
Evaluation of WHO's Presence in Countries

Corporate evaluation commissioned
by the WHO Evaluation Office



Report by Emma Henrion

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Acknowledgements

We would like to thank the WHO Heads of Country office in Bangladesh, Democratic Republic of Congo, Cambodia, Kyrgyzstan, Mexico, Morocco, Sudan and Uganda, and their teams for their help in arranging the visits to their countries and facilitating interviews with country partners. Their insights and perspectives on WHO's country presence were invaluable. We would also like to thank all the representatives from country governments, NGOs, Civil Society, professional associations, UN agencies and academics who also gave generously of their time. Global partners, WHO Regions and WHO-HQ staff and management also made thoughtful and important contributions. Lastly we would like to thank all the many country partners and WHO country teams who responded to the global survey.

Acronyms

AfDB	African Development Bank
ADB	Asian Development Bank
BCA	Biennial Cooperation Agreement
BMGF	Bill and Melinda Gates Foundation
CAP	Country Assistance Plan
CCS	Country Cooperation Strategy
CIDA	Canadian International Development Agency
CSCF	Civil Society Challenge Fund
CSO	Civil Society Organisation
CCU	Country Cooperation Unit
DFID	Department for International Development
EMG	Evaluation Management Group
EVO	WHO Evaluation Office
HCO	Head of County Office
HDI	Human Development Index
HSS	Health Systems Strengthening
HWO	Head of WHO Offices in Countries, Territories and Areas (also known as WRs)
IADB	Inter-American Development Bank
IHR	International Health Regulations
MoH	Ministry of Health
MTR	Mid Term Review
MOPAN	Multilateral Organisation Performance Assessment Network
NCD	Non Communicable Disease
NGO	Non-Governmental Organisation
NHPSP	National Health Policy Strategy and plan
OECD-DAC	Organisation for Economic Co-operation and Development Assistance Committee
PB	Programme Budget
PRD	Policy and Research Division
RBM	Results Based Management
RD	Regional Director
RFP	Request for Proposals
SDG	Sustainable Development Goal
SDH	Social Determinants of Health
SIDA	Swedish International Development Cooperation Agency
ToR	Terms of Reference
UN	United Nations
UNDAF	United Nations Development Assistance Framework

UN JIU	UN Joint Inspection Unit
UNDP	United Nations Development Programme
USAID	United States Aid to International Development
VFM	Value for Money
WB	World Bank
WHO	World Health Organization
WHO-HQ	Head Quarters (of WHO)
WR	WHO Country Representative (also known as Head of WHO Offices in Countries, Territories and Areas or HWOs)

Executive summary

Background

The role of WHO at country level has been identified as a priority in different WHO reform programmes since 1989. One of the stated purposes of the current WHO reform programme, the 12th General Programme of Work (12th GPW) launched in 2011, is to strengthen support to all the countries which WHO works with [1]. The 12th GPW addresses the importance of all three levels of the Organization working together as one, with differentiated roles, and of improving the flexibility, mobility and quality of staff.

The evaluation methodology was based on visits to eight countries in six WHO Regions; a global survey of Member States, country partners and WHO staff; and, interviews with regional and global partners, and a literature review.

Objectives and scope of the evaluation

The purpose of the evaluation is to provide evidence on progress towards the contribution of WHO to country-level goals and to the Organisation's wider outcomes. The evaluation also seeks to identify related synergies across the three levels of WHO, including inter-country and inter-regional cooperation towards maximising the combined contribution to country level goals. The scope of the evaluation was determined by five high level questions from WHO presented to the Executive Board in 2015 which, taken together, provided its substantive content.

Main findings related to each of the five high level questions

1. What does WHO presence in countries mean, and does it respond to Member States' and other relevant partners' expectations?

There is a broad level of consistency between country partners', governments' and WHO staff views on the main purposes of WHO at country level. Country partners gave a very clear primacy to WHO's roles in normative and technical assistance, to advocacy and to system leadership in the health sector. Fragile and lower Human Development Index (HDI) states are more likely to emphasise the importance of WHO in providing technical support, capacity building and implementation of programmes and coordinating emergency responses. Countries with higher HDI value particularly the normative and knowledge brokering role of WHO, and its support to health system reforms.

WHO's priorities are seen to be well aligned with priorities of Ministries of Health but less so with other government departments, indicating a need for stronger intersectoral work. The main WHO planning tools used in most regions for country work are not always used actively to ensure that WHO plans are clearly focused on current country needs and expectations. Alignment of WHO's planning processes with Ministry of Health and UN cycles will help ensure that WHO's work continues to meet national goals. There is room for stronger alignment of planning tools with Governments and UN agencies. There is a risk that earmarked programme funding and responding to health emergencies can divert WHO's activities away from strategic national priorities.

The evaluation found that the role of WHO was not consistently understood across all partners. There is room for WHO to become more visible and for more effective communication to make the role and purpose of WHO at the country level clear and activities known.

Recommendation 1: WHO should review and clarify its role and purpose at country level to ensure a common understanding within WHO and externally.

Actions:

- WHO leadership to convene a working group with representation from all three levels of WHO to develop a clear definition of the purpose and objectives of WHO at country level in the changing 21st century health context. This should define country level purpose for all countries, with or without office.
- WHO leadership to develop a resourced communications strategy to facilitate WHO country offices to communicate WHO country level purpose, priorities and activities clearly and accessibly to country stakeholders

2. What is the contribution of WHO presence in countries towards addressing global, regional, and individual countries' health priorities and needs?

WHO's activities at country level contribute to national goals and objectives and global and regional priorities, and WHO's are valued by partners. However, it is not possible to assess WHO's contribution objectively, since there are no measures for country level outcomes. This limitation has been highlighted in previous evaluations of WHO but has not yet been addressed. The WHO planning tools such as the CCS do not identify specific indicators; although the BCA used in WHO's Regional Office for Europe (EURO) and the WHO global results framework offer a basis for their development. There is no theory of change for country presence to assess country level contribution.

There is scope to use the CCS/BCA process more actively to review progress on WHO country- level work with Ministries of Health and country partners to provide accountability and learning. Planning and reporting processes across the Regions differ, so that there are variations in the ways that activities are assessed to show contribution to outcomes at country, regional and global levels.

From analysis of the findings, it is notable that the effectiveness of the contributions is increased through the strength of relationships that WHO has with country partners and its knowledge of country context. There are a number of areas where WHO could be more effective in its contribution, in particular in relation to intersectoral working, technical assistance for monitoring and evaluation, knowledge sharing on good practice, mainstreaming gender and human rights and enabling implementation of strategic plans.

Recommendation 2: WHO should develop and implement a methodology to assess performance at country level which is integrated with the CCS/BCA and WHO global results framework for purposes of learning and accountability.

Actions:

- WHO to develop a theory of change for WHO country level presence.
- WHO to develop a CCS and BCA/Biennium template based on the theory of change which includes information on deliverables, planned outputs (results) and outcomes and impact consistent with the WHO global results framework which can be used as a tool to support bottom up planning with country partners.
- WHO to develop CCS/ BCA methodologies to include a participatory process for annual reviews of progress on WHO country objectives with the country government and partners for learning and accountability purposes.
- WHO to review the planning processes used in different regions to ensure they are consistent with each other and with global reporting requirements at three levels and with the current CCS guidance.

3. What is WHO's added value at country level in the light of its level of investment?

WHO's added value is not explicitly defined in the Organisation. Nevertheless, WHO is seen to make a unique contribution as the global leader for public health, with a unique role in setting global norms drawing on its expertise and country presence. At country level it is particularly valued for its close relationship with Ministries of Health and its strengths in giving policy advice, brokering and diplomacy as well as to contextualising guidance and providing relevant support to the country's health needs. Added value at country level includes knowledge credibility and political legitimacy.

Risks to WHO's capacity to add value stem from internal organisational culture, systems and governance at all three levels, and include its bureaucratic and hierarchical nature, being slow to respond, being risk averse and reactive, and not working as One WHO. WHO's governance structure and organisational culture is seen to hamper effective inter-organisational response. There is also a risk to WHO's valued neutrality if its close relationships with Member States prevent it acting impartially. To preserve WHO's unique offer the Organisation will need to adapt proactively to the changes in the global health context, and define its future strategic offer among a range of global health actors.

There is scope for WHO to review and map how the different levels of WHO add value to each other and to the Organisation as a whole, to understand better what WHO invests in country level work. This would also facilitate improved inter-level and inter-regional working. There is also scope to assess better the relationship between investment and impact: in countries with a higher level of development and capacity, WHO can add large value through relatively small inputs, whereas in lower capacity countries this may require larger investments to achieve similar value.

Recommendation 3: WHO should review and map how the different levels of WHO add value to each other and to the Organisation as a whole, to understand better what WHO invests in country level work, and tackle the risks to its capacity to add value.

Actions:

- WHO to clarify, define and map the Organisation's investments at all three levels in relation to countries and how these contribute to the WHO global results framework at country level to identify where there is scope to increase effectiveness, efficiency and how and where most value can be added.
- WHO to address the internal risks to its capacity to add value, through improving internal systems to facilitate prompt country level responses to partners; to support greater innovation; to reduce silo working; and, to promote a more forward looking way of working. These risks will need to be addressed at all three levels to enable WHO to work more efficiently as One WHO.
- WHO to convene a working group to review WHO's functions in relation to other global health organisations and the UN to define more clearly WHO's unique offer and to avoid overlaps in roles.

4. What are the modalities for strengthening or reducing WHO's presence in countries, based on the different health status and needs of individual countries?

It is difficult to assess how well WHO country office capacities meet country needs as there is no explicit methodology for matching staff or budgets to countries on the basis of need. There is a wide variation in country office size which is not closely related to country needs.

Many country partners as well as WHO staff perceive WHO Country Offices to have less technical capacity and resources than required to meet planned activities. Furthermore, a number of internal organisational challenges affect WHO Country Office capacity and the extent to which it can adapt to changing country needs. These include delays in recruiting and appointing staff, challenges with the performance management system in WHO, lack of staff with the relevant expertise, organisational delays in deploying staff rapidly in response to emergencies. Some of WHO Regions and WHO-Headquarter contributions to capacity were identified as being extremely effective in augmenting country office teams by bringing in expertise and capacity for specific issues, or to help a country develop capacity. However, there were also many instances where a slow response from regions and HQ delayed the country response to a time critical need.

There is a need for a transparent methodology for determining the level and type of country presence. The likely indicators for allocating resources and staff skill mix for countries would include a combination of health needs, the capacity and strength of the government and country health systems, and the economic and social development of the country. Any new methodology should be linked to, or derived from, existing planning tools and should identify criteria for establishing a country office as well as for increasing or reducing presence, and for disinvesting.

Recommendation 4: WHO should ensure that the level of WHO country presence and capacity is appropriate to country needs, consistent with the WHO global strategy and WHO country purpose.

Actions:

- WHO to convene a working group to review and develop a methodology for determining country level presence, based on the revised statement of purpose at country level and the model outlined in this report. The methodology should be based on or closely aligned to the SBSA, or, if this is not adopted, a similar model based on indicators of country needs and capacity.
 - WHO to amend the global CCS guidance to include an assessment of country level staffing and staff skill mix, including administrative staff and the balance of national and international staff, consistent with WHO country budgets and country needs.
 - WHO to review internal recruitment and HR processes to ensure prompt appointments and effective processes for the development and performance management of staff.
 - WHO to review processes for accessing internal expertise and identify gaps in relation to new and developing areas such as health financing, private sector engagement, social determinants of health to ensure that all WHO Country Offices have adequate and prompt access to a good quality of expertise to respond promptly to country needs. The analysis should also include access to health emergency resources.
5. To what extent does WHO exert effective leadership and convening capacity at country level to mobilise different stakeholders and act as a broker of partnerships in support of the national health and development agenda?

The leadership capacity of the individual Head of WHO Offices (HWO) is widely seen as key to their effectiveness of WHO at country level. An effective HWO is also seen as one who maintains WHO's impartiality. National technical staff require similar leadership skills; leadership in WHO at country level extends beyond the HWO to the whole team. Leadership also needs to be appropriate to country context, and country cultural and social expectations and norms. All three levels of WHO contribute to country level leadership.

Regional and WHO-HQ support can be very effective, but there was evidence that the WHO global and regional processes systems can be barriers to country level leadership. This includes some weak communications between the three levels (country, regional and HQ), and relatively low levels of delegated authority. Country office leadership capacity is seen to be varied in quality and effectiveness.

Convening and brokering partnerships is an increasingly important role for WHO and partners see this as a key role for WHO and that there is a need to increase and strengthen capacity in this role. Partnership relationships with Ministries of Health are seen as strongest; however, WHO's relationships with other government ministries and parliament, Civil Society Organisations (CSOs) and non-governmental organisations (NGOs) are not as strong, affecting its capacity for intersectoral working. WHO's partnership working with the private sector is seen as least developed, and there is also scope to improve collaboration with Civil Society and NGOs.

Recommendation 5: WHO should ensure that HWOs and country staff have the necessary leadership skills to be effective at country level, and that they are supported in this by the systems and processes of the wider Organisation, and should strengthen partnership engagement to support the delivery of country level health and development objectives.

Actions:

- WHO to ensure that new HWOs and country staff recruited have strong skills and competencies in leadership, health diplomacy and partnership collaboration; training should be provided to existing staff where needed.
- WHO to ensure that all three levels of WHO are well aligned and coordinated to support country level leadership so that Country Offices receive consistent and systematic support from the other two levels of WHO.
- WHO to develop and institutionalise a process aligned with CCS development and review for Country Office teams to map all partners at country level to include new and emerging partners relevant to the country's needs such as CSOs, NGOs and the private sector. Country Office teams to be developed to improve their capacity to engage with the private sector.
- WHO to clarify the mutual accountabilities and responsibilities of WHO and Member State governments to ensure that each party has a clear understanding of its roles and relationship.

This evaluation has identified a number of recommendations very similar to those of previous evaluations of WHO. An additional recommendation is made therefore to facilitate implementation of recommendations from this and future evaluations.

Recommendation 6: WHO leadership should develop standard management processes to implement and follow up agreed recommendations from evaluations and identify organisational barriers to their implementation.

Actions:

- WHO leadership to allocate responsibility to specified senior roles to lead on agreed recommendations from this evaluation with implementation plans which are specific, time limited and accountable.
- WHO Evaluation Office to carry out a systematic review of the recommendations from other relevant reports on country strengthening and identify which are still

outstanding and relevant to produce a synthesised list of recommendations for agreement by the Global Policy Group.

- WHO Evaluation Office, in consultation with WHO leadership, to identify the barriers to implementation of outstanding recommendations, and to develop a plan of action to address barriers.

1. Background to the evaluation

1.1. Context

The context for the evaluation is the WHO Reform Programme launched in 2013 to enable WHO to address adequately the challenges of public health in the 21st century and the Twelfth General Programme of Work (12th GPW) for 2014- 2019 [1]. This evaluation has been commissioned to inform WHO on ways of implementing the reforms more effectively in relation to country (and regional and WHO-HQ) levels and ensuring that WHO's country presence is fit for purpose to meet the requirements of the 21st century.

The 12th GPW identifies WHO leadership at country level as a particularly important element of the reform agenda, and emphasises the requirement to strengthen WHO work at the Country Office level as well as its coordination with other levels in the Organisation. The MOPAN 2013 report on WHO, in its conclusions, notes that WHO does not provide strong evidence on a clear picture of the nature, magnitude or relative importance of its contributions to changes at country level [2]. This is underpinned by concerns about the implementation of the results framework and results based management practices at country level, and questions about the transparency of resource allocation. There are also questions concerning the resourcing, activities and strategic management of WHO Country Offices and the cultural and organisational change required to increase effectiveness and efficiency which are raised by the 2013 Final Report of the Evaluation of the WHO Reform Stage 2 [3].

WHO's country presence has been identified as a priority to address in different WHO reform programmes since 1989. One of the stated purposes of reform is to strengthen support to all the countries that WHO works with, both with and without a country office. The 12th GPW addresses the importance of all three levels working together as one, with differentiated roles, and of improving the flexibility, mobility and quality of staff.

There are a number of other published evaluations and reports which relate to country presence. The question of how WHO should most effectively work at country level was identified as an area for investigation by the Oslo study on support to country programmes in 1997 [4]. The findings from the Oslo study were used to inform the then on-going WHO reforms, and changes have been made since then. Some of the findings are still relevant. The Oslo study found among other things that there is no clear relationship between the size of the WHO office and the level of need; that regional offices act with a level of autonomy and have different ways of working, that recruitment is slow and staff capacity often not adequate to need, and that WHO does not adequately evaluate its performance in countries. A report of the UN Joint Inspection Unit in 1993 identified in WHO's three-layer organizational structure (headquarters, regions, countries) 'serious and complex problems of a constitutional, political, managerial and programmatic nature' [5].

In 2012, the Regional Office for the Western Pacific (WPRO) published *Placing Countries at the Centre* [6], which identified the following key areas for development to improve country level effectiveness: improved staffing, developing an evaluative and self-critical culture, making the Country Cooperation Strategy (CCS)¹ more responsive and better aligned with country planning processes and objectives, and a need to define better the role of WHO and WHO organisational culture and processes. It also noted the weakness of WHO in strengthening health systems. WPRO

¹ The Country Cooperation Strategy (CCS) is the principal strategic planning documents used by WHO at country level; in EURO many countries do not have a CCS but a Biennial Cooperation Strategy (BCA), although CCS are increasingly used.

has followed this work with a second external review and a plan of action [6]. The Regional Office for Europe (EURO) has undertaken a review of how to strengthen country presence [7] and the Regional Office for the Eastern Mediterranean (EMRO) has also carried out its own reviews of country level working.

The Report of the Ebola Interim Assessment Panel contained findings for WHO at all levels, but particularly emphasised the importance of WHO working robustly at country level and supporting strong health systems [8]. It identified the need to ensure that country circumstances are taken into account in staffing Country Offices, and to make sure that the HWOs, (also known as WHO Representatives or WRs) have an independent voice, fully backed by the regional and WHO-HQ levels.

There is therefore a history to the current evaluation of WHO country presence, which provides a context for it. Many of the findings of this evaluation will not therefore be new, but will provide a validation of what Member States, external partners and WHO staff see as the main opportunities and constraints to making WHO country presence fit for purpose in 2015.

1.2. The evaluation in organisational and historical context

Since WHO was established in 1948 it has grown and developed to respond to different global health needs, and the increasing complexity of health and development. It has a unique governance structure with all 194 countries in the world represented at the World Health Assembly (WHA), the governing body which authorises and endorses WHO strategies, budgets and activities. This allows it to have a direct relationship and engagement with all countries, making it a truly global organisation,

WHO has a unique structure of semi-autonomous regional offices which have their own governance structures within the global governance structure. The Pan-American Health Organization (PAHO), which was established in 1902 agreed to serve as Regional Office for the Americas (AMRO) joined WHO when WHO was founded in 1948; subsequently other regions were established. WHO regions (except AMRO) are defined partly by the WHO Member States' choice of which region to be in. For example, Pakistan is in the Eastern Mediterranean region (EMRO), India in the South-East Asian region (SEARO), while Cambodia is in the Western Pacific region (WPRO). Countries also occasionally change regions in response to particular political developments. For example, Morocco was in EURO but moved to EMRO some 20 years ago. Country Offices have developed incrementally in response to country needs and demands from the 1960s onwards. Today there are 150 countries with a Country Office. The incremental development of WHO as an organisation has led to a situation where there are differences between regions and countries in terms of their structure, staffing and ways of working not only due to different regional or country contexts but to historic developments and political choices.

Since 1948 there have been significant changes in the external context. There are more global players with the entry of the World Bank into health financing, and new organisations have been created such as UNAIDS, the GAVI Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund), developed to tackle specific disease problems. In the same period, WHO's secure funding from governments has not increased. The organisation has become highly reliant on voluntary contributions from governments and other actors usually earmarked for particular activities led by the donor. In recent years, the Bill & Melinda Gates Foundation (BMGF) has become one of the biggest voluntary contributors to WHO. Voluntary contributions now account for approximately 70% of WHO budgets, compared to less than a third thirty years ago. These changes pose questions for WHO at all three levels in regard to its primary purpose, raised by a 2013 report [9] but which are still relevant to this evaluation:

“Is WHO principally a norm-setting institution? Is it principally a provider of technical assistance to governments in relation to health? Is it supporting health system strengthening? Is it a broker of partnerships? What is its role in emergency response and implementing projects on the ground?”

1.3. Evaluation objectives and approach

Objectives

The purpose of the evaluation is to provide evidence on progress towards the contribution of WHO to country-level goals and to the organisation-wide outcomes. The evaluation was framed by five overarching questions from WHO presented to, and agreed by, the Executive Board in 2015:

1. What does WHO’s presence in countries mean, and does it respond to Member States’ and other relevant partners’ expectations?
2. What is the contribution of WHO presence in countries towards addressing global, regional, and individual countries’ health priorities and needs?
3. What is WHO’s added value at country level in the light of its level of investment?
4. What are the modalities for strengthening or reducing WHO’s presence in countries, based on the different health status and needs of individual countries?
5. To what extent does WHO exert effective leadership and convening capacity at country level to mobilise different stakeholders together and to act as a broker of partnerships in support of the national health and development agenda?

Approach

The evaluation was based on four components:

- Visits to eight countries across the six regions of WHO in which representatives of the Government, funders, country partners and WHO staff were interviewed; over 200 interviews were carried out.
- A global survey of Member States, country partners, Heads of WHO Office in Countries, Territories and Areas (HWOs), WHO Regions.
- Interviews with global partners, WHO Regions.
- Literature and document reviews.

The eight countries were visited were selected by the WHO Evaluation Office in consultation with the Evaluation Management Group (EMG)² and WHO Country Cooperation Unit CCU to ensure representation across WHO Regions, levels of development and fragility, as follows:

	AFRO	AMRO	EURO	EMRO	SEARO	WPRO
Fragile states	Democratic Republic Congo			Sudan		

² An Evaluation Management Group provided oversight for the evaluation; members were drawn from the six WHO Regions, WHO-HQ and UNAIDS, and coordinated by the WHO Evaluation Office.

Least developed	Uganda					Cambodia
Medium HDI			Kyrgyzstan	Morocco	Bangladesh	
High HDI		Mexico				
Very high HDI	To be covered as part of the survey to all Country Offices and country partners					

Each country visit took place over a three day period, during which time the evaluation team conducted interviews and focus groups with the HWO and WHO Country Office staff, country partners and wider stakeholders.

The evaluation has been based on the perceptions and views of Ministries of Health, country partners and WHO staff, and the document review to address the five high level questions. It therefore offers both an external and internal perspective on WHO's country presence. The country visits generated richer data than the survey since they allowed a deeper exploration of views, and provided a more holistic view of WHO's country presence. The survey enabled a wider range of participants to take part, in particular the countries without Country Office, and provided further triangulation of evidence to the country visits.

Limitations to the evaluation

The broad evaluation methodology was designed by the WHO Evaluation Office to ensure a strong country level focus. This had a positive effect in giving a strong voice to country level views and providing a country level perspective. However, as a result there were fewer opportunities for WHO Regional staff to take part, and so the findings may under-report regional activities and perspectives. WHO Regions were invited to interviews following the field work to balance the findings, but not all took the opportunity to do so.

The evaluation team analysis of country visits data was used to identify issues with strong supporting evidence in all countries; there was a high level of consistency of findings across countries and regions, despite their diversity. Country visit findings were triangulated against survey findings. The use of eight country visits as the principal method of investigation means that there may be exceptions to findings in some countries or regions.

The global survey received 282 responses from partners in 112 countries. However, numbers of responses from fragile states and low HDI countries without country office, and from EMRO and SEARO were relatively low.

2. What does WHO presence in countries mean, and does it respond to Member States' and other relevant partners' expectations?

2.1. Summary of findings

- Countries across the range of contexts have a shared view that WHO is a global normative and technical organisation. Fragile states are more likely to emphasise the importance of WHO in providing technical support, capacity building and coordinating emergency responses. Countries with higher HDI value the normative, knowledge brokering and health diplomacy role of WHO.
- Country partners stated a need for greater clarity and knowledge of what WHO's purpose and activities at country level are, and for WHO to be more visible.
- There is a broad level of consistency between country partners', governments' and WHO staff views on the main purposes of WHO at country level
- WHO's priorities and objectives are perceived to be well aligned with the Ministry of Health's priorities but less well aligned with other government departments, identifying a need for stronger intersectoral work.
- There is a risk that earmarked funding and responding to health emergencies can divert WHO's activities away from strategic priorities in-country
- A key advantage of WHO's country presence is the close relationship it has with the Ministry of Health; however this is also perceived by other partners as a risk to WHO which may undermine WHO's role as an impartial technical advisor if WHO's neutrality is not maintained.

2.2. Overview and background

At present there is no generic or overarching statement on the meaning and purpose of WHO's country presence. The nearest WHO has to a generic statement is contained in the report of the 2013 WHO Taskforce on the Roles and Functions of WHO at three different levels [10]. This report describes activities rather than purpose(s); however they are highly consistent with findings on how partners and WHO staff have described the purpose of WHO at country level in the country visits and survey responses, and we therefore include them here in Figure 1. The Country Office roles describe activities which should contribute to improved health and health systems at country level. There are no associated measures of outcome, impact or quality.

The Taskforce Report indicates, from our analysis of the functions designated to each level, that the purpose of WHO-HQ is to lead WHO at a global level and to backstop regions; WHO Regions' purpose is to lead on regional level activities, support Member States and backstop Country Offices as well as to lead country level responses where there is no Country Office; WHO Country Offices' purpose is to provide technical support and leadership for WHO at country level.

