expressed that there is room for further improving the planning process to ensure that the identified objectives are clear and realistic. Such broad workplans, on the one hand, allow flexibility for them to adapt to WHO's priorities, as these can shift during the designation period.; on the other hand, the breadth of these workplans often entails a need for more resources and capacity if the CCs are to fully utilise and to demonstrate tangible results.

The evaluation identified several key factors that have enabled CCs to work effectively and overcome their challenges. These include: effective communication between CCs and WHO from the planning stage to implementation and monitoring; effective planning processes that are facilitated by an open and transparent discussion on the roles of key stakeholders and expectations vis-à-vis the relationship. CC heads also underlined that networks of CCs working in the same or similar areas is a key factor enabling the achievement of results, although some also mentioned that more networking opportunities is warranted. They further noted that the WHO CC "brand" is a key factor that enables CCs to fulfil their role as it increases the institution's visibility and trust by the Government, partners and donors, and, consequently allows the institution to mobilise additional resources. Other enabling factors include positive working relationships between CCs and WHO based on mutual trust and the presence of a strategy or approach guiding WHO's work with CCs.

The most significant challenge faced by CCs, as expressed by the heads of CCs as well as WHO staff who work directly with CCs, is a lack of resources. While this is particularly true for CCs from low- or middle-income countries, CCs in high-income countries often have to justify to their institution why they deliver work as a CC considering that there is no financial benefit to their institution more broadly. Other key challenges faced by the CCs include: ambiguity over WHO's expectations; lack of joint planning; the administrative burden of the designation and redesignation process; and lack of transparent communication – especially in relation to the reasons for delays in the approval of proposals. Stakeholders also noted that there is a need for WHO to better communicate to CCs its changing priorities.

How efficiently did WHO manage its relations with CCs?

An assessment of the efficiency of WHO's work with CCs reveals a mixed picture. On the one hand, there has been considerable improvement in ensuring that inactive CCs do not continue to hold the CC designation, thus helping to avoid an overstretch of already-limited capacities for CC engagements. Improvements in the designation and redesignation process have reportedly helped in identifying institutions that have the capacity, resources and expertise to contribute optimally to WHO's results.

Human and financial resourcing of the CCs represents a distinct and considerable aspect of efficiency. WHO does not provide any financial resources to CCs for the implementation of their workplan, although it does dedicate significant staff time. By contrast, WHO CCs contribute significant levels of financial, human and technical resources to WHO. Stakeholders highlighted that having a strategic planning process in place at the regional, department or technical programme area level is essential to ensure that financial and technical resources are used efficiently and strategically, and that there is no duplication of efforts. CC heads also explained that part of their role as CCs is to respond to ad hoc requests to implement activities that are emerging priorities for WHO. CCs tend to see these ad hoc activities as an important element of their role, particularly in emergency situations. They further noted that mobilizing resources within a short timeframe has proved challenging, although CCs have responded to these requests in a timely manner. In this regard, CCs are perceived as highly cost-effective means of achieving the goals of the GPW.

At the same time, several challenges have hampered the efficiency of WHO's work with the CCs. In particular, there are substantial costs incurred by WHO in managing its work with CCs. These costs mainly involve the staff time of ROs and TCs, the majority of whom are senior-level officials, and those involved in decision-making on the designation and redesignation process – e.g., directors, Assistant Directors-General, Global and Regional Focal Points, and the FENSA due diligence team. Although it is difficult to monetize the exact value of such human investments, they are not negligible. However, considering the substantial amount of time that most ROs and some TCs spend undertaking CC-related work, this aspect of their work is rarely reflected in their Performance Management and Development System (PMDS) plans and performance assessments. Most fundamentally, despite the significant investment of human resource capacity in CC-related work, there has been a significant (some stakeholders say urgent) need for additional capacity to support the management of CCs at the global and regional levels – as well as for training and support for staff, especially surrounding good practice in working with CCs and awareness of the requirements of the FENSA due diligence process.

Other major efficiency-related concerns centre on: administrative and management systems; lack of joint decision-making on the designation and redesignation process of CCs, coupled with delays in these processes; the lack of transparent communication on the reasons for delays in approving a proposal and reasons for discontinuing a designation; as well as a lack of awareness of the work CCs deliver, both internally within WHO as well as externally.

For example, the administrative and management systems currently in place support both CCs and WHO staff throughout the process of designation and redesignation. These systems also support CC and WHO staff in planning and delivering CC activities. However, those who use this system report that it is not as efficient or robust as it could be. In particular, they indicate that the Electronic Collaborating Centres (eCC) system could be made more user-friendly and that the approval steps could be streamlined. They also noted that the system could allow for more flexibility in the permitted formats of eCC submissions.

Delays in the designation and redesignation process reportedly stem from: (a) a lack of engagement of all decision-makers from the beginning of the process; (b) the time required for due diligence review under FENSA; (c) delays in taking decisions on whether to continue or discontinue a CC; and (d) the

cyclical nature of the system, which requires that when feedback is provided at any point in the designation and redesignation process, it is resubmitted at the start of the system for approval by all stakeholders. These delays have resulted in a loss of momentum in the relationship, missed opportunities, mistrust, and negative expectations of working with WHO.

Communication between WHO staff and CCs is cited as another area in which timeliness and quality are less than optimal. In this vein, there is a substantial difference in the perception of WHO staff and heads of CCs surrounding the regularity of such communication. Whereas the vast majority of WHO staff who directly work with CCs mentioned that communication with the CCs occurs twice a year, over half of the heads of CCs noted that communication with WHO only happens once a year. As noted above, communication that feeds into monitoring systems presents a particularly significant challenge.

The internal and external lack of awareness of the work CCs deliver for WHO is seen as being the result of a lack of regular and formal communication processes. This lack of awareness has reduced opportunities to apply a more strategic approach to planning and implementing the work of CCs and to maximise the potential use of existing CCs to achieve major health objectives in an effective, efficient manner.

What are the main lessons learned?

The designation of a new CC or redesignation of an existing CC has been most effective when there is a strategic approach in place to ensure the relevance of the work of the CC and its alignment with WHO's priorities. Where there has been a systematic and transparent mechanism in place for approving designation/redesignation proposals, for engaging senior management, and for communicating decisions on the designation or redesignation of a CCs in a timely manner, it was easier for Responsible Officers to manage WHO's relationships with CCs. Continued designation and redesignation of ineffective and inactive CCs resulting from internal or external pressures could reduce the relevance of the work of the CCs to WHO's priorities, and entails potential reputational risks.

The effectiveness of CCs has been enhanced in situations where there is a regional, departmental or network strategy in place. These strategies often cover approaches to the identification, designation and redesignation of CCs, as well as the management and review of CCs and their work. The development and use of strategies for working with CCs by WHO staff and senior managers has increased the effectiveness of the CCs work and maximized their contribution.

Moving forward, there is a potential for WHO to work more effectively and efficiently with CC by establishing clear strategic plans, leadership and decision-making processes at the highest levels to formulate WHO's future approach of working with CCs. An organizational strategy for working with CCs could improve the effectiveness and efficiency of the work delivered by CCs. Likewise, the use of networks of CCs working in the same or similar technical areas can help CCs maximize their contribution to WHO's results.

There are several specific challenges faced by CCs based in low- and middle-income countries. Understanding their specific needs, challenges and capacities will likely help WHO staff to effectively manage those CCs and support the CCs to perform more efficiently going forward.

Recommendations⁴

1. **Develop, implement and disseminate a strategic framework for working with Collaborating Centres (CCs)** at global, regional and departmental level based on the policies and procedures detailed in the WHO Manual XV.5. This framework should include, as appropriate, measures to:
 - a. conduct a strategic review of current CCs by a panel of WHO senior managers to identify those that are inactive or ineffective and establish a process that will lead to the discontinuation of CC designations based on strategic alignment and risk considerations consistently across the Organization;
 - b. develop a robust monitoring and evaluation process to assess the work of CCs so as to maximize their relevance, effectiveness and efficiency, and ensure consistency of implementation across the Organization;
 - c. ensure more regular and systematic engagement of directors, Assistant Directors-General, and technical counterparts in designation/redesignation and planning processes;
 - d. review the designation of CCs or develop new categories of CCs to take into account the different needs of CC institutions in low- and middle-income countries, and WHO regional or country requirements; and
 - e. establish a mechanism for anticipating emerging health issues and forecasting needs, and for establishing pipelines for the development of new CCs to address these.
2. **Promote awareness of Collaborating Centres (CCs) and their contribution, both within WHO and with external audiences as appropriate.** Toward this end, it is recommended that:
 - a. a systematic mapping be undertaken of CCs' locations and areas of work (or specialization) and disseminated internally to various technical units and departments to improve awareness of CCs and the efficiency with which these are used across WHO;
 - b. high-level internal reporting systems be established to evaluate and report on CCs' contributions across WHO by ensuring that existing data are systematically analysed and made available to senior management periodically;
 - c. formal systems be put in place to showcase the work of CCs within WHO and externally; and
 - d. the contributions of CCs be included in high-level strategy documents and reported in an annual summary report.
3. **Develop a communication plan for the Organization's relations with Collaborating Centres (CCs)** that, *inter alia*:
 - a. ensures more regular and formalised communication throughout the CC designation/redesignation process;
 - b. establishes regular contact during the designation period and a systematic communication structure for ongoing monitoring of CCs' work;
 - c. engages CCs more systematically in wider WHO dialogues on strategic priorities and directions; and
 - d. allows more face-to-face engagement between WHO staff and CCs.

⁴ The evaluation has generated five overarching recommendations, covering areas also identified in the 2007 evaluation. These areas for improvement still require focused attention to ensure that WHO's collaborative relationship with Collaborating Centres is as relevant, effective and efficient as possible going forward.

4. **Use the forthcoming re-development of the Electronic Collaborating Centres (eCC) as an opportunity to improve the effectiveness and efficiency of the online system**, namely through measures to:
 - a. re-assess the ordering and requirements of each approval step to streamline the process and re-design the system to remove the need for resubmission and approval after each edit;
 - b. allow for more flexibility in the formats used for proposal submission in eCC;
 - c. improve the user interface and guidance notes of the eCC to make it more user-friendly; and
 - d. provide more guidance for users on the timeframe required for each step and how to avoid delays.
5. **Undertake a review of current staff support and management systems** to identify areas for improvement, with a view to:
 - a. increasing capacity in the functions of Regional Focal Points and the Global Focal Point team to include a networking, training and communication role;
 - b. establishing a training programme for staff on planning and management processes for working with CCs and on the Framework of Engagement with Non-State Actors (FENSA) due diligence process and requirements;
 - c. providing opportunities for peer learning for Responsible Officers and Regional Focal Points; and
 - d. including CC-related roles (i.e., Responsible Officers, Technical Counterparts) in WHO staff Performance Management and Development System (PMDS) processes.

1. Introduction

1.1 Background

1. WHO collaborating centres (CCs) have been in place since the founding of the World Health Organization (WHO), with the first WHO CC having been designated in 1948. WHO CCs are a mechanism of cooperation in which relevant institutions are recognized by WHO as assisting the Organization in implementing its mandated work by: supporting the achievement of WHO's planned strategic objectives at the regional and global levels, including objectives related to the development and strengthening of national and regional institutional capacity, and also enhancing the scientific validity of its global health work.⁵ The main functions of CCs include:

- collection, collation and dissemination of information;
- standardization of terminology and nomenclature of technology, diagnostic, therapeutic and prophylactic substances, and of methods and procedures;
- development of evidence-based technical guidance tools and resource materials;
- provision of reference substances and services;
- participation in collaborative research developed under WHO's leadership;
- training, including research training;
- coordination of joint activities;
- capacity building work at country level;
- and provision of monitoring, preparedness and response services to deal with disease outbreaks and public health emergencies.⁶

2. WHO's work with CCs is intended to benefit both parties. Through this work, WHO stands to gain access to leading institutions worldwide and the institutional capacity to support its work. In turn, institutions designated as CCs stand to gain visibility and recognition by national authorities, as well as greater attention from the public for the health issues on which they work. The centres also gain opportunities to work together towards common objectives by exchanging information, pooling resources and developing joint technical cooperation, particularly at the international level. Joint collaboration among CCs also give them the opportunity to mobilize additional and sometimes important resources from funding partners.⁷

3. Two evaluative assessments were conducted in the last two decades on the work of WHO with CCs. In 1997, the Executive Board (EB) requested the Director-General (DG) to undertake a situation analysis of CCs, which was completed and published in 1998. Together with other studies and recommendations of an interregional meeting in 1999, a report was submitted to the 105th session of the EB in January 2000 (EB105/21).

4. In 2007, the Office of the Internal Oversight Services (IOS) of WHO conducted an evaluation of WHO's work with CCs. The purpose of this evaluation was to examine the relevance, effectiveness, and efficiency of the programmatic contributions of CCs to the achievement of WHO objectives and results, and to identify lessons learned. The evaluation report proposed 39 recommendations⁸ to stimulate

⁵ A WHO CC refers to that part of an institution (e.g. university, research institute, hospital, academy, or government) that performs the agreed terms of reference and workplan with WHO – this in contrast to the other activities the institution performs outside the agreed terms of reference and workplan related to its relationship with WHO. See: WHO eManual, XV.5 Collaborating Centres

⁶ WHO Manual XV.5: WHO Collaborating Centres

⁷ Guide for WHO Collaborating Centres – WHO (2018)

⁸ The IOS report in 2007 used the term "options for consideration", instead of recommendations.

discussions on the future role of CCs and their relationship with WHO, and to guide the deliberations of the Global Steering Committee on CCs.

1.2 Evaluation purpose, objectives and scope

5. WHO's Thirteenth General Programme of Work (GPW13) is WHO's five-year strategic plan for the 2019-2023 period. It aims to contribute to the achievement of the Sustainable Development Goals (SDGs) and to drive public health impact at country level.⁹ Through its GPW, WHO aims to become more focused and effective in its country-based operations by working closely with partners, engaging in policy dialogue, providing strategic support and technical assistance, and coordinating service delivery, depending on the country context. In this regard, WHO CCs can play an important role in supporting the implementation of WHO's GPW.

6. The last evaluation of WHO's work with CCs was completed over 12 years ago. The recommendations in the 2007 evaluation addressed a wide range of issues, from putting in place or updating internal policies to guide the work with CCs at all levels of the Organization to changing administrative procedures for designating and redesignating CCs as well as developing a clear and common shared vision of the strategic role of CCs. Between 2004 and 2007 the number of CCs was reduced from 1200 to 896, mainly by introducing a rule to discontinue the designation of CCs once the designation period expires, unless the redesignation is formally requested and approved. Since 2007, WHO has continued its efforts to make its work with CCs more strategic by discontinuing the designation of inactive and ineffective CCs, resulting in a further reduction in the number of CCs to 822.

7. In light of the changing strategic priorities and initiatives at WHO, this evaluation is considered timely to inform policy and decision-making.

Evaluation objectives and scope

8. The objective of this evaluation was to examine the relevance, effectiveness, and efficiency of the programmatic contribution of CCs to the achievement of WHO objectives and expected results. The evaluation also documented successes, challenges and best practices, and provided lessons learned and recommendations for future use by management to inform policy and decision-making. It covered CCs that were active during the biennium 2018-2019. The evaluation was formative in nature and meets accountability as well as learning objectives.

Evaluation questions

9. Table 1 below presents the evaluation questions, sub-questions and areas of assessment that were examined throughout the course of the evaluation. The evaluation questions were developed based on a careful analysis of the findings and recommendations that emerged from the 2007 evaluation with the aim of understanding the extent to which these were taken into consideration in WHO's subsequent work with CCs.

⁹ Thirteenth General Programme of Work 2019-2023 – WHO (2018), <https://apps.who.int/iris/bitstream/handle/10665/324775/WHO-PRP-18.1-eng.pdf>, accessed 15 January 2020..

