Evaluation of the WHO normative function at the country level

Report
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EXECUTIVE SUMMARY

Background

i. WHO’s normative function is at the core of the Organization’s mandate and enshrined in its Constitution. An evaluation of WHO’s normative function was conducted in 2017. This proposed defining WHO’s normative function as a combination of core normative products and supportive normative functions – normative elements in all core WHO functions. It also recommended a follow up to the global evaluation, assessing WHO’s normative roles and functions from a country perspective in line with WHO’s focus on “placing countries squarely at the centre of its work”, as outlined in the Thirteenth General Programme of Work.

ii. This evaluation of WHO’s normative function at country level, which forms part of the WHO Evaluation Office biennial workplan for 2022–2023, fulfils this recommendation. Its purpose is to understand and strengthen WHO’s normative function at country level through an assessment of specific normative processes and products. For this, it addresses four overarching evaluation questions:

- How have different parts of WHO been involved in the identification, preparation, formulation and validation of global normative products?
- How have the normative products been used in countries?
- What results have been achieved at country level?
- How could WHO’s normative function be strengthened at country level?

iii. The evaluation aims to provide feedback and learning opportunities for the WHO Secretariat and Member States. A key intended user for the evaluation is the Department of Quality Assurance, Norms and Standards. Other key users include WHO management at HQ and Regional levels, technical departments and WHO country offices.

Methods

iv. This evaluation used a theory-based approach, mapping the changes documented during the evaluation against the expected contribution of WHO’s normative products and documenting “how” WHO has contributed to those changes.

v. The evaluation focused on a sample of six normative products:
   - 22nd WHO Model List of Essential Medicines (EML), 2021
   - Guidance for conducting a country COVID-19 intra-action review (IAR), 2021
   - HEARTS, Technical package for cardiovascular disease management in Primary Health Care (PHC), 2020
   - Guidelines for the treatment of malaria, 2015
   - WHO Guidelines for Indoor Air Quality: Household fuel combustion, 2014

vi. The uses and contribution to outcomes and impacts of these normative products were documented through seven country case studies conducted in Ethiopia, Jordan, Maldives, Pakistan, the Philippines, Rwanda and Uganda. In total, 46 respondents from WHO HQ and regional offices and 229 stakeholders at country level were consulted in the framework of this evaluation.
Although those normative products have been selected to help focus the scope of work, this is not an evaluation of the normative products included in the sample. In some instances, the evaluation has considered other relevant products in the country contexts. The evaluation also provided a light-touch analysis of the overall experience of WHO’s normative function in the selected countries. However, the current prioritization process is not systematically implemented since many normative products are published despite not being included in the priority list.

**Key Findings**

**Evaluation Question 1: Involvement of three levels of WHO in the identification, preparation, formulation, and validation of global normative products**

The process for selecting normative products is increasingly aligned to Member States’ priorities, through prioritization criteria based on the global mandate of WHO derived from World Health Assembly (WHA) resolutions and country technical assistance demands. However, the current prioritization process is not systematically implemented, since many normative products are published despite not being included in the priority list.

The process of developing normative products mostly happens at HQ level, with some involvement from Regional Offices (RO). There is no planned process to include WHO Country Offices (WCO) in the development of normative products beyond the prioritization phase.

WHO normative products are highly valued by Ministries of Health in particular, since they come from a trusted partner and are considered to have a global perspective and a strong evidence base.

Feedback loops to integrate learning from countries and users’ experiences in normative product development are not sufficiently developed and vary between normative products. Depending on the purpose of the product, timely availability can be key to ensuring that WHO normative products are relevant to their intended users.

Where country level stakeholders and users provide input into normative products, they have greater ownership of normative products and they are more adapted to their intended users. Normative products are not consistently provided with guidance on how to implement and monitor them, which reduces their usefulness.

**Evaluation Question 2: Use of the normative products at country level**

The evaluation case studies show that WHO normative products in the sample have been widely used at country level, although to different degrees.

The first step in using WHO normative products often involves adapting them to a specific country context. WHO normative guidance has also been used commonly to build country capacity, in particular technical areas, and to develop and strengthen health systems. In some cases, WHO normative guidance has been used to improve or extend health services and programmes. There was no specific example presented to the evaluation of WHO normative guidance being used specifically to promote gender equality and health equity.

The assumption that national governments, alone and unaided, can and will apply normative guidance provided by WHO is not verified. While Ministries of Health are key actors in using WHO normative guidance, a wide range of other actors are needed to participate in its implementation but are not sufficiently engaged with.

Normative functions of WHO at country level go beyond supporting the dissemination and adoption of global normative products. The implementation of normative products is not always well-integrated in overall country
planning. Also, resources are not aligned to the ambitions of WHO in terms of its normative role at country level. Key factors facilitating and hindering the use of WHO normative guidance relate to country health system maturity, time at which normative products are introduced in relation to the opportunities and events in a country, the level of resources of the WCO and other contextual factors.

xvii. WHO does not currently monitor systematically the use of its normative products.

**Evaluation Question 3. Results achieved at the country level**

xviii. The evaluation found evidence of contributions of the sampled normative products to the triple billion goals and related outcomes. Three of the products (malaria treatment guidelines, mhGAP and HEARTS) reviewed for the evaluation are likely contributing to improved access to quality and essential health services. While the evaluation did not encounter explicit evidence of a reduced number of people suffering financial hardship, it is probable that implementation of PHC-based guidelines will have that effect. The implementation of guidelines that promote preventive measures, for instance HEARTS and household air quality, could reduce the incidence of serious illnesses, such as cardiovascular and respiratory diseases, with the associated high costs of curative treatment. While most countries do have national essential medicine lists, the extent to which these reflect the WHO EML is unclear since this is not systematically monitored. There is little evidence, however, that national essential medicine lists contribute to more appropriate medicine use in countries. While it is likely that COVID-19 IARs have contributed to better COVID-19 responses, the evaluation also did not find any clear evidence that more people were protected from this emergency as a result. As the indoor air quality guidelines have not been widely implemented in case-study countries, it is not possible for the evaluation to comment on their impact in terms of promoting a healthier environment and sustainable societies.

xix. While WHO normative products may be seen as contributing to health equity as part of efforts to promote primary health care and universal health coverage, there is no other evidence from the evaluation of their impact on improving gender equality and health equity or reducing discrimination.

xx. Monitoring of contributions and evaluating the impact of WHO normative work at country level has been extremely weak.

xxi. The main factors influencing normative products’ contribution to impact have been identified as the extent to which the product has been used in a country, and external factors such as the COVID-19 pandemic.