Comments from HWOs indicate that the Taskforce functions and roles are not universally used within WHO. Some of the wording does not accurately describe country level functions as perceived by some HWOs and country partners including Ministry of Health. For instance, “leading the emergency response” was seen by some to be more accurately described as “*coordinating the health emergency response*”. Whether HWO’s should lead, coordinate or promote different areas of WHO activity was debated by some HWOs, indicating that there is room for clarification of the definition of roles.

Figure 1: Country Office roles from the WHO Taskforce on the Roles and Functions of the Three Levels of WHO

Function [10]³	Roles of Country Offices in performing six WHO core functions
Providing strategic and technical support and building capacity	<ul style="list-style-type: none"> • Lead the development of a country cooperation strategy (CCS) and its implementation. • Lead and manage the provision and brokering of technical cooperation • Lead in the implementation and monitoring of international commitments, conventions and legal instruments • Lead emergency response/action during crisis and emergencies
Providing leadership (in advocacy, health diplomacy, and coordination of the management response)	<ul style="list-style-type: none"> • Advocate for health in all policies and promote dialogue for intersectoral and multi-stakeholder collaboration • Lead WHO's UN interagency work in integrating national health priorities into the development agenda and UNDAF • Lead the convening and coordination of the health response in emergencies • Lead in strengthening country capacity in health diplomacy for better engagement in national and international processes, and global health governance
Setting norms and standards	<ul style="list-style-type: none"> • Support countries in the adaptation and implementation of guidelines, tools and methodologies • Contribute to setting global norms and standards by providing evidence from countries
Shaping the research agenda	<ul style="list-style-type: none"> • Promote research and the strengthening of research capacity in countries • Support and, when appropriate, conduct operational research and use of results • Contribute to the body of knowledge on best practices
Articulating policy options	<ul style="list-style-type: none"> • Lead health policy dialogue and provide policy advice to national counterparts and partners • Promote the engagement of countries in setting regional and global policies and strategies
Monitoring health trends	<ul style="list-style-type: none"> • Lead WHO's work in monitoring and evaluating national policies and programmes • Support the collection, analysis, dissemination and use of data for monitoring the national health situation

³ This draws on the core functions identified by 11th Global Programme Work adopted in 2006

2.3. Findings on the purpose of WHO's country presence

Views of different stakeholder groups

There is a need to have a clearer definition of the purpose and roles of WHO at country level and to communicate this better. All country partners - in some cases including the Ministry of Health – stated a need for greater clarity and knowledge of what WHO's purpose and activities at country level. There was some confusion about the role of WHO, and some partners have expectations that are outside WHO's remit. For instance, WHO was sometimes criticised for not undertaking tasks such as directly implementing programmes or increasing WHO staff presence on the ground to support health clusters. Some partners thought that WHO is a funder, some were aware of WHO's role in research but not of its policy work, others were aware of its emergency work but not its role in health system strengthening, and some donors were less aware of the norm setting function of WHO. These misconceptions mean that partners are frustrated when WHO does not meet their (sometimes incorrect) expectations, and WHO's reputation is consequently put at risk.

Country partners and governments all observed that WHO's country priorities and activities need to be much more visible and better communicated. Partners, including UN partners, were also often not sure about WHO's country strategy and plans, and said that they would value more information on these and being kept up to date with them.⁴

There is a broad level of consistency between country partners', governments' and WHO staff views on the main purposes of WHO at country level. There are differences of emphasis by partners according to respondent group and to their own roles and their level of engagement with WHO. Although the range of WHO's activities were discussed, partners gave a very clear primacy to its roles in normative and technical assistance, advocacy⁵ and system leadership in the health sector.

- The Ministry of Health in all countries visited gave a very clear view that the purpose of WHO at the country level is to support them and to work closely with them in support of their work and as the “go-to” partner for expert advice on health. The technical assistance and norm setting work is consistently seen as the most important, in particular in translating global norms to the local context, and in providing assistance with health reforms and health system strengthening. As well as WHO's technical expertise the closeness of WHO's relationship with the Ministry of Health is highly valued and the HWO and country team are seen as very closely aligned to the Ministry of Health's needs and responsive to the Ministry's requests and priorities. WHO's global and regional presence are also valued; Ministries of Health appreciate being linked to the different levels of debate and resources.
- UN partners' see WHO as a technical agency and therefore differentiated from the other UN agencies. WHO's role is seen as largely technical and norm setting, both in relation to the Ministry of Health and to the UNDAF. Providing clear leadership for health within the UNDAF and advocating for health within the country are perceived to be the other main roles. UN agencies also saw an opportunity for WHO to be more involved in the core UN business of advocating for human rights through work on health rights. Where WHO has begun to move into an implementation role UN

⁴ Good practice already exists within WHO, for example in the EURO region there is a short statement on what the WHO country office does on each country website, followed by a summary of the priorities and specific activities being undertaken. A similar model is used in some countries in other regions, such as Bangladesh in SEARO. However the model is not used globally.

⁵ Articulating policy options, function 5 in Figure 1

agencies commented that this is not WHO's main function, nor one which WHO necessarily has the capacity or skills to do well.

- NGOs⁶ and CSOs have a more varied understanding of the role of WHO. This partly reflected their different perspectives according to interest group and mode of engagement with WHO. WHO at country level is seen to play a vital and valued role in translating and adapting the technical and norm setting functions to fit local context. NGOs and CSOs have an expectation that WHO will serve as an advocate to government, to give voice to vulnerable and excluded groups and safeguard their access to health services.
- Funders have a strong expectation of WHO as a key source of technical assistance and of its norm setting function. However they also have an expectation that WHO will provide active system leadership and coordination of the work of health development partners with Ministry of Health. Funders emphasised the importance of WHO being able to use its influence with Ministry of Health on areas where the Ministry is perceived not to be sufficiently addressing health needs and priorities.
- Academics understand well the global norm setting role of WHO and its role in technical assistance. They also emphasise the importance of technical support for capacity building (both for knowledge transfer and training of professionals), support for research, and for maintaining a collaborative approach with countries and country institutions to improving public health and tackling disease.
- Professional organisations noted the importance of WHO's convening capacity to mobilise different stakeholders and resources, as well as in combatting disease and public health improvement, and its potential role to work more closely with them to develop health services and workforce capacity.

The differences in perspectives and expectations identify the need for WHO to consider how it might adapt and clarify its country roles to work in more effective partnership with the whole range of country partners.

Variations by country context

Expectations of WHO varied according to the country context. It is evident that countries in the lower and middle HDI countries have a stronger expectation that WHO will assist them more explicitly with developing national health strategies and plans. These countries see WHO's role at country level as being primarily for building capacity and providing extensive technical advice as well as mobilising funds and coordinating health emergency responses. Within fragile states there is a stronger perception of WHO as an important actor in assisting with implementation of, for example, immunisation programmes, coordination of the health cluster and of health emergency responses. Across the board however there is recognition of the importance of WHO's role in leading on global expertise and standards, as well as supporting countries in implementing these.

Within countries with medium HDI, health system strengthening is more explicitly perceived by Ministry of Health and partners as a higher priority. However, although the health emergency role is less highly prioritised, all of the more developed countries visited had also experienced emergencies or disease outbreaks. The Ministries of Health in these countries noted the importance of having a

⁶ NGOs include country and international NGOs; CSOs are all country based. NGOs generally have a service function, working on a specific issue or population group, and may receive funding to do so. CSOs are more likely to be representative or interest groups. In practice the categories often overlap, and there is considerable collaboration.

robust, well-coordinated and prompt WHO response in such situations. In countries with a higher level of government and health system capacity, expectations are focused on support to promoting a system of governance which integrates adoption of standards alongside on-going provision of technical expertise. An individual from a highly developed country without a WHO Country Office commented:

“WHO’s mission at country level depends on the level of the development of the country and the state of the health system. In a developed and industrialized country as ours, WHO is an important provider of information and evidence regarding the continuous improvement of the health system, where we see WHO as our partner.”

Health diplomacy can also be valued in countries with higher development status, with WHO playing a role of neutral broker. There is recognition by more developed countries of WHO’s contribution to maintaining global public health through its work in less developed countries and in emergencies and its leadership on the IHR.

WHO is seen to have a uniquely privileged position because of its access to the Ministry of Health, and its close relationship with the government. Close working allows WHO to be a trusted friend and advocate of the Ministry however if WHO cannot maintain neutrality, for instance in declaring outbreaks or challenging the Ministry on health rights issues or health financing, WHO’s credibility and authority to act is put at risk.

2.4. Alignment of priorities and processes

The extent of alignment between WHO’s and partners’ plans will facilitate the relevance of WHO’s activities and contributions. At government level, WHO’s plans are perceived to be well aligned with the Ministry of Health’s priorities but less well aligned with those of other government departments, identifying a need for stronger intersectoral work. As an example, in one country it was noted that although WHO planning is aligned with the Ministry of Health, it is not aligned with the Ministry of Finance, despite the role of the Ministry of Finance in setting health budgets

WHO’s planning tools; the Country Cooperation Strategies (CCS) and Biennial Cooperation Agreements (BCA) are designed to support alignment between WHO and country level objectives. The CCS provides a tool and a process to ensure that WHO activities and objectives are aligned with country objectives. Where the CCS process is used actively, the process of development provides an opportunity to ensure alignment with wider country priorities. A challenge to the relevance and utility of the CCS is that in many countries there is no up to date CCS, so that the CCS does not necessarily reflect country priorities. A second challenge to relevance is that CCSs are not consistently used as tools to review and update plans in discussion with partners.⁷

There are two particular situations observed where there are risks to with a clear focus on national objectives. These both show how health emergencies and /or programme funding can divert WHO from the strategic needs of the countries:

- Where there were larger donor budgets, partners noted that the focus of WHO and the government was influenced by the available earmarked funding rather than ensuring a more balanced approach to the wider health system . This also has implication for the sustainability of WHO work in country.

⁷ A similar point is made in a report from WPRO “Country Coordination Strategies (CCS), if known by counterparts and stakeholders, are seen as too static, insufficiently focused to be strategic and not respected, even by the Organization itself. The assessment revealed difficulties in linking the actual work plans and budget to the CCS in the countries.” Placing Countries at the Centre, A report on a fresh approach to assessing WHO country performance in the Western Pacific Region ,2012

- In fragile states where there are chronic emergency situations these absorb most attention and resources. However both partners and WHO staff noted that as a result, less priority is given by WHO to health systems strengthening, which although not urgent is more important, and will help the Ministry of Health to develop capacity to address emergencies better.

Full alignment with all partners is also affected by the extent to which other country partners (NGOs, CSOs, funders) are engaged in the development of the CCS and there is reported variation in this. The evaluation findings show there is more work needed to involve consistently a wider range of partners than the Ministry of Health. Partners reflected that the CCS development often appears to be internally focused within WHO. Non-Ministry of Health partners reflected that where there was difference of opinion, the Ministry of Health's priorities generally are adopted by the CCS. UN partners are formally involved through UNDAF processes, but not necessarily with CCS.

Ensuring that WHO and Country objectives remain aligned can be affected by the extent of alignment of planning cycles. There were observations from Ministry of Health in several countries in different regions that the planning cycles and timing of both the CCS and the biennial Programme Budget can impact on how well WHO and national objectives are aligned. The CCS cycle does not always converge with the planning cycle of a government. UN partners also report a number of differences between UN agencies planning cycles. These include aspects of WHO and UNDAF procedures where there are difficulties in harmonising operational systems.

3. What is the contribution of WHO presence in countries towards addressing global, regional, and individual countries' health priorities and needs?

3.1. Summary of findings

- There is evidence of relevant inputs to countries by WHO from all three levels and these are valued. However, it is not possible to assess their contribution to outcomes since there is no standard country level outcomes framework with metrics linked to the global framework. This makes it challenging to demonstrate country level contributions to country, regional and global priorities. There is no theory of change for WHO country presence which would underpin assessing country level contribution.
- The current planning tools are based on two and five-six year periods; many of the outcomes and impact indicators for health and health systems will require longer time periods to show change, and planning tools will need to be able to address this.
- The use of different planning tools in different regions, with different reporting frameworks and methodologies leads to variations in the ways that activities at country level are assessed. This is a barrier to consistent reporting and analysis at all levels.
- There are no standard annual processes used to review progress on WHO country-level work with MOH and country partners to provide accountability and learning.
- There are a number of areas where WHO could be more effective in its contribution, in particular in relation to intersectoral working, technical assistance for monitoring systems and evaluation, knowledge sharing on good practice, mainstreaming gender and human rights and enabling implementation of strategic plans.
- WHO is seen to be responsive to country requests for support, but there is room for improvement particularly in relation to emergency responses.

3.2. Overview and background

Contribution is currently assessed formally through the mechanisms of the CCS /BCA and the global results framework. These measure delivery of activities and committed budget expenditure. CCS reviews provide a qualitative analysis of contribution. There is no country level reporting against the global results framework to show contribution to outcomes and impact at country level.

This makes it challenging to demonstrate the value of WHO's work within the country in a systematic and rigorous way which can help show country level contributions to country, regional and global priorities. The use of the global results framework is now used to provide a systematic structure for activities at all levels. Despite this is still, however, no model used by WHO to assess its country level contribution to outcomes based on a theory of change for WHO's country presence.

No outcome indicators were specified in the CCSs reviewed. The CCSs include descriptions of objectives in relation to country level WHO priorities, and the planned activities (inputs) to deliver

them, and deliverables (outputs). These are not however linked to outcome measures with targets set at country level. It is possible that this reflects the age of the CCSs reviewed, since several predate the current global results framework. However, even more recent CCSs do not show outcomes at country level, although these use a structure which is more consistent with the results framework.

This does not necessarily mean that results were not delivered, but that it was not evident how they were evaluated. This was noted in the 2013 MOPAN report: “despite considerable normative and technical investments and support to countries, WHO fails to provide strong evidence or a clear picture of the nature, magnitude or relative importance of its contributions to changes at the country level.” [2]

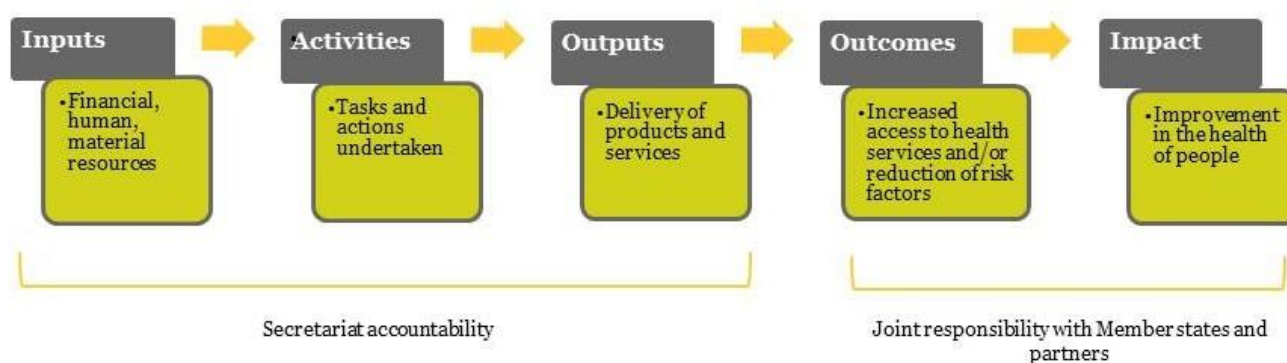
The BCA’s used in EURO are more clearly linked to outcomes and the global results framework and show which WHO outcomes are the priorities within each WHO programme area and category network. There is an opportunity to develop these further to show the contribution to defined outcomes and to country level impacts.

The 2014 CCS guidance provides a methodology [11] which, if implemented, will provide a clearer results chain between country activities and country level outcomes and enable assessment of their effectiveness and contribution. The guidance frames the CCS clearly within the global results framework and the objectives selected as relevant to the country in each CCS are explicitly linked to global WHO programme budget areas, each of which has a related results chain from deliverables to activities to outputs to outcomes to impacts.

3.3. Current processes and tools for assessing contribution and outcomes

The WHO results chain from the 12th GPW provides a very high level model of WHO achieves results [1]:

Figure 2: The WHO results chain



The outputs, outcomes and impacts in the WHO results chain are drawn from the global results framework. The Programme Budget used to allocate resources and assess global and regional effectiveness is based on the global results framework.

The Programme Budget process requires countries to select a limited number of relevant programme areas⁸ from the global results framework. Country level contributions to the results framework are

⁸ The WHO global results framework and associated Programme Budget structure has six category networks, 30 programme areas, 84 outcomes and 450 deliverables (outputs)

reported at the level of deliverables (outputs); however, the contribution of the deliverables to country outcomes is not monitored through the Programme Budget

There are three standard methodologies used by WHO for assessing the contributions of WHO activities at country level, set out below. Each has strengths and weaknesses. None as currently operated provide a model to show contribution to country level outcomes.

- CCSs have mid-term and final evaluations, which provide a narrative on technical and other assistance, contributions to reforms, new policies, and emergency responses. The midterm reviews outline activities, but the CCS and reviews do not use a results based framework which could show how WHO activities have contributed to outcomes. More recent CCSs in EURO however show use of measures within a strategic framework (Health 2020 [12]) which could be further developed to show contribution to longer term outcomes.
- Programme Budgets provide a framework for planning country level activities and budgets, and help ensure accountability, budget management and compliance. Since the implementation of the 12th GPW reforms, the Programme Budgets are structured using the global results framework, so that there is coherence between country, regional and global levels. Recent guidance to limit the number of programmes included in country level plans has also helped to set priorities at country level. But there are no metrics for reporting outcomes at country level, and no results chain showing countries' contribution to WHO global impacts. The Programme Budget model incentivises Country Offices to focus on achieving a specified activity such as holding a workshop or providing training, and accounting for their allocated budget, rather than on outcomes.
- BCAs in EURO are similar to the Biennium Programme Budgets; they are however more clearly based in a longer term set of objectives for the country and so form a hybrid between a CCS and a programme budget. EURO BCAs are strengthened by being set in the context of Health 2020 which provides an outcome focused strategic framework. This framework provides an opportunity for BCA s to show the results chain between outputs, outcomes and impact which could be developed.

There are a further two aspects of the planning and reporting process which can be barriers to how robustly they can show evidence of contribution to outcomes:

- The current planning models (CCS, BCA, and Programme Budget) are relatively short term; many of the outcomes for health and health systems will have time frames that extend beyond two or five years.
- The use of different planning tools in different regions, with different reporting frameworks and methodologies leads to variations in the ways that activities at country level are assessed. This is a barrier to consistent reporting and analysis at all levels.

In order to support a theory of change that includes contribution to outcomes and impact, WHO's planning tools, will need to be developed. Tools will need to include longer term outcomes to show the overall direction and framework for assessing effectiveness. Shorter term milestone indicators will need to show progress towards achieving outcomes. There is also scope to make tools for planning and monitoring consistent across levels and regions to ensure that all use the same methodology to show contribution to outcomes at country, regional and global levels.

3.4. Use of monitoring and evaluation findings for learning and accountability

There is currently no standard annual process used for reviewing progress on WHO country work with Ministries of Health and country partners to provide accountability and learning. The CCS Mid Term Reviews (MTRs), provide an opportunity for this, but are not regularly and systematically undertaken. The available MTRs for the visited countries were reviewed, but these did not show reporting of outcomes against indicators. Without regular review of performance, accountability, including mutual accountabilities between WHO and Ministry of Health government is weakened. An exception to this is that the EURO BCAs state specifically that BCAs may be formally amended to adapt to changes in requirements. There also appears to be little use of MTRs for structured learning about ways to improve the effectiveness of contributions from WHO and country partners. This is a missed opportunity for WHO to assure itself, country partners and funders of the value of its contribution at country level.

3.5. Developing a clearer model for assessing contribution to outcomes

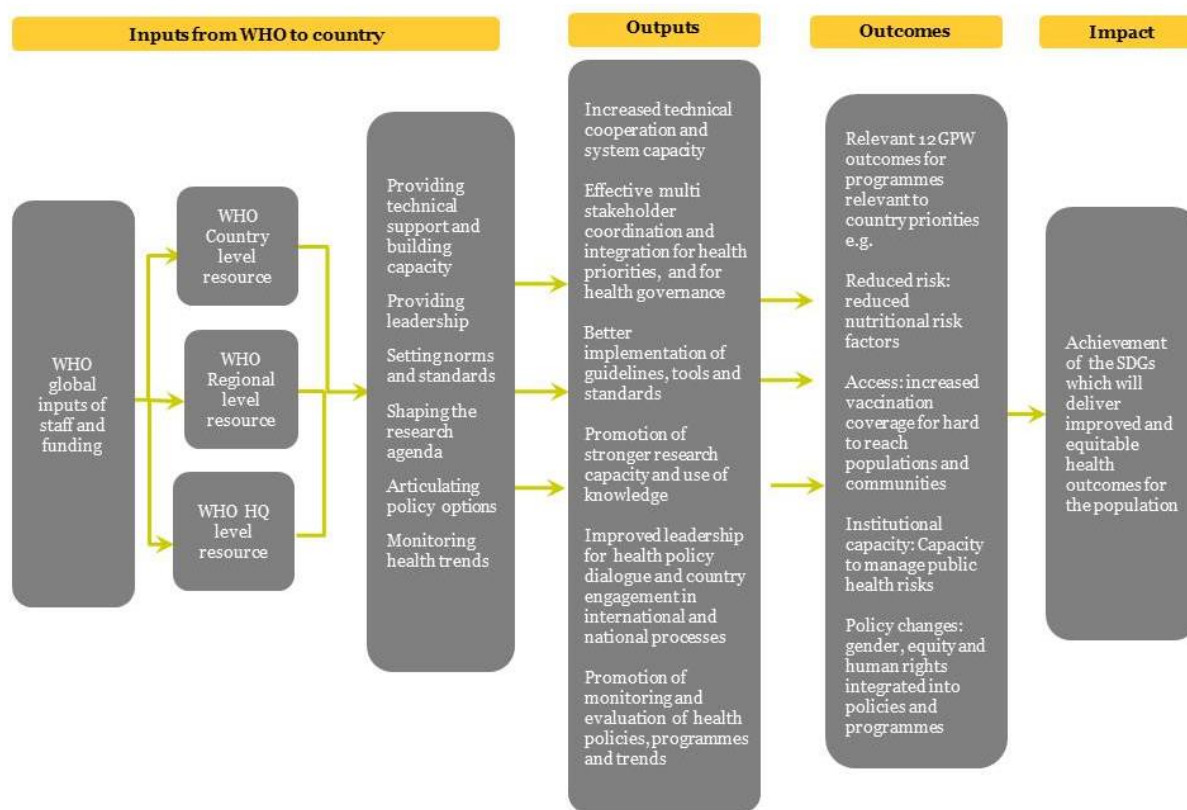
From the above there is an evident need to develop a framework to assess contribution to outcomes. Such a framework would need to be based on a broad theoretical approach common to WHO's work in all countries, which can be made specific to each CCS/BCA. The framework will need to be populated with a set of outputs and outcomes which are agreed within each country, consistent with country and WHO objectives.

While it will not be possible to show direct attribution with such a framework, it will be possible to show the outcomes to which WHO has contributed. The contributions which country partners value and see to have impact are linked clearly to the six core functions of WHO listed in Figure 1 above and are also consistent with the global results framework. This allows the framework to be based on existing planning tools. We propose that the long-term impacts are the SDGs, which will frame WHO's priorities from 2015 and which are also assessed at country level.⁹

We suggest an initial model in Figure 3 below. However, any final model will need to be developed and agreed through internal debate and decisions within WHO and be consistent with any future developments in the global results framework.

⁹ <https://sustainabledevelopment.un.org/sdg3>

Figure 3: Initial theory of change for WHO's country presence



3.6. Applying the theory of change

Below in Figure 4 are three examples of how the theory of change could begin to be applied to country level activities based on recent BCAs, biennial Programme Budgets and CCSs. The WHO global results framework does not identify a clear results chain from inputs to outcomes and impacts at country level [1]. Specific metrics for the outputs and outcomes would need to be developed to enable effectiveness in delivering results to be assessed at country level. Since CCSs are not always consistent with the global results framework some assumptions were made concerning the content of the columns on inputs, outputs and outcomes in Figure 4.

Figure 4: Initial mapping of CCS and BCA to the theory of change

Inputs	Outputs	Outcomes	Long term impact
Providing Technical support: Support, guidance and advice to the Government in implementing the Climate Change commitment to act regional framework and develop national health adaptation strategy.	Programme Budget output 3.5.1 Country capacity strengthened to assess health risks, develop and implement policies, strategies or regulations for the prevention, mitigation and management of the health impacts of environmental risks.	Institutional capacity: Strengthened capacity to manage public health risks.	SDGs: Integrate climate change measures into national policies, strategies and planning.