Table 1: Evaluation questions and sub-questions

	Evaluation questions	Areas of assessment	Evaluation sub-questions – developed from Areas of assessment
EQ1	To what extent is the work carried out by the CCs aligned to the relevant General Programmes of Work and their outputs/outcomes? (Relevance)	<ul style="list-style-type: none"> • Alignment of the work of CCs to WHO's strategic goals • Relevance of CCs work to achieving WHO outputs / outcomes • Relevance of expertise / designation 	1.1 What have been the changes since the last evaluation? 1.2 Have those changes taken into account the recommendations of the previous evaluation? 1.3 How important is the role of CCs in the context of GPW 13? 1.4 How does the designation / redesignation process ensure alignment with WHO's GPW? 1.5 To what extent do CCs understand their role / contribution within GPW 13?
EQ2	To what extent does the work of the Collaborating Centres contribute to the delivery of WHO's results? (Effectiveness)	<ul style="list-style-type: none"> • How CCs contribute to achieving results – <i>e.g. functions, skills, roles</i> • Extent to which CCs contribute to achieving results • Challenges and limitations for CCs in contributing to results • Added value of collaboration with CCs 	2.1 How do CCs deliver work that contributes to WHO results? 2.2 To what extent were the defined objectives of the CCs realistic? 2.3 What were the enabling factors for CCs in achieving their objectives? 2.4 What were the key challenges faced by CCs in contributing to the results of WHO? 2.5 What is the added value of collaboration?
EQ3	How efficiently did WHO manage its relations with Collaborating Centres? (Efficiency)	<ul style="list-style-type: none"> • How effective and robust the administrative and relationship management systems are • Communications between WHO and CCs, and internally within WHO • Consistency of approaches globally • The value of capacity development / networks for CCs 	3.1 What is the cost to WHO for managing the CCs. To what extent does the cost match with the benefits? 3.2 Were the services provided by the CCs timely, and used appropriately? 3.3 What is the level of awareness within WHO around the work of the CCs? 3.4 How efficient is the communication between CCs and WHO? 3.5 Are the administrative and management systems appropriate, robust and efficient?
EQ4	What are the main lessons learned and the strategic recommendations for the way forward?	<ul style="list-style-type: none"> • The main successes and challenges in the work with CCs • The key lessons learned (both positive and negative) • Recommendations for 3 areas - Relevance, Effectiveness, Efficiency 	4.1 What are the key lessons learned while working with the CCs? 4.2 Moving forward, how can WHO work more effectively and efficiently with the CCs in relation to achieving its results? 4.3 Are there any examples of good practice?

1.3 Methodology

10. This evaluation applied a mixed-method approach that combined several sources of qualitative and quantitative evidence, including:

- A review of key documents;
- face-to-face interviews and focus group discussions (FGDs) with key stakeholders; and
- two online surveys, one soliciting the perspectives of the heads of CCs and another soliciting the views of WHO staff who are working directly with CCs, such as the responsible officers and technical counterparts.

11. **Desk review:** Several documents were examined through the desk review. These included:

- WHO strategic documents in relation to work with CCs;
- documents developed by WHO headquarters (HQ) to support the staff of WHO and CCs to deliver their role (e.g., guidelines, policies or factsheets on WHO's work with CCs);
- WHO internal meeting reports and presentations related to its work with CCs;
- regional office reviews of their work with CCs;
- meeting reports from CC network meetings; and
- good practice documentation.

12. **Interviews and FGDs:** Between November and early December 2019, the evaluation team conducted interviews and FGDs in-person and remotely with 66 key informants from various stakeholder groups, most of whom were selected randomly within a purposively identified set of stakeholder groups. The list of interviewees is presented in Annex D. Key informants included:

- a. WHO staff who work directly with CCs, including: 1) Responsible Officers (ROs), who directly manage the collaboration; and 2) Technical Counterparts (TCs), who provide technical inputs;
- b. Directors of Programme Management (DPMs) and WHO Regional Focal Points (RFPs) for CCs from regional offices;
- c. Directors of departments from HQ and regional offices and Assistant Directors-General (ADGs)
- d. the WHO Global Focal Point (GFP) team for CCs;
- e. members of the Due Diligence and Non-State Actors team for the Framework of Engagement with Non-State Actors (FENSA); and
- f. heads of CCs.

13. **Online surveys:** The evaluation team administered two online surveys between 31 October and 18 November 2019 to gather feedback from two key stakeholder groups.

- a. The first survey targeted the heads of CCs from all 822 CCs. The overall survey response rate was 38%. CCs from all six WHO regions participated in the survey, which was made available in three languages (i.e., French, Spanish and English).
- b. The second survey was designed for WHO staff who directly work with CCs (i.e., ROs and TCs). All 391 ROs and TCs were invited to participate and the overall response rate was 25%. ROs and TCs from HQ and all six WHO regions participated in the survey, which was made available in French and English.

The detailed response rate for both surveys is presented in Annex E.

14. The evaluation report was developed following the quality criteria defined in the WHO Evaluation Practice Handbook.¹⁰ The evaluation findings presented in this report respond to the evaluation questions and sub-questions and were developed based on evidence gathered by the evaluation team. Owing to a lack of robust monitoring data on the work of CCs, the evaluation relied primarily on key informant interviews and the online surveys to answer the evaluation questions.

2. Findings

15. The evaluation findings presented in this report are organized according to the four evaluation questions.

2.1 To what extent is the work carried out by the CCs aligned to the relevant General Programmes of Work and their outputs/outcomes? (EQ 1)

16. This section presents the findings on the relevance of the work of CCs to WHO's GPW, and addresses five sub-questions in the following areas: (a) changes since the last evaluation; (b) the extent to which changes took into account the recommendations of the previous evaluation; (c) the importance of the role of CCs in the context of GPW13; (d) how the designation and redesignation process ensures

¹⁰

https://apps.who.int/iris/bitstream/handle/10665/96311/9789241548687_eng.pdf;jsessionid=4EF95A6B7304898465942B892F64B444?sequence=1, accessed 15 January 2020.

alignment with WHO's GPW; and (e) the extent to which the representatives of CCs understand the role and contributions of CCs within GPW13.

2.1.1 What have been the changes since the last evaluation? (EQ 1.1)

17. There have been significant changes in WHO's work with CCs since the 2007 evaluation. Those changes can be classified under two broad categories: (a) the approach to WHO's work with CCs; and (b) the processes for the designation and redesignation of CCs.

Changes in WHO's approach to working with CCs

18. Interviews with the heads of CCs and WHO staff indicate that there have been substantial changes in WHO's approach to working with CCs in recent years, mainly in two areas. First, during the designation of new CCs and redesignation of the existing CCs, WHO has increased its efforts to ensure that the work of CCs is aligned with WHO's priorities as elaborated in its GPW and Programme Budgets. Second, there has been a concerted effort from WHO to designate and redesignate only those CCs that can materially contribute to WHO's priorities. This also includes discontinuing the designation of those CCs that are inactive or ineffective, some of which have been designated as CCs for several years. For example, between 2004 and 2007, the number of CCs was reduced from 1200 to 896, mainly by introducing a rule to discontinue the designation of CCs once the designation period expires unless the redesignation was formally requested and approved. Since 2007, enhanced efforts have been made to make WHO's work with CCs even more strategic, and the number of CCs has been further reduced to 822.

Changes in the process of designating and redesignating CCs

19. There have also been significant changes in the processes and systems used by WHO to initiate and manage the collaboration with CCs. Several ROs as well as the heads of CCs interviewed explained that, over the past 10 years, the major change in the designation and redesignation process has been the introduction and continued improvement of the Electronic Collaborating Centres (eCC) system. This web-based interface processes the proposals for designation and redesignation submitted by CCs for approval and represents a step forward from the paper-based process previously used. In addition, WHO has made improvements and additions to key sources of guidance, such as the guidelines for WHO staff working with CCs¹¹, guidelines for heads of CCs¹² and the WHO eManual.¹³ These guidelines clearly articulate the roles and responsibilities of key stakeholders, and the expectations of WHO from the CC partnerships.

20. Interviews with the heads of CCs, many of whom have occupied this function for several years, revealed that both the use of the electronic system and more consultative planning processes, combined with improved guidance documents, have helped them to better understand WHO priorities and expectations. This has reportedly also helped ROs and heads of CCs also explained that this has helped them to better align the work of CCs with WHO's priorities during planning processes.

21. An important and recent addition to the designation and redesignation process is the introduction of the due diligence process of adherence to the Framework of Engagement with Non-State Actors (FENSA) by the Due Diligence & Non-State Actors team from the WHO Office of the Compliance and Risk Management and Ethics. This framework was introduced to strengthen WHO's engagement with non-State actors (i.e., NGOs, private-sector entities, philanthropic foundations and academic institutions), while protecting its work from potential risks such as conflict of interest, reputational risks, and undue influence. Until recently, this responsibility was handled by the Office of the Legal Counsel.

¹¹ Guide for WHO staff working with Collaborating Centres – WHO (2018)

¹² Guide for WHO Collaborating Centres – WHO (2018)

¹³ WHO eManual, XV.5 Collaborating Centres

2.1.2 Have those changes taken into account the recommendations of the previous evaluation? (EQ 1.2)

22. In the 2007 evaluation of WHO's work with CCs, 39 recommendations were presented as "options for consideration" in the following 10 areas: 1) strategic planning; 2) policy issues; 3) re-orienting perceptions; 4) awareness and involvement of technical staff and programmes; 5) involvement of WHO Country Offices (WCOs) in CC management and use; 6) alignment of the work of CCs with WHO objectives; 7) effective use of contributions by CCs; 8) administrative aspects; 9) resources to support the optimal use of CCs; and 10) monitoring and evaluation. Those recommendations were intended to increase the relevance, effectiveness, and efficiency of WHO's work with CCs.

23. The implementation of the recommendations from the previous evaluation has reportedly led to changes in WHO's approach to working with CCs as well as in the processes for designating and redesignating CCs, as explained in section 2.1.1 above. However, the lack of progress in some areas of WHO's work with CCs can likely be explained – at least in part – by the fact that some of the critical recommendations were not or only partially implemented.

24. As depicted in Table 2, 19 of the 39 recommendations were fully accepted for implementation, 10 were partially accepted, and 10 were rejected because they were not considered relevant, feasible or useful. Of the 19 fully accepted recommendations, 12 were reported to have been fully implemented, six were partially implemented, and one was not implemented. Of the 10 partially accepted recommendations, nine were partially implemented and one was not implemented.

For the full list of these recommendations and their status, see **Annex G**.

Table 2: Acceptance and implementation of recommendations from the 2007 CC evaluation

	Fully implemented	Partially implemented	Not implemented	Total
Fully accepted	12	6	1	19
Partially accepted	0	9	1	10
Not accepted			10	10
			Total	39

Source: Self-reported implementation of recommendations, Global Focal Point for CCs

25. A close inspection of the self-reported implementation of the recommendation further suggests that some of the critically important recommendations of the previous evaluation were either not implemented or partially implemented. For example, accepted recommendations that were partially implemented include, *inter alia*: developing more regional or departmental strategies for working with CCs; incorporating the input of CCs into internal WHO reporting frameworks; and allocating dedicated resources for managing CCs at HQ and in WHO regional offices. While some regional offices and HQ departments have developed and implemented internal strategies and action plans for working with CCs, most did not have any such plans or strategies. Similarly, while some departments report the contributions of CCs in their results-based management framework tools, most do not. Human resources to support the management of WHO's collaboration with CCs is another major concern raised by many WHO staff interviewed. At HQ, dedicated human resources include one full-time global focal point and one part-time support staff; moreover, only three of the six regional offices have dedicated Regional Focal Points with sufficient time allocated to CC-related activities.

26. In addition, some of the key recommendations were implemented on an ad hoc basis or were discontinued because they were no longer considered relevant in light of the changing context. For example, one of those recommendations targeted the terms of reference (ToR) of the Global Steering

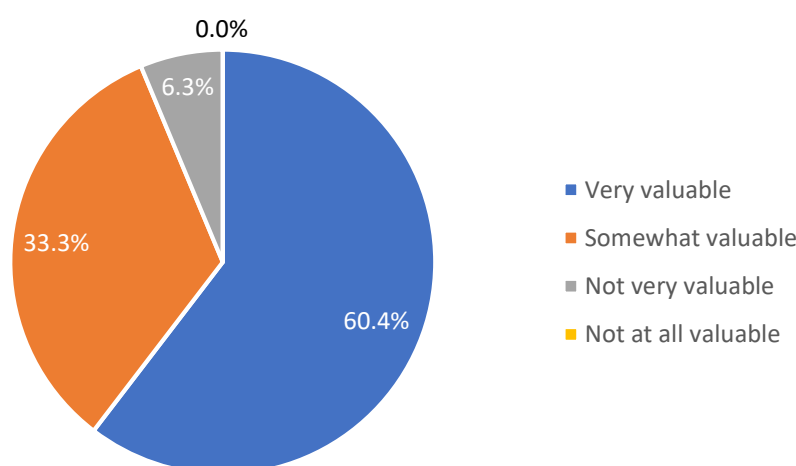
Committee.¹⁴ The ToR for the Committee, which is comprised of representatives from WHO regional offices and HQ, were revised during 2011-2012. One of the main responsibilities of this Committee when it was set up in 2000 was to engage all internal stakeholders in the review for the designation or redesignation of CCs, when there was no consensus between HQ and regional technical units regarding the decision for approval. In 2011-2012, ToR of the Committee was revised, such that their responsibilities no longer included the review of proposals and was limited to serving as a forum to advise on the policy for WHO CCs (see WHO Manual XV.5.1.130). The Global Steering Committee subsequently became defunct and has not met since 2013.

27. Some of the 2007 recommendations were not accepted by WHO, owing to their lack of clarity or feasibility, or to the lack of resources needed to implement them. Those include: having CC representatives involved in policy discussion on the CC mechanism; revising the regulations to explicitly state the role of WCOs in managerial and technical interactions with the CCs, including proposing CCs for designation; publishing a newsletter to share information about CCs and their work; and including a separate budget for CC development at the organization-wide level and within programmes. The recommendation to use CCs as preferred service providers in country workplans was considered not appropriate and was therefore rejected.

2.1.3 How important is the role of CCs in the context of GPW 13? (EQ 1.3)

28. As depicted in Figure 1, the majority of WHO staff considered the CCs to be making a highly valuable contribution to the achievement of WHO's objectives. Many considered CCs key partners, without which they would be unable to fulfil their WHO remit; this sentiment was particularly pronounced among WHO staff who work with limited financial resources or in very small teams.

Figure 1: WHO staff feedback on how valuable the contribution of CCs is for the achievement of WHO's objectives



Source: WHO staff survey

¹⁴ The Global Steering Committee was established in 2000 by Cluster Note 2000/20 to review all new proposals for designations of WHO collaborating centres originating from either a region or headquarters, as well as those redesignations or discontinuations where there is no consensus between HQ and regional technical units. In 2006, its functions were expanded by Information Note 26/2006 (and the name changed to Global Steering Committee) to also serve as a forum to discuss issues regarding WHO collaborating centre's policy. The competences of the Committee were revised again in 2011/2 and, as a result, the Global Steering Committee no longer reviews proposals for new designations of WHO CCs. Its current functions are limited to serve as a forum to discuss issues regarding WHO's CC policy (see WHO Manual XV.5.1.130).

29. WHO staff cited numerous specific ways in which CCs contribute to helping WHO achieve its mandate. Those include: increased access to technical expertise; increased capacity to deliver WHO objectives in varying locations; provision of contextual expertise in terms of understanding specific country/regional contexts and environments; opportunities to develop global thought leadership utilising a number of global experts; and increased political reach and influence, particularly by engaging in fora where it would be politically delicate for WHO to be directly involved. Hence, the contribution of CCs is particularly important in the context of GPW13, which aims to make a measurable difference in people's health at country level.