**Conclusions and recommendations**

xxii. This section addresses the fourth evaluation question (how could WHO’s normative function be strengthened at country level?), by drawing on the findings presented under each of the three first evaluation questions as they relate to normative product development, use, and impact at country level.

**Key conclusions**

- The prioritization process of normative product development has improved to align with Member States’ priorities, but there are still bottlenecks to ensuring it is effective.
- WHO normative products are seen as being high quality and are valued by stakeholders. However, in terms of positioning these products for use, feedback loops from country level stakeholders are insufficiently developed.
Normative products often do not sufficiently account for end-user needs, particularly in relation to guidance on implementation, resourcing and monitoring.

There is strong qualitative evidence that WHO normative products are being used at country level.

Support for the implementation, monitoring and evaluation of WHO’s normative products is not well integrated into country planning and budgeting processes. Key areas such as mental health, NCDs and environmental health are not resourced in line with WHO’s ambitions in terms of its normative role at country level.

The expected use and impact of normative products is insufficiently monitored and evaluated.

Gender equality and health equity are not sufficiently prioritized in WHO’s normative work.

Recommendations

**Recommendation 1.** Further improve the prioritization of normative products and guidance.

- Prioritise the development of normative products based on agreed Member States’ priorities. In particular, an analysis of the strategic priorities and deliverables in Country Cooperation Strategies (CCS) should be conducted as part of a country-led approach to prioritisation.
- Ensure that the normative products prioritization process is more systematically implemented by: i) strengthening oversight and accountability of the normative products process centrally and ii) ensuring that country-facing normative products are prioritized in line with available resources to support their development and use.

**Recommendation 2.** Revisit the process of normative product development to include feedback loop mechanisms and outline the role of regional offices and WCOs.

- Quality standards for normative product development should include meaningful engagement of expected users and practitioners in countries from the design stage, including promoting the development of normative products by practitioners and experts in countries where they are meant to be implemented.
- Develop key principles to ensure the relevance and usefulness of normative products for their intended users.
- Further clarify the roles of the three levels of WHO in fostering participation of country level stakeholders in normative product development, including:
  - At the global level, by developing avenues for country implementation experience so as to inform normative product development in a more systematic way
  - At a regional level, by ensuring that RO support the analysis and sharing of country-generated evidence and facilitate the participation of country level stakeholders in normative product development
  - At a country level, by emphasizing the role of the WCO in supporting country capacity to gather, analyse and use evidence to inform policy and programme decisions at the national level as well as global level.

**Recommendation 3.** Normative products to include mechanisms to support an implementation plan.

- Ensure that quality standards for normative products and accompanying products as part of guidance packages go beyond information provision to include guidance on how to implement, the resources needed and how to identify them, and what success looks like.
- Normative products/packages should include a monitoring framework that aligns to the WHO corporate result framework, outlining expected contribution at country level as well as contribution to WHO outcomes.

**Recommendation 4.** Incorporate the implementation of global normative products in Country Support Plans (CSP) based on country priorities and context. Normative work of WHO at country level to be planned as a process, beyond policy level, to include support for implementation and monitoring.

- Normative products should be highlighted to specific country offices and their counterparts in Ministries of Health based on an analysis of their CCS priorities.
- CSP should include activities to support the use and impact of normative products at country level in line with the delivery of WCO’s strategic objectives.
• The monitoring and evaluation of normative product implementation should be integrated in the overall M&E framework of the CSP as part of the WHO corporate monitoring system.

• WCOs to identify and work with a wider range of stakeholders wherever possible, such as other sectors, civil society, and private health care providers, as part of their implementation strategy for normative products, without undermining their relationship with Ministry of Health.

**Recommendation 5.** Resources in line with planned activities and expected results should be made available at country level to support the adoption and implementation of normative products, with sufficient flexibility for WCO to align resources with priority areas.

• Ensure that there are plans to resource the implementation and monitoring of normative products at country level. This may be achieved by ensuring that i) the planning of normative products to be developed during a biennium is linked to resource allocation for their implementation, ii) there is funding available centrally to support the implementation of critical normative products in selected countries, and iii) that an increasing share of flexible funding be dedicated to developing WHO country capacity and normative work.

• Ensure that where it is not feasible for WHO to provide all the support needed for implementation, WHO advocates to mobilise domestic funding and supports the government to develop proposals and obtain the funding from other partners.

• Ensure that sufficient technical capacity is available in country offices in priority areas so that WHO is a credible partner for stakeholders implementing normative products, including through leveraging existing human resources policies and developing incentives to strengthen human resources capacity at country level.

• Ensure that WCO can use resources more flexibly to support country capacity as needs arise.

• Ensure that emergency funding supports capacity development of the health system, from continuity of support to the implementation of normative products.

**Recommendation 6.** Evaluation of WHO’s normative work implementation and contribution at country level should be strengthened.

• A cross-departmental, corporate theory of change outlining WHO’s normative function in different contexts should be designed as the basis for assessing the use and impact of normative products.

• Based on this, WHO’s normative work use and contribution at country level should be better reflected in WHO’s corporate monitoring system.

• Once normative products have been identified for the biennium, WCO should report on how they have been used and what difference they have made over the expected timeframe.

• WHO should conduct more country-level evaluations.

**Recommendation 7.** Ensure that gender equality and health equity and human rights (GER) considerations are integrated in WHO’s normative work.