(Source: Kyrgyzstan BCA 2014-15)			
Providing Technical support: Malaria elimination strategies are updated and a costed national malaria strategic plan 2016–2020 is developed through WHO support. (Source: Cambodia CCS 2009 -15)and MTR)	Programme Budget Output 1.3.2. Updated policy recommendations, strategic and technical guidelines on vector control, diagnostic testing, and antimalarial treatment, integrated management of febrile illness, surveillance, epidemic detection and response.	Access: Increased vaccination coverage for hard to reach populations and communities. Institutional capacity: Capacity to manage public health risks.	SDGs: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.
Technical support and capacity: Policy articulation: Develop a model for community health centres based on community and family health principles. (Source: Draft 2016-17 Programme Budget for Morocco)	Programme Budget Output 4.2.1. Policy options, tools and technical support to countries for equitable people-centred integrated service delivery and strengthening of public health approaches.	Access: Outcome 4.2. Policies, financing and human resources are in place to increase access to integrated people-centred health services.	SDGs: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

WHO's contributions at country level

Findings from both the country visits and the survey responses described the contribution of WHO in terms that closely reflect the six core functions in Figure 1. Some examples are given below. It is notable that the effectiveness of the contributions is increased through the relationships that WHO has with country partners and its knowledge of country context.

Core function 1 Technical assistance and capacity building: this is made more effective and relevant through good knowledge of country context and systems. Much of the effectiveness of WHO is seen to stem from the way WHO Country Office staff work alongside country institutions (*“accompanying us”*). The example below shows how consistent and committed engagement can increase capacity.

Capacity building over the long term

The development and maturity of the whole of the health system in Cambodia over the past 2 decades owes much to the skills of WHO as a partner working alongside the Ministry of Health to develop capacity and processes. This included in the past funding scholarships for Ministry staff who have now returned and are leading and delivering system change locally. The consequence of this input is the high esteem that the HWO has in country with the Ministry of Health.

The technical expertise brought by WHO consultants from regions and WHO-HQ ranges from supporting vaccination campaigns to supporting training on maternal and child health expertise. Health systems strengthening work, including health financing, ensuring the production of high

quality of medical supplies, and building health workforce capacity are also highly valued, and noted as important areas for WHO to support.

Technical expertise to catalyse access to resources

Moroccan health partners appreciate the technical partnership, and catalytic use of WHO's small funds to enable larger funds to be accessed and be effective. An example was the technical inputs that WHO made to the development of the concept note to support a Global Fund bid. This was for \$8 million to support health systems strengthening in relation to TB aligned with the Ministry of Health priority on health systems strengthening and increasing access to services by vulnerable groups.

Core function 2 Leadership: leadership for convening development partners and health diplomacy: this is with leadership for health advocacy is seen as a key way in which WHO can contribute effectively to improved country level outcomes. Coordination of development partners is particularly important to ensure that funds, responses, policies and programmes are well aligned. Effective leadership and engagement with different partners is seen to enable WHO to maximise the impact of the combined resources and actions of the government, development partners and other country partners.

Partnership leadership

In Kyrgyzstan the Country Office identified the problem of development partners working independently on Maternal and Child Health (MCH) programmes. MCH in country was fragmented, with different agencies providing support in an ad hoc manner in provinces. This made it difficult to compare and measure between the programmes as no standardised approach. Development partners were developing their own protocols. WHO proposed and facilitated a national standardised approach for all partners which has been effective and continues to be used.

In addition, WHO is valued for its neutrality which enable it to reaching places and groups that others cannot. This includes brokering agreements for example on sugar and tobacco taxes, negotiating with different interest groups to do so, as well as engaging in politically sensitive areas such as ensuring application of the WHO Health Workers Accord to prevent the loss of much needed health workers from a country.

Using WHO's neutrality

WHO worked closely with health and development partners in Bangladesh in order to deliver health care to the tribal areas. These were hard-to-reach areas in view of complicated local politics in the context of civil unrest. The WHO had the neutrality that allowed it to enter the tribal areas, negotiate with local stakeholders and ensure delivery of services to what would be otherwise an inaccessible area for the formal state services.

Core function 3 Setting norms and standards: the production of international guidelines and their adaptation to country context, is widely seen as WHO's central contribution to improving health in countries. Ministries of Health, professional organisations and NGOs in particular all emphasised the importance of the normative role. The impact of WHO's work in norms is seen to come from the successful translation and adoption of guidelines which contribute to improved health outcomes in country context. WHO's norm setting function also provides a clear model of how the different levels can work effectively together. WHO-HQ produces guidelines and protocols but requires the Country Office to adapt and translate them to the local context. Regional offices provide consultants to countries to support implementation and training.

Core function 4 Shaping the research agenda: this is seen as valuable at all three levels of WHO. WHO's support for the Collaboration Centres was cited as a strong example, particularly in AMRO and EURO.

Supporting Collaboration Centres and knowledge brokering

In Mexico, WHO created a network of Collaboration Centres at national level, and facilitated national meetings. This is linked to a network at regional level (the Americas). Some examples of Collaboration Centres with which the country office has frequent exchanges and provides technical expertise include Rehabilitation, which is part of the Ministry of Health, the National Institute for Public Health, and the Centre for the Classification of Diseases. Collaboration Centres incorporate work with CSOs.

Core function 6 Articulating policy options: doing this in a way that meets local needs is an important aspect of promoting new knowledge and assisting with policy and priority setting. Examples were given of the value of national and regional conferences organised by WHO country and WHO regions to stimulate and support thinking and debate on new and emerging policy issues, and to provide a thinking space for policy development.

3.7. Areas for development to increase the effectiveness of contributions

Country partners in both the survey and the country visits were asked to identify any gaps or weaknesses in the WHO offer at country level, and for areas which could be developed to ensure more effective contribution to country level results. Although the majority of partners find that WHO's contribution to national health and development objectives is adequately effective or very effective, funders were less likely to find this. WHO country staff were more likely to see the WHO contribution as very effective than any other stakeholder group; this difference between staff and partners' perceptions is an area for WHO to explore further.

Many partners observed that if WHO can fulfil the six core functions well this would be sufficient, with recognition that Country Offices do not have capacity for additional work. Areas consistently reported to be in need of development to improve the effectiveness of the country offer are presented below.

Intersectoral working: A strong and consistent finding from survey and country visits is that there is a need for increased intersectoral working to address intersectoral issues including the social determinants of health (SDH), water and waste management, non-communicable diseases (NCDs), transport/access, social protection. WHO is not seen to be very effective at this either by external partners, particularly the UN and CSO partners, or by WHO country staff. Intersectoral working is also understood by global partners to be essential to implementing the IHR and developing whole system resilience. WHO Country Offices often have engagement with non-health government departments, but this is not always strong or systematic, and is often managed through the Ministry of Health. HWOs understand the importance of an intersectoral approach and in some cases have tried to strengthen it, but with mixed results. An important point was made by a country partner that *"WHO at all three levels needs to work to change this mind-set"*.

Technical assistance for monitoring and evaluation: Partners noted a need for more increased WHO support for countries to develop and use robust information systems for monitoring and evaluations. This is seen as a priority area for contribution from WHO for both national and global surveillance purposes, and an area where WHO's performance is seen as not consistently effective at country level. A related finding was that when WHO carries out evaluations the recommendations and findings are not followed up promptly.

Knowledge networks: Partners identified the need for an extension of the evidence function to provide more knowledge brokering of good practice and policy information. WHO has global knowledge; the request is for more effective, systematic and targeted ways of sharing this with Ministries of Health and country partners in order to strengthen health systems, policy and practice. Possible methods proposed included setting up knowledge networks such as communities of practice, to enable countries to learn from each other as well as from WHO expertise.

Sharing evidence based good practice relevant to context: Partners see a great value in WHO providing more evidence-based good practice relevant to their country context. The expressed need was for examples of interventions that had been effective in tackling specific issues such as immunisation, SDH, NCDs, especially in similar countries, with an understanding that interventions need to be context specific.

Greater technical assistance in operationalising plans for implementation: in a number of less developed countries WHO can do more to help operationalise plans with Ministries of Health. There is a need for technical support to enable health strategies to deliver. This is seen as an area where WHO could provide more input to ensure that there is a strong methodology for planning, prioritising and resourcing national objectives and monitoring delivery, including the IHR. WHO's ability to translate policy into action is seen as being weaker than its technical expertise: "*WHO has knowledge, but not knowhow for implementation.*" (UN agency)

Relevance, accessibility and quality of expertise: Both country partners and global partners commented that WHO has a shortage of sufficient, high quality expertise in some areas. These include expertise in the social determinants of health, health system financing and health insurance, private sector engagement and public-private partnerships. Several partners also commented that WHO at country level appears sometimes to no longer be at the cutting edge of knowledge, and so partners turn to other organisations. Some non-Anglophone countries commented that it can be difficult to access high quality expertise in other languages (e.g. French and Russian) from WHO.

Ensuring sustainability: A challenge for WHO at country level is adapting its offer to suit changing country needs and ensure it is supporting sustainable systems. An observation was made by global partners and WHO staff of the need to build sustainability explicitly into the WHO model of contribution so that its activities enable development of local capacity rather than substituting for it. For example, in one country visited, the national public health institute lacked opportunities to develop and take on a knowledge function as the Ministry of Health would instead seek WHO input. An external partner in a fast developing middle income country observed that WHO needs to adapt to countries as they develop and to support countries to act on their own

Increased focus on gender, women's empowerment, human rights. The contribution of WHO to vulnerable and excluded groups is seen to be made principally through its normative function. Guidelines on gender-based violence, maternal health, HIV and addiction were cited as particular examples of where WHO had provided technical assistance to address the needs of different groups. However, gender is not mainstreamed. There was not a consistent understanding of gender across WHO's work, nor always specific time in their work plan to undertake gender work. WHO gender focal points often have multiple roles and gender work was not consistently prioritised. Some UN partners and CSOs cited examples of where they perceived WHO had not taken action on human rights issues and thought this a deficit, for instance in relation to criminalisation of men who have sex with men, or discrimination against marginal groups. This can be an area where WHO's close relationship with the Ministry of Health can be a barrier to WHO in speaking openly. The difficulties for WHO in doing this are recognised by some partners.

Responsiveness: A critical aspect of effective contribution relates to responsiveness. There are two challenges for WHO at country level in relation to responsiveness:

- **Prioritisation:** HWOs see it as important to be responsive to maintain a good relationship with the Ministry of Health and be seen as helpful partners. However, capacity to deliver agreed priorities can be diluted if the Country Office is highly responsive to requests which are not prioritised within agreed work plans, and can impact on capacity to deliver agreed priorities. A balance needs to be made between responsiveness and effectiveness. Many partners commented that WHO spreads itself too thinly across a wide workload and area of activity.¹⁰
- **Organisational systems:** WHO at country level is often dependent on decisions from WHO at regional and WHO-HQ levels. Responses from these levels can be slow, and therefore impact on the responsiveness of the Country Office.

The evidence from survey data and country visits from fragile states confirmed that WHO is often seen to be slow to respond to emergencies, for instance in declaring outbreaks, or bringing in external resources promptly. It was observed that WHO's response time compares unfavourably with the response time of other development partners.

¹⁰ A similar point is made in the 2103 WPRO report: "WHO country offices are seen as trying to cover too many topics. As a consequence some areas are handled superficially. WHO cannot do everything in every country. Country offices still have difficulty resisting activities decided by the Regional Office or Headquarters, even when they are not in line with country priorities." Placing Countries at the Centre, A report on a fresh approach to assessing WHO country performance in the Western Pacific Region ,2012

4. What is WHO's added value at country level in the light of its level of investment?

4.1. Summary of findings

- Added value was defined as the unique offer WHO makes, to understand its advantage in relation to other organisations.
- WHO is seen as making a unique contribution as the global leader in the public health arena, and in particular for its role in setting global norms drawing on its expertise and presence in all countries. At country level it is particularly valued for its close relationship with the Ministry of Health, and its ability to contextualise guidance and provide relevant support to the country's health needs, for its neutral and authoritative voice on health, and for enabling country access to regional and global WHO knowledge and resources.
- The ability of WHO to work across its three levels enables it to capitalise on its country engagement to strengthen its overall value and impact.
- The main advantages of WHO appear to hold true for countries with different levels of development. How WHO contributes these in practice differs with more fragile states and less developed countries valuing a more practical level of contribution than countries with higher development.
- There are however also risks to WHO's added value. These risks partly stem from its internal organisational culture and systems and governance arrangements at all three levels, and include slow responses, risk aversion, and not working fully effectively as One WHO.
- There is also a risk to WHO's unique offer if it does not adapt proactively to the changes in the global health context, and clearly define its future strategic offer among a range of global health actors.
- There is scope for WHO to review and map how the different levels of WHO add value to each other and to the Organisation as a whole, so as to understand better how and what WHO invests in country level work. This would also facilitate improved inter-level and inter-regional working.

4.2. Overview and background

WHO's added value in the sense of what is additional to the core WHO offer at country level cannot be clearly identified since this offer is not itself defined. For the purpose of this evaluation added value was therefore defined, in discussion with the WHO Evaluation Office, as the perceptions of Member States and partners on the unique offer WHO makes that other organisations do not. This definition was then used to elicit views on what makes WHO's offer special, and understand better its advantage in relation to other organisations. Investment is a wide term; financial investment alone was agreed not to be sufficient in relation to the added value of WHO. Given the lack of definition of core offer, it is also difficult to make an objective assessment of the level of investment in relation to it. This question was therefore addressed by gathering partners' views on WHO's unique offer, and by exploring how WHO invests in country level work to add value.

4.3. The specific value of WHO

WHO is widely seen to have a very specific offer that flows from its unique role in setting norms and standards in global health practice and policy, for its public health expertise and global presence. Respondents from all groups in the country visits made a strong point that WHO is irreplaceable and that there would be a large gap in the country (and globally) without WHO country presence. Even where partners voiced frustrations with the operations of WHO, they almost universally commented that WHO still makes an important offer.

WHO's global advantages provide the foundation for country level value and effectiveness. WHO's country level engagement provides a deep understanding of local contexts which provides greater legitimacy and authority to its global activities. Country presence enables WHO to be rooted in country needs and connected to the real world and population needs on the ground.

The global advantages of WHO are perceived to be that it has:

- A recognised role in setting global guidance, protocols, and health standards.
- Engagement with in all countries as a universal organisation which s gives it reach and legitimacy beyond other UN agencies.
- A global brand that gives it authority to speak and act at all levels.
- World class expertise; viewed as the undisputed health expert.
- A wider remit than the other agencies since WHO addresses the health of all, not just one specific group or condition, which gives it a unique overarching perspective.

These findings are reflected in the WHO perception survey 2015 which finds that¹¹ respondents most valued WHO's work in technical support and expertise, setting standards, providing reliable information, professional leadership and positive impact on health outcomes, capacity building and guidance.

At country level WHO is seen to have the following advantages:

Close relationship with the Ministry of Health: For countries with Country Offices, WHO is close to the Ministry of Health. This allows WHO scope to engage with and influence policies and plans, and provide effective health advocacy. It also allows WHO to be build its contribution from the country level upwards, in close collaboration with country governments and country partners.

Contextualisation of norms and guidelines: the norm setting function of WHO is seen as one of its most essential contributions. However it is critical for guidelines to be contextualised to country contexts, and WHO Country Offices, with a strong understanding of local capacity, systems and cultures are able to do this well.

Strong understanding of country context to ensure appropriate expertise and interventions: having a base in countries, and relationships developed with country partners over years enables WHO to

¹¹ From an early draft of the WHO Perception Survey 2015 shared with IOD PARC authors by the WHO Evaluation Office, December 2015.

understand local population needs and concerns and the local context for delivery, so that the WHO offer is appropriate and effective. WHO is seen to be “*there for the longer term*” which helps develop greater confidence in Country Offices.

Neutral and authoritative voice on health: WHO’s neutrality allows it to advocate credibly for health policies, and to speak with authority in assessing health situations and outbreaks. WHO at country level also plays a role as the organisation that can step in when others cannot, based on its neutrality, knowhow, and authority as a neutral broker.

Working across the three levels of WHO: WHO adds value through enabling country level access to regional and global WHO knowledge and resources. Further, through working closely with Member States and at and across regional levels WHO can link national with international systems. An example is in coordinating systems and knowledge on the detection and control communicable diseases to support greater country and regional resilience, which creates a sum greater than the parts. Such cross level work draws on and is strengthened by WHO’s strong understanding of country contexts and its relationships with country government counterparts.

The main advantages of WHO summarised above appear to hold true for countries with different levels of development. How WHO implements these in practice may differ, with more fragile states and less developed countries valuing a more practical type of contribution. An example was given of a medium developed country in which WHO provided advocacy to support development of national policy on tobacco use, and in ensuring that a health insurance package included treatment for hepatitis, and of a lower HDI country, where the need was for practical support from WHO on how to implement guidelines for drug resistant TB.

For highly developed countries without Country Offices, the added value was summarised by one respondent as: “*as an objective partner in health to the government..... WHO has a strong impact on national health policy by its leading role on global health matters, high quality expertise and normative and standard setting role which are seen as the key organisational strengths.*”

4.4. Organisational risks to WHO’s added value.

WHO is seen to add great value through using its resources, position and unique scope and role. Country and global partners also noted however that if WHO is not seen to operate and deliver effectively as a leader for global health, and does not respond quickly to changing contexts and priorities, its global authority and relevance will be at risk. Most risks stem from internal factors of organisational culture, systems and governance; one relates to the external environment. They relate to all three levels of the organisation. The main risks identified by partners and Ministries of Health are:

- Slow and over bureaucratised responses from all three levels to country needs and requests
- Being risk averse
- Working in vertical silos, not engaging in cross sector working
- WHO seen not to be acting as one WHO across WHO-HQ, regional, country levels
- Being reactive rather than forward looking
- Overlap and confusion of roles with other global players

Slow and over bureaucratised responses: The organisational culture of WHO is described by partners and WHO staff as bureaucratic, hierarchical and slow to respond. This is particularly acutely felt at country level since countries are at the bottom of the WHO organisational hierarchy and decision making processes. Slow reactions are also seen to put WHO at a disadvantage compared to other UN agencies, NGOs and major funders who can act quickly and respond to country needs. These organisational characteristics and ways of working pose risks to the strength of WHO's leadership, relevance and effectiveness at country level.

Being risk averse: There is a focus on compliance with WHO processes rather than on outcomes. Hierarchy and bureaucracy in organisations tend to promote activities based on compliance with processes, and a reluctance to innovate or take risks for fear of the consequences. Global and country partners commented on the difficulties that WHO country staff have in making innovations and addressing the strategic big picture. Risk aversion poses a risk to WHO's capacity to respond quickly to changing or unforeseen situations and to innovate.

Working in vertical silos: The vertical boundaries that exist between regions and between WHO programmes and category networks are seen to foster silo working, rather than collaboration. Silo working poses a risk to WHO's capacity to work intersectorally, and to capitalise on opportunities for synergising and coordinating activities and resources.

Working as One WHO: There appear to be weaknesses in coordination and communications between Country Offices, WHO Regions and WHO-HQ. An observation made at country level is that there appears to be a distance between national and global WHO activities. Currently Regions are the main conduit for communications for WHO-HQ, however there is a perception that there are sometimes disconnects between country and global activities. There is therefore scope to explore the effectiveness of internal communications within WHO across the three levels in both upwards and downwards directions.

The three levels of WHO can act in uncoordinated ways. An example was given of a global partner who was explicitly requested not to engage with a HWO by WHO-HQ, but asked to do so by the Regional Office. A second example was given of a global agreement reached with WHO-HQ which was not communicated to the relevant Country Offices. As a result the Country Offices did not fully deliver a funded partnership programme. While these are single examples, comparable concerns were raised in different country offices. The risk from WHO not working – and not being seen to work- as One WHO is that there are inefficiencies as different levels are not working in alignment which reduces value. There is also a risk of fragmentation of activities and purpose which undermines credibility.

Being reactive rather than forward looking: WHO was often described in interviews as reactive rather than proactive in relation to new and emerging issues. WHO was described by one partner as:

“...running to catch up with the train, instead of being ready in the station with its bags packed.”

WHO is not being sufficiently forward looking to engage well with new issues and developments. At country level this was experienced as a lack of horizon scanning to enable countries to prepare for the future. At organisational level, WHO is still seen by global partners as needing to accelerate considerably its reform programme to ensure it adapts to the needs of the 21st century and to delivery of the SDGs. As noted by the 12th GPW, the global health context is rapidly changing with new health issues arising from climate change, mass migration, social and economic changes; the health needs and capacities of countries also changing as they become more developed. The risk posed to WHO is that its offer and objectives may not be fit for purpose in future.

Duplication with other global players: WHO is seen as having a global health leadership role, but its contribution in relation to other key players such as the Global Fund, Gates Foundation, GAVI, CDC and the World Bank is not clear to external partners. There are sometimes overlaps of roles; for

example, there were several examples given where the guidelines of the CDC or technical support from the Gates Foundation were adopted by country partners instead of WHO's own guidelines. This was sometimes because the CDC or Gates Foundation could react more quickly but shows that guidelines from elsewhere are sometimes seen externally as equally valid to those of WHO. There were also instances where other organisations were seen to have more up to date expertise and therefore preferable to work with. The risk to WHO is that its unique offer will be lost if there is not clear positioning of WHO in relation to other global players, and that its value will consequently be reduced.¹²

4.5. Adding value at country level in relation to investment

To identify how WHO can add value most effectively to country level and what level of investment is appropriate will require a clearer understanding of what outcomes WHO seeks to achieve at country level. It will then be more feasible to assess how well these are achieved and what inputs (investments) are needed to do so and whether these provide good value. In the absence of a definition of value and added value, we offer reflections on what types of investment are actually made and how to develop a model of investment value that goes beyond finance. These are exploratory and would need to be developed within WHO as part of a wider review of how it conceptualises value and investment.

Considering the added value of WHO at country level raises the question of how WHO understands its investment at all three levels in relation to countries. The investment of WHO-HQ and WHO Regions will include contributions such as normative work, expertise, global advocacy, Member State and donor dialogue, as well as WHO infrastructure support from WHO-HQ and funding. Developing greater clarity on how these functions contribute to the WHO global results framework at country level will help to identify where there is scope to increase effectiveness and how and where most value can be added.

Some activities will require less investment to achieve planned outcomes; for example investment in health system strengthening and policy advice will require less investment in terms of time/expertise and money than activities which relate to implementation, such as vaccination or emergency responses. Countries with higher level of development and capacity such as Morocco and Mexico show how large value can be added through relatively small inputs, with WHO acting as a catalyst to leverage funds or bring about system changes. In order to assess the relative return on investment WHO will need to develop a framework to compare and evaluate the outcomes resulting from its activities. The methodology will also need to identify the timescales over which WHO seeks return on its investment in different programme areas.

Value will come from all three levels of WHO. The investment flows between WHO-HQ, WHO Regions and WHO country levels can be mapped to identify which investments have most impact on value at country level. At present much of the investment is described as a top down activity with value flowing from WHO-HQ to WHO Regions to WHO at country level. This is mitigated to some extent by the existence of different category and theme networks which operate across levels and regions, but there may be scope to expand this cross level and cross regional activity.

¹² A similar point was made in 1997 in the Oslo report "With country health scenes becoming increasingly crowded with a variety of actors, there is a pressing need for WHO to define more precisely its optimal role in the different countries." Cooperation for Health Development - WHO's support to programmes at country level \ Summary September 1997. The Royal Ministry of Foreign Affairs, Norway, 1997

5. What are the modalities for strengthening or reducing WHO's presence in countries, based on the different health status and needs of individual countries?

5.1. Summary of findings

- There is no explicit methodology for matching staff or budgets to countries on the basis of need linked to a definition of the WHO country presence offer and objectives.
- Countries have different levels of WHO presence, but there is no explicit link between country presence size and level of need. There is scope to consider adopting a more transparent model for allocating staff and resources to countries building on methodologies recently developed by WHO.
- Many country partners as well as WHO staff perceive WHO Country Offices to have less technical capacity and resources than needed to meet country objectives.
- Some WHO Regions and WHO-HQ contributions to capacity were identified as being extremely effective in augmenting Country Office teams through bringing in expertise and capacity for specific issues, or to help a country develop capacity. However the slow response from WHO Regions and WHO-HQ can delay the country responses.
- All three levels of WHO contribute to country level capacity, and need to be well aligned so that country offices receive consistent and systematic support from the other two levels of WHO.
- Regional and WHO-HQ support can be very effective, but there was evidence that WHO global and regional systems can also be a barrier to country level leadership. These include delays in recruiting and appointing staff, challenges with the performance management system in WHO, lack of staff with the relevant expertise, organisational delays in deploying staff rapidly in response to emergencies.

5.2. Overview and background

There are a number of recent and planned developments which are relevant to the question of country-level capacity. Among them are changes in WHO Human Resource systems to improve staff quality, capacity and recruitment processes. They include introduction of the HWO (WR) roster to encourage more transparent recruitment, and orientation training for HWOs and a new mobility system which will lead to mandatory staff rotation between countries and levels. The 2014 CCS guidance includes a methodology for reviewing country staff levels to ensure that they are appropriate to WHO country needs. WHO has recently agreed a new methodology for allocating country level budgets which is highly relevant to any plans for changing WHO country level presence in countries [13]. WHO Regions have also carried out regional reviews on how to strengthen country presence and better support country-level working in recent years [6].

5.3. How well does existing staff capacity match and adapt to countries' needs?

It is difficult to assess the extent to which staff capacity currently meets countries' requirements, as there is no methodology for allocating staff or expertise to countries on the basis of need. There is no definition of the core minimum function or size of a WHO Country Office. Some teams are temporarily larger due to the mobilisation of donor funds and staff are recruited to fulfil time limited programmes. Technical programmes are also used to fund core staff. Office size therefore may not relate only to WHO's analysis of country need but also be strongly affected by the Country Office's success in mobilising funds.