2.1.4 How does the designation/redesignation process ensure alignment with WHO's GPW? (EQ 1.4)

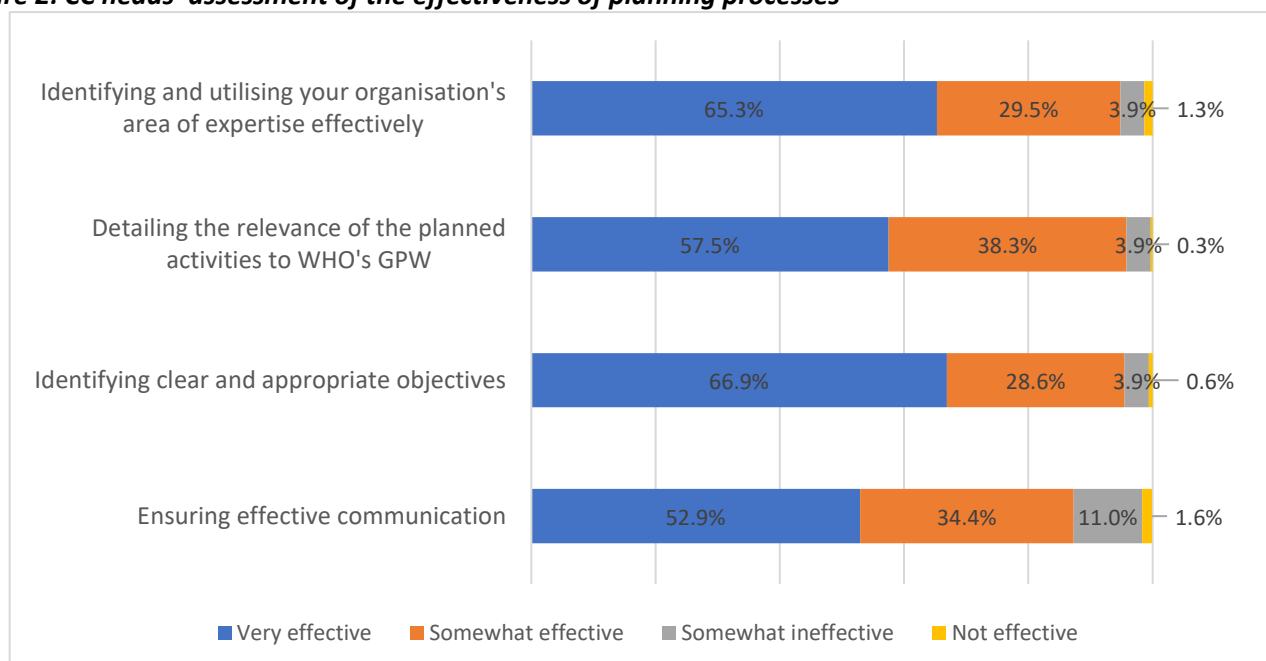
30. This section discusses the role of the designation and redesignation process in aligning the activities of the CCs with WHO's objectives. Broader questions around the administrative challenges of the electronic system (eCC) and the designation/redesignation process are discussed in section 2.3.4.

31. Feedback from WHO staff and heads of CCs indicates that there has been considerable improvement in the alignment of work of the CCs with WHO's priorities in the recent years, and that the use of eCC has helped significantly to improve this alignment. This alignment occurs at different stages of planning, as described in the remainder of this section, in line with the sequencing of the process.

The planning process and development of the Terms of References of CCs

32. As shown in Figure 2, the results of the survey with the heads of CCs suggest that the majority of respondents perceive the planning process as very effective in all four categories examined, namely: (a) identifying clear and appropriate objectives; (b) identifying and utilising the Organization's areas of expertise; (c) detailing the relevance of the planned activities to WHO's GPW; and (d) ensuring effective communication.

Figure 2: CC heads' assessment of the effectiveness of planning processes



Source: Survey with heads of CCs

33. The alignment of the potential contribution of CCs to WHO's priorities is the criterion that most commonly identified by WHO staff survey respondents as having an influence on the decision to designate

or redesignate a CC. This was corroborated by many ROs, who also identified several ways in which the planning process enables decisions to be rendered in a streamlined manner. For example:

- The current eCC system is clearly structured and explicit about identifying the WHO objectives to which the work of the CC is linked.
- Several checks are currently in place to ensure this alignment. These include: initial discussions between the RO and the potential CC; interaction with the GFP team and RFPs; and the FENSA due diligence process. To a certain extent, discussions with TCs and technical programme directors also ensure some degree of alignment.
- Use of guidelines and policies for working with CCs are clear and instructive about the importance of alignment.
- The support provided by RFPs and the GFP team is of high quality and very effective in supporting ROs through the planning process.

34. Other factors that are considered by WHO staff when planning the designation or redesignation of a CC include: technical or scientific capacity of the CC and its ability to deliver activities; a history of collaboration or previous working relationship with WHO; area and level of expertise; organisational reputation; commitment of the CC; and location and level of existing support provided to regions or countries.

35. Despite this considerable improvement, the survey with the heads of CCs also shows that there is still scope for improvement in all four areas summarized in Figure 2, namely: (i) ensuring effective communication; (ii) describing the relevance of planned activities to GPW; (iii) identifying clear and appropriate objectives; and (iv) identifying and utilising the Organization's areas of expertise effectively. In particular, more than one-third of the respondents perceived the first and third areas to be only somewhat effective.

36. Another important gap is the systematic engagement of all key stakeholders in the planning process for designating or redesignating a CC prior to submitting a proposal in the online system, with a view to ensuring better alignment of CC workplans with WHO's priorities. Although there are opportunities for engaging stakeholders at this stage, in practice many TCs are only consulted right before the submission of the proposal or are informed afterward, which defeats the purpose of this engagement. In interviews, these staff reported that their engagement at that stage might cause additional delays in the approval process, and they are therefore reluctant to contribute. This represents a missed opportunity for involving those staff who are most technically engaged in the issues at stake.

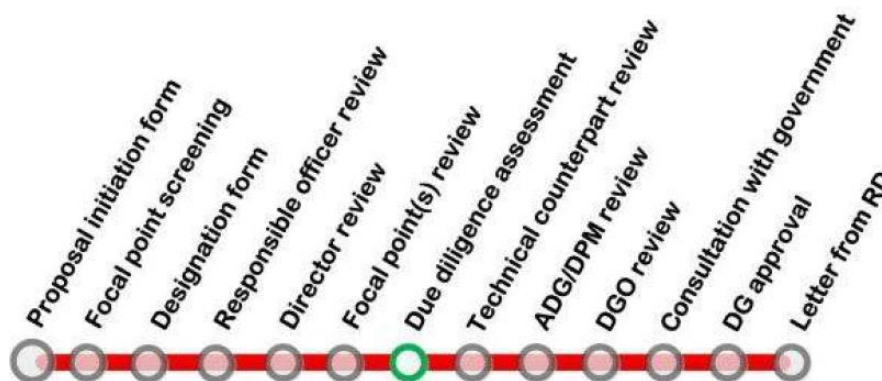
37. Interviews with ROs also noted that the engagement and influence of technical programme directors in the planning process are limited, and the effective use of guidelines and policies for working with CCs could be further enhanced.

The approval processes

38. The approval process for the designation or redesignation of CCs using the electronic system eCC involves several steps, as shown in Figures 3 and 4. The proposal is initiated in eCC by the head of CC in discussion with (and with the support of) the RO. It must then be reviewed and approved by WHO stakeholders at HQ and in regional offices. At this point, the proposal is reviewed by the Director-General's Office (DGO) and consultations are held with the respective host government. Finally, the designation is submitted to the Director-General (DG) for approval.

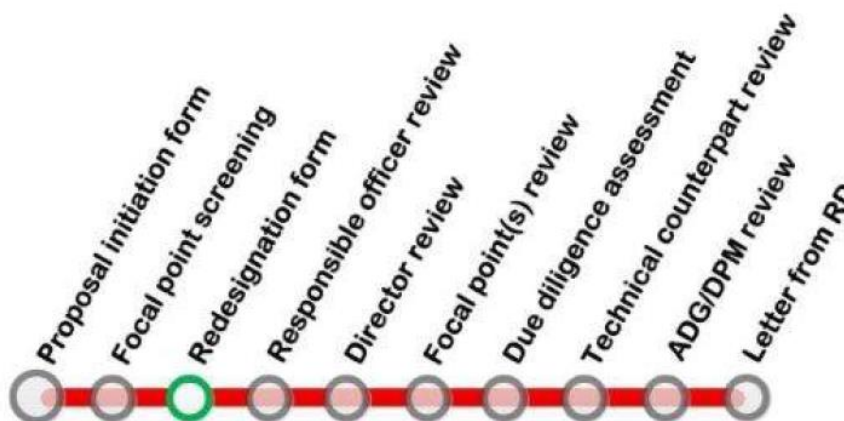
39. As part of the collaboration with WHO, CCs are required to submit annual reports, which are reviewed by the ROs and WHO senior staff, although feedback on these reports by WHO staff is not mandatory.

Figure 3: eCC process map for the designation of CCs



Source: Guide for WHO Staff Working with WHO Collaborating Centres, 2018

Figure 4: eCC process map for the redesignation of CCs



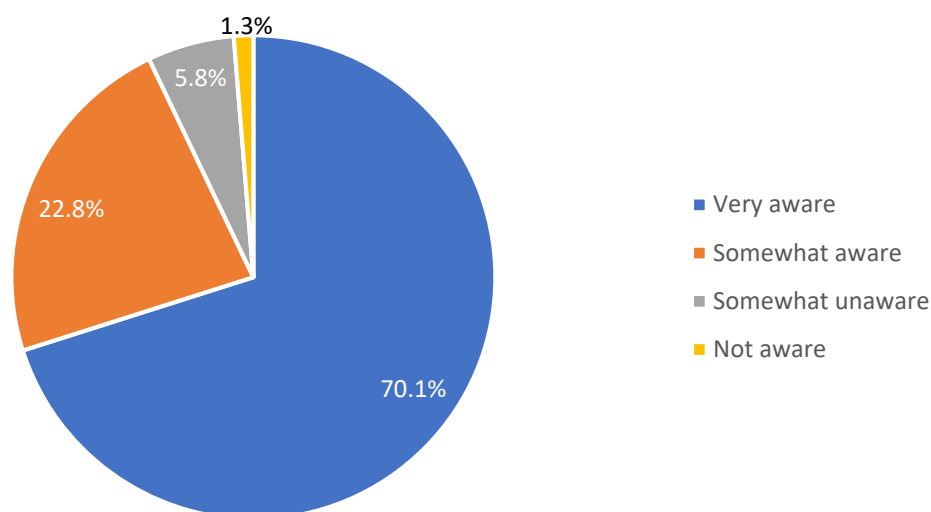
Source: Guide for WHO Staff Working with WHO Collaborating Centres, 2018

40. The approval process represents one opportunity to ensure that the workplan of a CC is further aligned with WHO's priorities. It involves a review of the proposal by several stakeholders, as shown in Figures 3 and 4 above. However, some WHO senior managers expressed concerns that even after going through the approval process, there are still a considerable number of CCs that are inactive or that carry out work that is not relevant to WHO's priorities. This lack of clear alignment is, according to many WHO senior managers, due to the lack of strategic coordination of the work carried out by CCs across the Organization.

2.1.5 To what extent do CCs understand their role/contribution within GPW13? (EQ 1.5)

41. Survey results indicate that the majority of CC heads are very aware of how the work of CCs contributes to WHO's priorities. However, as shown in Figure 5, there is still a high proportion (29.9%) of respondents who reported not having this level of complete awareness of how their institution contribute to WHO's work.

Figure 5: CC heads' awareness of how the CCs contribute to WHO's work



Source: Survey with heads of CCs

42. Interviews with ROs indicate that there are two general ways in which WHO communicates with CCs about how their work fits with WHO's broader priorities. These include: (a) communicating only the current gaps that the work of CCs could help fill; and, alternatively, (b) discussing the broader strategic directions and priorities of WHO with a view to jointly identifying ways in which CCs might contribute to WHO's work, based on their capacities and resources.

43. However, interviews with ROs and the heads of CCs also indicate that there is little discussion on how the work of CCs fits within WHO's broader priorities. Several heads of CCs interviewed highlighted their limited understanding of WHO's priorities has created missed opportunities for their CCs to maximize their contribution to WHO's results. Many ROs and heads of CCs stated that fully engaging CCs in discussions around WHO's wider strategic directions could further improve the alignment of the work of CCs with WHO's priorities. They also explained that this would help CCs to fully understand where and how their work can contribute, and also give them the opportunity to identify further areas of collaboration.

Good practice example: Engaging the CCs on the wider strategic directions of WHO

An RO from one of the WHO regions took the initiative to work with an established network of CCs. It took several months of engagement before s/he was able to position WHO's priorities at the centre of the network's planning process. These efforts resulted in increased awareness and understanding among CCs of WHO's priorities, and how these can better align their work with those priorities. It also gave CCs the opportunity to identify new areas of collaboration and to further contribute to the wider priorities of WHO.

2.2 To what extent does the work of CCs contribute to the delivery of WHO's results? (EQ 2)

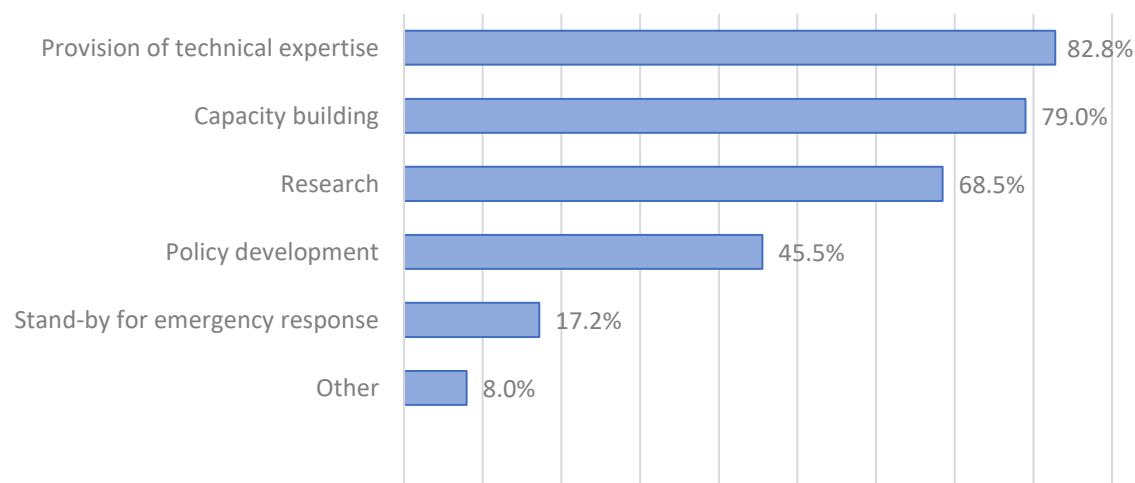
44. This section presents the findings regarding the extent to which CCs contribute to delivering WHO's results. It addresses five sub-questions in the following areas: (a) ways in which CCs contribute to WHO's results; (b) how realistic are the planned objectives of CCs; (c) factors that enable CCs achieve their objectives; (d) key challenges faced by CCs in contributing to the results of WHO; and (e) the added value of this collaboration.

2.2.1 How do CCs deliver work that contributes to WHO's results? (EQ 2.1)

45. In interviews, ROs and some TCs reported that CCs have contributed significantly to the delivery of WHO's results. An effective planning process is reported to be the major reason for this contribution. The majority of ROs interviewed described the work of CCs as 'filling gaps' or delivering needs-based work to contribute to WHO's results by providing technical expertise or engaging in capacity-strengthening activities. Interviewees further noted that the degree to which CCs contributed to WHO's results is contingent upon the extent to which a CC is active, how clearly its leadership understands the role of CCs, and how clearly its workplan is aligned with WHO's priorities.

46. In their survey responses, the heads of CCs were of the view that their CCs make important contributions to WHO, most notably through the provision of technical expertise and capacity building, followed by support for research, policy development, and emergency response. Figure 6 below presents the proportion of respondents who identified CCs' contributions to WHO's result per category.

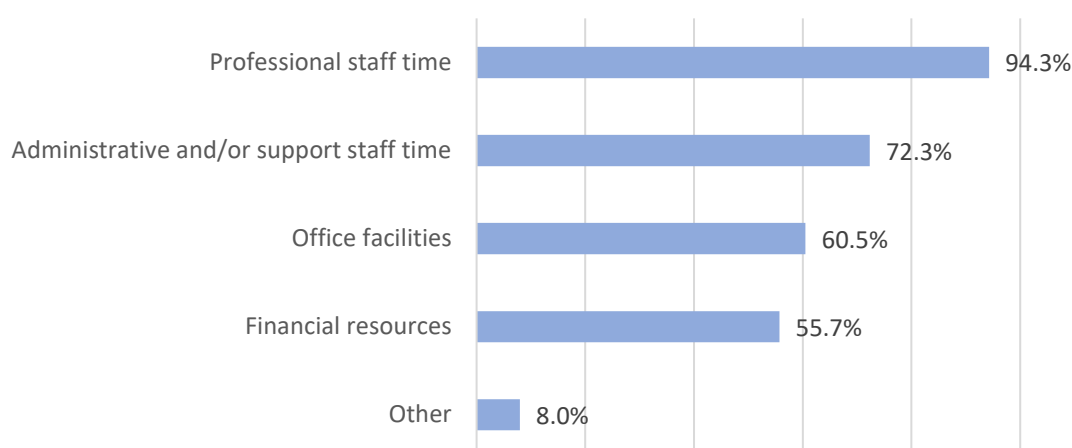
Figure 6: CC heads' feedback on the most critical contributions CCs make to WHO



Source: Survey with heads of CCs

47. As shown in Figure 7, when asked in the survey about the type of resources that their institutions provided in 2018-2019 in support of WHO's work, heads of CCs most commonly identified professional time, followed by administrative and/or support staff time, office facilities, and financial resources to implement projects and deliver outputs specified in the workplan.