• Ensure that the corporate theory of change of WHO’s normative function outlines how it intends to contribute to GER.

• Ensure that normative products specify how to implement the recommendations in a way that promotes GER.

• Ensure that GER considerations are included systematically in the monitoring of the contribution that normative products make to outcomes and impacts, along with clear guidance on disaggregated data collection and analysis. This may be done as a collaboration between the GER Unit and QNS Department.

• Ensure all WCO staff have adequate awareness and capacity on gender equality, health equity and human rights.
INTRODUCTION AND BACKGROUND

1. WHO’s normative role is at the core of the Organization’s mandate. According to its Constitution\(^1\), WHO has the “authority to adopt conventions or agreements with respect to any matter within the competence of the Organization”. The Thirteenth General Programme of Work\(^2\) (GPW13) provides additional guidance on WHO’s normative role. It expects the WHO Secretariat to reinforce its science-based and evidence-based normative work, anticipate and assess the impact of research on public health and support countries in the implementation of WHO’s norms, standards and agreements. The Secretariat is also expected to support Member States in building their health information systems by strengthening their capacity to collect, analyse, disseminate, and use national and subnational disaggregated data to develop and monitor their policies and plans.

2. The 2017 evaluation of WHO’s normative function\(^3\) noted that there was no clear conceptual framework for WHO’s normative function, and set out “to review and develop a clear framework for defining aspects of normative work”. It suggested defining WHO’s normative role as a combination of (a) core normative products – international public goods\(^i\) including the normative conventions, regulations, recommendations, Secretariat guidelines and health trend assessments and (b) supportive normative functions – normative elements in all its core WHO functions.

3. A strategic shift in the GPW13 was to “place countries squarely at the centre of its work” to drive and strengthen public health impact in countries. In line with this country focus, the Evaluation of WHO’s normative function recommended a follow up to the global evaluation – assessing WHO’s normative roles and functions from a country perspective – making a 180-degree shift from the global perspective. As outlined above, it argued that normative work is not a global activity in opposition to technical cooperation in countries. The two are intertwined. WHO at regional and country level plays a role in informing the policy process and in the validation of their relevance. WHO also has normative country functions to perform. Last, but not least, it is at country level where the normative products are expected to make a difference.

4. This evaluation follows on from the 2017 Evaluation’s recommendation and forms part of the WHO Evaluation Office biennial workplan for 2022-2023. Its purpose is to understand and strengthen WHO’s normative role and function at country level through an assessment of specific normative processes and products. Its specific objectives are:
   - To assess plans and processes at WHO headquarters (HQ) for dissemination, use and follow up in countries, using a sample of global normative products.
   - To assess how and to what extent the normative products are found to be relevant in a sample of countries and how they have been adapted, used and incorporated in health policies and programmes, and to document aspects of contribution to improved health outcomes.
   - Draw conclusions on how WHO could improve/strengthen its country-level normative role and functions.

5. This is done through addressing four core evaluation questions:

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\(^1\) There are many terms related to the concept of normative products that have been successively used by WHO: international public goods, global public health goods, WHO Public health goods, and technical products on norms and standards, data and research. While these different terms reflect an evolution of the Organization’s thinking on its normative role, they are not discussed in detail here. The evaluation focuses on the definition of normative products as presented in the 2017 Evaluation of WHO’s normative function. The Evaluation identified two broad categories of normative products: (a) legal instruments provided for by WHO’s Constitution and endorsed by the World Health Assembly, including conventions, regulations, and regulatory recommendations; and (b) scientific and technical normative products – norms and standards set by the Secretariat on a broad range of thematic areas, based on scientific evidence and advice from leading technical experts, and issued under a general grant of authority by the governing body.
How have different parts of WHO been involved in the identification, preparation, formulation, and validation of global normative products?

How have the normative products been used in countries?

What results have been achieved at country level?

How could WHO’s normative function be strengthened at country level?

6. The evaluation covers OECD/DAC evaluation criteria. It focuses on relevance to country needs and priorities, effectiveness and impact (medium and long-terms results relating to health systems and health outcomes). Internal coherence is addressed in questions one and two dealing with the process of developing normative products and their use; and coordination aspects, including partnerships and linkages with other actors, are addressed across all questions. Issues of efficiency (timely and efficient use of human/financial resources) are discussed, but not the financial aspects of costs and benefits. Sustainability is addressed under the third question regarding the results achieved at country level, which investigates issues of institutionalisation of the norms and standards. The cross-cutting criteria of participation, disability inclusion, gender equality and non-discrimination are covered under the process and outcome-related and impact-related questions.

7. The evaluation focuses on the use and contribution of WHO normative products at country level. Normative products belong to the broader category of technical products on norms and standards, data and research. Within this, “norms and standards”, or normative products, are defined as products that tell the end-user what to do or how to perform an action. When considering specific normative products, the evaluation also reviewed accompanying products that provide additional guidance, for example on implementation or monitoring.

8. In terms of its scope, the evaluation provides insights that are relevant to the normative work of all WHO country offices (WCO), by documenting lessons learned and providing recommendations that are widely applicable. To do so, the evaluation focuses on the use of six selected normative products, using a country-case study approach. Beyond the use of the selected products, the evaluation provides a light-touch analysis of the overall experience of normative functions in the selected countries. The focus of the evaluation is at country level because aspects relating to the normative role of WHO at global level have been covered in the global Evaluation of WHO’s normative function (2017). The timeframe covered is since 2014, which is the publication date of the first normative product considered in the sample that is under review.

9. Although a small number of normative products have been selected to help focus the scope of the work, this is not an evaluation of the normative products included in the sample. Hence, the findings do not reflect the range of uses and contributions those products may have in other contexts. In some instances, the evaluation has also considered other relevant products in certain country contexts.