With this caveat, from the eight countries visited it is clear that staff are expected to cover a very wide range of activities and are expected to deliver a heavy workload; in smaller country teams with three or four technical staff, this is particularly challenging, although the larger teams were also under pressure. It was notable from survey findings that almost half of country partners consider that WHO country level resources do not meet or only partially meet country needs. WHO country and regional offices also view financial resources to be low in relation to meeting country needs. This may indicate that the spread of planned work at country level is too wide for staff to deliver effectively on all planned work with current Country Office resources; it may also reflect partners and WHO staff's ambitious expectations. Survey findings showed that about a third of partners think that WHO Country Offices have insufficient technical capacity.

Below are some organisational issues which affect Country Office capacity and the extent to which it can be reshaped to meet changing country needs. These issues were raised with the evaluation team, either in country visits or in interviews with global and regional partners

- Delays in recruiting staff, including HWOs, with long periods of posts held vacant
- A high number of short term/temporary posts
- Lack of mechanisms to change staff numbers/expertise to meet changed country priorities
- Delays in relation to emergency responses in getting regional/WHO-HQ staff with the right expertise deployed
- Lack of staff with the relevant expertise, in particular in relation to NCDs and SDH, working with the private sector, private-public partnerships, and health financing/UHC
- Inadequate numbers of administrative staff; need to increase project management capacity
- Silo working
- The sustainability of WHO country presence

The WHO HR system and processes are seen to pose challenges to ensuring the right level and quality of staffing. The system for recruitment is seen as a particular barrier; examples were cited of recruitment to posts taking from 3 to 11 months during which time they remain vacant. Delays were perceived by Country Offices to come from Regional Office and WHO-HQ and a slow Human

Resource system. A large number of temporary posts can aid flexibility, but does not enable Country Office teams to develop strong, stable teams. The impact of high vacancy rates was particularly acute in the two fragile states visited.¹³

HWOs also commented that they have little input to the appointment of international staff to their teams which is largely managed by Regions. The limitations of the WHO system for performance management were cited by several HWOs. The WHO performance management system (PMDS) is reported only to recognise pre-specified outputs rather than effective performance. The system is described as mechanistic, and as encouraging staff to be risk averse in that it assesses deliverables rather than outcomes. This affects the extent to which staff can be motivated to innovate and achieve, and limits the constructive performance management of underperforming staff.

Country team skills and experiences are not always adequate to Country Office needs. The comparative advantages of international and national staff have been discussed; some country teams observe that the lack of internationals affects their capacity negatively. WHO team staff skills do not always match country needs, and both staff and external partners identified areas of deficit such as SDH and private sector engagement. The deficit areas are mainly in those areas which are newer to WHO and those which are not within the traditional health domain.

Silo working is seen by WHO staff and partners as a barrier to effective intersectoral work. Staff now require more than a single speciality and having only expertise in one area such as TB or malaria is no longer adequate for a context in which staff also need to address wider issues such as SDH, health financing and private sector engagement. Lastly, there is a need for adequate administrative staff resources since administration, budget and project management are all essential and time consuming elements of the Country Office work.

Capacity is also affected by staff development and morale. WHO staff are generally highly committed, but there is a perception that career progression is difficult, and staff see no systematic personal and professional development programme available to them. Some non-Anglophone staff noted that their career mobility is often limited to countries speaking their first language, rather than being better supported to develop new language skills. Recruitment processes are not seen to be transparent so that staff are sometimes not sure why selections have been made. The HWO recruitment process, although recently revised to increase transparency is still seen to be opaque. All of these factors can affect staff morale negatively.

The skills and competencies of the team need to be well matched to the country needs. From the response to the survey and the country visits it is clear that fragile states in particular will need a HWO and country team which can build capacity and provide more practical support to the Ministry of Health. Fragile states will also require greater capacity to coordinate emergency responses. More highly developed countries are likely to need more strategic health diplomacy skills to strengthen health systems and facilitate policy articulation and coordinate partnerships, as well as have more sophisticated knowledge and engagement skills. The profile of staff competencies needed as well as their technical skills will thus be different.

WHO needs to be able to modify its capacity in an agile and responsive way as country needs change in order to ensure continued relevance and sustainability. An example was given of how a CCS had become out of date due to the rapid development of the country. The Country Office was still staffed to offer technical capacity building as in the original CCS, but the country needs had meanwhile

¹³ A similar point is made in the 2012 WPRO report: "Current recruitment delays resulting in long vacancies in key posts severely hamper effectiveness and productivity at the country level and are perceived by partners and governments as a major weakness of WHO" Placing Countries at the Centre, A report on a fresh approach to assessing WHO country performance in the Western Pacific Region, 2012

evolved and the need was for help to design a health insurance policy which the Country Office could not assist with. There is evidence of CCS midterm reviews being used to identify opportunities to reduce staffing levels, which is consistent with the purpose of CCS and with the 2014 CCS guidance. Partners noted the importance of developing the sustainability of WHO Country Offices consistent with the long term vision for WHO's in-country presence. Ensuring a sustainable and appropriate level of presence will require a plan for adaptation to changes and an exit strategy when WHO country presence is no longer relevant.

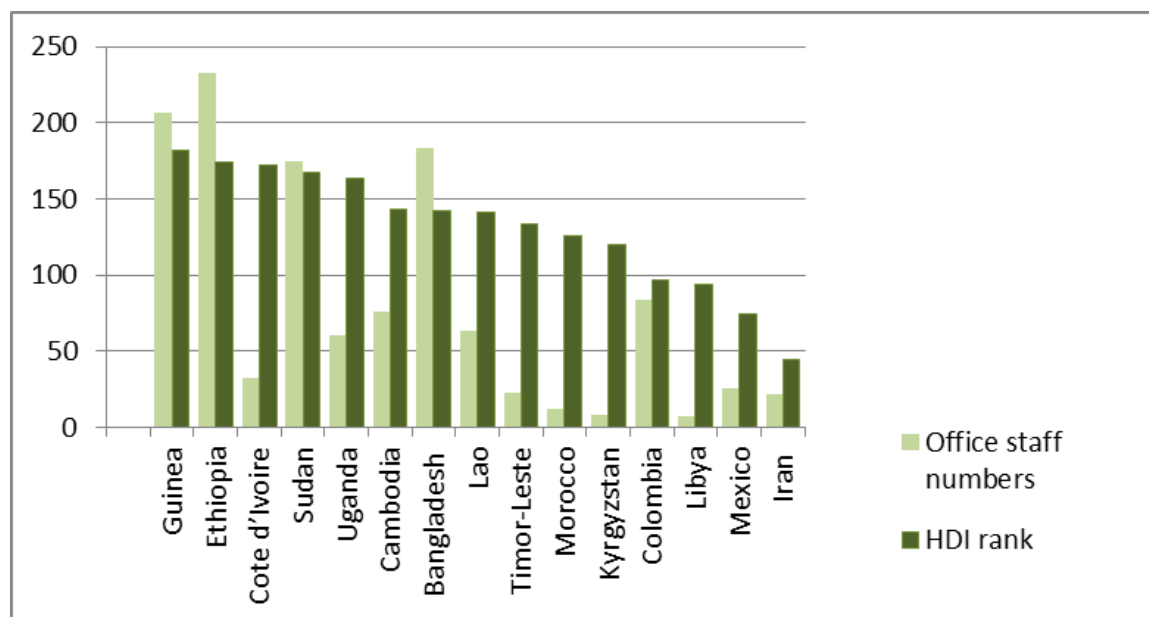
5.4. Regional and WHO-HQ contribution to country level capacity

All three levels of WHO contribute capacity to meet country requirements. There were many instances of the WHO Regions and WHO-HQ contributions to capacity which were identified as being extremely effective in augmenting Country Office teams for example through bringing in expertise and capacity for specific issues, or through helping a country develop capacity or policy. However, there were also instances where the slow response from WHO Regions and WHO-HQ delayed the country response to a specific and time critical need. A further question was raised concerning the adequacy of WHO-HQ and regional staff to respond to country requests. In some cases there were insufficient WHO-HQ/Regions experts available to meet an urgent need; in others the consultants sent out were perceived not to be as expert as required, with partner comments that some were out of date in their knowledge. As already noted, there are shortages of experts speaking some of the Organisation's six official languages, with a bias towards Anglophones which means that some expert capacity is not accessible to some countries.

5.5. Country Office size and WHO country presence

At Country Office level, there is wide variation in numbers of staff from two people (in eight Country Offices in EURO) to outliers such as Nigeria and India (576 and 2140 respectively including all staff) [14]. The larger offices reflect the history of WHO development in the countries, and generally also the presence of a large country donor programme; countries which have had large country programmes such as polio eradication also have many staff. The smaller offices are generally newer. However, there is no evident link between Country Office size/presence and country size, country capacity, HDI rank or health needs. This partly reflects the limitations of HDI as the sole indicator for health investment; however countries with comparable HDI ranks have very different staff levels as seen in Figure 5 below.

Figure 5: WHO Country office staff levels by HDI ranking 2015



(source WHO Country Presence Report, 2015 [14]; 2015 HDI)

There are about 45 countries without a dedicated Country Office; some have shared offices. These include both countries with a very high HDI, and some which have a lower HDI but are too small to make a Country Office cost effective, such as a small island state. Understanding how WHO works with these countries will also inform how WHO can work effectively without country presence. As none of these were visited in this study, we do not have a detailed understanding of how the relationships are managed, but from survey responses it was clear that countries with and without country office had a consistent understanding of WHO's contribution.

5.6. Modalities for increasing or reducing WHO country presence

No evidence was supplied of a published methodology within WHO for identifying optimum staffing for country presence requirements in different contexts. There are examples of Country Offices being opened to respond to need (e.g. a number in EURO since 1990; WPRO opened a Country Liaison Office covering three Northern Pacific island countries in 2011 and upgraded a Country Liaison Office in Solomon Island to a Country Office in 2012.) or closed (e.g. Republic of Korea) to respond to reduced need. There are also examples of WHO plans for reducing Country Office size in middle income countries as their needs change. There is, however, no agreed threshold for investing in or opening Country Offices nor for reducing staff and presence or closing offices when they are no longer needed. It is therefore worth exploring possible factors which indicate the need for different levels of country presence.¹⁴

The country visits and the survey show that WHO is carrying out the six core functions across all countries with Country Office and that they are relevant, to differing degrees, in all country contexts. The extent to which they are implemented and valued and what inputs the functions include is related to the country's level of development and capacity. Higher HDI countries emphasise the importance

¹⁴ A proposal for assessing a country's situation with a view to establishing an appropriate level of essential presence there, with a similar outline approach to this is made in Cooperation for Health Development - WHO's support to programmes at country level \ Summary September 1997. The Royal Ministry of Foreign Affairs, Norway, 1997

of norms, surveillance and evidence, middle countries still value these but also require a level of technical capacity and partnership brokerage, and lower income countries seek in addition a greater emphasis on technical support to build capacity and coordinate the health emergency response. This indicates a direction towards a typology of country presence which is related to health need and system capacity, and one that reflects current thinking expressed by WHO country offices in the PAHO region.

Providing an outline offer for countries with different levels of need in relation to the typology would increase transparency on what WHO will provide. Country Offices need a clear guideline setting out what the core offer is; this will help manage internal and external expectations, as well as identifying resource needs. It is still possible for country resources to be added in the case of an emergency; for instance, in Kyrgyzstan, WHO was able to very successfully provide surge capacity to meet temporary extra needs in an emergency, and then to withdraw it as the situation stabilised.

The obvious indicators for allocating country presence will include a combination of health needs, the capacity and strength of the government and country health systems, and the economic and social development of the country. A methodology using such an approach has been recently developed by WHO to allocate country budgets. The Working Group on Strategic Budget Space Allocation (SBSA) has proposed a new methodology for allocating budgets to countries which was endorsed by the Executive Board in 2015 [13]. The SBSA model uses a combination of indicators for health status, economic variables and access to allocate budgets. It also classifies countries into groups so that the least needy countries would receive no allocation. The main impact of this model is seen to be at country budget level.

The implications for Country Offices size and activity were not considered directly in the model, although clearly there will be a relationship between the size of budget and the quantum of core country staff. The SBSA methodology potentially provides the basis for country budget allocation and can be used to identify countries which would not need a Country Office. We propose therefore that any method for adapting country presence to needs should be based on or closely aligned to the SBSA, or, if the latter is not adopted or is amended, a similar model based on country needs and capacity. Building on models already used (or planned to be used) by WHO will help ensure consistency and alignment of budgets and planning.

The SBSA methodology does not identify what kind of skills and staffing are needed for different offices. For this we suggest that in addition to the methodology used for calculating budget, which will provide a country budget envelope, that there should be a second level of analysis undertaken for countries which will determine the content and contribution of the Country Office work. This analysis would be undertaken through the CCS process. One of the key recommended actions in both the CCS Guides 2010 and 2014 is to use the outcomes of the CCS situation analysis and the agreed country strategic priorities to determine the required WHO Presence in the country. This would identify the key areas of input needed based on a country situation analysis, and enable WHO to resource these in relation to their importance and potential for having impact. The CCS methodology also helps ensure that plans and resources are based on a costed budget. Lastly, the CCS process can be used to include can the MOH in the rationale for staffing and Country Office plans.

There is a need to identify of the level of input WHO will make to different countries based on an assessment of the need for Country Office. We suggest below a typology of countries based on HDI which was the WHO typology provided for this evaluation. A future typology should be based on the finalised SBSA. The SBSA methodology would provide a more accurate set of indicators for WHO investment than the HDI used below.

In Figure 6 below an initial model is presented on an approach to identifying the need for a WHO Country Office. The WHO inputs are based on the six core functions of WHO, simplified and

amended. This is an initial model which would require further development by WHO. The rationale for the model draws on the findings of this evaluation on different countries' requirements from WHO as differentiated by level of development, as well as other WHO reports [4, 15].

The model is presented for WHO to debate and develop, but sets out a deliberately simple approach to test understanding of what the purpose of a WHO Country Office should be. For instance if only the first two inputs listed are relevant to a country, there would be no need for a Country Office. The inputs relate to those regularly required in the country. If there is a need for emergency response in a medium or highly developed country; this could be addressed by a surge capacity from WHO Region or WHO-HQ. The inputs listed are similar to but not the same as the six core functions; the inputs given provide a set of activities which are more closely linked to different levels of need of countries with different levels of health need and capacity. Again, these could be developed further within WHO to ensure a robust methodology. The inputs are consistent with the way that country partners in Member States with different levels of HDI described which WHO inputs they value most.

HDI score has been used as the indicator as this is currently used by WHO; in a future version a composite score from e.g. the SBSA if this is WHO's chosen methodology, would be more appropriate, combined with inequity and inequality indices.

Figure 6: An initial country typology for WHO country presence

Country type	Fragile state	Least developed	Medium developed	High HDI	Very high HDI
WHO inputs					
Normative, guidelines	✓	✓	✓	✓	✓
Global surveillance, evidence, information	✓	✓	✓	✓	✓
Brokering partnerships	✓	✓	✓	✓	
Technical assistance	✓	✓	✓	✓	
Building capacity	✓	✓	✓		
Coordination of emergency response	✓	✓			
Country Office needed?	Yes	Yes	Yes	Possibly	No

This simple matrix would provide an indication of the inputs required from WHO at country level. The CCS priorities will inform the areas of expertise and balance of staff between input areas required in each country. WHO will need to provide guidelines on the level of staffing needed for different input areas; these should remain as guidelines since HWOs will need to identify the mix of staff which best fits local needs, and may seek creative ways of using staff across input areas. This would also help reduce silo working and improve development opportunities for country-based staff.

The 2014 CCS guidance on process includes a requirement for annual reviews. This would provide a mechanism for regularly reviewing the changing needs for staff levels and expertise and allow staff levels to be linked to projected needs as well as budgets to develop a three to five year forward plan. Using a five year period will allow Country Offices which are relatively overstaffed in relations to

identified requirements to be reduced over time, and offices which are lower staffed relative to requirements to increase.

6. To what extent does WHO exert effective leadership and convening capacity at country level to mobilise different stakeholders?

6.1. Summary of findings

- The need for effective WHO leaders at country level cannot be overstated; the HWO represents WHO at country level, and the reputation and impact of WHO in country largely depends on their skills in engaging with partners and mobilising resources from WHO and externally and capacity to maintain WHO's neutrality. Country office leadership capacity is considered to be varied in quality and effectiveness.
- Leadership needs to be appropriate to country context, and country cultural and social expectations and norms.
- Ensuring the right balance of international and national staff will support HWO's capacity to lead. National technical staff will need to have similar leadership skills to HWOs to engage with partners and the Ministry of Health; leadership in WHO at country level extends beyond the HWO to the whole team.
- Convening and brokering partnerships is an increasingly important role for WHO in providing leadership at all three levels with the wide range of different health development partners. Partners see this as a key role for WHO and emphasise that there is a need to increase and strengthen capacity in this role.
- Partnership relationships with the Ministry of Health are seen as strong; however, WHO's relationships with other government ministries and parliament, CSOs and NGOs are not seen to be as strong, negatively affecting its capacity for intersectoral working. WHO's partnership working with the private sector is seen as least developed.

6.2. Overview and background

The question addresses two aspects of leadership: the extent to which WHO exercises the qualities needed to lead, and the extent to which WHO convenes and brokers partnerships effectively. Leadership is widely seen as a key area for WHO at all three levels and has been supported recently by several development programmes for staff, in particular for HWOs. The importance of working in partnership with external partners is explicitly recognised by the 12th GPW.

6.3. Effective leadership

Partners see WHO leadership at country level as varied in quality, and highly dependent on the skills of the individual HWO. There were examples of HWOs who are seen to lead very effectively. HWOs' effectiveness was judged by partners on the basis of their visibility at health events and meetings, providing an authoritative voice; showing that WHO is engaged; partnership work with country based organisations such as professional associations and civil society and NGOs, as well as development partners; and good communication skills. Examples were also given of HWOs who did not lead

appropriately. The consequences of this were seen as damaging to the WHO Country Office reputation long after the HWO's departure.

The need for effective leaders at country level cannot be overstated; the HWO represents WHO at country level, and the reputation and impact of WHO in country heavily depends on them. Comments from partners made clear that a highly competent HWO will be a decisive factor in making WHO's country presence highly effective and valued.

6.4. Contribution of the three levels to country level leadership

All three levels of WHO contribute to country level leadership, and therefore need to be well aligned with each other to make it successful. HWOs require consistent and systematic support from the other two levels of WHO to lead and achieve effective outcomes and impact at country level.

At country level, WHO leadership is primarily seen as embodied in the role and person of the HWO. The leadership capacity of the individual HWO is widely seen as key to their effectiveness and the representation of WHO. In every country visited, and in many global and regional interviews, the point was made that the HWO must have the skills, competencies and personality to lead, including a capacity to influence Ministry of Health and government, a keen understanding of political processes, strong health diplomacy skills, a commitment to being visible, an ability to build relationships with partners, and to regularly engage and communicate with them. Technical expertise is seen as lending additional credibility, but is secondary to leadership skills since others in WHO (or in other organisations) can provide it. The HWO relationship with Ministry of Health is critical; where HWOs are seen to have a strong relationship with the Ministry of Health which allows them to influence and advocate for health, they are perceived to be more effective.¹⁵

An effective HWO is also seen as one who maintains WHO's neutrality. There were examples of HWOs actively used existing WHO guidance on the roles of WHO and counterparts and on planning processes to set out very clearly the responsibilities and accountabilities of Ministries of Health and WHO to facilitate discussions. The HWOs used this managerial approach to state their respective roles and responsibilities in a transparent and neutral way. This approach helped to overcome any potential political sensitivities. Many WHO staff outlined the care they take to ensure that they can both observe neutrality and be seen to observe it but also noted the difficulties of balancing neutrality with a strong relationship with the Ministry of Health.

The added value of international HWOs was made by numerous partners and by WHO staff. International staff are seen by country partners to provide a higher profile and stronger and more effective leadership, even though a country national staff member may be equally competent and capable of being an effective HWO elsewhere. Being an international staff member confers greater status on the HWO in dealing with Ministry of Health and partners and gives more weight to their actions; they are seen as more independent of the Ministry of Health, and therefore capable of acting more impartially. One funder commented that "*an international person can occupy a different space in relation to government and development partners*", and is regarded as having more influence both in the country and regionally.

International professional staff are similarly seen to add value, although this view was expressed more by WHO staff and HWOs than by country partners, and varied between countries. HWOs also value international staff as they often bring greater health diplomacy and influencing skills, as well as

¹⁵ A similar point is made in a 2012 WPRO report: "WHO's country performance mainly depends on good leadership of the WHO country office (WCO) and having high-quality staff". Placing Countries at the Centre, A report on a fresh approach to assessing WHO country performance in the Western Pacific Region, 2012

benefiting from their relative independence from national government. An issue raised in the countries visited was the importance of having the right balance of international and national staff.

National technical staff require similar leadership skills to HWOs to engage effectively with partners and the Ministry of Health; leadership in WHO at country level extends beyond the HWO to the whole team. Taking a leadership role, however, can cause difficulties for national staff as their different position in relationship to government may inhibit their scope for leading and influencing. The movement of national staff between Ministries of Health and WHO provides good grounding in local context, but can also limit their capacity to be independent. In some cases the national staff did not have the skills and experience to act effectively in coordination and leadership.

Leadership needs to be appropriate to country context, and country cultural and social expectations and norms. From the visits to different countries it became clear that different approaches are needed to be effective.

At regional level Regional Offices' role is to provide support to Country Offices and to help access resources of staff and funding. This can work well, and examples were given of Regions very effectively and responsively arranging regional conferences, consultants, and access to funds and regional expertise and providing political support to HWOs.

However, WHO Regional Offices were not experienced as universally supportive by WHO country staff.¹⁶ Some country partners observed that Regional Offices can pose barriers to Country Offices' ability to be effective. From country partners and WHO staff, examples were provided of Regions' slowness in decisions on allocating resources and agreeing plans, which impacted on the authority and capacity of HWOs to respond in a timely way to country needs. The need for systems to ensure accountability and transparency is recognised. However, the administrative and compliance systems used by WHO are seen by country partners and country staff as supporting Regional Office processes which often have the effect of limiting the HWOs' authority and capacity to act.¹⁷ ¹⁸The relative autonomy of other UN agencies such as UNICEF heads of Country Office is compared favourably with that of WHO HWOs. Regions are not always observed by partners to provide consistent support to WHO Country Offices on politically sensitive questions where WHO needs to maintain its neutrality in relation to the MOH.

The survey findings showed that there are differences in views on country performance between WHO Country and Regional Offices. The Country Office respondents often gave a more positive view of the effectiveness and relevance of their contributions than appears to be held by Regional Offices. While the survey response from Regions was low, the differences in perception indicate that it would be valuable to investigate this issue further.

At WHO-HQ level: WHO-HQ offers global leadership, and is seen by country partners as providing overall authority for WHO's work, and also for leading global partnerships. The value of WHO-HQ in

¹⁶ Practice between regional offices was reported as varied; the points made here may not apply to all regions

¹⁷ A similar point was made in the 1997 Oslo report: "The team further recommends that the WHO country office, where one exists, should be fully involved in the management of all WHO resources flowing into the country from the different levels of the organization" Cooperation for Health Development - WHO's support to programmes at country level \ Summary September 1997. The Royal Ministry of Foreign Affairs, Norway, 1997

¹⁸ A similar point was made in the 2012 WPRO report: "The assessment teams found more efficiency gains could be achieved by WHO representatives having more authority to define strategies and make resource allocation decisions. Many WHO processes are seen as slow and inefficient, especially staff recruitment and in some cases procurement. The time (and frustration) of working with the Global Management System (GMS) are made even greater where internet connectivity is inadequate" Placing Countries at the Centre, A report on a fresh approach to assessing WHO country performance in the Western Pacific Region , 2012

providing leadership on standards, norms and policy is highly valued and legitimises country level work.

6.5. WHO as a convener and broker of partnerships

Convening and brokering partnerships is an increasingly important role for WHO in providing leadership at all three levels with the wide range of different health development partners. Intersectoral working to support delivery of the SDGs will also require WHO to work effectively across agencies to coordinate activities to support and monitor their delivery.

As the strategic health lead, WHO is seen as the obvious convener of multi-agency and intersectoral meetings related to health. Development partners regularly referred to their expectation of strong and visible leadership from WHO for convening and coordinating. Partners expect WHO to provide technical advice to help set priorities and frame funding plans, and also to be an active health diplomat in helping to engage and align the objectives and plans of Ministry of Health and development partners.