Figure 7: CC heads' feedback on resources provided by their institution in 2018-2019



Source: Survey with heads of CCs

48. Interviews with heads of CCs and ROs suggest that CCs linked to WHO regional offices tend to focus more on the provision of direct technical assistance and capacity-building support to countries in their region, while improving WHO's access to high-quality technical and scientific expertise and research capabilities at regional level. Those linked to HQ technical programmes, by comparison, tend to work on areas that are global in nature, such as research, guidelines and policy development. These HQ-linked CCs are reported to be an effective mechanism for developing global thought leadership and increasing the evidence base for policy-making.

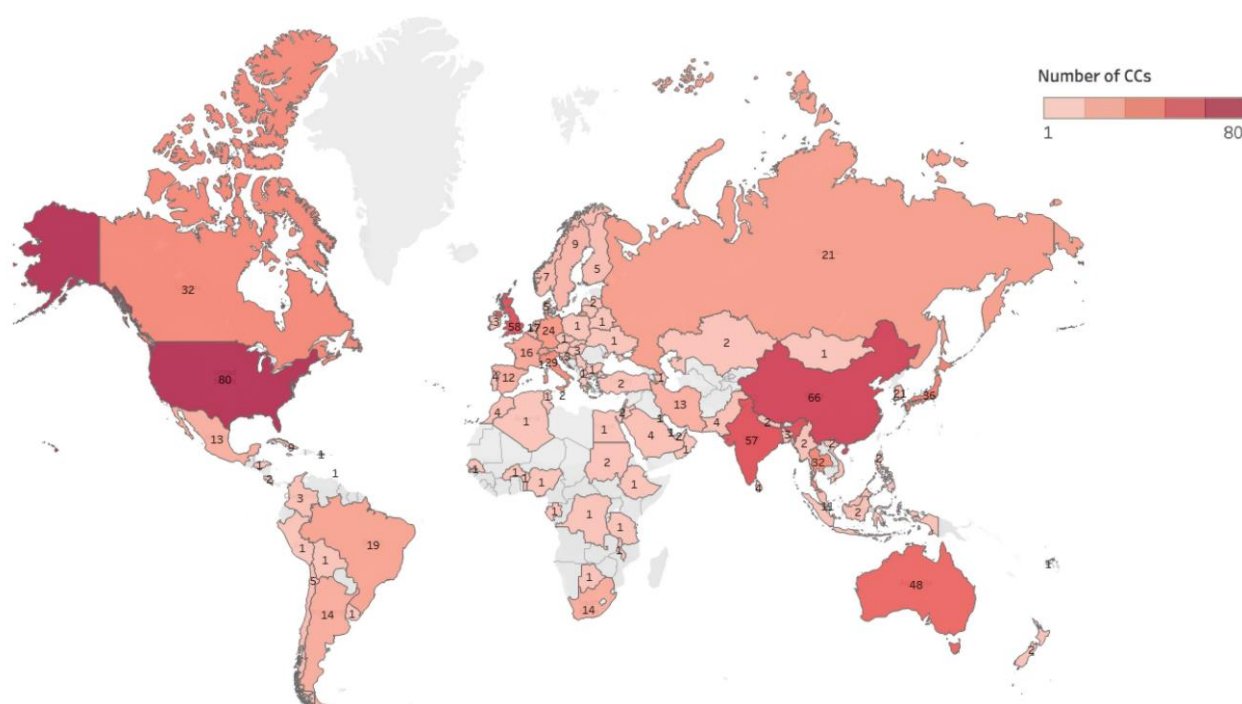
49. Although the location of CCs is not of primary concern for WHO, as the CCs are expected to deliver outputs that are regional and global in nature, CCs located in low- and middle-income countries often face challenges related to the availability of resources, which can adversely affect their ability to fulfil their role as CCs. An analysis of the location of all 822 currently designated CCs, which are based in 99 countries across all six WHO regions, reveals that there is an imbalance in the geographic distribution of CCs in favour of high-income countries and specific regions. Table 3 indicates that 33% of CCs are based in WHO's European Region, followed by 24% in the Western Pacific Region, 22% in the Region of the Americas, 13% in the South-East Asia Region, 5% in the Eastern Mediterranean Region, and 3% in the African Region. Furthermore, as depicted in Figure 8 below, nearly 60% of all currently designated CCs are based in 22 countries, 13 of which are high-income countries. As a result, the potential for CCs to make a meaningful contribution globally is limited by the unevenness in their global presence and reach.

Table 3: Location of CCs

Regional Office	Number of CCs	%
AFRO	26	3
AMRO/PAHO	184	22
EMRO	42	05
EURO	272	33
SEARO	103	13
WPRO	195	24
Total	822	100

Source: WHO CC database, December 2019

Figure 8: Global location of CCs



Source: WHO CC database, December 2019

2.2.2 To what extent were the defined objectives of the CCs realistic? (EQ 2.2)

50. The majority of heads of CCs interviewed felt that the objectives laid out in their ToR were realistic and achievable. As shown in Table 4, this was also reflected in the survey with the heads of CCs, where over 76% of respondents felt that the defined objectives of their CCs are very realistic. However, the survey of WHO staff working directly with CCs shows that these respondents are somewhat less confident about how realistic the objectives of CCs are.

Table 4: CC heads' and WHO staff feedback on how realistic CC objectives are

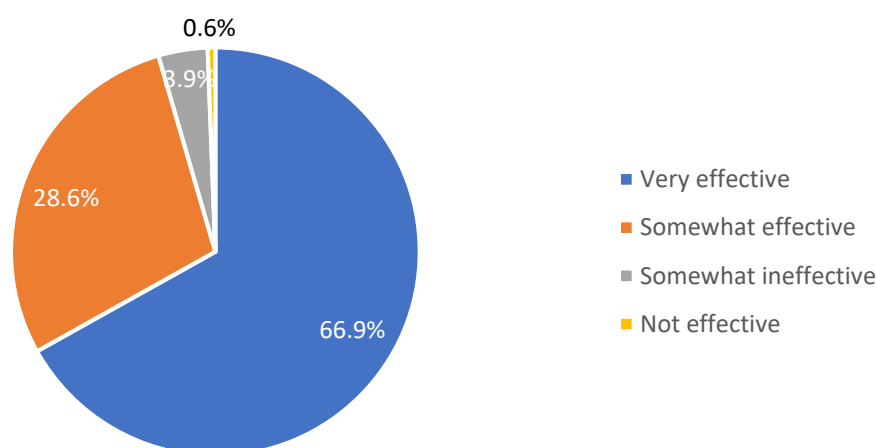
Response	Heads of CCs (%)	WHO staff (%)
Very realistic	76.1	56.4
Somewhat realistic	20.0	40.4
Not very realistic	03.9	03.2
Not at all realistic	0.0	0.0
Total	100.0	100.0

Source: Survey with heads of CCs and WHO staff

51. Interviews with the heads of CCs and ROs suggest that there are two main factors that determine how realistic the objectives of CCs are: (a) effective planning; and (b) internal decision making within the institution.

52. Effective planning, and most importantly transparent communication throughout the planning process, allows for both WHO and CCs to carefully consider and agree on relevant activities that are feasible and achievable within the established timeframe (see Figure 9).

Figure 9: CCs heads' feedback on effectiveness of the planning process in identifying clear and appropriate objectives



Source: Survey with heads of CCs

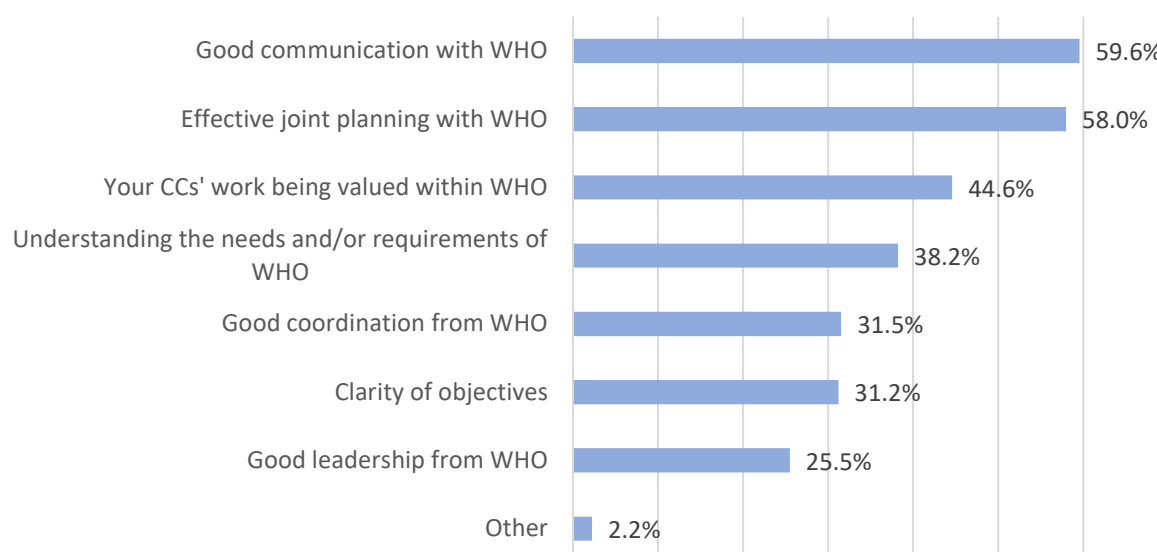
53. Another important factor identified by the heads of CCs was the internal decision-making processes within their respective institution for determining the level of resources that can be allocated to their work with WHO. This helped to ensure that the CCs did not overstretch their resources or agree to activities that were unrealistic to them.

54. A considerable number of WHO staff consulted through the survey and the interviews indicated that there is still scope for improvement in the planning process, especially with respect to the identification of clearer and more appropriate objectives, and the elaboration of CC workplans that are more realistic. Interviews with heads of CCs and WHO staff also suggest that the workplans of CCs are often too broad and therefore difficult to implement within the designation period. However, broad workplans give CCs the flexibility to adapt their work to WHO's priorities, which may change during the four-year designation period. These broader workplans, however, often require more resources and capacity to show tangible results.

2.2.3 What were the enabling factors for CCs in achieving their objectives? (EQ 2.3)

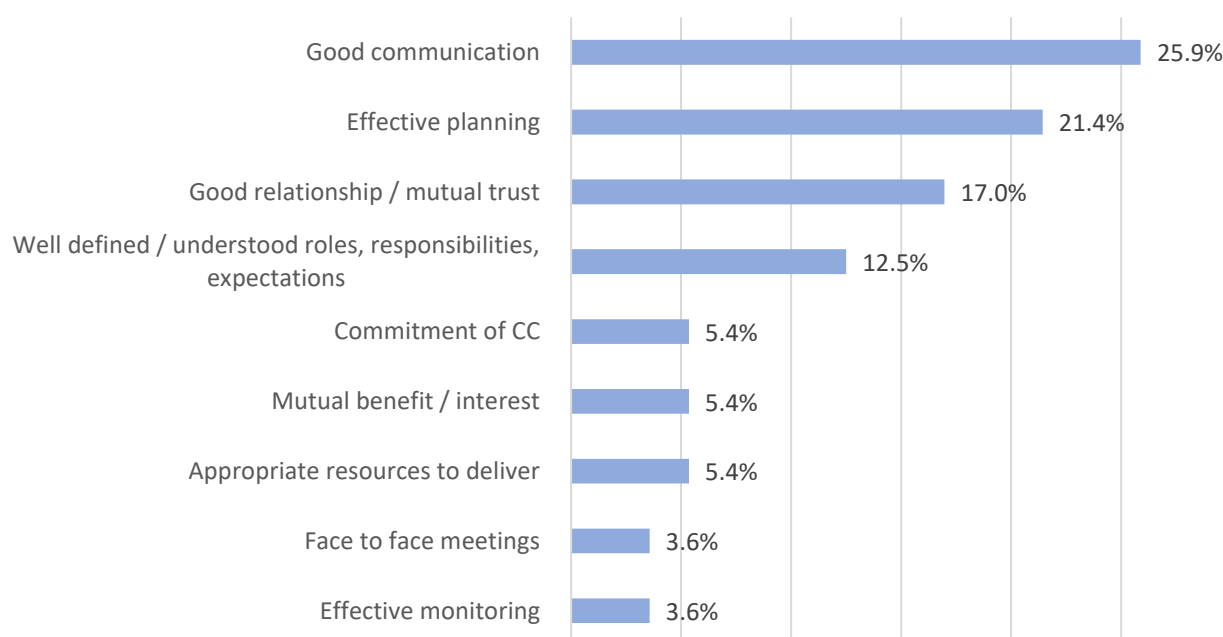
55. According to the heads of CCs and WHO staff consulted through the survey, the two main factors that enable the achievement of CC objectives are effective communication between WHO and CCs and effective planning (see Figures 10 and 11 for survey results). Other important enabling factors, particularly from the perspective of the heads of CCs, include: the value that WHO gives to the work of CCs, the level of understanding among CCs regarding the needs and/or requirements of WHO, the clarity of CC objectives, and the strength of WHO's leadership. By contrast, the enabling factors most commonly identified by WHO staff include a good relationship and mutual trust as well as the clarity with which roles, responsibilities and expectations are defined. Additional factors highlighted by both stakeholder groups included: the development and use of networks of CCs; the strategic use of the "WHO CC brand"; and having a clear strategy or approach guiding the work with CCs. These key enablers are briefly described in the paragraphs that follow.

Figure 10: CC heads' feedback on the factors enabling the achievement of CC objectives



Source: Survey with heads of CCs

Figure 11: WHO staff feedback on the factors enabling the achievement of CC objectives



Source: WHO staff survey

Communication between CCs and WHO

56. The importance of regular, open and transparent communication between WHO and the heads of CCs was a consistent theme that emerged from interviews with both the heads of CCs and WHO Staff. This includes communication during the planning and the implementation of the activities. It also includes ongoing communication to keep CCs well informed about the changing priorities of WHO. Current practices in WHO's communication with CCs and its effectiveness are discussed in detail in section 2.3.4.

Effective planning processes

57. Effective planning processes were also identified by WHO staff and heads of CCs as an important factor that enables CCs to achieve their objectives. This includes clarifying expectations on both sides and ensuring that roles and responsibilities are clearly defined. Another important factor includes investing time in proper planning by engaging key stakeholders prior to the submission of a proposal in eCC, as this helps to ease the approval process. However, this practice is undertaken largely on an ad hoc basis when an RO takes the initiative and is not part of a systematic process.

Good practice example: Engaging all stakeholders in the planning process

An RO from one WHO region organised annual planning meetings in which the RO, the HQ-based TC and representatives from the CC were involved. This platform allowed the CC to benefit from collaborative planning and to receive input from the TC, which strengthened its designation application and workplan. It also provided an opportunity to discuss changes in priorities and ensure realignment and generated additional opportunities for the CCs. These joint meetings also allowed all stakeholders involved to establish a good relationship.

Positive working relationships between CCs and WHO

58. Establishing a positive working relationship based on mutual trust between WHO staff and the heads of CCs was identified as an important enabler by WHO staff in both the survey and interviews. Commitment on the part of WHO staff and the heads of CCs as well as open and transparent communication are critical in establishing this working relationship.

Establishing and utilising networks of CCs

59. Some WHO technical programmes have established networks of CCs that are working on the same or similar technical areas and some of the regional offices have also taken similar initiatives. Many of the heads of CCs and ROs interviewed highlighted that having a network of CCs is an important factor that facilitates effective planning, increases the relevance of the work of CCs, provides opportunities for capacity strengthening and mutual learning, and ensures accountability. Notwithstanding the aforementioned, some CC heads mentioned the need for more opportunities to network with other CCs working in the same or similar technical areas, as further detailed in section 2.3.4.

Use of the “WHO CC brand”

60. In interviews, several heads of CCs highlighted the importance of being designated as a “WHO CC”, a highly valued brand that can help them to mobilise additional resources. Many specifically noted that having the WHO CC “brand” is very important for them as it helps to increase the visibility of the institution and gain the trust of national authorities, partners, and donors. However, many heads of CCs also felt that the use of the WHO CC “brand” should become more flexible and less restrictive, and that they need more guidance on how to use this brand more effectively.