Methods

10. The evaluation design used mixed methods, relying on both quantitative and qualitative data. The evaluation was based on country case studies in a purposively selected sample of seven countries and focused on the use and impact of six selected normative products in those settings. A non-experimental design was adopted since it was not possible to identify a control group of countries, or to rely on pre-intervention or post-intervention data. The evaluation used secondary and primary data sources. Secondary data sources consisted of policy documents from WHO as well as published papers relating the WHO’s normative role at country level, and the six normative products selected for the evaluation. Documents such as national policy and programme framework documents and evaluation reports related to the thematic areas of the six normative products were sourced in each case study country. Primary data sources consisted of: i) individual interviews with key stakeholders from WHO at all three levels and external stakeholders involved in the implementation of WHO normative products (government staff, experts, multi-lateral and bi-lateral organisations and non-State actors); ii) group discussions with end-users not directly involved in implementation (patients, clinical staff); and iii) observation in clinical settings.
11. This evaluation is built on a theory-based approach, mapping the changes documented during the evaluation against the expected contribution of WHO’s normative products, as described by key stakeholders and inferred from documentation analysed during the inception phase. The evaluation’s theoretical model is aligned to the pathway presented in the draft Quality Assurance, Norms and Standards (QNS) Handbook, which describes distinct phases after the publication of normative products toward expected impacts enshrined in the Triple Billion goals. This pathway is organized according to four successive phases: Reach, Uptake, Use and Impact, as shown in Figure 1:

Figure. 1 Four distinct phases towards the impact of normative products, post publication (Source: Quality Assurance draft Handbook of QNS)

12. The evaluation investigates each phase of this pathway using the evaluation questions. The first evaluation question relates to the “reach” phase, in terms of understanding how normative products are developed and disseminated. The second question focuses on the “uptake” and “use” phases, based on the premise that both changes in country policy frameworks and in health programmes can be considered forms of use of normative products. The third evaluation question focuses on the “impact” level, both in terms of changes in health systems capacity and in terms of health outcomes. Finally, under the fourth evaluation question as to how to strengthen WHO’s normative role at country level, the evaluation gathers conclusions and proposes recommendations.

13. While this pathway clarifies what is expected to happen to achieve results, it does not outline assumptions. There are, however, implicit assumptions in this model, which could be described as follows. i) Normative products are prepared by WHO headquarters (HQ) with support from technical experts and in consultation with WHO regional/country offices. The major outcome is a high-quality document with strong recommendations based on solid evidence. ii) Such a document is made available and circulated to countries and global partners. iii) The use and impact of the normative product is expected to follow on from the high quality of the document, the leadership and authority of WHO and country needs for guidance. iv) The role of regions is that of capturing country needs, adaptation and capacity strengthening. v) Change and results happen through “diffusion” (guidance and recommendations are supplied) – without a clear and explicit plan for implementation, dissemination and follow up. These assumptions are discussed in the evaluation findings.

14. Outcome harvesting guided the data collection and analysis approach. Outcome harvesting is particularly well suited to the evaluation of complex topics that do not have a clearly predefined monitoring and evaluation framework, as is the case for WHO’s normative function at country level. Outcome harvesting collects (“harvests”)

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ii The triple billion target is that by the end of the GPW13 implementation period (2018-2025) the following goals will be achieved: 1 billion more people benefitting from universal health coverage, 1 billion more people better protected from health emergencies, and 1 billion more people enjoying better health and well-being.

iii Outcome Harvesting is an evaluation approach developed by Ricardo Wilson Grau. It consists of collecting evidence of what has changed and then, working backwards, determines whether and how an intervention contributed to these changes. This approach is opposed to measuring progress towards predetermined objectives or outcomes. The outcome(s) can be positive or negative, intended or unintended, direct or indirect, but the connection between the intervention and the outcomes should be plausible. More information on this approach can be found at [https://outcomeharvesting.net/](https://outcomeharvesting.net/), accessed 03/08/2023.
evidence of what has changed ("outcomes") and then, working backwards, determines whether and how an intervention has contributed to these changes. It uses a participatory process requiring engagement of the main implementers (in this case WCOs, RO and normative product owners), other stakeholders engaged in implementation (for example counterparts in the Ministries of Health) and stakeholders that are affected by the intervention, but not directly engaged in its implementation (clinical staff, patients, and user groups).

15. In the case of this evaluation, the six steps of the outcome harvesting approach have been applied as described in Table 1:

<table>
<thead>
<tr>
<th>Outcome Harvesting step</th>
<th>How it has been done in this evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Design the outcome harvest</td>
<td>Inception report described the main implementers of normative products (normative product owners and WCO), as well as the key data sources.</td>
</tr>
<tr>
<td>Review documentation and draft outcome descriptions</td>
<td>Using a theory of change model developed during the inception phase, the evaluation team drafted (the broad categories of) expected outcomes from the use of the normative products.</td>
</tr>
<tr>
<td>Engage with informants in formulating outcome descriptions</td>
<td>The six normative products’ owners were interviewed to provide a description of expected outcomes and pathways, captured in the Normative Products Briefs (See Annex 5). During the first group meeting with WCO in country case studies, the expected outcome descriptions and pathways were discussed along with the technical focal points of the products, and some expected outcomes were added/refined.</td>
</tr>
<tr>
<td>Substantiate</td>
<td>During data collection in country case studies, third party stakeholders involved in the use of the normative products were invited to comment on expected outcomes (for example Ministry of Health counterparts), and supportive secondary data was sought. Where possible, the evaluation triangulated the information provided with the views of end users who were not directly involved in decision-making (patient groups, clinical staff).</td>
</tr>
<tr>
<td>Analyse and interpret</td>
<td>Classification and grouping of outcomes from country case studies (reflected in the Evaluation Question 3 section on the outcomes and impacts of normative products).</td>
</tr>
<tr>
<td>Support use of findings</td>
<td>Dissemination phase consisted in a first feedback session at country level with WCO staff, and a series of validation and dissemination workshops involving WHO staff from the three levels of the Organization.</td>
</tr>
</tbody>
</table>

16. In addition to being guided by the WHO Evaluation Practice Handbook, the evaluation is based on the relevant subject-specific guidance produced by the United Nations Evaluation Group (UNEG). It is rooted in the UNEG Norms and Standards for Evaluation and the UNEG Ethical Guidelines for Evaluation.