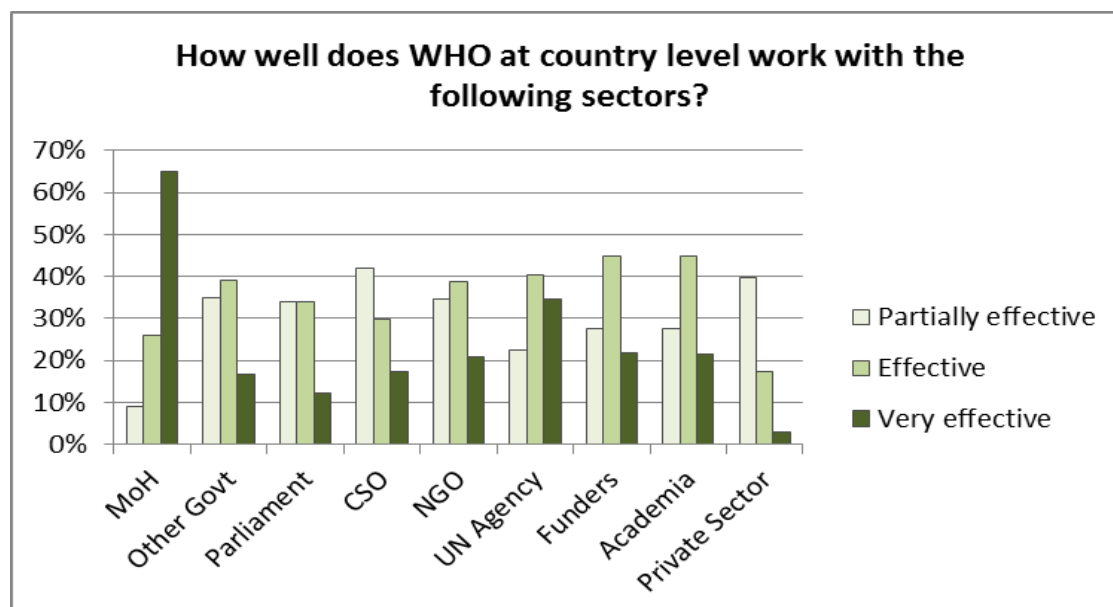
In many places convening of partners works well, and the HWO is able to provide able leadership across the sector. Where this is less well done, WHO is perceived to be weak, and partners expressed frustration; this is the case in a substantial number of countries. In an extreme example, WHO's leadership role in a partners' meeting was taken by another agency that was perceived to have a greater capacity to convene effectively. Instances were given of WHO not being included, or not participating, in important coordinating mechanisms and groups, leading to gaps in WHO engagement and credibility. This was seen as being particularly problematic in fragile states with a need for high level of donor and emergency coordination. There are also contexts in which it is less essential to lead coordination. In a different country context the HWO asked a country partner to chair a coordinating group as an explicit method of building local capacity and sustainability. This was a strategic decision by the HWO rather than a reflection on his capacity or competence.

Ministries of Health and funders in particular, perceive mobilising and leading partnerships to be an activity where WHO needs to increase its effectiveness, and views from the global survey confirmed that this is an area which WHO will need to strengthen.

6.6. How well does WHO work in partnership with different organisations/sectors?

The partnership with Ministries of Health is seen as strongest, which is not surprising given its primacy. However, it is notable that WHO's current collaboration with other government ministries and with parliament is not seen as very strong. This was raised as an issue by all partners as relationships that needs to be strengthened in order to develop a more intersectoral approach. Figure 7 below shows the perceived relative effectiveness of WHO's country level work with different sectors. It possibly reflects the effect of WHO's history in countries, with a pragmatic emphasis on relationships with Ministries of Health, UN and funders. The move to greater intersectoral working indicates a need to work more with other parts of governments as well as with Ministries of Health; WHO now has a clearer brief than in the past to engage with Parliamentarians, and is beginning to do so.

Figure 7: Partner views on how effectively WHO at country level works in partnership with different sectors



From the country visits it was clear that partnerships with the UN agencies are important at country level; there is close collaboration with the agencies that also have health interests such as UNFPA, UNICEF, UNAIDS, UNHCR and WFP. In most instances WHO is perceived to work effectively in partnership with the UN through the UNDAF framework, and also practically in day to day collaboration. The overlapping UN agency areas of responsibility on child and maternal health, reproductive health, HIV/AIDS and associated diseases, and nutrition however, create a situation which can lead to duplication of activities, or a lack of clear leadership, as well as, on occasion, friction between agencies. Where different UN roles are well defined and observed, WHO can maintain a stronger technical leadership role and facilitate the use of resources by others in partnership. For instance in Bangladesh a UN partner reported very positive experience of joint working with able leadership from WHO, partly because the respective roles were very clear.

Partnership collaboration with CSOs or NGOs is reported still to be underdeveloped. CSO partners noted that there is scope for WHO to engage more with civil society and access their social capital and networks. Survey comments from all groups noted the importance of WHO increasing engagement with civil society in countries to build capacity and ensure relevance.

Partnership collaboration with the private sector is seen as the least effective, consistent with findings in the country visits that this area of expertise and engagement is generally still weak in WHO and in need of development. Professional organisations and funders interviewed in particular noted the need for WHO to develop its skills and understanding for working with the private sector as a part of strengthening health systems to build capacity, equity of access and quality in services and products.

7. Conclusions

7.1. Summary

The objective of the evaluation was to inform WHO reform in relation to the three levels, and to understand the contribution of WHO's country presence and identify ways to make it more effective and efficient. The evaluation also addresses relevance through considering how WHO's country presence aligns with both country and WHO objectives, and the appropriate level of WHO investment at country level. It was a formative evaluation, used to elicit understanding of the current situation building on the observed and reported experiences of different countries. These conclusions are presented to explore some of the common themes relevant to WHO's reform programme.

The findings from the high- level questions 1, 2 and 3 all show that WHO is valued, and makes important contributions to country level health objectives, in particular through its work in developing and adapting guidelines, its health expertise, its potential to lead health development partners and its role as a neutral actor.

Partners' views on the contribution and purposes of WHO at country level were remarkably consistent across countries with different levels of development and contexts. However, as might be anticipated, countries with lower levels of development placed a higher value of practical support to build capacity and expertise and for greater contribution to developing health policies and plans, as well as health emergency responses. Countries at a higher level of development valued the global expertise of WHO, its potential for health diplomacy and its global role in guidelines and expertise. Countries see it as important that WHO can customise its offer to meet the specific needs of different countries.

There are however a number of themes emerging from the evaluation areas which WHO needs to address to strengthen the effectiveness and relevance of its country presence summarised here and discussed below:

- Gaining clarity on purpose: There is a need for WHO to agree a clear purpose for its country presence, which is clearly communicated with partners to ensure a common understanding of WHO's presence, including how it engages in countries with no WHO country office. WHO should also position its 'offer' in relation to other global actors.
- At present there is not a theory of change for WHO's country presence; this should be developed from the agreed purpose, and used to identify what outcomes will be delivered at country level, to enable WHO, Ministries of Health and partners to assess WHO's effectiveness and contribution for both learning and accountability purposes.
- The three levels of WHO do not consistently work as one; there are disconnects in communications and a lack of coordination between the levels which weaken country level effectiveness. There are also differences between the six Regions' processes and systems which weaken global level accountability and effectiveness.
- The mutual accountabilities of WHO and Member States are not consistently upheld to support the role of WHO as a neutral actor promoting improved health outcomes at country, regional and global levels .
- Organisational systems for planning, allocating funding and HR are evidently slow and can be barriers to country level efficiency and leadership; these need to be reviewed and developed to support effective WHO country presence. Organisational culture can hamper country leadership and weaken use of learning from evaluations.

- There is an opportunity for WHO to consolidate evidence and recommendations from existing studies, with new WHO planning guidance and recent proposals for country budget allocations and regional governance to build a stronger and clearer methodology for determining and assessing country presence.

7.2. Clarity of purpose and role

Currently WHO provides a very wide range of activities across many health areas at country level. It can appear fragmented and without a clear focus. The visits identified that there are many different expectations of WHO, and what it does and should do. They also showed that WHO country staff are under pressure from different demands. Many partners queried whether WHO is stretched too thinly over too many areas.

There are roles which are unique to WHO and globally valued. These include the norm setting work of WHO, and its expertise/technical assistance, and its public health role in monitoring global health and responding to emergencies. WHO is perceived to occupy a particular and privileged space with the brand of global health leader. It has a unique authority due to its actual or virtual presence in all countries in the world which provides an understanding of country contexts and legitimacy to act globally. These are assets which draw on work of WHO at all three levels, and show the importance of WHO's country level and global presence.

Future health profiles and needs will look different to those of today. WHO's vision about its future role working in this context will impact on its decisions about how it prioritises its objectives and activities, and the appropriate resources for its work at WHO-HQ, Regional and Country levels. There are a wide range of other actors – for instance the Global Fund, GAVI, BMGF, CDC, World Bank are major organisations which also have an investment in global health. WHO's role and functions will need to clearly differentiate it from these other players to identify its unique role and offer at all three levels.

These changes in the external context suggest that to ensure effectiveness, WHO's role will need to become more of a broker and facilitator of partnerships and other players, bringing its technical expertise to provide strategic direction and ensure high quality evidence-based interventions. Other partners may be better suited to deliver the activities associated with programmes and implementation. As a part of this, WHO will need to consider how it can more clearly focus its resources on the areas where WHO can use its unique position to have greatest impact, and add most value.

7.3. Evaluation for accountability and learning

There is now an established global results framework in place in WHO that is the basis of the Programme Budget and regional and country planning tools. The Global Results Framework can show the relationship between country, regional and WHO-HQ activities and how they contribute to global impacts. There is however a lack of a country level theory of change and metrics for understanding and assessing country level results and outcomes.

The current model leans heavily towards process outputs such as provision of technical advice and facilitation. These contribute to the outcomes specified in the 12th GPW, but it is not clear how these are measured at country level. WHO will benefit from adopting a more outcomes and results-based approach linked to country level reporting. This would engender a greater focus on achieving health outcomes and appropriate monitoring systems and reporting time frames can then be devised to capture these. Use of a monitoring framework which measures outcomes at country level would make

it possible to identify which activities and outcomes add value to the core offer. It will also facilitate a more results focused way of thinking and operating within the Organisation.

From reviewing the CCS planning and review documentation and from discussions with WHO staff and country partners there is scope for development of the CCS review process to make it more effective as a way of assessing contribution and impact at country level. The current methodology is based on self-reporting which reduces the objectivity of assessment. It is unclear how the reporting is used for learning and adapting programmes. The recent CCS guidance [11], if fully implemented, should begin to address some of these issues.

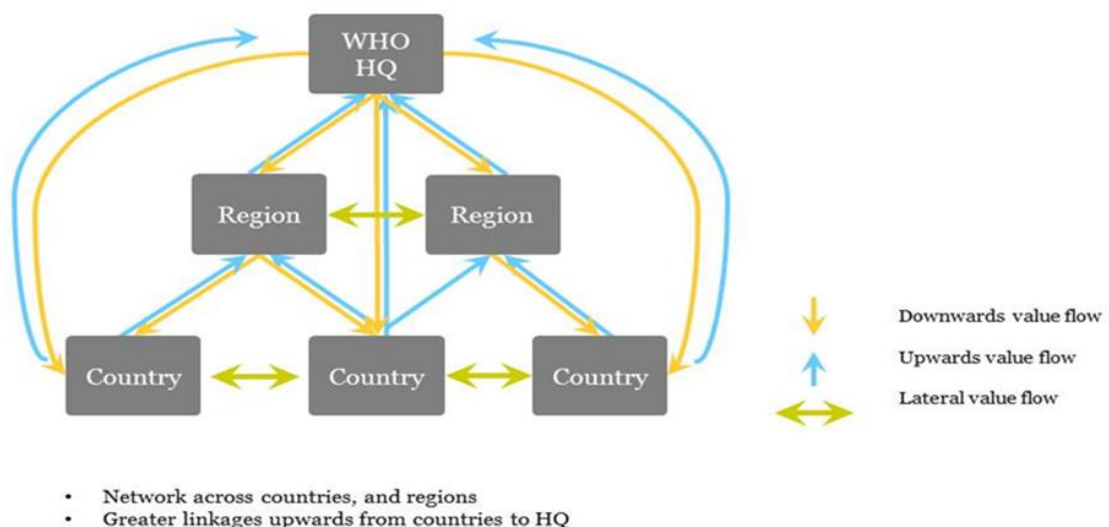
7.4. Working as One WHO to add value

Findings across the evaluation questions posed by WHO showed that strengthening the ways that WHO works as one across all levels and regions (“One WHO”) will help strengthen WHO’s country presence. There is scope to review and clarify organisational understanding of the relationship between the three levels and across Regions and the functions of each.

Country Offices add value through informing WHO Regions and WHO-HQ levels of country perceptions and needs, and ensure that WHO is responsive and relevant. Country Offices also offer WHO a locus for demonstrating how it adds value and has impact. However, the organisational relationship is not clearly framed as one of Regional and WHO-HQ levels supporting country levels, and countries providing input to the Regions and global activities. Currently WHO appears to operate a top down hierarchy in which the country level of WHO is seen as the bottom of the hierarchy. There are also differences between regional processes which diminish WHO’s capacity to work well as One WHO.

There is scope to change this through a more transparent mapping of value contributions between levels, and reviewing processes to ensure that systems facilitate country level impact. Country CCSs are already used to inform the global planning process as WHO moves to a more bottom up approach; there is scope to strengthen this, through modelling explicitly the flows of value between levels, countries and regions. This will not be a unidirectional flow of value; WHO-HQ and regions need country engagement as much as countries need WHO-HQ and regional resources. There is also scope to increase the horizontal and cross level flows of value. A simple future model of flow of value could be as in Figure 8.

Figure 8: Value flow in WHO between and across levels



7.5. Governance to support effective country level WHO leadership

WHO's relationship with Member States is a strength, in that it gives a close relationship to each country and ensures that all countries are engaged with global health. However, the need to maintain a good relationship with the Ministry of Health can overshadow the need to advocate neutrally for global and local public health priorities.

In order to be able to advocate effectively, the HWOs need to have confidence they will be strongly supported by Regional Office and WHO-HQ in the case that they need to challenge the Ministry of Health. However WHO relationships at all three levels with Member States can affect the extent to which such support is available. If WHO cannot act with full impartiality at country level this can pose a risk to WHO's credibility with country partners other than the Ministry of Health, and to WHO's capacity to be fully effective in delivering WHO's global objectives. It will be important for WHO to further develop its own governance processes to ensure that there is a strong mutual understanding of accountabilities and responsibilities with Member States.

The primacy of the relationship with the Ministry of Health can also reduce the scope for intersectoral working with government and other sectors relevant to development and health. This will become increasingly important as WHO positions itself to facilitate delivery of the SDG goals.

WHO has begun work on governance reform to develop greater clarity on the responsibilities of Member States both to help shape WHO but also to be responsible for delivering their commitments. This work may be a way forward to better defining the relationship between countries and WHO which will enable WHO to act with greater impartiality at country level [16].

7.6. Organisational culture

The evaluation provided an insight into the organisational culture of WHO, and how the existing culture can facilitate or prevent effective working at country level. There is scope to use the current WHO reform programme to introduce organisational changes to support staff working at country level to provide greater leadership for the Organisation. Areas for improvement are set out below.

Valuing and developing staff: The Organisation's staff are its main asset; however although staff are highly committed and engaged in country work, there is a level of low morale in relation to how they are recognised and valued by the Organisation. Ways of recognising and developing staff and providing positive feedback are needed. A more holistic and person centred approach would help develop the skills needed and improve staff motivation.

Authority to act: Systems are biased towards compliance with processes which can be a barrier to a focus on outcomes. Micro-management and a compliance culture often develop when roles and levels of authority are not clearly defined. There is scope for WHO to develop greater clarity on roles and responsibilities, which would enable greater delegation of authority within bounded limits.

Permission to take risks – There are several systems targeted at managing and reducing risk, but none which allow and facilitate risk. Yet some of the most praised work came from innovations introduced by HWOs who took risks. There is scope to consider how to loosen systems and structures to allow greater flexibility and authority to work to deliver outcomes and be responsive to country need.

Reducing silo working – WHO at country level still appears to work in health topic related silos; this possibly reflects the organisation as a whole, which has similar programmatic model. With an increasing need to work across sectors, ways of bridging silos will be needed to ensure continued relevance. Increasing integration of work will enable preparation for the SDGs. There is a cultural bias

to a medical model of responding to a clinical or epidemiological situation, rather than working as a strategic manager of an organisation.

Developing external engagement –WHO has a tendency to look inwards as an organisation. Validation comes primarily through internal processes. Although there is external engagement, there is not always a strong sense of how WHO positions itself in the world, nor how the organisation compares itself with others. There is relatively little energy or resource spent on communicating with partners at country level or hearing their concerns.

7.7. Developing an evaluative organisational culture

Evaluation and monitoring is only useful if it is used for learning and action through review and implementation of the recommendations. Internal monitoring and review processes as well as external evaluations need to be used for learning and accountability. Most importantly, there needs to be a mechanism to translate recommendations into action. A comment made in different countries and by different partners is that WHO evaluates but does not consistently use the findings and follow up with actions and put knowledge into action.. Many of the recommendations from this evaluation are similar to recommendations made in previous evaluations and assessments [2-4, 6]. The question for WHO may be why these have not been used to implement changes and what the barriers are to WHO using the evidence it already has.

The development of an evaluation culture is a key objective of the 12th GPW. It would be worth considering developing this to become an *evaluative* culture. An evaluative culture includes undertaking evaluations, but it also means actively learning from evaluations and using that information to implement and manage change. Mayne (2008) defines an evaluative culture as:

“an organizational culture that deliberately seeks out information on its performance in order to use that information to learn how to better manage and deliver its programs and services, and thereby improve its performance... it engages in self-reflection and self-examination.... engages in evidence-based learning.... encourages experimentation and change.” [17]

WHO’s commitment to developing an evaluative organisational culture will need to include development of increased organisational capacity for self-reflection and self-examination. Such a culture goes beyond carrying out evaluations to systematically integrating reflection and learning into organisational processes.

7.8. Looking to the future

The next fifteen years will be the years of the SDGs. These provide an incentive to develop consistent country level monitoring and evaluation frameworks that enable reporting on outcomes at country level for the SDGs. The high level impacts of WHO are consistent with the SDGs, and will support WHO in reporting progress on the goals. The SDGs also provide an opportunity for WHO to consider how it can act as One WHO to develop greater synergy across organisational levels, networks and programmes to make sure it is supporting SDGs delivery effectively, and in particular at country level, which is where the SDGs will have impact.

The SDGs have a high requirement for intersectoral working. This should be an incentive to review and strengthen WHO’s role in facilitating partnerships and engaging fully with all partners to enable WHO to lead the health related SDGs effectively. Lastly, this will allow WHO to focus closely on how it can add value to countries in the context of the SDGs and help ensure the sustainability of health systems.

8. Recommendations

Question 1: What does WHO presence in countries mean, and does it respond to Member States' and other relevant partners' expectations?

Recommendation 1: WHO should review and clarify its role and purpose at country level to ensure a common understanding within WHO and externally.

Actions:

1.1 WHO to convene a working group with representation from all three levels of WHO to develop a clear definition of the purpose and objectives of WHO at country level in the changing 21st century health context. This should define country level purpose for all countries, with or without office.

1.2 WHO to develop a resourced communications strategy to facilitate WHO country offices to communicate WHO country level purpose, priorities and activities clearly and accessibly to country stakeholders.

Question 2: What is the contribution of the WHO presence in countries towards addressing global, regional, and individual countries' health priorities and needs?

Recommendation 2: WHO should develop and implement a methodology to assess performance at country level which is integrated with the CCS/BCA and WHO global results framework for purposes of learning and accountability.

Actions:

2.1 WHO to develop a theory of change for WHO country level presence.

2.2 WHO to develop a CCS and BCA/Biennium template based on the theory of change which includes information on deliverables, planned outputs and outcomes and impact consistent with the WHO global results framework which can be used as a tool to support bottom up planning with country partners.

2.3 WHO to develop CCS/ BCA methodologies to include a participatory process for annual reviews of progress on WHO country objectives with the country government and partners for learning and accountability purposes.

2.4 WHO to review the planning processes used in different regions to ensure they are consistent with each other and with global reporting requirements at three levels and with the current CCS guidance.

Question 3: What is WHO's added value at country level in the light of its level of investment?

Recommendation 3: WHO should review and map how the different levels of WHO add value to each other and to the Organisation as a whole, to understand better how and what WHO invests in country level work, and tackle the risks to its capacity to add value.

Actions:

3.1 WHO to clarify, define and map the Organisation's investments at all three levels in relation to countries and how these contribute to the WHO global results framework at country level to identify where there is scope to increase effectiveness, efficiency and how and where most value can be added.

3.2 WHO to address the internal risks to its capacity to add value, through improving internal systems to facilitate prompt country level responses to partners; to support greater innovation; to reduce silo working; and, to promote a more forward looking way of working. These risks will need to be addressed at all three levels to enable WHO to work more efficiently as One WHO.

3.3 WHO to convene a working group to review WHO's functions in relation to other global health organisations and the UN to define more clearly WHO's unique offer and to avoid overlaps in roles.

Question 4: What are the modalities for strengthening or reducing WHO's presence in countries, based on the different health status and needs of individual countries?

Recommendation 4: WHO should ensure that the level of WHO country presence and capacity is appropriate to country needs, consistent with the WHO global strategy and WHO country purpose.

Actions:

4.1 WHO to convene a working group to review and develop a methodology for determining country level presence, based on the revised statement of purpose at country level and the model outlined in this report. The methodology should be based on or closely aligned to the SBSA, or, if this is not adopted, a similar model based on indicators of country needs and capacity.

4.2 WHO to amend the global CCS guidance to include an assessment of country level staffing and staff skill mix, including administrative staff and the balance of national and international staff, consistent with WHO country budgets and country needs.

4.3 WHO to review internal recruitment and HR processes to ensure prompt appointments and effective processes for the development and performance management of staff.

4.4 WHO to review processes for accessing internal expertise and identify gaps in relation to new and developing areas such as health financing, private sector engagement, social determinants of health to ensure that all WHO Country Offices have adequate and prompt access to a good quality of expertise to respond promptly to country needs. The analysis should also include access to health emergency resources.

Question 5: To what extent does WHO exert effective leadership and convening capacity at country level to mobilise different stakeholders together and to act as a broker of partnerships in support of the national health and development agenda?

Recommendation 5: WHO should ensure that HWOs and country staff have the necessary leadership skills to be effective at country level, and that they are supported in this by the systems and processes of the wider Organisation, and should strengthen partnership engagement to support the delivery of country level health and development objectives.

Actions:

5.1 WHO to ensure that new HWOs and country staff recruited have strong skills and competencies in leadership, health diplomacy and partnership collaboration; training should be provided to existing staff where needed.

5.2 WHO to ensure that all three levels of WHO are well aligned and coordinated to support country level leadership so that Country Offices receive consistent and systematic support from the other two levels of WHO.

5.3 WHO to develop and institutionalise a process aligned with CCS development and review for Country Office teams to map all partners at country level to include new and emerging partners relevant to the country's needs such as CSOs, NGOs and the private sector. Country Office teams to be developed to improve their capacity to engage with the private sector.

5.4 WHO to clarify the mutual accountabilities and responsibilities of WHO and Member State governments to ensure that each party has a clear understanding of its roles and relationship.

This evaluation has identified a number of findings and recommendations similar to those of previous evaluations of WHO's country presence. An additional recommendation is made therefore to facilitate implementation of recommendations from this and future evaluations.

Recommendation 6: WHO leadership should develop standard management processes to implement and follow up agreed recommendations from evaluations and identify organizational barriers to their implementation.

Actions:

6.1 WHO leadership to allocate responsibility to specified senior roles to lead on agreed recommendations from this evaluation with implementation plans which are specific, time limited and accountable.

6.2 WHO Evaluation Office to carry out a systematic review of the recommendations from other relevant reports on country strengthening and identify which are still outstanding and relevant to produce a synthesised list of recommendations for agreement by the Global Policy Group.

6.3 WHO Evaluation Office, in consultation with WHO leadership, to identify the barriers to implementation of outstanding recommendations, and to develop a plan of action to address barriers.

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Annex 1: Terms of Reference

Introduction

Objective of the RFP

The purpose of this Request for Proposals (RFP) is to enter into a contractual agreement with a successful bidder and select a suitable contractor to carry out the following work: *To conduct an external evaluation of the “World Health Organization (WHO) Presence in Countries”.*

The evaluation will address the following high level questions:

- What does WHO presence in countries mean, and does it respond to Member States’ and other relevant partners’ expectations?
- What is the contribution of WHO presence in countries towards addressing global, regional, and individual countries’ health priorities and needs, and the overall country development agenda?
- What is WHO’s added value at country level, taking into account the level of investment?
- What are the modalities to strengthen or reduce the WHO presence in countries, based on the health status and needs of individual countries?
- To what extent does WHO exert effective leadership and convening capacity at country level to bring different stakeholders together and to act as a broker of collaborative arrangements in support of the national health and development agenda?

WHO is an Organization that is dependent on the budgetary and extra-budgetary contributions it receives for the implementation of its activities. Bidders are therefore requested to propose the best and most cost-effective solution to meet WHO requirements, while ensuring a high level of service.

This work is expected to take place between June 2015 and November 2015.

About WHO

WHO Mission Statement

The World Health Organization was established in 1948 as a specialized agency of the United Nations. The objective of WHO (www.who.int) is the attainment by all peoples of the highest possible level of health. Health, as defined in the WHO Constitution, is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. WHO's main function is to act as the directing and coordinating authority on international health work.

Structure of WHO

The World Health Assembly (WHA) is the main governing body of WHO. It generally meets in Geneva in May of each year and is composed of delegations representing all 194 Member States. Its main function is to determine the policies of the Organization. In addition to its public health functions, the Health Assembly appoints the Director-General, supervises the financial policies of the Organization, and reviews and approves the proposed programme budget. It also considers reports of the WHO Executive Board, which it instructs with regard to matters upon which further action, study, investigation or report may be required.

The Executive Board is composed of 34 members elected for three-year terms. The main functions of the Board are to give effect to the decisions and policies of the WHA, to advise it and generally to

facilitate its work. The Board normally meets twice a year; one meeting is usually in January, and the second is in May, following the World Health Assembly.

The WHO Secretariat consists of some 8,300 health and other officers at the Organization's headquarters in Geneva, in the six regional offices and in countries. The Secretariat is headed by the Director-General, who is appointed by the WHA on the nomination of the Executive Board. The current Director-General is Dr Margaret Chan. The head of each regional office is a Regional Director. Regional directors are appointed by the Executive Board in agreement with the relevant regional committee.