61. Many ROs and WHO senior managers interviewed clearly underlined that the WHO CC designation should be used by CCs diligently and only within the framework of their collaboration with WHO, as agreed in the workplan. The guidelines for the use of designation by CCs explicitly state that the WHO name, emblem and flag can only be used by CCs after the DG has authorized each proposed use, which is granted on a case-by-case basis. This means that each time the institution intends to use the WHO name, emblem or flag for a specific purpose, a request must be made to WHO to obtain authorisation. Although the guidelines are very clear, many WHO staff suggested that, in practice, CCs often use the WHO brand for unauthorized purposes. Interviewees explained that this practice

constitutes a significant reputational risk for WHO, particularly if the brand is used inappropriately. They further noted that regular communication to reinforce WHO guidelines is crucial.

62. Additionally, many WHO staff interviewed also highlighted that the WHO CC “brand” can help CCs in low- and middle-income countries to improve their reputation with local authorities and donors, thereby enhancing their ability to attract financial resources. CCs based in some high-income countries were less concerned with improving their status through the CC designation, although in some of these countries resources are increasingly tied with the status of WHO CC designation.

63. Alongside being recognised as a WHO CC, many heads of CCs also explained that it is important for them that WHO values their work by further recognizing their technical inputs and by engaging them in the organization-wide strategic planning that are relevant to their technical areas of expertise.

Strategy/approach to working with CCs

64. The importance of an internal strategy or approach guiding WHO’s work with CCs emerged as a consistent theme during the interviews with WHO staff. Where strategies or more formalised approaches to working with CCs existed, WHO staff were able to identify, designate or redesignate CCs in a more structured and strategic way. In these instances, they were also more likely to have a communication plan, and more formalised monitoring and accountability systems. However, interviews with WHO staff indicate that there has so far only been a limited number of internal strategies guiding WHO’s work with CCs.

2.2.4 What were the key challenges faced by CCs in contributing to the results of WHO? (EQ 2.4)

65. Heads of CCs consulted through the survey identified several challenges that they face when contributing to the results of WHO. As shown in Figure 12 below, the challenges most commonly identified by respondents are the lack of resources, followed by the ambiguity over the needs and/or requirements of WHO, lack of joint planning, poor communication, and the administrative burden of the designation/redesignation process. Lack of coordination and leadership from WHO, the absence of clear objectives or activities, and lack of acknowledgement of the CCs’ contribution to WHO results were also identified as challenges, though more infrequently.

Figure 12: CC heads’ feedback on the main challenges they face



Source: Survey with heads of CCs

Lack of resources

66. The heads of CCs consulted through the survey and the interviews reported that a lack of financial and human resources constitutes the most significant challenge faced by their CC. While this is particularly true for CCs from low- or middle-income countries, CCs in high-income countries often have to internally justify delivering work as a CC when there is no financial benefit to the wider institution. Several WHO staff consulted in interviews agreed that this constitutes an issue, and further noted that CCs are often obligated to only plan those activities for which they have internal resources readily available.

Ambiguity over the need/requirements of WHO and lack of communication

67. Another key challenge raised by consulted stakeholders relates to the ambiguity of WHO's needs and requirements, and lack of communication about changing needs. While majority of the heads of CCs and ROs interviewed stated that ensuring alignment with WHO's priorities is their primary concern when planning the work of CCs, many also indicated that changes in WHO's priorities are seldom communicated to the CCs. This means that CCs find it difficult to understand, and therefore respond to, these changing needs and priorities of WHO.

Lack of joint planning

68. Another key challenge faced by CCs is the lack of joint planning with WHO. ROs and the heads of CCs who involved wider WHO stakeholders in the planning process felt that they were able to take a more strategic approach in planning for longer-term activities. Some WHO staff interviewed also highlighted the importance of investing in the planning process to ensure clarity of the roles and responsibilities of all stakeholders and to plan for clearly defined activities. In addition, some of the heads of CCs felt that the planning process lacks transparency mainly due to lack of clarity on what needs to be included in proposals, and lack of communication regarding the reasons for delays in the approval of the proposal. This often leaves the CCs feeling disengaged from the process, and frustrated.

Administrative burden of the designation and redesignation process

69. The administrative burden of the designation/redesignation process is considered as a significant challenge for CCs. Many heads of CCs and WHO staff alike interviewed perceived delays in the process as a major hurdle to the work with CCs. While there is widespread agreement that a robust process is needed to mitigate reputational risks associated with WHO's work with CCs, consulted stakeholders also felt that the process could be further streamlined to make it more efficient. This issue is explained in further detail in section 2.3.5.

2.2.5 What is the added value of WHO'S collaboration with CCs? (EQ 2.5)

70. The heads of CCs and WHO staff highlighted that there are several benefits associated with the collaboration that accrue to WHO and the CCs alike.

Added value for WHO

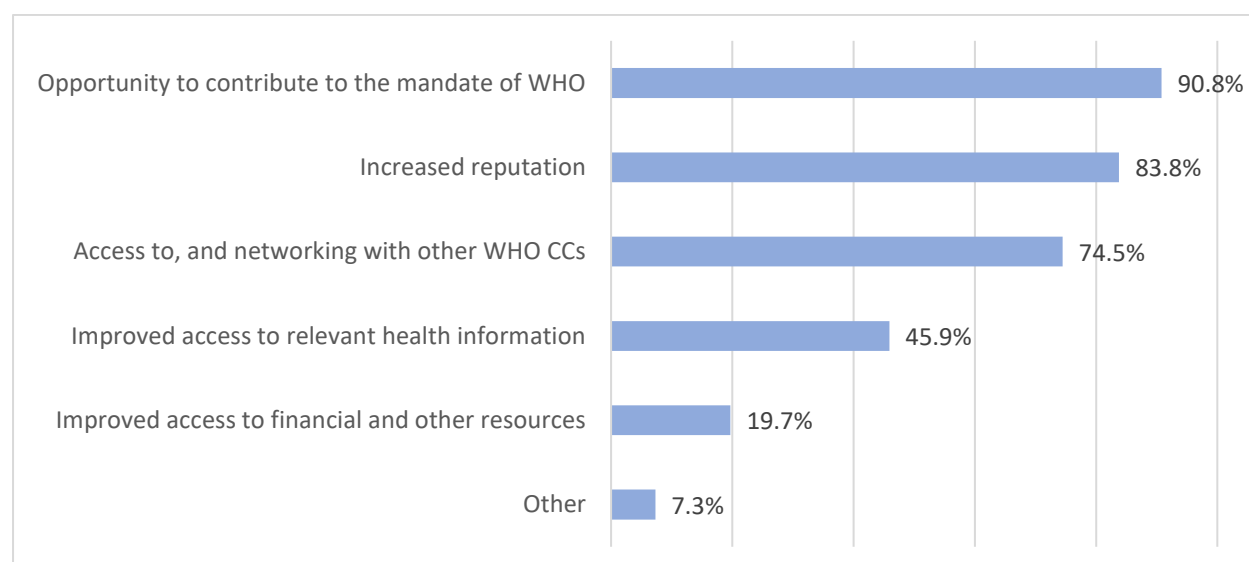
71. The development of global thought leadership and global communities of advocates for WHO's work is one of the key added values that was identified in the interviews with WHO staff and the heads of CCs. This was particularly relevant for CCs that worked as part of a network of CCs. Accessing global experts to engage in dialogue around policy or research allowed for collaborative knowledge generation. Many experts from CCs bring in knowledge or expertise that WHO staff may not necessarily have. For example, through their presence at country/regional level, CCs bring local knowledge that can increase the quality and relevance of WHO's work on policy and research and development. In addition, this collaborative work extends WHO's scope of influence, as it generates

more advocacy opportunities for WHO’s policy initiatives in several countries. This is particularly important in fora where it would be politically sensitive for WHO to be involved.

Added value for CCs

72. When asked in the survey (see Figure 13) and interviews what their institution most gained from being a WHO CC, CC heads explained that contributing to global health outcomes by supporting WHO’s mandate constitutes one of the main added values of their relationship with WHO. In addition, they asserted that being recognised through a formal relationship with WHO helps CCs improve their visibility and reputation. They further noted that the relationship with WHO helps the institutions of CCs gain access to global networks of institutions working in similar fields and increase their visibility at regional or global level. Increased involvement in policy-making processes was also identified as a key value addition of the collaboration with WHO. Moreover, some institutions apply the learning and good practices that emerge from their role as CCs across other programmes, thereby improving the quality and consistency of the work delivered by the institution as a whole.

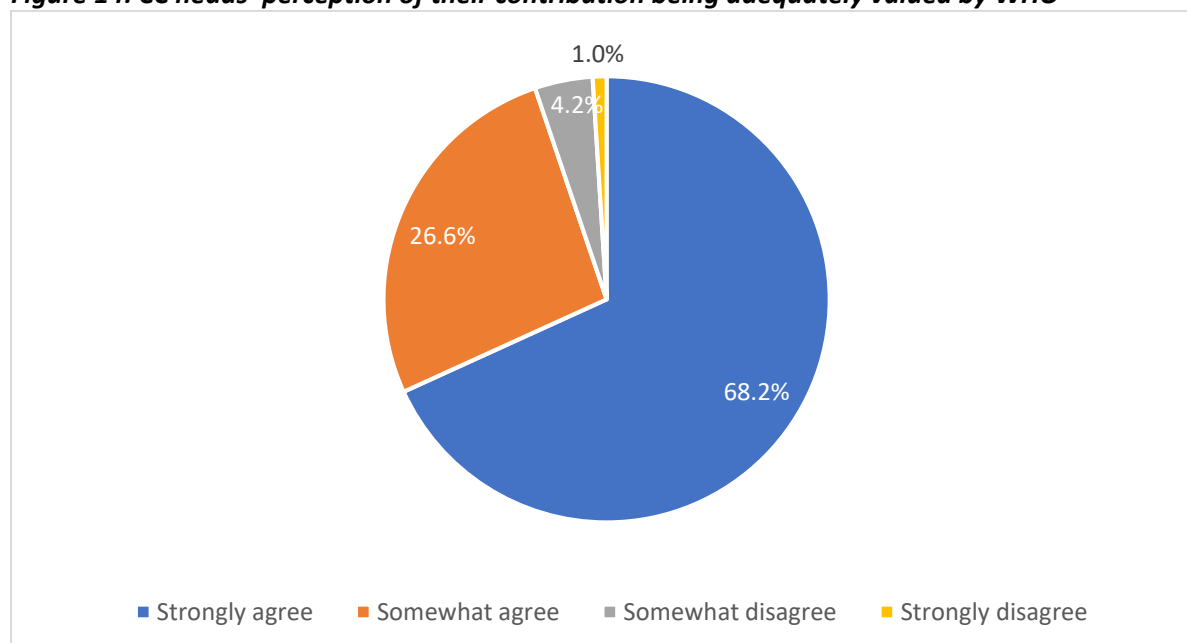
Figure 13: CC heads’ feedback on what they gain from being a WHO CC



Source: Survey with heads of CCs

73. As depicted in Figure 14, a considerable proportion of surveyed CC heads strongly agreed that their contribution is valued by WHO. However, the survey and interviews with the heads of CCs also suggest that there could be more opportunities to showcase the work of CCs both within WHO and externally, potentially through systematic analysis and synthesis of existing performance data and the production of high-level reports or other analytical pieces that could be made available to policy-makers and senior WHO staff. Many WHO staff interviewed concurred with this view.

Figure 14: CC heads' perception of their contribution being adequately valued by WHO



Source: Survey with heads of CCs

2.3 How efficiently did WHO manage its relations with collaborating centres? (EQ 3)

74. This section elaborates on the findings related to the efficiency of WHO's work with CCs. It addresses five sub-questions in the following areas: (a) the costs and benefits of CCs' work to WHO; (b) timeliness and appropriateness of the services provided by CCs; (c) level of awareness and visibility of the CCs within WHO; (d) efficiency of the communication between CCs and WHO; and (e) robustness and appropriateness of the administrative and management systems.

2.3.1 What is the cost to WHO for managing the CCs? To what extent does the cost match with the benefits? (EQ 3.1)

Costs to WHO

75. Human and financial resourcing of the CCs represents a distinct and considerable aspect of efficiency. As previously noted, WHO does not provide any financial resources to CCs for the implementation of their workplan. However, it does incur substantial human resource costs to manage its collaboration with CCs. These costs mainly involve the staff time of ROs and TCs (the majority of whom are senior WHO officials), and that of those involved in decision-making during the designation and redesignation process – mainly directors, ADGs, RFPs and the GFP team, and the FENSA due diligence team. Currently, WHO does not systematically record data on staff costs related to CC collaboration and it is therefore not possible to calculate these costs.

76. Because ROs and TCs are the WHO staff that work most closely with CCs, the profile of respondents from the WHO staff survey provides a proxy indication of the overall magnitude of the human resource costs WHO incurs. Of those who responded, half are senior managers at the P5 professional grade or higher (see Table 5 below). Moreover, one-third of respondents act as both an RO and a TC, meaning that for some CCs they play the role of RO while for others they act as TC. Close to half of respondents hold the role of RO only (see Table 6 below).

Table 5: WHO staff respondents' professional grade

Grade	Number of respondents
P5 or above	51
P4-P3	44
P2-P1	1
Total	96

Source: WHO staff survey

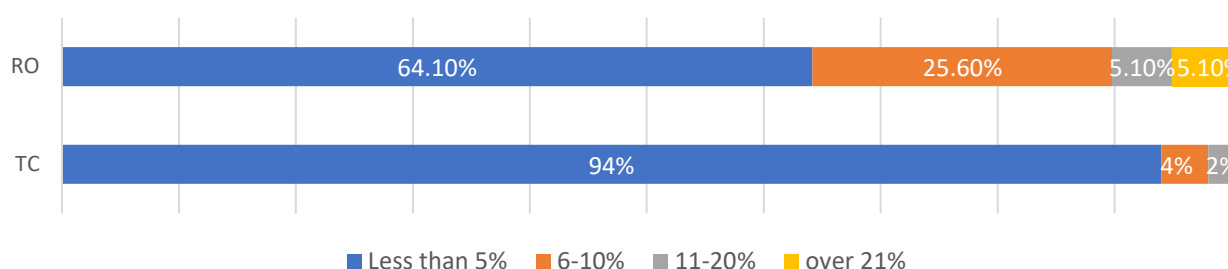
Table 6: WHO staff respondents' role related to CCs

Role	Number of respondents
Responsible Officer (RO) role	46
Technical Counterpart (TC) role	17
Both RO and TC role	33
Total	96

Source: WHO staff survey

77. Results from the WHO staff survey also indicate that nearly two-thirds of ROs spend less than 5% of their time per week managing the work with CCs (see Figure 15 below). One-fourth of ROs spend between 6% to 10% of their time on CC-related work while one-tenth dedicate more than 11% of their time. As for TCs, because their involvement is mostly limited to providing technical input at the planning stage, the vast majority of them spend less than 5% of their time on CC-related work. It was also noted that, in some cases, TCs are also engaged at the implementation stage, especially when there is joint work between WHO HQ and regional offices.

Figure 15: WHO staff members' self-reported amount of time spent on CC-related work per week



Source: WHO staff survey

78. WHO staff who responded to the survey are responsible for varying numbers of CCs. The majority of respondents are responsible for between one and three CCs, either as RO or TC. However, there are a considerable number of ROs and TCs who are responsible for more than six CCs, and some are responsible for more than 10. A small number of TCs are responsible for more than 25 CCs. In interviews, it was suggested that there have been considerable structural changes in recent years in some WHO technical programme areas, resulting in some staff taking over the role of RO or TC for a considerable number of CCs. Some of the ROs and TCs responsible for a large number of CCs indicated that they are unable to provide 'quality time' to manage this collaborative work. This also clearly indicates a lack of strategic thinking and efficient use of available resources at the technical programme level.

Financial and in-kind contributions made by CCs

79. As is the case for estimating the costs incurred by WHO to manage the work with CCs, the financial, human resource and other in-kind contributions from CCs are also difficult to gauge. Indeed, the often-qualitative nature of non-pecuniary contributions, such as human resource capacity and technical expertise, makes it challenging to quantify these costs. However, the heads of CCs and ROs consulted through the survey and the interviews indicated that financial and in-kind contributions

from CCs are very significant, and that CCs represent a highly cost-effective means of achieving the goals of the GPW.