17. The evaluation mainstreams the cross-cutting issues of gender equality, health equity and human rights (GER) in its design, findings and recommendations. It includes a specific sub-question on intended and unintended consequences in terms of gender equality, health equity, discrimination and disability inclusion under the evaluation question related to impact of normative products (see the Evaluation Matrix in Volume 2, Annex 2). It also addresses GER under the evaluation questions related to the design and implementation of normative products. In relation to participation and inclusion and gender equality and non-discrimination criteria, the evaluation methods have sought to gather views from the end-users targeted by the normative products, in other

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words patients in clinical settings and members of civil society organizations (CSOs) accessing health services. Participants in group discussions were split by age and gender. The gender disaggregation of respondents is presented in the methods section, and implications are discussed. While the views of people living with disability were not collected in the data collection phase, issues related to access to care and specific barriers for people living with disabilities were specifically inquired about from respondents. The country case studies also present evidence relating to issues of gender, health equity and discrimination.

**Sampling strategy**

18. The evaluation used purposive sampling methods for the selection of countries where the case studies took place, as well as for the normative products being focused on, as described below.

**Sampling strategy of normative products**

19. This evaluation focuses on six normative products. The evaluation does not assess the individual normative products themselves, but rather focuses on how WHO has leveraged them to enhance its contribution at country level.

20. The products were selected according to the following criteria:
   - Normative products that have been in use for some time, to be able to assess their contribution to WHO’s impact in a country. The timeframe for the products included in this sample is 2014–2021.
   - Products support all three strategic goals, corresponding to several of the outcomes identified in the GPW13.
   - The perceived level of dissemination and follow-up in countries – based on findings from interviews and progress reports
   - That they are representative of the diversity of categories of normative products including guidelines, global action programmes, and global strategies.
   - Feasibility, specifically the level of data and references available as background material.

21. It is noteworthy that some of those products were not actively supported in all case study countries, and all products were not included in all country case studies. For example, the HEARTS package is only considered to be fully implemented by the NCD Department in two of the seven case study countries: Ethiopia and the Philippines. In other countries, the HEARTS package was only piloted or disseminated to some extent.

22. Table 2 presents the six selected normative products:

<table>
<thead>
<tr>
<th>Normative product</th>
<th>Category of expected change</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target 1: Universal Health Coverage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One billion more people benefitting from universal health coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22nd WHO Model List of Essential Medicines (2021)</td>
<td>Clinical level change</td>
<td>Strengthened country capacity in data and innovation</td>
</tr>
<tr>
<td>mhGAP Intervention Guide (2019)</td>
<td>Clinical level change</td>
<td>Improved access to quality and essential health service</td>
</tr>
<tr>
<td>Guidelines for the treatment of malaria (2015)</td>
<td>Clinical level change</td>
<td>Improved access to quality and essential health services</td>
</tr>
<tr>
<td><strong>Target 2: Health emergencies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One billion more people better protected from health emergencies</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Sampling strategy of case study countries**

23. The case study countries selection was discussed during the inception phase with WHO HQ technical departments responsible for the selected normative products, regional offices (RO) and the WCO of the proposed case study countries themselves. The following criteria was used for selection:

- Geographic spread, with a balance between geographic regions to learn from different contexts (see Table 2)
- Countries of central importance to the normative products (where normative products have been present and distributed), in which a minimum of two products could be traced (see Figure 2)
- Different levels of WHO engagement (see Table 3)
- Countries where there was potential for useful lessons learned that could be shared
- Willingness of/feasibility for the WCO to participate in the evaluation.

24. In total, seven country case studies were conducted. Five were conducted in person and two virtually (see Table 3).

**Table 3. Distribution of country case studies according to WHO region and whether virtual or in-person**

<table>
<thead>
<tr>
<th>Region</th>
<th>Country</th>
<th>Virtual</th>
<th>In person</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFRO</td>
<td>Ethiopia</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rwanda</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Uganda</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>EMRO</td>
<td>Jordan</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pakistan</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>SEARO</td>
<td>Maldives</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>WPRO</td>
<td>The Philippines</td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>

25. No country was proposed as a case study in the European Union (EU) region; however, members of the WHO Regional Office for Europe (EURO) participated in interviews to provide insights on the regional context. The WHO Regional Office for the Americas (AMRO) did not participate in the evaluation.

26. Table 4 below describes how the countries sampled for case studies in the frame of this evaluation are distributed according to their level of engagement with WHO.

**Table 4. Distribution of country case studies according to the level of effort of WHO**

<table>
<thead>
<tr>
<th>Region</th>
<th>Country</th>
<th>Level of effort</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFRO</td>
<td>Ethiopia</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td>Rwanda</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td>Uganda</td>
<td>High</td>
</tr>
<tr>
<td>EMRO</td>
<td>Jordan</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td>Pakistan</td>
<td>High</td>
</tr>
<tr>
<td>SEARO</td>
<td>Maldives</td>
<td>High</td>
</tr>
<tr>
<td>WPRO</td>
<td>The Philippines</td>
<td>High</td>
</tr>
<tr>
<td>Country case Study</td>
<td>Level of engagement</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>----------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>X</td>
<td>A1 High income with currently no CO</td>
<td></td>
</tr>
<tr>
<td>X</td>
<td>A2 Policy support</td>
<td></td>
</tr>
<tr>
<td>Maldives</td>
<td>B Targeted technical support</td>
<td></td>
</tr>
<tr>
<td>Jordan</td>
<td>C Moderate technical support</td>
<td></td>
</tr>
<tr>
<td>The Philippines, Rwanda, Uganda</td>
<td>D Full technical support</td>
<td></td>
</tr>
<tr>
<td>Ethiopia, Pakistan</td>
<td>E Full technical support with field operations</td>
<td></td>
</tr>
</tbody>
</table>

27. Figure 2 below illustrates the distribution of normative products that were investigated in the evaluation according to country case studies.