Description of DGO/EVL

As part of the on-going WHO reform process, strengthening evaluation and organizational learning has been identified as one of the critical components to take forward. In support of this, the Evaluation and Organizational Learning unit (EVL) was established within the Office of the Director General (henceforth referred to as the Evaluation Office). The mission of the Evaluation Office is to contribute to establishing a culture of evaluation at all levels of the Organization, so that evaluation plays a critical role in WHO in improving performance, increasing accountability for results, and promoting organizational learning. The Director-General's Representative for Evaluation and Organizational Learning heads EVL.

Definitions, Acronyms and Abbreviations

The following are the various acronyms and abbreviations that will be found in the attached documents:

EVL: Evaluation and Organizational Learning Office (here, “the Evaluation Office”)

RFP: Request for Proposals

WHA: World Health Assembly

WHO: World Health Organization

GPW: General Programme of Work

CCS: Country Cooperation Strategy

MOPAN: Multilateral Organisation Performance Assessment Network

UN: United Nations

JIU: United Nations Joint Inspectorate Unit

UNDAF: United Nations Development Assistance Framework

HCO: Heads of Country Offices

UNEG: United Nations Evaluation Group

DESCRIPTION OF SUBJECT / PRESENT ACTIVITIES

Context of the evaluation

The World Health Organization pursues a results-based management approach and its expected deliverables and budget requirements for the coming planning cycle are included in WHO's Twelfth General Programme of Work for 2014-2019 (12th GPW)¹⁹ and Programme Budget²⁰. WHO has also embarked on a major systemic reform to enable the Organization to adequately address the increasingly complex challenges of public health in the 21st century. The scope of the reform effort includes a managerial reform component in pursuit of organizational excellence. The establishment of a rigorous evaluation function is one of its essential pillars.

The 12th GPW recognizes that WHO's action at country level is a critical element of the WHO's agenda with a focus to meet countries' needs. It also recognizes that WHO's leadership at country level is a particularly important element of the reform agenda, and encourages strengthening the effectiveness of WHO work at the country office as well as its coordination with the other levels of the Organization.

In this context, the Evaluation of the WHO Presence in Countries has been designated as one of the priorities for WHO in 2015.

The "*WHO Country Presence*"²¹ is the WHO platform for effective cooperation with countries to advance its global agenda, contribute to national policies and plans; and facilitate global policies and priorities. It refers to the work of the Secretariat as a whole, carried out through (i) a physical WHO presence, through the action of the 150 WHO country offices and decentralized sub-offices in provinces and districts, (ii) WHO's normative work: involving norms and standards setting, and (iii) the coordinated support from other levels of the Secretariat through the technical backstopping from the regional and headquarters levels, including technical support, capacity building, programme management and coordination for country support.

The need for evidence of progress towards WHO's contribution to countries' goals and priorities was highlighted in the 2013 report of the Multilateral Organisation Performance Assessment Network (MOPAN).²² The United Nations Joint Inspectorate Unit (JIU)²³ had also encouraged the evaluation of the country support function and of its related planning instruments, such as the WHO Country Cooperation Strategy (CCS), as well as the level of cooperation with other organizations of the United Nations system. Additionally, the independent 2013 Evaluation of the Second Stage of the WHO Reform²⁴ recommended that attention be paid to aspects of accountability, the match between the structure and service requirements at country level and the level of coordination with other development partners.

Objectives of the evaluation

The purpose of this evaluation is to provide evidence on progress towards the contribution of WHO to country-level goals and to the organization wide outcomes. Further, this evaluation seeks to identify the programmatic articulation effort and related synergies across the three levels of WHO, including

¹⁹ Twelve GPW. Chapter 2. WHO Unique values, functions and comparative advantage

²⁰ Proposed Programme Budget 2014-2015. Sixty-Sixth World Health Assembly. A66/7 World Health Organization 2013.

²¹ WHO Presence in Countries. 2012 Report. CCO/12.05

²² MOPAN. Multilateral Organisation Performance Assessment Network. Institutional report. World Health Organization (WHO). Executive Summary. 2013

²³ Joint Inspection Unit. Review of Management, Administration, and Decentralization in the World Health Organization (WHO) Part II Review of Decentralization in WHO. JIU/REP/2012/7

²⁴ WHO Reform Stage 2 Evaluation - Final Report. http://www.who.int/about/who_reform/reform-stage2-evaluation/en/http://www.who.int/about/who_reform/whoreform-stage2evaluation-pwc-2013.pdf?ua=1

inter-country and interregional cooperation towards maximizing the combined contribution to country level goals.

This evaluation will address the following high level questions:

1. What does WHO presence in countries mean, and does it respond to Member States' and other relevant partners' expectations?
2. What is the contribution of WHO presence in countries towards addressing global, regional, and individual countries' health priorities and needs, and the overall country development agenda?
3. What is WHO's added value at country level, taking into account the level of investment?
4. What are the modalities to strengthen or reduce the WHO presence in countries, based on the health status and needs of individual countries?
5. To what extent does WHO exert effective leadership and convening capacity at country level to bring different stakeholders together and to act as a broker of collaborative arrangements in support of the national health and development agenda?

The evaluation will consider a set of criteria of relevance, effectiveness, efficiency and impact to respond to these overarching questions, and will be based on a robust methodology and work plan.

Target Audience

The principal target audience of this evaluation are WHO Senior Management, Heads of WHO Country Offices, WHO governing bodies and national constituents.

The findings of this evaluation will inform the on-going reform efforts, in particular, in relation to WHO's role at country level.

Activity coordination

The evaluation will be commissioned and coordinated by the Evaluation Office.

The successful Bidder(s), the Contractor(s), will report to the Director General's Representative for Evaluation and Organizational Learning in his capacity of Evaluation Commissioner. A WHO Senior Evaluation Officer will act as the Evaluation Manager, representing the Evaluation Commissioner in the management and day to day operations of the evaluation. An Ad-Hoc Evaluation Management Group will assist the Evaluation Manager.

The work will be coordinated by WHO headquarters in Geneva. It will include inputs from WHO Headquarters, the six WHO Regional Offices, WHO's Country Offices and relevant WHO partners as will be described in Section 3 of this RFP.

Requirements

Introduction

WHO requires the successful bidder, the Contractor, to carry out tasks outlined below. The Annexes to this RFP form an integral part of this RFP.

Characteristics of the provider

Status

The selected provider(s) shall be an institution, private sector entity, and/or established team of individuals with proven experience of conducting rigorous impact evaluation based on robust theories of change. Preferably, the contractor will also have proven expertise in working with UN Agencies, intergovernmental organizations, and global initiatives in conducting impact and complex evaluations

Criteria of the evaluation team

Criteria: The capacity profile of the team members proposed by the contracting provider should include the following attributes and skills:

- a) Relevant technical experience with sectorial public health policy development and programme implementation, health system reform, programme planning, monitoring and evaluation,
- b) Experience in health systems and services delivery planning and management,
- c) In-depth understanding and experience of quantitative and qualitative evaluation methodologies; and
- d) Experience of conducting reviews and robust evaluations in international/multilateral organizations.

Impartiality: No member of the evaluation team proposed by the contracting entity should have a conflict of interest.

Composition: The proposed evaluation team is required to include members with the expertise described above (with the possibility of sub-contracting specialist resources). The Evaluation Team leader will be tasked with keeping WHO informed of specific issues of relevance arising during the evaluation. In its proposal, the team may request occasional support of WHO staff for its work as needed. The proposed involvement of the WHO staff needs to be time-bound, with clear indications of how the learning from this evaluation will contribute to a wider process of learning within WHO.

Previous experience

Required: Previous experience in conducting impact and complex evaluations with WHO, UN Agencies, other international organizations and/or major institutions in the field of impact evaluation or public policies and programmes.

Required: Documented in-depth knowledge of the global health landscape.

Highly desirable: Proven experience in implementing multisite complex impact evaluations in the public and non-for profit sector, involving multi-stakeholder actors.

Highly desirable: Proven experience in designing and implementing change management strategies.

Desirable: Proven intercultural sensitivity.

Logistical capacity

The selected provider(s) shall have the logistical capacity to manage virtual global meetings and to arrange the required travel.

Staffing

The selected provider(s) will arrange to have staff dedicated to the Project, or specified phases thereof, on a full-time basis.

It is expected that the team identified in the contracting institution's proposal shall be those assigned/dedicated to the Project, or specified phases thereof in accordance with the approach, methodology and work plan proposed. If for any exceptional circumstances there is a need to substitute a member or members of the final team, WHO will need to be consulted to ensure that the pre-defined quality and experience requirements are maintained.

Should the contracting institution anticipate the occasional support of WHO staff for its work, the proposal should include the details (i.e. the tasks and timing) of the expected use of WHO staff and the related outputs.

Scope of the evaluation

The scope of this evaluation will comprise the specific contribution of WHO to country-level public health goals and to the relevant organization wide outcomes at country level, including relevant aspects of the development agenda.

WHO levels involved

The evaluation will assess the contribution of WHO as a whole, including the contribution of its country offices and sub-offices and the backstopping support of the regional and headquarters levels to the achievement of the stated goals.

The WHO Taskforce on the Roles and Functions of the Three Levels of WHO²⁵ provides the conceptual framework for the division of roles and functions across the Organization, as summarized in the table below and the following paragraphs

Function	Roles of Country Offices in performing six WHO overarching functions ⁷
Providing strategic and technical support and building capacity	<ul style="list-style-type: none"> • Lead the development of a country cooperation strategy (CCS) and its implementation. • Lead and manage the provision and brokering of technical cooperation • Lead in the implementation and monitoring of international commitments, conventions and legal instruments • Lead emergency response/action during crisis and emergencies
Providing leadership (in advocacy, health diplomacy, and coordination of the management response)	<ul style="list-style-type: none"> • Advocate for health in all policies and promote dialogue for intersectoral and multi-stakeholder collaboration • Lead WHO's UN interagency work in integrating national health priorities into the development agenda and UNDAF • Lead the convening and coordination of the health response in emergencies • Lead in strengthening country capacity in health diplomacy for better engagement in national and international processes, and global health governance
Setting norms and standards	<ul style="list-style-type: none"> • Support countries in the adaptation and implementation of guidelines, tools and methodologies • Contribute to setting global norms and standards by providing evidence from countries
Shaping the research agenda	<ul style="list-style-type: none"> • Promote research and the strengthening of research capacity in countries • Support and, when appropriate, conduct operational research and use of results • Contribute to the body of knowledge on best practices
Articulating policy options	<ul style="list-style-type: none"> • Lead health policy dialogue and provide policy advice to national counterparts and partners • Promote the engagement of countries in setting regional and global policies and strategies
Monitoring health trends	<ul style="list-style-type: none"> • Lead WHO's work in monitoring and evaluating national policies and programmes • Support the collection, analysis, dissemination and use of data for monitoring the national health situation

²⁵ Report of the Taskforce on the roles and functions of the three levels of WHO.

http://www.who.int/about/who_reform/task_force_report_three_levels_who_2013.pdf?ua=1

According to the WHO Taskforce on the Roles and Functions of the Three Levels of WHO, Regional and Headquarters offices provide technical backstopping to country offices through the development of norms, technical support, capacity building, programme management and coordination for country support. Supporting functions by headquarters and regional planning units include the Department of Country Cooperation & Collaboration with the UN System, the Office of Compliance and Risk Management and Ethics, and others, through their various planning tools such as the CCS. The CCS is WHO's key instrument to guide the work of Country Offices in support of the country's national health policies, strategies and plans; and the main process for harmonizing WHO's collaboration in countries with that of other United Nations bodies and with development partners.

Evaluation Criteria and Evaluation questions

Evaluation criteria

The evaluation will consider the following criteria:

1. **Relevance:** The extent to which the objectives of the WHO's country presence are consistent with Member States' needs, relevant partner organizations' needs and with the global priorities and policies of WHO
2. **Effectiveness:** The extent to which the explicit objectives for the WHO presence in countries have been achieved.
3. **Efficiency:** The relationship between the extent of goal achievement and the inputs and resources used to achieve those goals and objectives.
4. **Impact:** The contribution of WHO presence in countries towards addressing countries' health priorities and needs and WHO health strategic priorities

Evaluation questions

Based on the objectives and scope of work, the evaluation should address the following key issues and questions. The Evaluation Team is encouraged to develop additional questions for discussion with the Evaluation Commissioner and Evaluation Manager.

1. What does WHO presence in countries mean, and does it respond to Member States' and other relevant partners' expectations?

The main issues to be explored under this heading are:

- whether there is a shared and consistent understanding among all relevant WHO offices and partners regarding the basic mission underlying WHO's presence in countries;
- whether there is alignment of objectives and expected results with Member States' needs, the needs of other relevant country partner organizations, with the United Nations Development Assistance framework (UNDAF), the UN Country Team, and with WHO's own global and regional priorities and policies;
- whether WHO alignment and allocation of functions at various levels is relevant and adequate to meet Member States' needs
- whether WHO's structural set-up and planning documents and tools reflect Member States' and other partners' needs adequately;

2. What is the contribution of WHO Presence in Countries towards addressing global, regional and individual countries' health priorities and needs?

Key issues under this heading include:

- What is WHO's specific contribution towards the development agenda of its Member States and of other partners (e.g. its contributions to innovative approaches, the extent of implementation of its norms, standards and guidelines) and what are the specific weaknesses and challenges?
- How effective is WHO's delivery at all levels as measured against Member States' and country partners' expectations, competing requests and demands, including in unforeseen emergencies?

3. What is WHO's added value at country level taking into account the level of investment?

Key issues under this heading include

- the effectiveness, efficiency (as measured against the level of inputs) and comparative advantage of WHO in relation to other international development players;
- the quality and responsiveness of existing mechanisms to facilitate increased alignment of the various inputs in order to maximize the overall value added;
- the overall Value For Money (VFM) of WHO's achievements at country level and possible ways to increase it further, including alternative ways of engagement.

4. What are the modalities to strengthen or reduce the WHO presence in countries, based on the health status and needs of individual countries?

Key issues under this heading include:

- Are the criteria for establishing and disestablishing WHO country offices still adequate in light of the changes in the level of development in various regions of the world?
- Is WHO's adaptive capacity to strengthen or reduce its country presence in line with changing support needs adequate in terms of analytics, management tools and decision-making processes?
- Do the present WHO country office structure as well as the capacity and resources of WHO as a whole still match the countries' evolving service requirements?

5. To what extent does WHO exert effective leadership and convening capacity at country level to bring different stakeholders together and to act as a broker of partnerships in support of the national health and development agenda?

Key issues under this heading include:

- Does WHO exert effective leadership in terms of its convening and mobilization capacity, including resources, with regard to Member States and partners at country level to support the national health and development agenda effectively?
- What are WHO's contributions to broader development issues and goals (gender equality, women's empowerment, human rights and South-South cooperation)?

Methodology

The evaluation methodology will follow the principles set forth in the *WHO Evaluation Practice Handbook*. It will also follow the United Nations Evaluation Group (UNEG) norms and standards for evaluations as well as ethical guidelines. The evaluation team will ensure that the evaluation adheres to WHO cross-cutting strategies on gender, equity and human rights.

The selected evaluation team will prepare an **Inception Report**, which will include a detailed evaluation proposal based on sound methodology aimed at addressing all evaluation questions, together with proposed data collection instruments, and an adequate and relevant work-plan for the

implementation of the evaluation. The Inception Report will also include the strategic partners to be involved and a schedule of key milestones, deliverables and responsibilities, as well as the detailed resource requirements to be committed by the evaluation team. It will also include a section detailing how the evaluation will adhere to the WHO evaluation policy and UNEG principles.

The evaluation team shall define a specific theoretical framework for the evaluation, including a detailed theory of change, appropriate to the evaluation questions. The theory of change will describe the relationship between the relevant inputs, activities and functions, and the outputs and outcome measures that will be the focus of the evaluation.

The evaluation will use a mixed methods design, combining desk review and analysis of relevant documents and indicators with primary data collection through surveys, key informant interviews and/or other qualitative methodologies.

It is expected that the evaluation team will gather structured data from all WHO Country Offices through surveys and document review. In addition, the evaluation team will perform in-depth analysis of a selection of between 8 to 12 countries involving a combination of in-depth document analysis together with the gathering of qualitative perspectives from key stakeholders. It is expected that between 50 to 65 interviews will be conducted as part of the in-depth country analysis.

The selection of countries for the in-depth review and of key stakeholders for all qualitative data collection will be discussed and approved by the Evaluation Manager.

Selected countries for the in-depth analysis will represent all relevant country typologies as described here below:

- Group 1: Countries, territories and areas in fragile situations;
- Group 2: Countries, territories and areas with a low Human Development Index as well as Least Developed Countries;
- Group 3: Countries, territories and areas with a Medium Human Development Index;
- Group 4: Countries, territories and areas with high and very high Human Development Index;
- Group 5: Countries with no WHO Country Office.

To the extent possible, the results of the WHO Presence in countries evaluation will be segmented by the above country categories.

Relevant stakeholders for the evaluation are:

- All WHO Country Offices
- Country support, Planning and technical units at WHO headquarters and at the six WHO regional offices
- Technical departments of WHO Headquarters and of the six WHO Regional Offices;
- WHO partners at country and corporate level, including Ministries of Health, UN Agencies, other relevant multilateral organizations, donor agencies, academia and relevant corporate partners as appropriate, NGOs, and civil society

The evaluation team will identify the relevant indicators and parameters for the document review based on the predefined theory of change. The evaluation team will also develop and propose for approval by WHO the specific data-collection tools, taking into consideration their needs for adaption and translation to the official WHO languages when relevant. Their development will follow state of the art scientific methodologies, and will be piloted prior to its use.

Time span to be covered

The time frame for the evaluation will encompass the last five years, from 2010 to 2014, both included.

Work to be performed

The final output will consist of an **Evaluation Report** describing the evaluation findings that fully address the evaluation criteria.

Key requirements

The Evaluation Team will be expected to conduct at a minimum the following tasks:

- Participate at a Kick-Off meeting at WHO Headquarters in Geneva to agree on the terms and conditions of the contract
- Develop a set of specific evaluation questions for review and approval with WHO based on the high level questions identified in this RFP
- Design a methodologically sound evaluation proposal and project plan as part of the **Inception Report** for review and approval by the WHO Evaluation Commissioner.
- Lead and conduct a methodologically sound, relevant, and appropriate desk review
- Lead, organize and conduct a process of primary data collection, inclusive of major key stakeholders as described in the methodology section, involving all WHO Country Offices, the six WHO Regional Offices and WHO Headquarters, and relevant WHO partners at their headquarters' offices and in a selection of 8 to 12 countries.
- Conduct a survey (in the form of a questionnaire) to, at least, all WHO Country Offices
- Perform between 50 to 65 interviews.
- Travel and hold meetings with key stakeholders as required
- Analyse the inputs received based on a sound methodology
- Manage inputs and consultations from all parties throughout the process
- Identify sound evidence-based recommendations based on the findings and against each of the evaluation criteria and evaluation questions
- Meet with designated WHO officials for input, review and approval of the various deliverables
- Liaise with the Evaluation Manager for feedback, performance management and quality control, and problem solving during the course of the evaluation
- Present and discuss **Preliminary Results** with the Evaluation Manager and Evaluation Commissioner and consider relevant feedback
- Write the **Draft Evaluation Report** and present it to the Evaluation Manager, Evaluation Commissioner and other WHO officials as deemed necessary by the Evaluation Commissioner, including a presentation to WHO Heads of Country Office.
- Make adjustments as feedback comes from WHO to elaborate the **Final Evaluation Report**, including the final laid-out version.

Timeframe and Deliverables

The timeframe for the work is set out in the table below:

18 May 2015	Deadline for submission of bids	
30 June 2015	Deadline for submission of Inception Report	Deliverable 1

30 October 2015	Deadline for Submission of Draft Evaluation Report	Deliverable 2
30 November 2015	Deadline for Submission of Final Evaluation Report	Deliverable 3

The Evaluation Report

The evaluation report shall be based on the quality criteria defined in the WHO Evaluation Practice Handbook.

The report will illustrate the evidence found through the evaluation in response to all evaluation criteria, questions and issues raised in the Request for Proposal for this evaluation. It should be relevant to decision-making needs, written in clear and easily understandable language, of high scientific quality and based on the evaluation information without bias.

The Evaluation report will include an Executive Summary and evidence-based recommendations directly derived from the evaluation findings, and addressing all relevant questions and issues of the evaluation. Supporting documentation detailing, at least, the methodology, evaluation activities performed and the relevant information sources used in the evaluation will be included in Annexes. The detailed list of participants and their respective contributions will be annexed.

The report will be prepared in English and is expected to comprise approximately between 80 to 120 pages, including its Annexes. It will be considered final only when approved by WHO. Its structure and specific outline will be discussed with, and approved by, the WHO Evaluation Commissioner and the WHO Evaluation Manager early during the evaluation process.

Reporting requirements

As per completion of deliverables and schedule of performance monitoring meetings established with the Evaluation Manager. The schedule of performance management meetings will be established at the commencement of the evaluation.

Performance monitoring

The evaluation team will meet periodically (every 4-5 weeks) with the Evaluation Manager to report on progress and for performance monitoring. Performance indicators will be established at the commencement of the evaluation.

Annex 2: Key Stakeholders interviewed

Interviewee	Organisation	Country
Bangladesh		
Additional Director General (Planning & Development) & Director	Ministry of Health, MIS	Bangladesh
Director, Institute of Epidemiology Disease Control & Research	Ministry of Health, IEDCR	Bangladesh
Line Director	Ministry of Health, NCDC, Other Public Health Interventions	Bangladesh
Senior Secretary	Ministry of Health and Family Welfare	Bangladesh
Additional Chief Engineer (Planning)	Department of Public Health Engineering (DPHE)	Bangladesh
Project Director, Perinatal Care Project	National Diabetic Association of Bangladesh (BADAS)	Bangladesh
Dept. of Epidemiology and Research	National Heart Foundation Hospital & Research Institute	Bangladesh
Director	Institute of Health Economics, University of Dhaka	Bangladesh
Programme Coordinator, Health, Nutrition and Population Programme	BRAC	Bangladesh
Executive Director	International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR'B)	Bangladesh
Director of Health, Nutrition and HIV/AIDs	Save the Children International	Bangladesh
Country Representative	UNICEF	Bangladesh
Deputy Representative	UNFPA	Bangladesh
Chief of RH	UNFPA	Bangladesh
Country Representative	UNAIDS	Bangladesh
Deputy Country Director	UNDP	Bangladesh
Director, Office of the Population, Health, Nutrition and Education	USAID	Bangladesh
Health and Population Adviser	DFID	Bangladesh
Senior Health Specialist	World Bank	Bangladesh
WHO Representative (WR)	WHO	Bangladesh
Country Office Team	WHO	Bangladesh
Medical Officer – IVD	WHO	Bangladesh
National Professional Officer – VBD	WHO	Bangladesh
National Professional Officer – NCD	WHO	Bangladesh
Medical Officer – MCH	WHO	Bangladesh
Technical Officer	WHO	Bangladesh
Technical Officer – Health Financing	WHO	Bangladesh
Administrative Officer	WHO	Bangladesh
TIP-Monitoring and Reporting	WHO	Bangladesh
Cambodia		
Secretary of State	Ministry of Health	Cambodia
Deputy General, Health	Ministry of Health	Cambodia
Deputy General, Administration & Finance	Ministry of Health	Cambodia
Director	Department of Planning & Health Information, Ministry of Health	Cambodia
Director	National Center for HIV/AIDS, Dermatology	Cambodia

	& STDs	
Director	Cambodia National Malaria Center (CNM)	Cambodia
Director	Cambodia National Center for Tuberculosis and Leprosy Control	Cambodia
UN Resident Coordinator	UNRC	Cambodia
Country Representative	UNICEF	Cambodia
Country Representative	UNAIDS	Cambodia
Senior Health Economist	World Bank	Cambodia
Country Director	USCDC	Cambodia
Deputy Director	USCDC	Cambodia
Programme Manger	USCDC	Cambodia
Global Fund Liaison Officer	USCDC	Cambodia
Director of USAID/Cambodia Office of Public Health and Education	USAID	Cambodia
Global Fund Liaison Officer	USAID	Cambodia
Social Health Protection Programme	GIZ	Cambodia
Representative	KfW	Cambodia
Representative	JICA	Cambodia
Former Health Partners Group Co-Chair/DFAT Health Advisor	Clinical Advisor on Quality of Care, URC	Cambodia
WHO Representative (WR)	WHO	Cambodia
Country Office Team	WHO	Cambodia
Team Leader, Health Systems Development	WHO	Cambodia
Democratic Republic of the Congo		
Secretary General – Health	Ministry of Health	DRC
Advisor to the Secretary General – Health	Ministry of Health	DRC
Advisor to the Minister	Ministry of Social Protection	DRC
Representative	Ministry of Finance	DRC
UN Country Team Coordinator, Deputy Representative	UNFPA	DRC
Cluster Coordinator: Intercluster National	UNOCHA	DRC
Representative	UNAIDS	
Regional Director, Africa – Interim WR	WHO	DRC
Country Office Team	WHO	DRC
WHO Representative (WR)	WHO	DRC
National Professional Officer	WHO	DRC
Representative	UNICEF	DRC
Head of Sector Health, EU Delegation to DRC	European Union	DRC
First Secretary	Programme Support Unit (PSU), Canadian Cooperation in DRC	DRC
Counsellor – Health	Programme Support Unit (PSU), Canadian Cooperation in DRC	DRC
Public Health Expert	USAID	DRC
Senior HIV Care and Support Advisor	USAID	DRC
Cluster Co-ordinator, Health, Country Director	ADRA DRC	DRC
Health Co-ordinator	SANRU	DRC
Representative – Kinshasa, DRC	Médecins Sans Frontières	DRC
Representative – Bunia, DRC	Mission MSF en DRC	DRC
Director	Action Damien	DRC
Health Cluster Co-ordinator	Médecin d’Afrique (MDA)	DRC
Member	Conseil National des ONG de Santé (CNOS)	DRC