80. WHO has previously attempted to estimate the value of the contributions made by CCs. An internal review based on the annual reports submitted by CCs between March 2018 and September 2019 was conducted by the GFP team to identify the average financial contribution of CCs by estimating staff salaries. The review showed that staff salaries made up approximately 59% of financial contributions from CCs. The average salary contribution per CC was approximately US\$ 25,000, and total contributions amounted to approximately US\$ 21.3 million for all CCs. A similar analysis undertaken by EURO revealed that the estimated in-kind contributions of CCs from the region totalled approximately US\$ 27 million per biennium.

81. In the survey with the heads of CCs, close to 56% of respondents estimated the cost of the resources provided by their respective CC during the 2018-2019 biennium. It shows that a total of US\$ 31.5 million was spent by the 147 CCs during that biennium, at an average of about US\$ 214,000 per CC. If this average figure is applied to all 822 CCs, the total financial contribution from all CCs would amount to approximately US\$ 175.9 million for a biennium. These estimates are not to be considered as definitive but rather as indicative of the size of CCs' contributions to support the achievement of WHO's results. In interviews, the heads of CCs and the ROs confirmed that CCs indeed provide substantial financial contributions to implement their workplan. Those include: staff/professional time and related costs; activity costs – which include training, capacity building, costs for material, etc.; costs related to infrastructure such as office/lab space; and costs related to communication.

2.3.2 Were the services provided by the CCs timely, and used appropriately? (EQ 3.2)

82. In addition to implementing activities that are included in their workplan, CCs also respond to ad hoc requests from WHO. These ad hoc requests include, for example, attending meetings or conferences and responding to emergency situations. The heads of CCs reported that mobilizing resources and capacities quickly to respond to ad hoc requests within a short timeframe is challenging. Even so, they felt that this constitutes a valuable element of a CC's role. In interviews, ROs confirmed that many CCs respond to WHO's ad hoc requests in a timely manner.

83. In interviews, the heads of CCs and ROs highlighted the importance for WHO to have a strategic approach or plan at the regional, department or technical programme area level to guide its work with CCs, and flexible workplans to enhance efficiencies in the implementation process. There is currently a certain degree of flexibility to adapt workplans by integrating new activities that fall within the TORs or by not including activities that had originally been agreed upon in the written agreement. However, heads of CCs and ROs suggested that they lack awareness regarding this flexibility and how to use it. This would ensure that the work is delivered and used in a timely manner, and that there is no duplication of efforts.

84. Another challenge reported by the heads of CCs and several ROs during interviews is the timeframe of the CC workplan. For the first designation, the workplan is prepared for a four-year period; for subsequent workplans, the timeframe is a maximum of four years though it can be shorter. Several heads of CCs and WHO staff found it problematic to plan activities over the four-year designation period. Some heads of CCs also expressed frustration that the activities originally planned are often no longer relevant after a couple of years, as WHO keeps changing its priorities. They further noted that there is little or no flexibility to adapt activities to the changing context. Redesignation for shorter periods provides an alternative option to address this issue. However, WHO staff and heads of CCs are often reluctant to take this option mainly due to the length of time the redesignation

process takes. The key concern is more about managing unplanned changes in WHO priorities during the lifespan of the designation, and the difficulty of pre-emptive planning for possible changes. It was also noted that this forces some ROs to develop workplans that are much broader.

2.3.3 What is the level of awareness within WHO around the work of the CCs? (EQ 3.3)

85. Lack of awareness about the work of CCs and the visibility of their contribution across the Organization was a consistent theme that emerged during interviews with the heads of CCs and WHO staff.

86. The level of awareness of WHO senior managers regarding the work of CCs varied significantly. Some senior managers interviewed were not aware of the number of CCs working in their technical area and what their work entailed. For example, a senior manager at a WHO regional office explained that he/she invited experts from a CC located in another region to support the response to a health emergency, but later found out that there was already a CC with the same expertise in the country where the intervention took place. Information on the profile and technical expertise of CCs is available on the eCC system but interviews with ROs and other WHO staff suggest that it is often not accessed, either because staff are unaware of how to access the information or because they do not think about the strategic importance of doing so.

87. Most ROs interviewed suggested that they are fully engaged with most or all the CCs for which they are responsible. However, many also noted that they work in isolation and do not have information about the type of activities undertaken by CCs that are managed by other ROs, resulting in missed opportunities to create synergies among CCs that work in similar areas. Several ROs expressed the desire to be networked with other ROs to share experiences and learn from each other, which would allow them to improve the way they manage their own portfolio of CCs. They further noted that the GFP team and RFPs would be well positioned to provide this type of networking support, in addition to other types of support that they already provide to ROs.

88. The extent to which TCs are aware of and engage in the work of the CCs to which they are assigned varies significantly. Some WHO staff interviewed who acted as TC explained that they are very involved in the designation/redesignation, planning and review process. However, the majority of TCs interviewed noted that they are only involved in the process when notified through the eCC system to approve proposals and have little awareness of the proposed workplan and its objectives.

89. Although ROs and TCs dedicate a considerable amount of time managing the collaboration with CCs, they generally indicated that this aspect of their work is not recognized in their individual workplans and performance appraisals, which form part of WHO's Performance Management and Development System (PMDS). As shown in Table 7, only about 15% of respondents to the WHO staff survey reported that their role of working with CCs is well reflected in their PMDS. Interviews with WHO staff corroborated this finding.

Table 7: WHO staff feedback on the extent to which their role with CCs is reflected in the PMDS

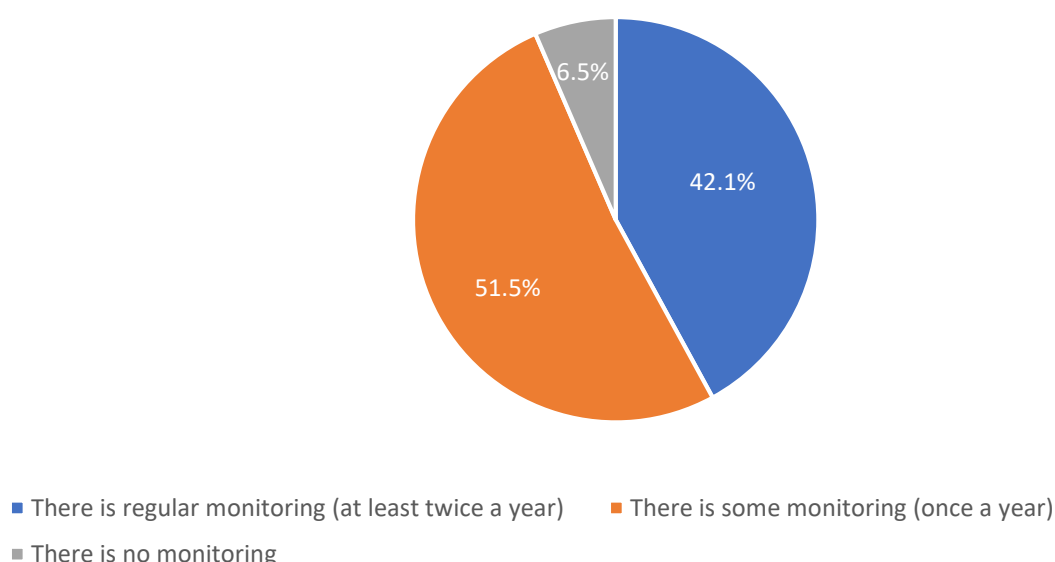
Response	%
Well reflected	14.6
Reflected to some extent	41.6
Not at all reflected	43.8
Total	100.0

Source: WHO staff survey

2.3.4 How efficient is the communication between CCs and WHO? (EQ 3.4)

90. As indicated in section 2.2.4, effective communication between WHO and CC staff is a key enabling factor for CCs to deliver their work effectively. However, the frequency of communication between WHO staff and CCs is cited as an area for improvement. Results from the surveys with the heads of CC and WHO staff show a mixed picture regarding the frequency of communication (as further depicted in Figure 16 and Table 8). While the vast majority of WHO staff who work directly with CCs reported that they have contact with their CCs at least twice a year, approximately half of the heads of CCs stated that communication happens only once a year. Only a small proportion indicated that there is no communication. In interviews, many ROs indicated that they have virtual meetings with CCs on a regular basis, and in some cases have in-person meetings when they undertake duty travel. Some ROs also reported taking the initiative to meet key CC staff in their technical area when conducting in-country field visits and found these encounters very useful.

Figure 16: CC heads' feedback on the frequency of communication with WHO on agreed workplan activities



Source: WHO staff survey

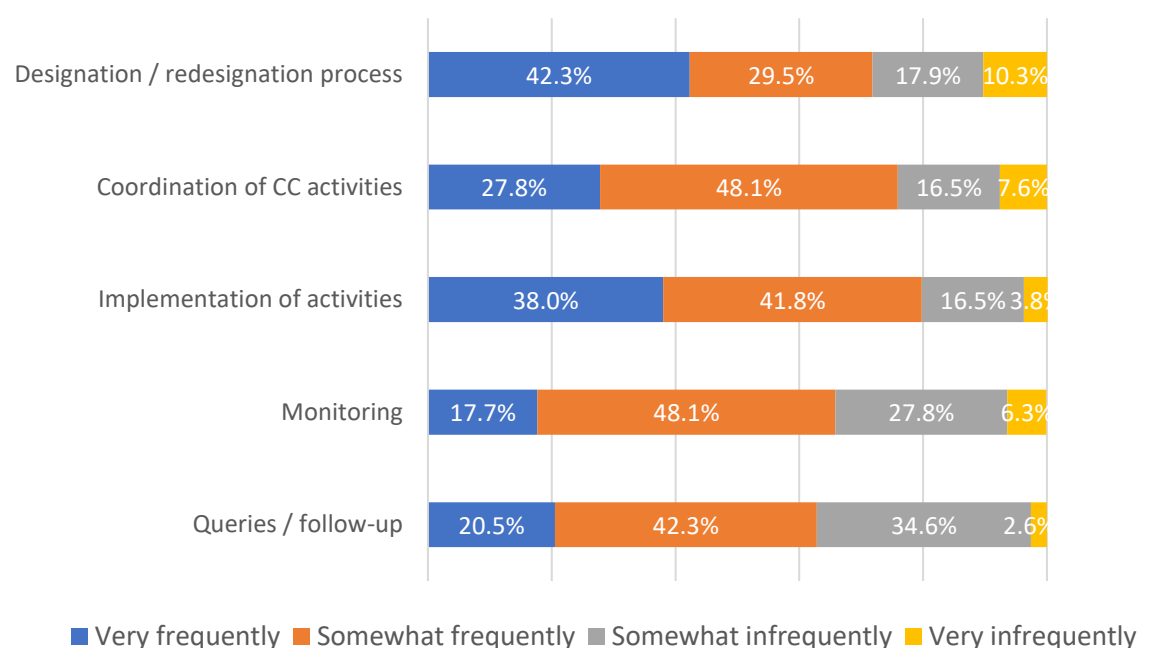
Table 8: WHO staff feedback on the extent of contact they have with their CCs

Response	%
There is regular contact (at least twice a year)	82.2
There is some communication (at least once a year)	3.8
There is no contact	1.3
Other	12.7
Total	100.0

Source: WHO staff survey

91. There are several other opportunities for the ROs to communicate with CCs. Those include key junctures in the designation and redesignation process, in the implementation of activities, in queries or follow up, and in monitoring. As shown in Figure 17, the WHO staff survey indicates that communication happens most frequently during the designation and redesignation process, and least frequently during monitoring.

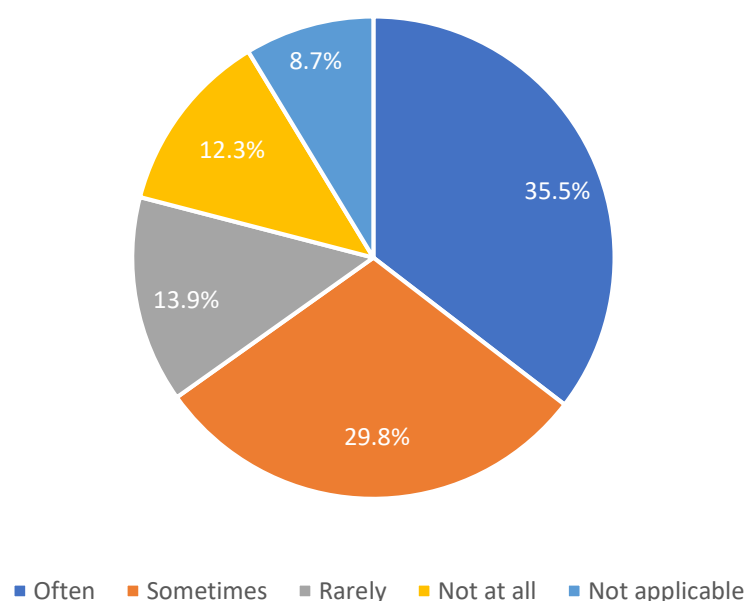
Figure 17: WHO staff feedback on the purpose of communication with CCs



Source: WHO staff survey

92. Another opportunity for ROs to communicate with CCs occurs after the submission of annual reports by CCs. Interviews with the heads of CCs indicate that they expect ROs to provide timely feedback on these annual reports. However, close to one-third of the heads of CCs reported that they receive feedback only occasionally, while a quarter reported that they rarely or never receive feedback (see Figure 18 for survey results).

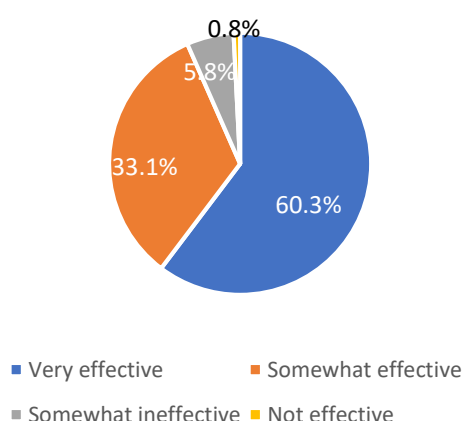
Figure 18: CC heads' responses on receiving feedback on annual reports



Source: Survey with heads of CCs

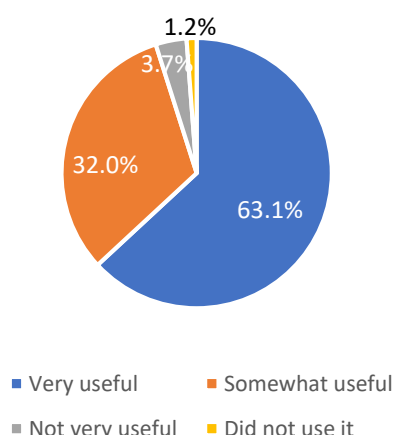
93. Other areas for improvement identified by WHO staff and the heads of CCs include: monitoring the work that is delivered by CCs; evaluating the outputs delivered by CCs; and reporting on their achievements and contributions. Although there are opportunities for WHO staff to provide feedback on the outputs delivered by CCs and on the annual reports that they submit, responses from the heads of CCs suggest that, in practice, the quality and usefulness of the feedback provided by WHO does not meet expectations (see Figures 19 and 20 for survey results). More importantly, there is a missed opportunity for WHO to measure the contribution of the work of CCs to WHO's results and its impact on broader health goals.

Figure 19: CC heads' rating on the quality of feedback from WHO



Source: Survey with heads of CCs

Figure 20: CC heads' response on usefulness of feedback in improving delivery of its activities



Source: Survey with heads of CCs

94. Other important aspects highlighted by the heads of CCs and WHO staff in relation to communication include the need to have more face-to-face meetings, regular communication on changes in the priorities of WHO, and more opportunities for CCs to network with other CCs that work in the same technical area of work.