**Figure 2. Distribution of selected normative products by case study countries**

![Distribution of selected normative products by case study countries](image_url)

**Data collection**

28. The data collection consisted of the following sources:

**Secondary data review**

29. Secondary data analysis included a review of relevant documents (programme/project plans, progress reports and evaluations), related to WHO’s normative function, in particular documentation provided by the QNS Department and by the persons of reference for the six normative products in HQ. RO and WCO of countries selected for case studies also provided relevant documentation on normative work in their context in relation to the selected normative products, as well as background information (for example, regional key performance indicators (KPIs) relating to the normative function, Country Cooperation Strategies (CCS), Country Support Plans (CSP), reviews or evaluations of normative work in the case study countries).

**Key informant interviews at global and regional levels**

30. Interviews at HQ and regional levels were limited to prioritize consultations with country level respondents, and also because global and regional perspectives were the focus of the 2017 evaluation of WHO’s normative function. A select number of interviews were conducted with WHO staff and global experts (for example, Country Strategy and Support Department, Quality Assurance of Norms and Standards Department, Transformation, and the team
from Montreal University conducting a study on uptake of WHO normative guidance in law\textsuperscript{vi}). Reference persons for the 6 normative products in WHO technical departments in HQ were also interviewed to provide insights on expected change pathways as part of the outcome harvesting approach. At regional level, group interviews were proposed to normative product focal points, sometimes followed by individual interviews, and focal points for QNS and Evaluation were also consulted. Twenty-three respondents were interviewed at global level and 23 at regional level.

**Country case studies**

31. In-person country case studies were conducted in Jordan, Maldives, Pakistan, Rwanda and Uganda. The organisation of these case studies was supported by the evaluation focal points in the respective regional offices and the country offices teams. They included a five-day visit with the purpose of consulting with a broad range of stakeholders beyond those directly involved in the implementation of WHO normative products. An introductory meeting with the WCO staff served to discuss WHO’s normative role in the country overall, and to understand expected outcomes and change pathways related to the selected normative products’ implementation in each country. Interviews were then conducted with external respondents from government (Ministry of Health and other Ministries and bodies), UN and bilateral partners, CSOs and experts to explore changes related to the expected outcomes, as well as other unintended changes and what led to those following an outcome harvesting approach. The perspectives of intended beneficiaries and end-users of WHO’s normative work, such as members of patients groups and health workers were also sought. These consultations took the form of group discussions and were accompanied by observation sessions in clinical settings.

32. Country consultants supported in-person country case studies in four countries (Jordan, Maldives, Rwanda and Uganda), but it was not possible to recruit a country consultant in Pakistan since the selected person cancelled their participation shortly before the evaluation country visit. Country consultants were instrumental in fulfilling the evaluation’s objective of investigating the use and impact of normative products in countries. They collected in-depth information from a wide range of stakeholders, including expected beneficiaries, end-users such as patients and clinical staff and conducted observations in clinical settings. They also provided relevant contextual insights and participated in the validation of country case studies and in the data analysis for the overall evaluation report.

33. Virtual case studies were conducted in Ethiopia and the Philippines. The organisation of the case studies was also supported by the Evaluation Focal Points in the respective regional offices, and included individual and group interviews with stakeholders that were directly involved in implementing the products, the WCO staff and counterparts in the Ministry of Health and other public health institutions.

34. Overall, in country case studies, 229 stakeholders were interviewed in individual or group interviews, and 17 members of patients’ associations and 53 health workers participated in group discussions. The evaluation team was also able to conduct direct observation sessions in seven clinics and hospitals. The number of people consulted varied among country case studies, depending on the number of normative products implemented and the engagement of national consultants that allowed for expanding the number of consultations conducted (see Annex 4).

35. Table 5 provides a summary of the distribution of country case study respondents according to different stakeholder groups.

\textsuperscript{vi} The study, conducted by researchers from the University of Montreal (Canada), is still ongoing. It aims to understand why and how WHO standards circulate from the international to the national level. The driving question of the research project is the normative effectiveness of WHO in the domestic law of different case study countries.
Table 5. Distribution of country case studies respondents by categories

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>Ethiopia</th>
<th>Jordan</th>
<th>Maldives</th>
<th>Pakistan</th>
<th>Philippines</th>
<th>Rwanda</th>
<th>Uganda</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>WCO staff (WR, normative products FP, M&amp;E Officers)</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>13</td>
<td>1</td>
<td>8</td>
<td>6</td>
<td>49</td>
</tr>
<tr>
<td>Member States stakeholders (Ministry of Health counterparts, other ministries)</td>
<td>2</td>
<td>11</td>
<td>17</td>
<td>12</td>
<td>8</td>
<td>6</td>
<td>17</td>
<td>65</td>
</tr>
<tr>
<td>UN, multi-lateral and bilateral partners</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>CSOs (e.g. on NCDs, malaria, pollution)</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>Health workers</td>
<td>20</td>
<td>20</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td></td>
<td>53</td>
</tr>
<tr>
<td>Members of patients’ associations and CSOs working on relevant themes (e.g., NCDs, women groups, youth, PLHIV)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>13</td>
<td>17</td>
</tr>
<tr>
<td>Experts and academia</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>46</td>
<td>53</td>
<td>34</td>
<td>15</td>
<td>28</td>
<td>45</td>
<td>229</td>
</tr>
</tbody>
</table>

36. Validation of country case studies consisted of the following: At the end of the case study data collection, a short feedback meeting was organised with the WCO to present emerging findings and seek clarifications, check facts and validate interpretations, and discuss possible recommendations. After the case study reports were drafted, they were sent for factual checks and comments to the respective WCOs.

Gender distribution of respondents

37. There was a total of 123 female (45%) and 152 (55%) male respondents consulted as part of this evaluation. The respondents’ gender distribution is skewed towards male respondents, especially at global and regional levels (see Figure 3). The proportion of male and female respondents varied between countries (see Annex 4) but was overall fairly balanced at country level.