Member	Conseil National des ONG de Santé (CNOS)	DRC
Kyrgyzstan		
Vice-Prime Minister	Government	Kyrgyzstan
Deputy Minister	Ministry of Health	Kyrgyzstan
Head of the Department of Coordination and Reform Implementation	Ministry of Health	Kyrgyzstan
Director	Mandatory Health Insurance Fund	Kyrgyzstan
Country Co-ordinator	UNAIDS	Kyrgyzstan
Acting Global Fund Grant Manager	UNDP	Kyrgyzstan
UNICEF Representative	UNICEF	Kyrgyzstan
Health Specialist	UNICEF	Kyrgyzstan
Senior Health Specialist	World Bank	Kyrgyzstan
Country Manager	World Bank	Kyrgyzstan
Senior Programme Officer	Embassy of Switzerland	Kyrgyzstan
Health Project Management Specialist, TB Leading Specialist, Health and Education Office	USAID	Kyrgyzstan
Head of PLHIV Network	Edinstvo LJV - Network of HIV Positive People	Kyrgyzstan
Director	Sotciaum	Kyrgyzstan
Head of NGO	Alternativa v narcologii	Kyrgyzstan
WHO Representative (WR)	WHO	Kyrgyzstan
Country Office Team	WHO	Kyrgyzstan
Head of Country Office	WHO	Kyrgyzstan
Mexico		
Director General	Department of International Relations, Ministry of Health	Mexico
Strategy & Development Director, Healthy Environments.	Ministry of Health	Mexico
Head of Unit – Primary Health Care	Ministry of Health	Mexico
Head of Medical Care Unit, Mexican Social Security Institute	Mexican Social Security Institute	Mexico
Head of Division – Multilaterals	Instituto Mexicano del Seguro Social , Government of Mexico	Mexico
Director General	National Center for Gender Equity and Reproductive Health	Mexico
Director General	National Center for Preventive Programs and Disease Control	Mexico
Director of Epidemiological and Psychosocial Research	National Institute of Psychiatry , Department of Health & WHO Collaborating Centre for Research and Training in Mental Health and Substance Abuse	Mexico
Director General	El Centro Nacional de Excelencia Tecnológica en Salud (CENETEC), Ministry of Health	Mexico
Director of Health Services Information Systems	El Centro Mexicano para la Clasificación de Enfermedades (CEMECE)	Mexico
Representative	El Centro Mexicano para la Clasificación de Enfermedades (CEMECE)	Mexico
General Manager of Research and Dissemination	Comisión Nacional de Arbitraje Médico (CONAMED)	Mexico
Director	Technical Secretariat of the National Council for the Prevention of Accidents	Mexico
Executive President	Fundación Mexicana para la Salud	Mexico

	(FUNSALUD)	
UN Resident Coordinator and UNDP Resident Representative in Mexico	UNDP	Mexico
National Health and Nutrition Officer	UNICEF	Mexico
National Programme Officer & Head of Sexual and Reproductive Health	UNFPA	Mexico
Director	Fundación Mídete Coordinador Coalición ContraPESO	Mexico
Director	Fundación InterAmericana del Corazón México	Mexico
Director Mexico Country Office	MacArthur Foundation	Mexico
Acting WHO Representative (WR)	WHO	Mexico
Former WR Mexico	WHO	Mexico
WHO Administrative Staff	WHO	Mexico
WHO National Professional Staff	WHO	Mexico
WHO International Professional Staff	WHO	Mexico
PAHO Consultant	WHO	Mexico
Morocco		
Secretary General	Ministry of Health	Morocco
Director of Planning and Financial Resources	Ministry of Health	Morocco
Director of Hospitals and Ambulatory Care	Ministry of Health	Morocco
Director	Epidemiology and Fight against Diseases (DELM), Ministry of Health	Morocco
Head of Europe Division	Ministry of Finance	Morocco
Head of the Multilateral Financing Division	Ministry of Finance	Morocco
Director General	National Agency for Health Insurance	Morocco
Director, School Life and Technical Education	Ministry of National Education and Vocational Training	Morocco
Secretary General	National Observatory of Human Development	Morocco
Director	National School of Public Health (ENLP)	Morocco
President	National Order of Physicians	Morocco
Central Station Coordination	Royal Gendarmerie	Morocco
President	Association of General Practitioners, Private Sector	Morocco
President	Association of Midwives in Morocco	Morocco
UNDP Representative, Resident Coordinator	UNDP	Morocco
Representative	UNFPA	Morocco
Representative	UNICEF	Morocco
Programme Officer	European Union	Morocco
Programme Officer, Medical Coverage Programs and Social Protection	European Union	Morocco
Health Nutrition Population Specialist	World Bank	Morocco
Management Unit Coordinator	The Global Fund	Morocco
President	Association for the Fight against AIDS	Morocco
President	Moroccan Association for Solidarity and Development	Morocco
President	Moroccan Association for the Promotion of Healthy Lifestyle and Fight against Obesity	Morocco
President	SOS Tuberculosis	Morocco
WHO Representative (WR)	WHO	Morocco
Country Office Team	WHO	Morocco
Sudan		

Undersecretary	Ministry of Health	Sudan
Director General International Health	Ministry of Health	Sudan
Deputy General Human Resources	Ministry of Health	Sudan
State Minister of Health	Ministry of Health	Sudan
Deputy General River Nile	Ministry of Health	Sudan
Deputy General Kassala	Ministry of Health	Sudan
State Minister of Water Resources and Electricity	Ministry of Water, Resources and Electricity	Sudan
Head of Exams and Accreditation Department	Sudan Medical Council (SMC)	Sudan
International Relations Unit Manager	Sudan Medical Specialisation Board (SMSB)	Sudan
Representative	Sudanese Red Crescent	Sudan
Health Manager	UNHCR	Sudan
Health Officer	UNHCR	Sudan
WASH Focal Point	UNHCR	Sudan
Chief of Health	UNICEF	Sudan
Representative	UNICEF	Sudan
Deputy Representative	UNICEF	Sudan
Country Director	UNAIDS	Sudan
Health Manager	DFID	Sudan
Poverty Reduction Team Leader	DFID	Sudan
Project Formulation Advisor	JICA	Sudan
Head of Office	EU	Sudan
WHO Representative (WR)	WHO	Sudan
Country Office Team	WHO	Sudan
Finance and Administrative Officer	WHO	Sudan
Technical Lead	WHO	Sudan
Cluster Coordinator	WHO	Sudan
Uganda		
Minister of Health	Ministry of Health	Uganda
Director General Health Services	Ministry of Health	Uganda
Director of Health Services	Ministry of Health	Uganda
Chairperson	Health Service Commission, the Human Resources Agency for the Ministry of Health	Uganda
Representative	National Medical Stores	Uganda
Head of Drug Information	National Drug Authority	Uganda
Dean, School of Public Health	Makerere University	Uganda
Public Health	Makerere University	Uganda
Technical Advisor	Centre for Disability and Rehabilitation (CRD)	Uganda
UN Resident Coordinator	UNDP	Uganda
Head of Office	UNDP	Uganda
UN Country Team	UNWomen, UNICEF, UNHCR, UNFPA, UNAIDS	Uganda
Senior Health Specialist	World Bank	Uganda
Attache International Cooperation	Belgian Development Agency (BTC)	Uganda
Country Director	AMREF	Uganda
Uganda Health Advisor	Save the Children	Uganda
WHO Representative (WR)	WHO	Uganda
Country Office Team	WHO	Uganda
Global or Regional Stakeholders		
Chief of the Global Noncommunicable Diseases (NCD)	Center for Disease Control (CDC)	Global/Regional

Permanent mission of the African Union, Geneva	African Union	Global/Regional
Head of Health and Education	Commonwealth Secretariat	Global/Regional
Head of Access to Funding Department	Global Fund	Global/Regional
Global Health Program	Gates Foundation (AFRO)	Global/Regional
Executive Director	Global Fund (AFRO, EMRO)	Global/Regional
Director, Polio Plus Program	Rotary International	Global/Regional
WHO Management		
AMRO Regional Director	WHO	Global/Regional
Assistant to Director-General	WHO	Global
Chief Budget & Resource Allocation, Planning, Resource Coordination & Performance Monitoring (PRP)	WHO	Global
Chief Finance, Planning, Resource Coordination & Performance Monitoring (PRP)	WHO	Global
Comptroller & Director of Finance, Planning, Resource Coordination & Performance Monitoring (PRP)	WHO	Global
Coordinator, Office of Internal Oversight Services	WHO	Global
Coordinator, Risk Management and Humanitarian Response	WHO	Global
Director of Planning, Resource Coordination & Performance Monitoring (PRP)	WHO	Global
Director, a.i., Department of Country Cooperation and Collaboration with United Nations System (CCU)	WHO	Global
Director, Department of Health Systems Governance	WHO	Global/Regional
Director, Office of Internal Oversight Services	WHO	Global
Director, Polio Programme	WHO	Global
Director, Risk Management and Humanitarian Response	WHO	Global
Executive Director, Planning, Resource Coordination & Performance Monitoring (PRP)	WHO	Global
Head of Health Financing Policy Team	WHO	Global/Regional
Senior Planning officer, Planning, Resource Coordination & Performance Monitoring (PRP)	WHO	Global
Technical Officer, Compliance, Risk Management and Ethics (CRE)	WHO	Global
WPRO Regional Director	WHO	Global/Regional

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Annex 4: Methodology

The evaluation is based on four activities using a mixed methods approach:

- Visits to eight countries across the six regions of WHO in which representatives of the Government, funders, country partners and WHO staff were interviewed
- A global survey of Member States, country partners, WHO HWOs, WHO regional staff
- Interviews with global partners, Regional Offices
- Literature and document reviews

Evaluation questions

The five high level evaluation questions and evaluation criteria related to each as listed in the RFP are set out below in Table 1. These questions were discussed and agreed with Member States at the Executive Board in January 2015. They are therefore endorsed at a senior level, and were maintained as the questions to be answered, we include the evaluation criteria which each question addresses:

Table 1 Evaluation questions and related evaluation criteria

Evaluation objective	Evaluation Criteria
1. What does WHO presence in countries mean, and does it respond to Member States' and other relevant partners' expectations?	Relevance
2. What is the contribution of WHO presence in countries towards addressing global, regional, and individual countries' health priorities and needs?	Effectiveness, efficiency, impact, relevance
3. What is WHO's added value at country level in the light of its level of investment?	Effectiveness, efficiency, relevance
4. What are the modalities for strengthening or reducing WHO's presence in countries, based on the different health status and needs of individual countries?	Effectiveness, relevance, sustainability
5. To what extent does WHO exert effective leadership and convening capacity at country level to mobilise different stakeholders together and to act as a broker of partnerships in support of the national health and development agenda?	Effectiveness, capacity, impact

The evaluation considered the contribution of WHO as a whole, including the contribution of its Country Offices and sub-offices and the backstopping support of the regional and headquarters levels to the achievement of the stated goals.

Methodology for the country visits

Eight countries were visited, selected by the WHO Evaluation Office to ensure representation across WHO regions, levels of development and fragility, as follows:

	AFRO	AMRO	EURO	EMRO	SEARO	WPRO
Fragile states	Democratic Republic Congo			Sudan		
Least developed	Uganda					Cambodia
Medium HDI			Kyrgyzstan	Morocco	Bangladesh	
High HDI		Mexico				
Very high HDI	To be covered as part of the survey to all Country Offices and country partners					

Each country visit was held over a three day period, during which time the country evaluation team met with the HWO and WHO staff, and held interviews and focus groups with representatives from:

- The Ministry of Health
- Other relevant government departments; and /or cross government groups;
- The UN country team Resident Coordinator and UN agency representatives
- Cluster coordinators (where applicable)
- Major international NGOs working in the health sector
- National NGOs working in the health and development sector
- CSOs working in the health and development sector
- Bilateral and multilateral funders
- Professional organisations
- Academics

Interviews and focus groups used a standard interview guide. Where local partners were not available in the visit period, telephone interviews were held following the country visit.

Survey

The survey was developed to complement the country visits. Its purpose was to provide breadth of data and views, compared to the depth provided by the eight country visits. It provides a wider data set to confirm or modify country visit findings and allows analysis of a wider range of respondents.

Surveys were sent electronically to all HWOs, all WHO Regions and some WHO headquarters staff. Member States were invited to take part through two main routes: HWOs were asked to forward the survey link to their Ministry of Health counterparts as well as other Government departments and country partners. The Permanent Missions in Geneva were also asked to forward the link to the

relevant government counterparts; this ensured that those countries without Country Office were also included in the survey. Surveys were provided in English, French and Spanish. The survey was initiated on 21 October 2015 and was closed on 16 November 2015. Three reminders were sent out.

This methodology meant it was not possible to provide a response rate, since there is no count of how many people were invited to take part beyond the HWOs and regional staff.

Additional interviews

Interviews were conducted with global partners and WHO Regional Directors, or their nominees, following the country visits. Standard interview guides were used for these. Other interviews were carried out with WHO WHO-HQ staff in our two visits to Geneva in July and November 2015.

Desk review of documents and reports

Selected WHO documents from headquarters, countries and regions, and country plans and health documents have been reviewed. Other literature relevant to the evaluation has also been reviewed, and is referenced where used.

Analysis

An analysis framework based on the five high level questions and evaluation criteria was used to collate and review data. For the country visits, each team of two reviewed and confirmed their analysis. Findings from all country visits were then reviewed by the whole evaluation team to draw out common themes and areas of difference. Survey data has been added later, using the same framework, and used to modify, confirm or add to the country visit findings. The data were reviewed iteratively through several processes to ensure they were robust and triangulated to ensure that findings are robust, and that findings identified have sufficient commonality to be validity.

Notes on findings

The findings draw on the country visits, intelligence from global and regional interviews, the global survey, documents and wider literature reviewed. No countries are identified individually in terms of assessments, consistent with the approach agreed that there would not be reporting at country level to guard confidentiality. The exception is where country or regional examples help illustrate a point, and the example draws on published data.

Since the methodology used generated a majority of data from the country level, there may be a bias towards the perspectives of lower HDI countries with Country Offices. There were also as a consequence fewer interviews with regional staff than country partners and staff. This may be appropriate to the evaluation scope, but does mean that the view described is largely from the perspective of the country partners and WHO Country Office. The survey provides balance to this as countries without a Country Office and regional staff took part.

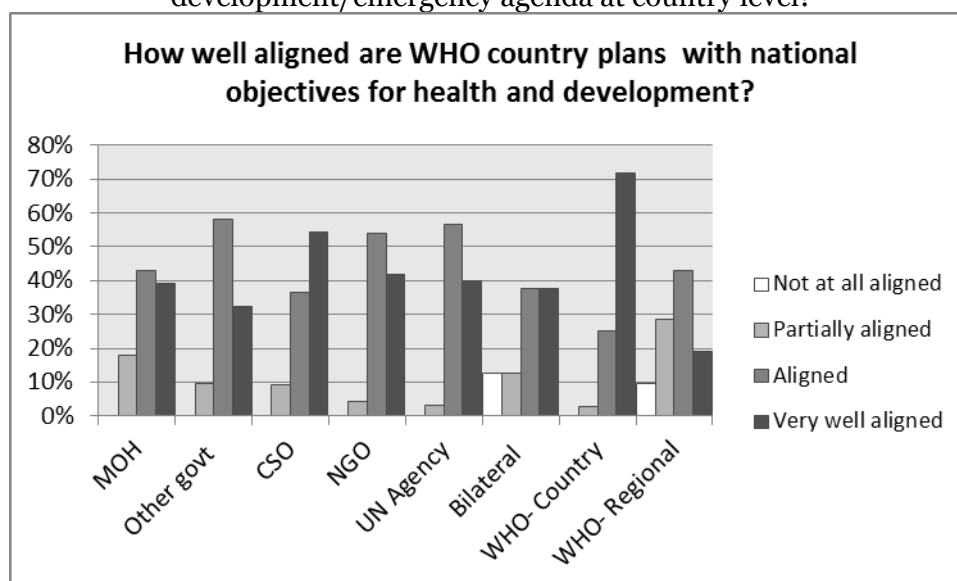
Annex 5: Survey findings

Responses by organisation type:	
Ministry of Health	60
Other government representative	32
Civil Society Organisation	13
Non-Governmental Organisation	25
UN Agency	32
Bilateral Development Partner	10
WHO- Country	75
WHO- Regional	21
Professional Organisation	3
University/Research	4
Other	7
Total Responses	282

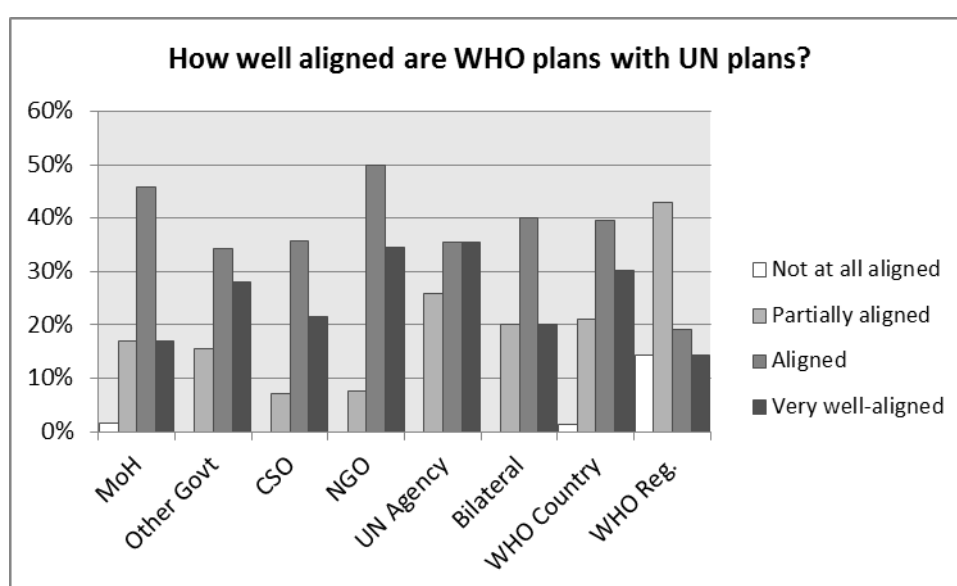
Responses - countries with a Country Office	248
Responses - countries with no Country Office	17
WHO Regional responses	17
Totals	282

Responses by region	
AFRO	41
EMRO	28
EURO	67
PAHO	63
SEARO	25
WPRO	41
WHO Regional	17
Total	282

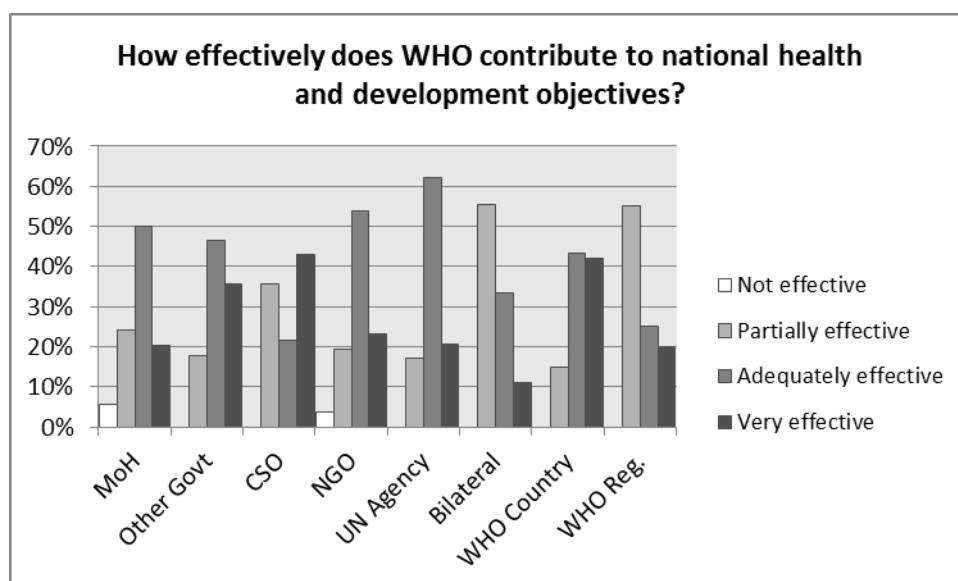
To what extent are WHO country level plans aligned with national objectives to meeting the health development/emergency agenda at country level?



To what extent are WHO plans at country level aligned with UN partners' plans for health and development?

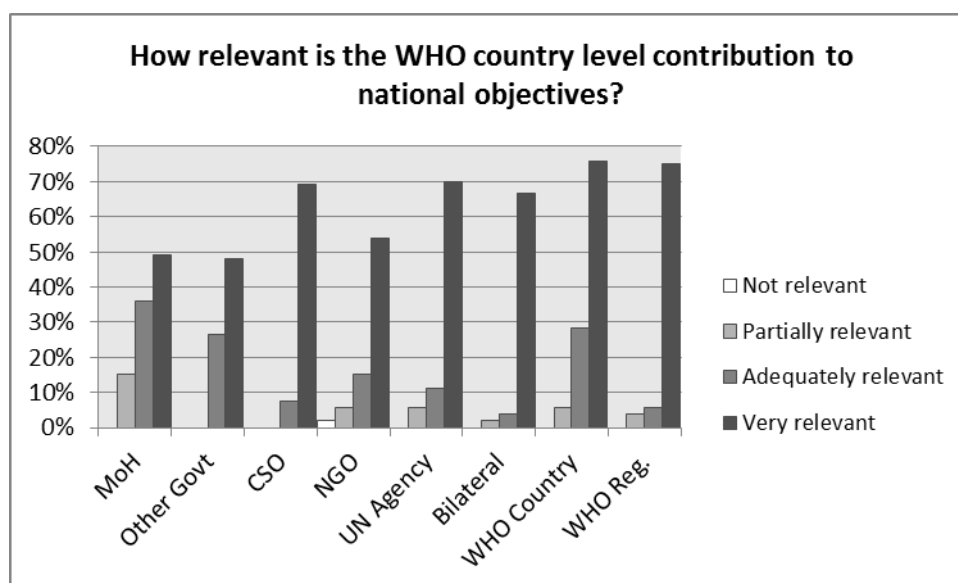


How effectively does WHO at country level contribute to country needs and objectives to meet the public health development/emergency agenda?