2.3.5 Are the administrative and management systems appropriate, robust and efficient? (EQ 3.5)

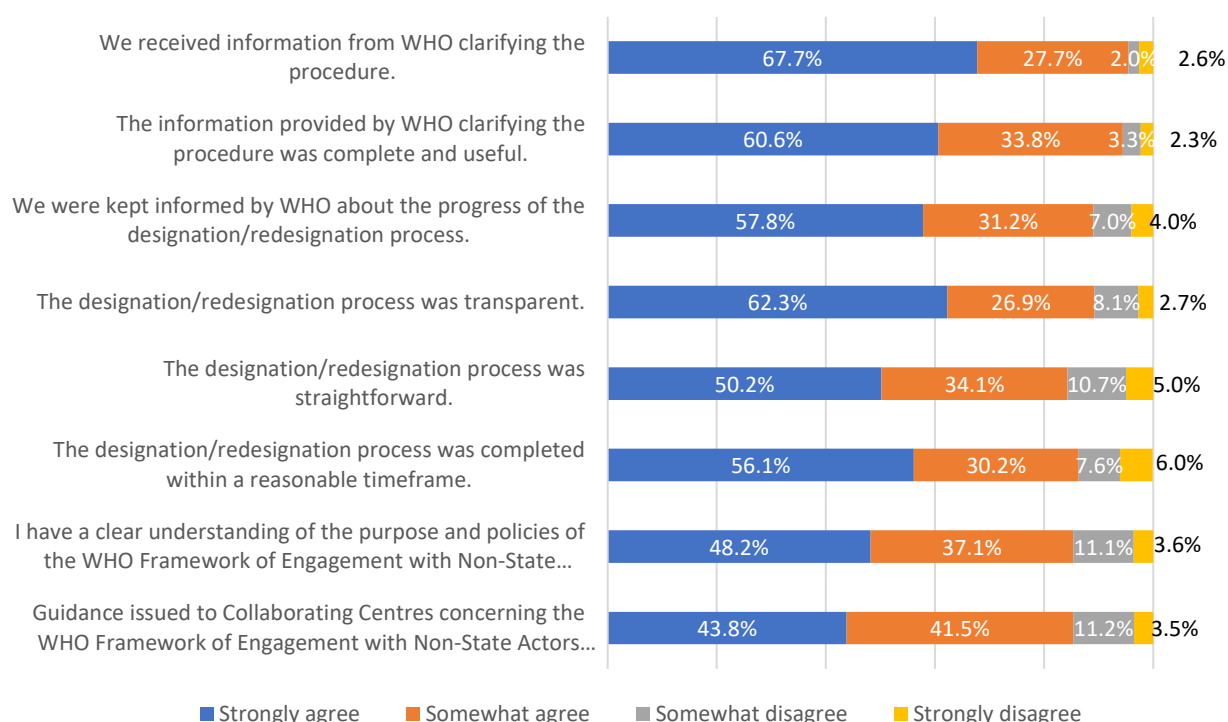
95. The administrative and management systems currently in place support both CCs and WHO staff throughout the designation/redesignation process and also during the planning and delivery of activities. As discussed in section 2.1.1, the introduction of eCC and guidelines to work with CCs have recently resulted in important changes in the administrative and management systems supporting WHO's work with CCs. Key stakeholders reported that some of these changes have improved efficiency, but there are still several gaps that negatively affect the efficiency of WHO's collaboration with CCs.

Perceptions of the heads of CCs

96. In the survey with CC heads, the majority of respondents strongly agreed that they receive clear and complete information from WHO on administrative procedures and that the designation/redesignation process is transparent. As shown in Figure 21, respondents generally agreed on all statements related to the efficiency of administrative systems, although they provided

somewhat less positive responses for the following elements: (a) CCs have a clear understanding of the purpose and policies of the FENSA; and (b) guidance issued to CCs concerning the FENSA.

Figure 21: CC heads' feedback on the efficiency of administrative systems



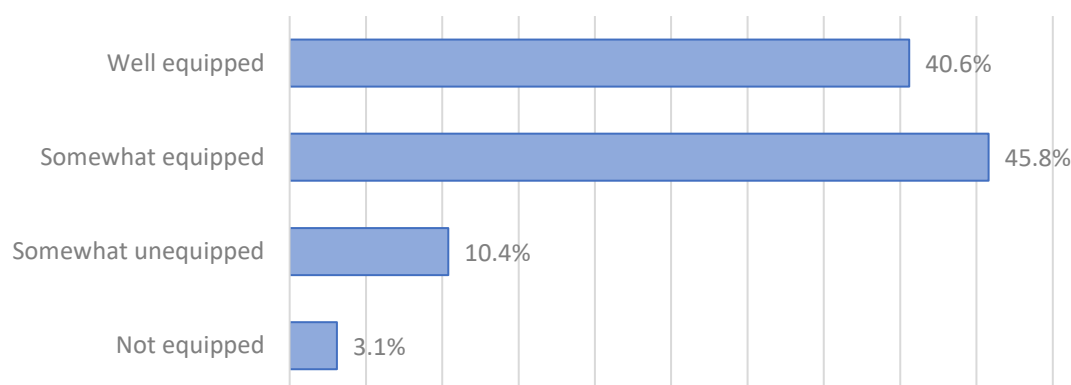
Source: Survey with heads of CCs

Perceptions of WHO staff

97. Most ROs interviewed expressed appreciation for the guidelines for working with CCs (such as the eManual), as well as the roles played by the RFPs, the GFP team, and the FENSA due diligence team. ROs explained that the eManual is helpful and that the high-quality support provided by the GFP team and the RFPs often helps them overcome the challenges they encounter. However, as shown in Figure 22, more than half of WHO Staff consulted through the survey felt that they are not well equipped to fulfil their role. WHO staff provided suggestions for additional support to better fulfil their function: (a) increased time and capacity to perform their role; (b) resources to allow face-to-face meetings and better communication with CCs; (c) more recognition from managers of their role with CCs; and (d) better systems for monitoring, evaluation and follow-up on CC activities.

98. ROs and other WHO staff who are directly involved in establishing and supporting WHO's collaboration with CCs also revealed during interviews that current support units at HQ and in regions are inadequately staffed. This results in delays in the processing of proposals and affects the overall timeliness of the support they receive. While they appreciated the efforts made by the GFP Secretariat and the RFPs to provide support, especially considering the large number of proposals and requests that need to be processed, they considered that timely support would require additional technical capacity at the GFP and RFP levels.

Figure 22: WHO staff responses on how equipped they are to fulfil their role with CCs



Source: WHO staff survey

Delays in the designation and redesignation process

99. While the designation and redesignation process aims to engage all relevant stakeholders to ensure the quality of workplans as well as their relevance and alignment with WHO's priorities, the amount of time that it takes to complete the approval process is a major concern raised by WHO staff and the heads of CCs. Many WHO staff stated that the process often takes more than six months and, in some cases, longer than a year. The GFP Secretariat indicated that there are valid reasons for delays in the approval of in certain proposals, including the poor quality of a proposal, its lack of alignment with WHO's priorities, and limited follow-up by the ROs during the approval process.

100. Interviews with WHO staff shed light on the reasons that explain these delays. These include: (a) the lack of engagement from the outset of those involved in the approval process; (b) the time required for the FENSA due diligence review; and (c) the cyclical nature of the approval process and inflexibility of the system.

- a. **Lack of engagement of those involved in the approval process:** Checks for alignment have been less effective than intended, mainly due to the lack of a proper mechanism or strategic approach to engage WHO senior management in the approval of designation/redesignation proposals. Some ROs felt that they are not empowered to influence senior colleagues – who may have other priorities – to provide timely input, resulting in lengthy approval processes. However, those ROs who have developed a more collaborative or strategic approach to planning through the engagement of all relevant stakeholders prior to initiating the approval process in the electronic system found this to be less of an issue.
- b. **FENSA due diligence process:** In interviews, most of the ROs who have recently partaken in the designation or redesignation of CCs suggested that the FENSA due diligence process is currently the most complex issue associated with designation/redesignation. In 2017, the then Partnerships with Non-State Actors team, which was responsible for ensuring FENSA due diligence within the Organization, was given the responsibility to conduct due diligence of proposals for the designation and redesignation of CCs. At that point, a new set of more comprehensive guidelines were launched to ensure the appropriateness and relevance of the work with CCs. The remit of the team was to ensure compliance with these guidelines. However, no additional resources or capacity were provided to the team to take on the significant extra workload associated with the approval of CC proposals. While recognizing the importance of this process, several ROs and other WHO staff noted that it could be

streamlined. Two key challenges have been identified from the interviews with WHO staff, as follows¹⁵:

- *Review by the due diligence team*: The current practice includes reviewing the proposal to ensure that there is no duplication of work, ensuring that activities are aligned with WHO's priorities, checking compliance with FENSA, and correcting the language of the proposal. Several interviewees suggested that this level of detailed editing be re-considered by the due diligence team, which could limit the review to the essential requirements of FENSA compliance.
 - *Lack of RO understanding of the role of the FENSA due diligence*: There is considerable confusion among ROs as to why certain changes to designations and redesignations are proposed by the due diligence team. Many WHO staff interviewed noted that this is likely due to the lack of training provided to ROs on FENSA requirements. There is also a lack of understanding about the time it currently takes for the FENSA due diligence team to approve an application for redesignation. The proposals for redesignations are often submitted close to the deadline without consideration of this time requirement. ROs who involved or contacted the FENSA due diligence team before or during the process reported a much smoother due diligence process. However, this is an informal process, and is unlikely to be sustainable as the workload of the due diligence team increases.
- c. **Cyclical nature of the approval process and inflexibility of the system**: When feedback is provided at any point in the process, the proposal for designation and redesignation has to go back at the beginning of the process and must be approved by all stakeholders. This often results in major delays in the approval process. In addition, the current system only allows to upload documents in a non-editable online format. This means that feedback and suggestions for edits cannot be done in track changes, causes further delays of the approval of revised proposals. Furthermore, a redesignation process cannot be active in the system for longer than six months; therefore, if a proposal is not approved within this timeframe, the redesignation process has to start from the beginning. This has created frustration among WHO staff and the heads of CCs, who have had to go through the redesignation process multiple times.

101. These delays have reportedly resulted in a loss of momentum in the relationship between WHO and CCs, as well as missed opportunities, since the implementation of the proposed workplan often does not begin at the expected start-date, thus posing a reputational risk for WHO. Heads of CCs recently designated also indicated that the lengthy process created a negative expectation of their future working relationship with WHO.

Challenges in relation to discontinuing the designation of CCs

102. Several ROs and WHO senior managers interviewed suggested that discontinuing the designation of ineffective or inactive CCs, especially those that have had a long history of working as a CC, is still a significant challenge. This challenge appears to stem from the lack of understanding of the concept of CCs among some heads of CCs. WHO staff who have been involved in the discontinuation of a CC designation indicated that there are often political implications, as the CC designation is considered as a recognition and is highly valued by most CC institutions. Therefore, the

¹⁵ A separate evaluation on the implementation of the FENSA was completed during the course of the present evaluation, and action on its recommendations should serve to reduce these awareness and knowledge gaps. ¹⁵ [Initial evaluation of the Framework of Engagement with Non-State Actors: Report and Annexes](https://www.who.int/docs/default-source/documents/about-us/evaluation/fensa-report-final.pdf?sfvrsn=c62a32c5_8). WHO, December 2019. Available at https://www.who.int/docs/default-source/documents/about-us/evaluation/fensa-report-final.pdf?sfvrsn=c62a32c5_8 (accessed on 8 May 2020)

removal of the designation is seen as the failure or loss of status for the institution involved. Many ROs interviewed also felt that without the support from WHO senior management they often cannot discontinue contracts with CCs, and that it could cause significant issues in the relationship with the concerned institution as well as with the local authorities. WHO senior managers interviewed described the process of discontinuing a CC designation as “extremely painful” due to the political pressure linked to the designation. However, this shortcoming is being addressed successfully through the creation of proper mechanisms to engage senior management so that the decision to discontinue a designation is communicated to CCs in a transparent manner.

2. 4 What are the main lessons learned and the strategic recommendations for the way forward? (EQ 4)

103. Key lessons learned emerging from WHO’s work with CCs are summarized in this section. These complement the good practices described in earlier sections of this report.

2.4.1 What are the key lessons learned while working with the CCs? (EQ 4.1)

Designation and redesignation process

104. Interviews with ROs and other WHO staff suggest that the designation of a new CC or redesignation of an existing CC is most effective when there is a strategic approach in place to ensure the relevance of the CC’s work and its alignment with WHO’s priorities. Where there were systematic and transparent mechanisms in place for approving proposals, for engaging senior management, and for communicating decisions to CCs in a timely manner, it was easier for ROs to manage WHO’s relationship with CCs. Continuing the designation of ineffective or inactive CCs because of internal or external pressure reduces the relevance of the work of CCs to WHO’s priorities and entails potential reputational risks.

Good practice example: Streamlining the work with CCs

The WHO Western Pacific Region established a Screening Committee to streamline its work with CCs, including for the designation and redesignation process. The committee involves the senior management team, including the department of directors. The Screening Committee usually meets on a monthly basis, at which time proposals for designation and redesignation are presented by the respective ROs and discussed by the committee. The Screening Committee examines the alignment of proposals with WHO’s priorities and the needs of the countries in the region. It then makes a decision to proceed with the proposal, suggest modifications to it, or reject it. The decision is communicated to the institution as the collective decision of the Screening Committee. This process protects the ROs from undue pressure, in case s/he has to convey the rejection of the proposal or request a major revision. This mechanism was also found to be effective in engaging ROs and senior management in a more productive and strategic way, both in ensuring the relevance of the work of CCs and in taking timely and informed decisions.

The use of a strategy for working with CCs

105. Interviews with WHO staff suggest that a strategic approach to working with CCs at the regional, department or technical programme area level can bring distinct advantages to the Organization. They asserted that a more comprehensive organizational strategy for working with CCs, building on the vision and mission detailed in the WHO Manual XV.5.1, could help maximize the contributions of CCs to WHO results, and that it should include plans to: (a) systematically identify and select potential CCs based on their institutional capacities and the needs of WHO; (b) have transparent and efficient ways of designating and redesignating CCs; (c) manage more effectively the relationship

with and work of CCs; and (d) ensure timely reporting and dissemination of the results of WHO's collaboration with CCs.

Good practice example: Engaging CCs for strategic thinking

All WHO regional offices have undertaken consultations with CCs in their respective regions as part of a strategic thinking process to make the work of CCs more relevant to WHO's priorities. WPRO convenes a biannual forum with CCs, and AFRO and SEARO have both held consultation sessions with CCs recently. EMRO shared a questionnaire with ROs to gain feedback on the challenges of working with CCs. EURO facilitated a consultation with CCs to support the development of their Corporate Strategy for CCs. Finally, AMRO/PAHO is currently conducting an assessment of its work with CCs.

Use of networks of CCs

106. The use of networks of CCs working in the same or similar technical areas can be highly effective to maximise the contribution of CCs to WHO's priorities. CC networks often have clear communication plans and strategies for planning the work of CCs across the network. Where networks of CCs are engaged in the planning process, a more strategic approach to achieving objectives has been possible. This approach has also allowed for greater clarity of the role and contribution of individual CCs to the broader objectives of WHO. Some of the ROs interviewed explained that this has allowed them to have individual workplans that fit within a wider strategic approach across the CC network.

Good practice example: Working effectively with networks of CCs

A CC network on bioethics facilitated by concerned technical programme at WHO HQ identified key areas of work and has developed a planning matrix to coordinate activities. The matrix provides details of thematic areas of expertise and the network then jointly plans the tasks for each CC within these themes. These tasks are recorded on the matrix and a CC lead is identified to oversee the working theme for the network. In addition, the matrix is used by each CC lead CC to report back to the network on progress towards the completion of tasks for each theme.

Location of CCs and related challenges

107. CCs based in low- and middle-income countries have distinct needs and often face challenges related to the availability of resources to fulfil their role as CCs. Understanding the specific needs, challenges and capacities of CCs based in these countries would likely help WHO staff to manage more effectively the relationship with CCs, and provide them with the support that they need to perform more effectively and make a meaningful contribution to WHO's results.

108. While the location of CCs is not a predominant selection criterion, there is an imbalance in the location of designated CCs that highly favours a limited number of high-income countries and a handful of low- or middle-income countries. This calls for WHO to consider whether global representation of CCs should be considered as an important factor for the CC programme and therefore for the selection of future CCs.

2.4.2 Moving forward, how can WHO work more effectively and efficiently with the CCs in relation to achieving its results? (EQ 4.2)

Establishing strategic leadership for working with CCs

109. Moving forward, the development and implementation of a strategic framework at global, regional and department level to guide WHO's work with CCs will constitute a key area for action for WHO. This could include: having a strategic approach to identifying inactive or ineffective CCs; establishing a transparent process for reviewing the proposals for designation and redesignation to ensure that heads of CCs are kept informed throughout the process ensuring effective communication from WHO staff, and to take decision to continue, revise or discontinuing the designation of CCs; and developing robust monitoring systems and effective evaluation processes to analyse and report on the contribution of CCs to WHO's results. The strategic framework should also include an approach for working with existing CCs in low- and middle-income countries, taking into account the specific challenges that they face, and for establishing pipelines for the development of new CCs, especially from low-income countries.