Figure 3. Distribution of respondents at the three levels by gender
Analysis methods

38. Data analysis consisted of four phases: first, expected change pathways for each normative product were identified for the six normative products based on HQ and RO respondents’ interviews and documentation. Second, data was triangulated for each country selected for the case study, to identify emerging findings relating to use and outcomes/impacts of WHO normative work at country level. Third, comparing case studies with expected change pathways served to generate emerging findings under each evaluation question. Fourth, a one-day evaluation team workshop was organised on 20 June 2023, to which both core and country consultant team members contributed. Themes from the different case studies were compared and elements of difference and convergence were discussed to generate findings, conclusions and recommendations.

Reporting and dissemination

39. Findings, conclusions and proposed recommendations were presented to WHO in a 90-minute feedback workshop held on 11 July 2023, to which 26 WHO staff from HQ, regional and country offices participated. The workshop served to present emerging findings and conclusions, and it focused on discussing recommendations. A follow-up meeting was held with the QNS Department on 31 July 2023 to further fine-tune the recommendations.

40. Other avenues for dissemination of the evaluation included a session with the focal points of normative function from regional offices and selected country offices, participation in the Second Global Consultation: Implementation of WHO guidelines and norms and standards, organised by the QNS Department in Geneva between 31 August and 1 September, and sharing key lessons with the GPW14 formulation team.

Limitations, risks and mitigation measures

41. A key limitation was that there was limited time available for the evaluation team compared to the ambition of the evaluation. This was mitigated against by ensuring that primary data collection focused on country level consultations, and by regularly adjusting the evaluation delivery plan. To ensure sufficient depth of data collection, country consultants were recruited in four countries to reach the required range of stakeholders.

42. Normative work takes a long time to have an impact. The evaluation provided a perspective on normative product use in case study countries at a specific point in time, at which normative products may have been recently introduced and may not represent the full potential of their contribution after some years. To mitigate against this limitation, the evaluation used a theory of change process developed during the inception phase to map more immediate, medium-term and long-term changes, thus helping to tailor expected results to the phase and duration of implementation of the normative products.
There is no specific monitoring and evaluation (M&E) framework for WHO’s normative role at country level\textsuperscript{vii}. Hence, expected outcomes were often not clearly defined and difficult to measure. There are multiple determinants of success, for example when a national government adopts a particular health policy or a new treatment practice, there may not be a direct causal link between WHO normative action and intended outcomes. Planning, implementation, and follow-up practices in relation to normative work may be both formal and informal, and as such the tracking of progress may not be well documented. These limitations were mitigated against by:

- Considering alternative explanations: awareness and acknowledgement of the risk of bias during data collection and analysis helped mitigate against bias.
- Using an Outcome Harvesting approach, which enabled the identifying of intended and unintended outcomes, and mapping expected change pathways to observed changes, seeking to identify contribution of the normative work of WHO while working backwards from the changes documented.

A key risk for the evaluation was scope creep. Given the focus on six normative products, a major risk was for the evaluation to stray into evaluating the normative products themselves, rather than the extent to which they enhanced WHO’s normative work at country level. This risk was mitigated against by developing normative product papers that reflected the intended use and impact of those products at country level and by analysing WHO’s normative role in those thematic areas at country level in their light.

Despite important risks and limitations identified in this evaluation, the evaluation team is confident that mitigation measures enabled the production of a robust, evidence-based evaluation.

**FINDINGS**

**Evaluation Question 1: Involvement of three levels of WHO in the identification, preparation, formulation and validation of global normative products**

**Introduction**

This section presents evidence relating to the role of different parts of WHO in the identification, preparation, formulation and validation of global normative products. Only WHO involvement is mentioned in the evaluation question. However, so as to respond to the sub-question, “To what extent have normative products been relevant to country needs and national priorities?” (see Volume 2, Annex 2, presenting the Evaluation Matrix), it seemed necessary for the evaluation to consider the involvement of other stakeholders likely to reflect country needs and priorities. This is why this section also discusses how and to what extent country level actors and intended users are involved in normative product prioritization, their development process and content definition. This section also discusses the extent to which normative products respond to their intended users’ needs. All these aspects determine the extent to which normative products are relevant to country needs and are useful to their intended audience, which in turn influences the level of uptake of these products.

**Key findings under the Evaluation Question 1 are:**

\textsuperscript{vii} The QNS Department is currently working to develop an impact framework and associated M&E framework for WHO normative products.
The process for selecting normative products is increasingly aligned to Member States’ priorities, through prioritization criteria based on the global mandate of WHO derived from World Health Assembly (WHA) resolutions and country technical assistance demands. However, the initiation of normative product development remains driven by technical departments in WHO HQ.

The process of developing normative products mostly happens at HQ level, with some involvement from RO. There is no systematic process to include WCO in the development of normative products beyond the prioritization phase.

WHO normative products are highly valued by Ministries of Health, in particular, since they come from a trusted partner and are considered to have a global perspective and strong evidence base.

Feedback loops to integrate learning from countries’ and users’ experiences in normative product development are not sufficiently developed and vary between normative products.

Depending on the product, timeliness can be key to ensuring that WHO normative products are relevant to their intended users. There is sometimes a trade-off between ensuring timeliness and an in-depth consultation process before publishing normative products.

Where country level stakeholders and users provide input for normative products, they have greater ownership of those products, which are more adapted to their intended users.

Normative products do not consistently provide guidance on how to implement and monitor them, which reduces their usefulness for intended users.

Finding 1. The selection process of normative products is increasingly aligned to Member States’ priorities. However, the prioritization process is not systematically implemented, with many normative products produced without going through it.

48. The Thirteenth General Programme of Work (GPW13) states that to fulfil its normative role, WHO must “ensure that global public goods are driven by country needs and deliver tangible impact at the country level”. This implies that, given limited resources to develop normative products, there is the need to prioritize those that will be most impactful on health at the country level. However, the 2017 Evaluation of WHO’s Normative Function noted that there was no strong system in place to prioritize normative products based on an analysis of countries’ needs. The situation has improved since the 2017 evaluation, as efforts were undertaken, as part of WHO Transformation, to design the prioritization process for Global Public Health Goods (GPHG). Prioritization criteria were established.