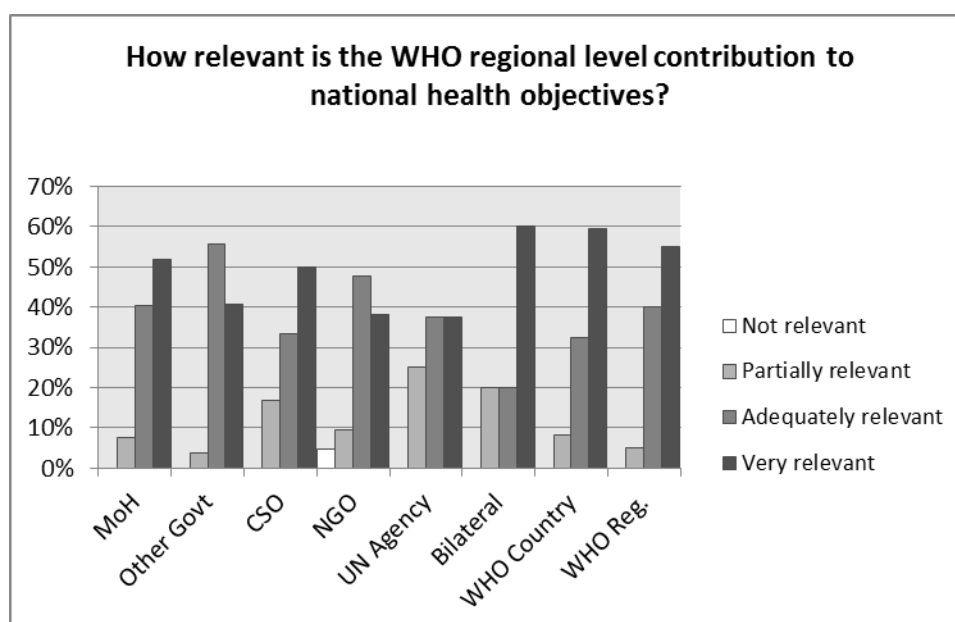


The relevance and effectiveness of the contribution of WHO

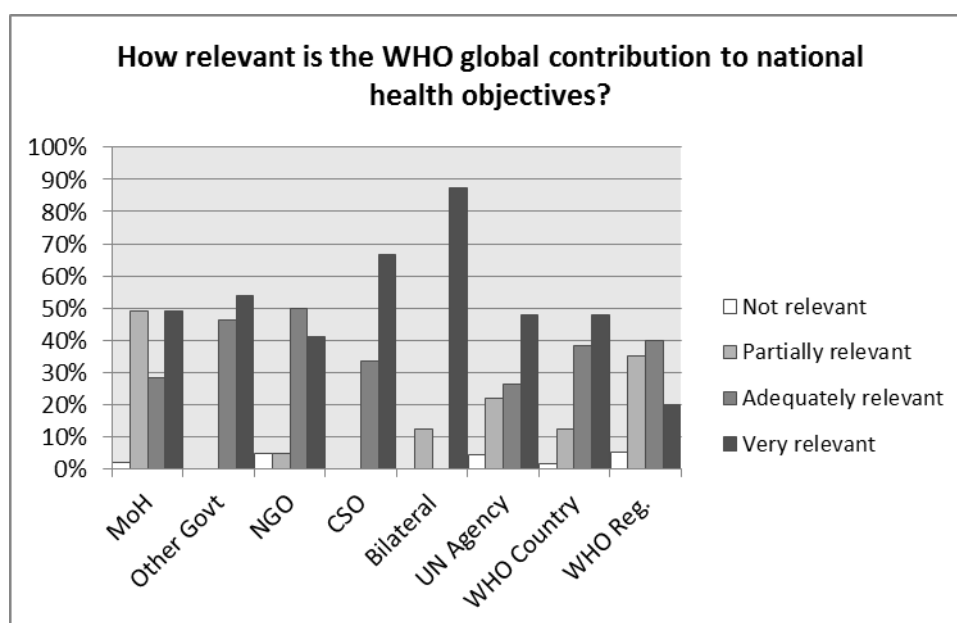
Country level WHO contribution relevance



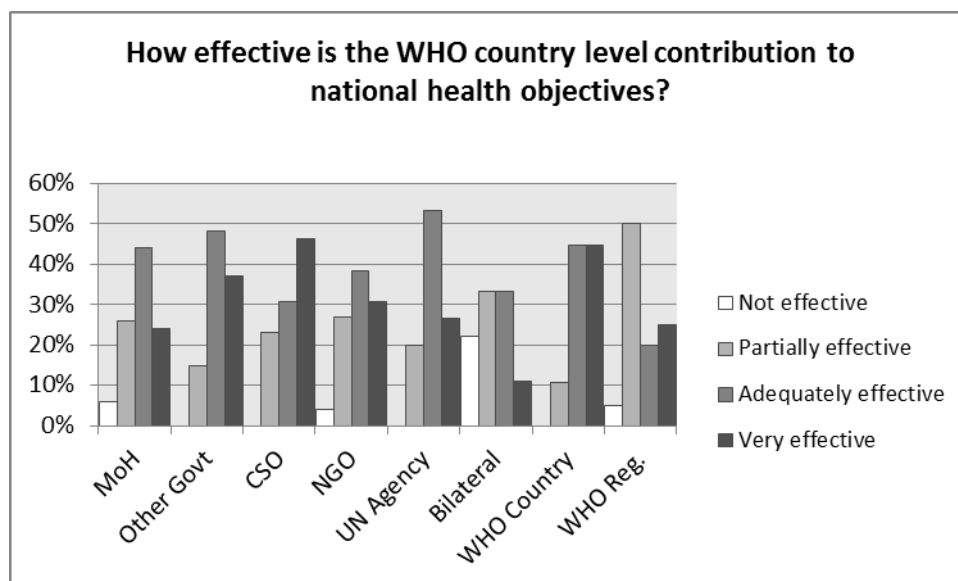
Regional level contribution relevance



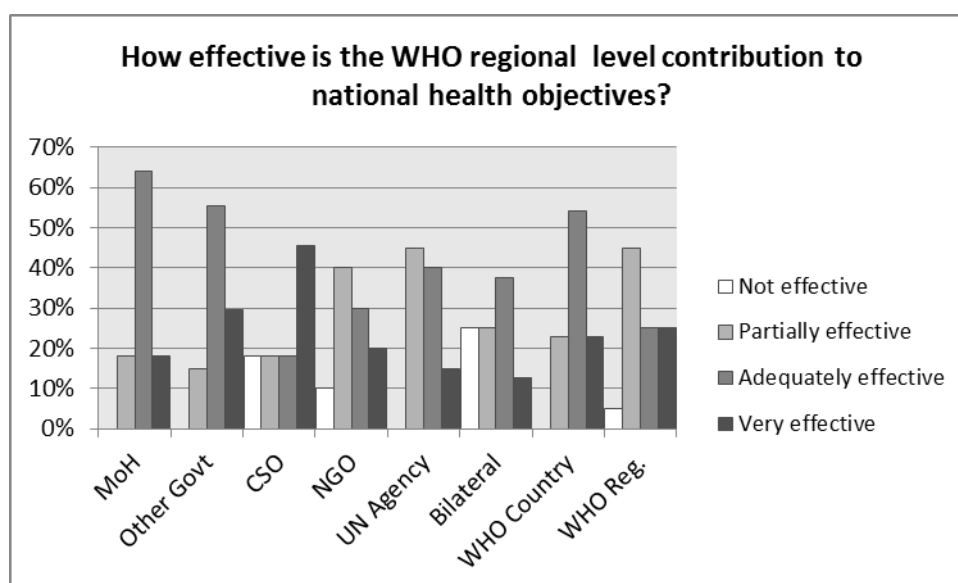
WHO-HQ contribution relevance



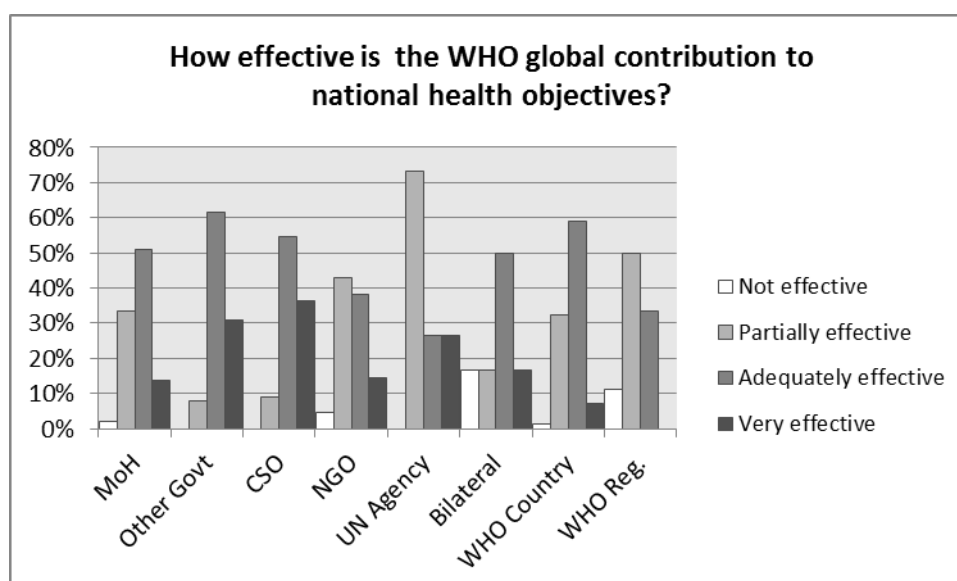
Country level contribution to effectiveness



Regional level contribution effectiveness

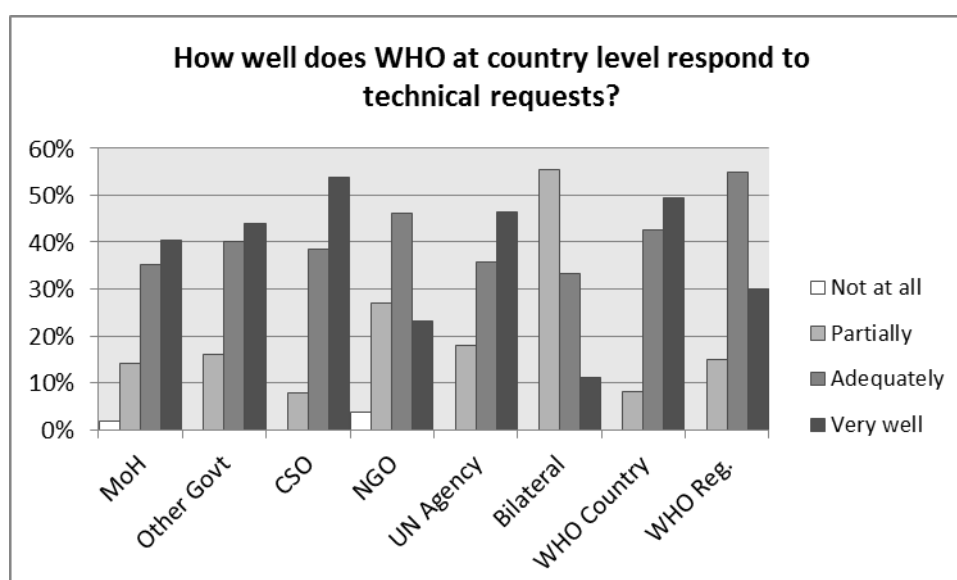


WHO-HQ contribution to effectiveness

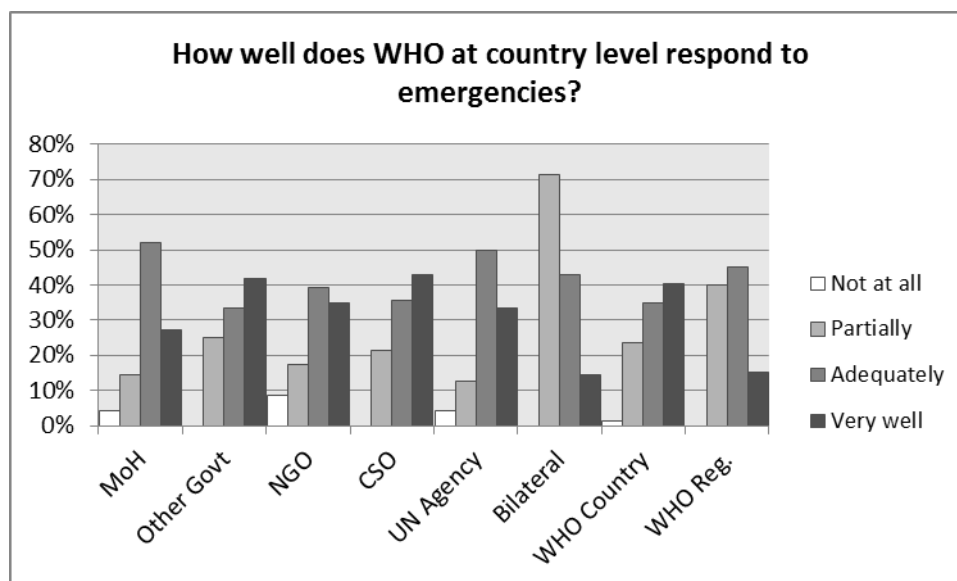


How well do you think that WHO at country level does the following:

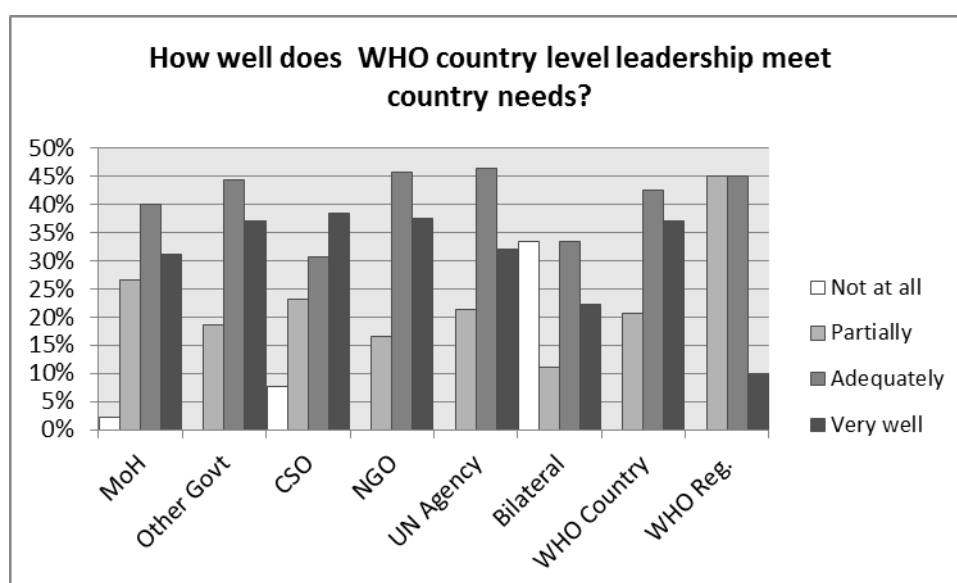
Responds/reacts quickly to health sector requests for technical support?



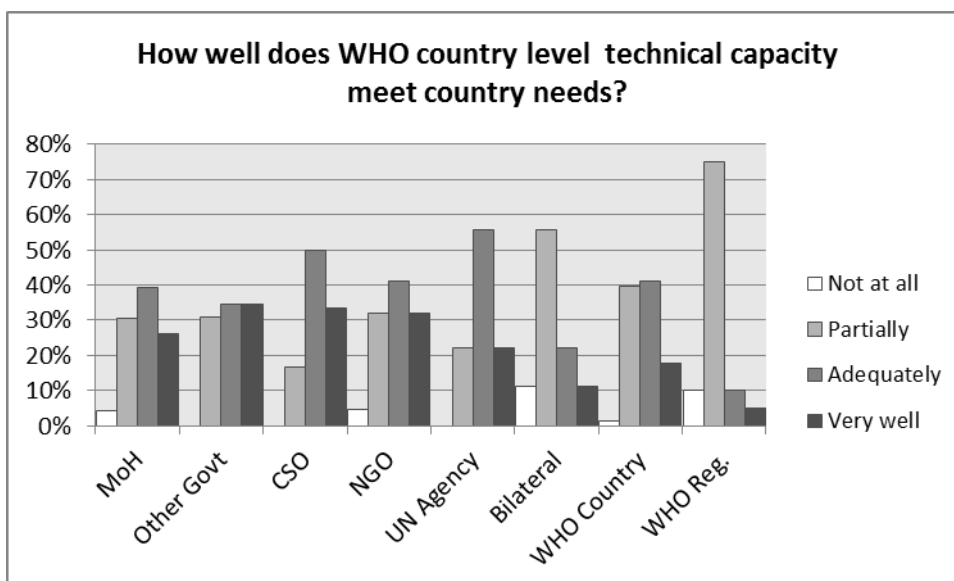
Is proactive in promoting health responses to emergency or unforeseen events?



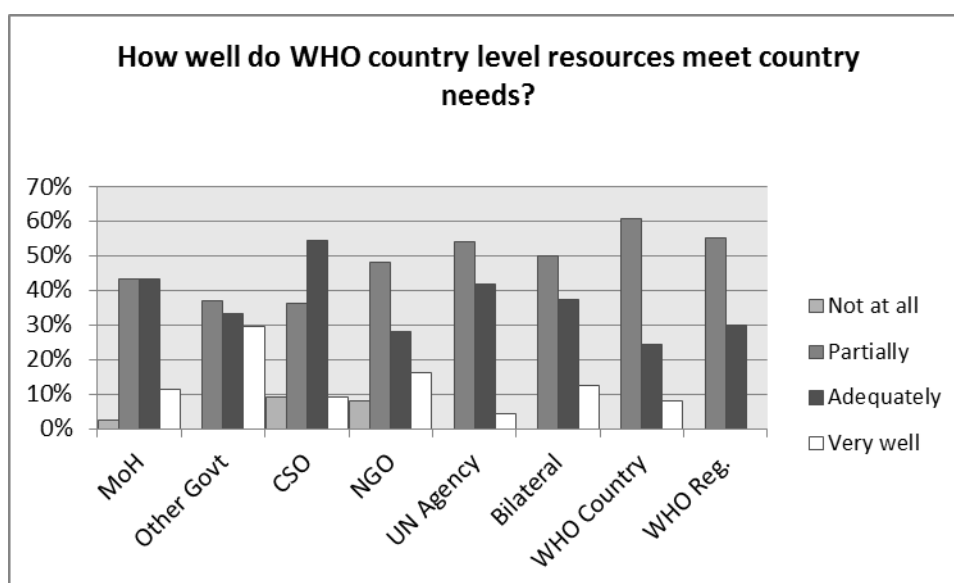
How well does WHO country level leadership meet country needs?



How well does WHO country level technical capacity meet country needs?

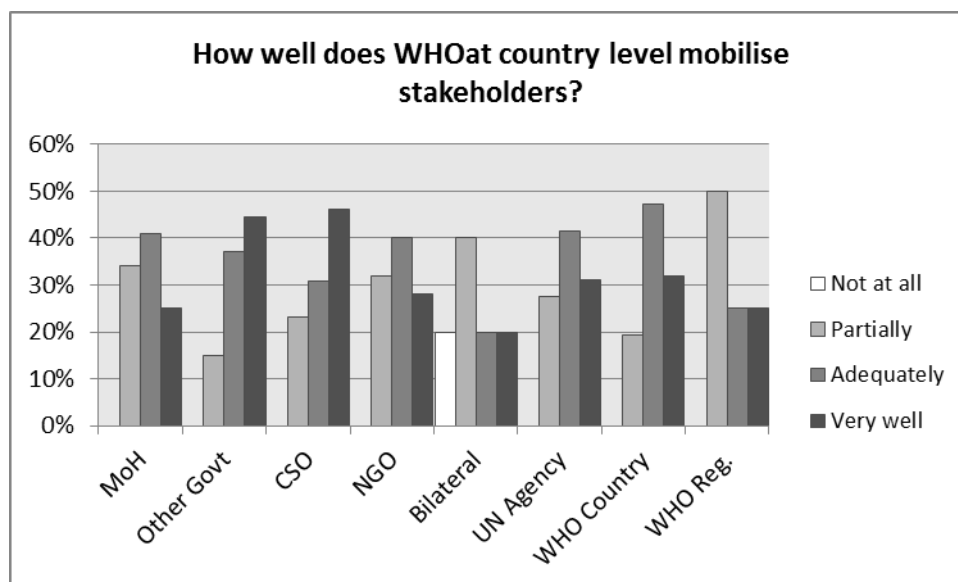


How well do WHO country level resources meet country needs?

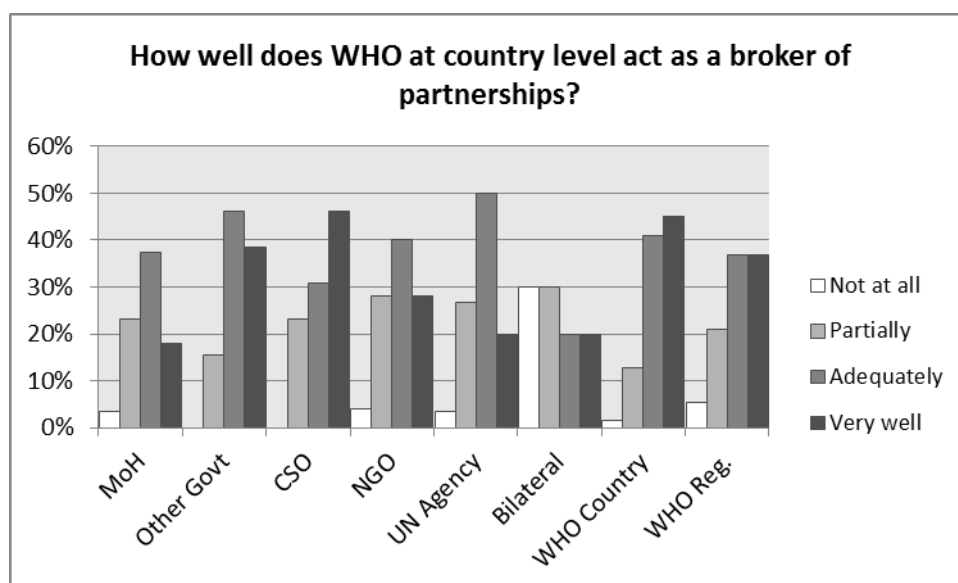


How well does WHO's leadership at country level do the following....?

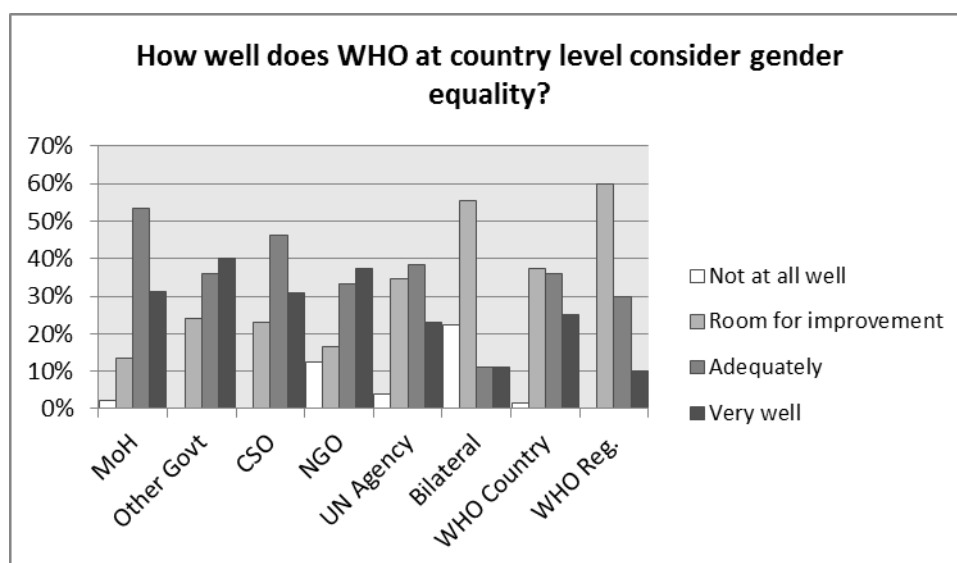
Mobilize different stakeholders



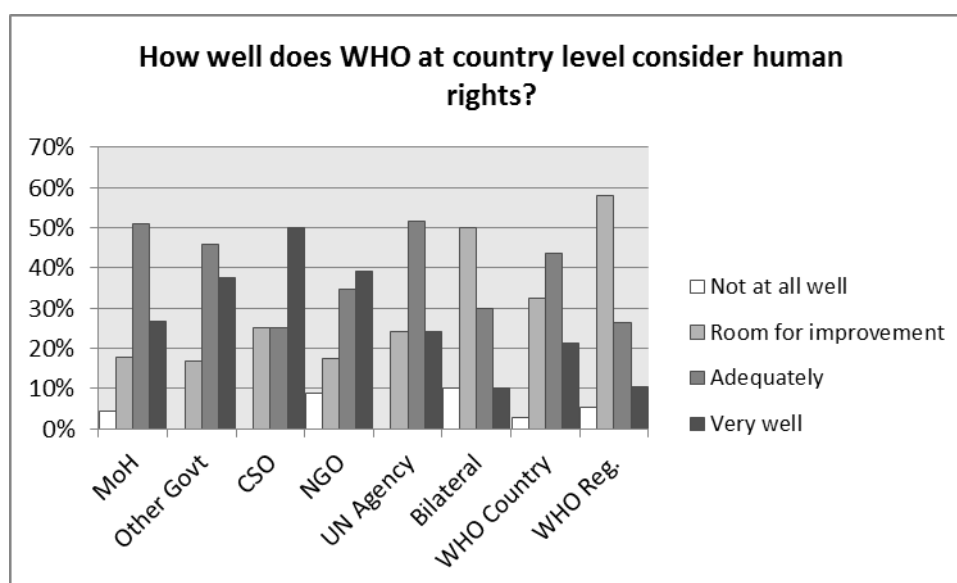
Act as a broker of partnerships which support the national health and development agenda?



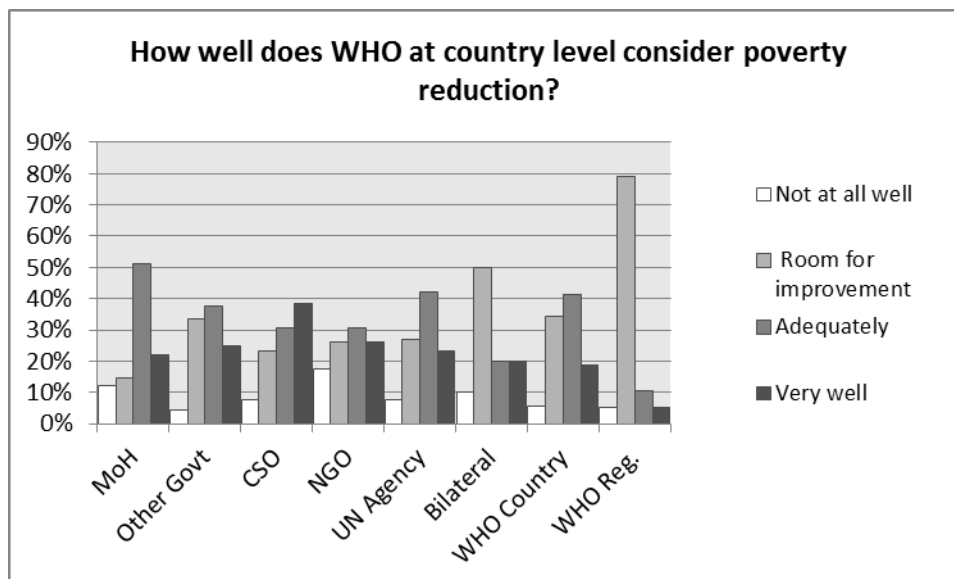
How well does WHO at country level consider gender equality and women's empowerment?



How well does WHO at country level consider human rights?



How well does WHO at country level consider poverty reduction?



How well does WHO at country level consider environmental protection?