Increasing the visibility of the work with CCs

110. Although CCs provide important support that helps WHO achieve its results, lack of a systematic process for monitoring and reporting results in low awareness among WHO staff across the organization of the contribution of CCs to WHO's priorities. There is an urgent need to increase awareness and recognition of the contribution of CCs internally and externally. This could be done by: improving the efficiency of existing systems; conducting a systematic mapping of the work of CCs; and strengthening internal monitoring, reporting, and evaluation systems.

Communication strategy

111. In order to increase the relevance and effectiveness of the work of CCs, a formalized communication strategy is important. This would help ensure consistency in the approach for communicating with CCs across WHO. It would also be helpful to establish better working relationships between WHO and CC staff. Such a strategy could include approaches to communicate more effectively in the following areas: the designation and redesignation process; the purpose and process for discontinuing CC designations; the reporting of CCs' contribution to WHO's priorities; and the provision of systematic and structured feedback on CC activities. In addition, there is a need for WHO to better communicate to CCs the changing priorities of the Organization.

Collaborative planning and internal support systems

112. WHO's work with CCs can be more efficient by adopting a more collaborative designation and redesignation process. Engaging all key stakeholders in the planning process allows gathering the input of other WHO staff and also helps streamline the approval process because decision-makers have the opportunity to provide input to the proposal before it is submitted in the eCC.

113. WHO can improve the working practices of ROs and TCs by increasing the support to WHO staff holding these roles. This may include increasing the capacity and resources for key support roles (i.e., GFP and RFP) to provide more support to regional and HQ-based ROs. Consideration could also be given to providing specialist support for developing CC networks. In addition, training on best practices in working with CCs and on communication could be developed for WHO staff working with CCs. A structured training program covering all areas of the planning process, particularly alignment with and understanding of the FENSA due diligence process, would help ROs to be more prepared when submitting designation and redesignation proposals. In addition, sharing experiences between RFPs and ROs would increase their understanding of good practices in working with CCs across WHO regions. This may also include more formal recognition of the RFP and RO roles, particularly in staff PMDS.

Improvement in the electronic system

114. The efficiency in the designation/redesignation approval process can be improved by reviewing the steps the process requires and re-developing the eCC to make it more user-friendly. Where possible a re-assessment of the needs or requirements for each step (e.g., the current requirements of the FENSA due diligence approval process) may identify areas where the system can be streamlined.

115. There are also a number of changes that may improve the efficiency of the eCC system and make it more user-friendly for WHO and CC staff. WHO senior staff could review the eCC system to identify areas for development or improvement prior to the forthcoming eCC re-development process, building on the challenges identified through this evaluation. For example, removing the requirement to re-submit proposals for the approval of designation/redesignation after each edit, or introducing the use of Word documents rather than non-editable online form in the eCC system.

3. Conclusions

To what extent is the work carried out by CCs aligned to the relevant GPW and their outcomes / outputs? (EQ 1)

116. Since the 2007 evaluation of WHO's work with CCs, there have been significant changes in WHO's approach to working with CCs, and considerable improvements in the efficiency and transparency of processes to designate and redesignate CCs. Changes have also brought about improved alignment of the work of CCs with WHO's priorities. These changes have also led to the discontinuation of some of the old CCs that were inactive or ineffective and the creation of new CCs that have the potential to contribute to WHO's priorities. However, there are still several CCs that are inactive or not currently relevant to WHO's work. While some of these changes and improvements are clearly the result of implementing some of the key recommendations detailed in the 2007 evaluation, there were also a number of recommendations that were not approved or deemed not useful.

117. The majority of the work of CCs is relevant to the priorities expressed in WHO's GPW and Programme Budgets. The importance of the work of CCs and their contribution to WHO's priorities are well recognized within the Organization, especially in some of the critical areas of work where resources are limited. There is also a good level of understanding among heads of CCs about how their work contributes to the delivery of WHO's priorities. However, lack of strategic coordination of the work of CCs across the Organization is still an important gap that limits the maximization of their contribution to WHO's priorities.

118. The current planning and designation/redesignation process through the electronic platform (eCC) provides several opportunities to identify clear and appropriate objectives, detail the relevance and alignment to WHO's priorities, match the entities to which CCs are linked, and ensure effective communication. In addition, the development and improvement of WHO guidelines – such as the eManual that details the alignment process to be followed by WHO staff and heads of CCs – have contributed to improving clarity over the steps to follow. The process of aligning the work of CCs with WHO's priorities is particularly successful when done through collaborative planning processes that involve all key stakeholders, such as WHO senior management and TCs, or through CC network planning.

119. The engagement of all key stakeholders from the beginning of the approval process is crucial in ensuring alignment with WHO's priorities, a timely approval as well as the effective implementation,

monitoring and evaluation of the work with CCs. The process is often initiated by ROs and involves other stakeholders, including TCs, RFPs/GFPs, the FENSA due diligence team, the department directors and the ADGs. The engagement of TCs in the designation and redesignation process and in planning the work of CCs varies significantly, and their role is often not recognized or given due consideration. There are also several examples of the successful engagement of all stakeholders that resulted in timely approvals.

120. However, there are several issues that need to be addressed to further improve efficiency and to make the designation and redesignation process through eCC more user-friendly, quicker and more transparent. Delays in the designation and redesignation processes resulting from lack of engagement of some of the key stakeholders, the complexity of the FENSA due diligence process, and the lack of joint decision-making when it comes to the discontinuation of some ineffective or inactive CCs generate frustration among ROs. Lack of transparency in communicating to CCs the reasons for delays in the decision-making process in a timely manner creates mistrust and frustration among key people in CC institutions. Similarly, giving ROs the full responsibility for communicating decisions on the discontinuation of CCs, which can have political implications, often puts them in a difficult situation. After a CC is discontinued, a formal letter is sent by the concerned Regional Director to thank the CC for its contribution, though this is done at the end of the process. Therefore, a systematic, reliable and timely designation/redesignation process that involves senior management, as well as the timely communication of joint decisions made at senior level, are essential to ensure credibility of the process and the Organization. In addition, engaging TCs and senior WHO staff in planning and designation/redesignation processes is important to ensure these are effective. Having broader discussions and dialogues with CCs around WHO's priorities and strategies also helps to align the work of CCs more closely with the priorities of the Organization.

121. Limited understanding of the needs and requirements of the FENSA due diligence process among CC staff and ROs make it difficult for them to understand the feedback that they receive from the FENSA due diligence team on their proposal.

To what extent does the work of CCs contribute to the delivery of WHO's results? (EQ 2)

122. CCs contribute to several critical areas and effectively support the delivery of WHO's mandate by: increasing WHO's access to high quality technical and scientific expertise; strengthening research capabilities; delivering capacity strengthening; and policy development. CCs are also an important mechanism for developing global thought leadership and increasing the influence of WHO globally.

123. CCs particularly value the opportunity to contribute to the global and regional mandate of WHO. They also value the increased reputation that the designation brings to their institution and the opportunities to network with other CCs working in similar areas. However, there are a number of issues that need to be addressed to make the work of current and future CCs more effective.

124. The needs of CCs often depend on where the CC is located. CCs that are located in low- and middle-income countries often face challenges in accessing the technical and financial resources that they need to deliver their work. The principle of working with CCs is that WHO does not provide any financial resources to CC institutions. Lack of institutional capacities in low-income countries combined with lack of resources results in higher representation of CCs in high-income countries. This uneven distribution across regions is particularly challenging as some regional offices depend on CCs from other regions to respond to health emergencies and outbreaks.

125. Because regional offices and HQ have different functions, CCs linked to regional offices often focus on the provision of technical expertise and capacity strengthening, while those linked to HQ

focus more on research and the development of guidelines or policies. Consideration needs to be given to what types of CC can provide the services that best respond to the different needs of WHO HQ and regional offices. This will enable a more effective collaboration with CCs at both regional and global level.

126. There are several key factors that enable CCs to work effectively and overcome challenges. These need to be considered in the development of any future approach to working with CCs:

- ensuring that the roles and responsibilities of both WHO and the CC detailed in the WHO Manual XV.5.3 are fully clarified at the start of the designation process;
- identifying realistic objectives for CCs, particularly for those CCs in low-income countries;
- improving formal communication processes between WHO and CCs throughout the designation period, including at the planning stage and through further engagement of CCs in wider discussions on WHO's priorities and strategies;
- improving the evaluation and feedback mechanisms for CCs' work;
- encouraging collaborative planning processes that involve TCs, RFPs, senior WHO staff and the FENSA due diligence team;
- reducing the administrative burden of the designation and redesignation process, including by informally engaging relevant staff early on and introducing the use of editable online forms;
- enhancing clarity about alignment to and use of the WHO CC "brand"; and
- facilitating CC network planning processes, where appropriate.

127. The most significant challenge faced by the CCs is a lack of resources. While this is particularly true for CCs from low- and middle-income countries, CCs in high-income countries often have to internally justify delivering work as a CC, where there is no financial benefit to the wider institution.

128. Networks of CCs working in the same or similar areas often adopt a more collaborative and strategic approach to planning. This helps maximise the effectiveness of individual CCs. Network planning happens most effectively when CC networks prioritise structured communication between CCs across the network and between WHO and the network. Other factors that help collaborative planning include better engagement of CCs in wider WHO dialogues as well as increased visibility and accountability of the work of individual CCs and that of CC networks as a whole.

How efficiently did WHO manage its relations with CCs? (EQ 3)

129. The efficiency of WHO's work with CCs is mixed. WHO CCs bring important financial, technical and scientific resources to WHO. The extent to which these resources have been used efficiently is contingent upon the presence of strategic planning processes that ensure the non-duplication of work. In addition, proper planning processes to develop ToRs and workplans ensure that the majority of CC activities are timely and used appropriately.

130. The investment for WHO to manage the work with CCs mostly includes human resources to coordinate this relationship, the cost of which is not easy to quantify. However, rough estimates based on feedback from the head of CCs suggest that CCs contribute a substantial amount of financial, human, and administrative resources to support the implementation of the mandate and priorities of WHO.

131. One of the key issues hindering the efficiency with which WHO manages its relationship with CCs is the lack of awareness among WHO staff of the type of work delivered by CCs across the organization. This has reduced opportunities to apply a more strategic approach to planning the work

of CCs and to maximise the potential of CCs by creating synergies among those working in similar technical areas. Effective communication between WHO staff and their CC counterparts has resulted in improved efficiency and increased support to CCs to fulfil their role effectively. However, there is room for improving the consistency and frequency of communication by establishing regular and formal communication processes. Mechanisms and resources could also be put in place to support more in-person meetings between WHO and CC staff.

132. There are administrative and management systems currently in place to support CCs and WHO staff in the designation/redesignation process, and in the planning and delivery of CC activities. However, there is a need to make these systems more efficient and robust. In particular, the eCC system needs a number of improvements, including: (a) making the system more user-friendly; (b) streamlining the steps for approval; (c) removing the requirement to re-submit applications from the start of the process when edits are made; and (d) introducing editable formats of submission. When accessed and used correctly, the support mechanisms in place are effective in supporting WHO staff. However, improvements can be made in the provision of support for WHO staff by: (a) increasing the capacity of the RFPs and the GFP team to provide support; (b) developing new training and support for staff (e.g., on good practices in working with CCs and on the requirements of the FENSA due diligence process); (c) ensuring that support systems are accessed effectively by WHO staff.

What are the main lessons learned? (EQ 4)

133. Having a strategic approach and strong leadership when working with CCs is important to ensure the relevance of the work of CCs to WHO's priorities. Collaborative planning, engaging all stakeholders from the beginning of the process, and facilitating networks of CCs working in the same areas are some of the key strategies that contribute to increasing the effectiveness and efficiency of WHO's work with CCs.

134. Discontinuing the designation of ineffective or inactive CCs are essential to reduce the potential reputational risks for WHO. New proposals of potential CCs that are not relevant for the work of WHO also need to be assessed in a transparent manner. Both require a systematic and transparent approach to decision-making. The engagement of senior management in decision-making processes was identified as a factor facilitating the effective discontinuation of inactive or ineffective CCs, especially in cases where those have been working as WHO CCs for a long time.

135. Timely and transparent communication between WHO and CCs is essential to ensure trust in the relationship and to maximize the impact of the work of CCs. This also includes communicating (a) the reasons for delays in decision-making (b) suggested changes to the proposals, and (c) decisions on the proposals.

136. The use of a web-based platform such as eCC can improve transparency in planning and increase efficiency in decision-making. It can also facilitate alignment of CCs' work with WHO's priorities. However, the technology needs to be assessed and updated regularly to ensure its user-friendliness.

137. Effective engagement with CCs can contribute significantly to WHO's results. This requires expressing clearly WHO's needs and priorities, identifying the expertise of potential CCs and linking it with that of other CCs, and regularly monitoring and evaluating the work of CCs.

4. Recommendations

138. The evaluation has generated five overarching recommendations, most of which are similar to the recommendations that emerged from the 2007 evaluation. Twelve years have passed since the previous evaluation, and these areas for improvement still require focused attention to ensure that WHO's collaborative relationship with Collaborating Centres is as relevant, effective and efficient as possible going forward.

1. Develop, implement and disseminate a strategic framework for working with Collaborating Centres (CCs) at global, regional and departmental level based on the policies and procedures detailed in the WHO Manual XV.5. This framework should include, as appropriate, measures to:

- a. conduct a strategic review of current CCs by a panel of WHO senior managers to identify those that are inactive or ineffective and establish a process that will lead to the discontinuation of CC designations based on strategic alignment and risk considerations consistently across the Organization;
- b. develop a robust monitoring and evaluation process to assess the work of CCs so as to maximize their relevance, effectiveness and efficiency, and ensure consistency of implementation across the Organization;
- c. ensure more regular and systematic engagement of directors, Assistant Directors-General, and technical counterparts in designation/redesignation and planning processes;
- d. review the designation of CCs or develop new categories of CCs to take into account the different needs of CC institutions in low- and middle-income countries, and WHO regional or country requirements; and
- e. establish a mechanism for anticipating emerging health issues and forecasting needs, and for establishing pipelines for the development of new CCs to address these.

2. Promote awareness of Collaborating Centres (CCs) and their contribution, both within WHO and with external audiences as appropriate. Toward this end, it is recommended that:

- a. a systematic mapping be undertaken of CCs' locations and areas of work (or specialization) and disseminated internally to various technical units and departments to improve awareness of CCs and the efficiency with which these are used across WHO;
- b. high-level internal reporting systems be established to evaluate and report on CCs' contributions across WHO by ensuring that existing data are systematically analysed and made available to senior management periodically;
- c. formal systems be put in place to showcase the work of CCs within WHO and externally; and
- d. the contributions of CCs be included in high-level strategy documents and reported in an annual summary report.

3. Develop a communication plan for the Organization's relations with Collaborating Centres (CCs) that, *inter alia*:

- a. ensures more regular and formalised communication throughout the CC designation/redesignation process;
- b. establishes regular contact during the designation period and a systematic communication structure for ongoing monitoring of CCs' work;
- c. engages CCs more systematically in wider WHO dialogues on strategic priorities and directions; and
- d. allows more face-to-face engagement between WHO staff and CCs.

- 4. Use the forthcoming re-development of the Electronic Collaborating Centres (eCC) as an opportunity to improve the effectiveness and efficiency of the online system,** namely through measures to:
 - a. re-assess the ordering and requirements of each approval step to streamline the process and re-design the system to remove the need for resubmission and approval after each edit;
 - b. allow for more flexibility in the formats used for proposal submission in eCC Collaborating Centres;
 - c. improve the user interface and guidance notes of the eCC to make it more user-friendly; and
 - d. provide more guidance for users on the timeframe required for each step and how to avoid delays.

- 5. Undertake a review of current staff support and management systems** to identify areas for improvement, with a view to:
 - a. increasing capacity in the functions of Regional Focal Points and the Global Focal Point team to include a networking, training and communication role;
 - b. establishing a training programme for staff on planning and management processes for working with CCs and on the Framework of Engagement with Non-State Actors (FENSA) due diligence process and requirements;
 - c. providing opportunities for peer learning for Responsible Officers and Regional Focal Points; and
 - d. including CC-related roles (i.e., Responsible Officers, Technical Counterparts) in WHO staff Performance Management and Development System (PMDS) processes.