<table>
<thead>
<tr>
<th>Priority</th>
<th>Criteria</th>
</tr>
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</table>
| High     | Obligatory/Absolute requirement  
  • Resolutions: WHA; RCs; EB decisions  
  • Global legal agreements; and key UN resolutions  
  • Responding to acute health emergencies (fast track)  
  • Critical contributions to achieve triple billions (cost of not doing GPHG) |
| Medium   | Clear collective demands from countries  
  • Country Support Plans  
  • Political mandates and expressed needs covering at least one region  
  • Multi-departmental (multi-regional) technical know-how |

GPHG are now called technical products, all of which are not normative products. However, all normative products are included under the term ‘technical products’.
The criteria considers both country demands and World Health Assembly (WHA) resolutions reflecting the global priorities set by Member States for the WHO. It is worth noting that the latter takes precedence over the former, since “clear collective demands from countries” is only a medium priority criterion. This means that normative products are not mechanically selected according to the highest number of countries’ demands, but also with a view to advancing the priorities set for WHO at the global level. These criteria contribute to the prioritization process for technical products, formerly called GPHG, becoming more formalized and considering countries’ priorities.

There is a STEPwise process in place for the three last biennia as part of the biennium workplan development process, whereby WCO communicate priority areas in their countries to the regional offices, and then the technical products to be developed within those areas are discussed in the Technical Expert Networks, which gather staff across the three levels of the Organization.

In practice, however, the process of initiating the development of normative products is largely driven by the technical departments in HQ. The 2021 Technical Products guide states that “there are no restrictions on the total number of technical products proposed for selection and for approval as long as they meet the selection criteria and have the budget and resources available for development and implementation at the various budget centres involved”. Many normative products are being planned because of the array of health topics covered in WHO’s normative guidance. Given the limited resources available, some of these products may not developed as planned, resulting in a backlog of guidance to be issued by WHO and, in some cases, in guidance not being up to date (see Table 7).

Table 7 Number of technical products approved for development by biennium (Source: WHO database of technical products)

<table>
<thead>
<tr>
<th>Biennium</th>
<th>Number of technical products greenlighted</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019-2020</td>
<td>352</td>
</tr>
<tr>
<td>2021-2022</td>
<td>857</td>
</tr>
<tr>
<td>2023-2024</td>
<td>440 proposed, in addition to some carried over from the previous biennium</td>
</tr>
</tbody>
</table>

While the technical products guide outlines oversight mechanisms for the prioritization process, incentives for product developers to engage with the prioritization process or clear accountability mechanisms to ensure that the planned technical products are aligned to organisational ambitions and resources are lacking. While funds for development are available, deprioritizing the development of some of the products becomes complex. Given this, all normative products may not go through the planned prioritization process. For example, a search on the IRIS database for the “technical documents” category published by HQ in the period 2021–2022 gives 13,917 entries. While all of those may not be technical products, and even fewer may be considered normative products, it is likely that a number of products with normative aspects are included in this list but have not been formally selected through the prioritization process. In this context, an important driver for whether a product is developed or not may be the availability of earmarked donor funding for specific areas of work.

Normative products relating to thematic areas that may not make it in the top priorities of country demands may be instrumental in progressing WHO’s mandate, by helping maintain the focus on specific areas such as neglected tropical diseases or sexual and reproductive health rights. For example, a respondent from a WCO explained that evidence briefs were used to drive advocacy at a higher level, to raise awareness on certain issues and encourage efforts from other partners.
Finding 2. The process of developing normative products mostly happens at HQ level, with some involvement from Regional Offices. There is no systematic process to include Country Offices in the development of normative products.

54. The process of designing normative products is highly variable from product to product. While some involve country experts through a structured process (such as the WHO Model List of Essential Medicines (EML)), others seem to rely on evidence gathered and analysed at the global level. Technical departments are encouraged to include regional office and regionally balanced stakeholders as well as country counterparts in this process. However, according to a HQ respondent, this engagement is framed by soft guidance rather than by explicit, strong requirements. WCO respondents, when asked about their participation in normative product development, all considered that such engagement was mostly limited to the regional office. Once developed in HQ, the list of prioritized GPHG was shared for validation with Regional and Country Offices. However, this consultation was deemed rather superficial by WHO country respondents who had been involved in it; they said that there was no opportunity for dialogue beyond providing one-off written feedback.

55. The role of regional offices (RO) in normative processes is outlined in the GPW13. This includes designing regional strategies, contextualizing global frameworks, providing knowledge synthesis to reflect evidence generated by countries, and facilitating the dialogue between global level and country priorities. In practice, however, the extent to which this brokering role is applied during the development of normative products seems to be highly variable. WCO respondents also considered that there was some level of duplication between RO and HQ levels in terms of the normative product prioritization, development and implementation process, with parallel priority-setting processes.

Finding 3. WHO normative products are highly valued by Ministries of Health and other stakeholders, particularly since they are considered to have a strong evidence base.

56. Ministry of Health stakeholders, as well as other partners at country level, valued WHO as the main source of normative guidance on health. They especially mentioned the importance of the global reach of the Organization, which sets it apart from other agencies that have a narrow thematic or geographical focus.

57. WHO’s guidance draws on evidence and data from a wide range of countries and settings which result in scientifically valid, state-of-the-art normative guidance and standards. Technical departments have various ways of ensuring that data is collected and analysed to feed into guidance development.

Finding 4. While there are positive examples of country-generated evidence being used as a basis for normative product development, feedback loops to integrate country experiences in normative product development are not sufficiently developed.

58. Uganda’s experience of innovation on malaria prevention and treatment presents some of the challenges and opportunities for integrating countries’ experiences into WHO’s global standards. This illustrates that the extent to which country stakeholders are involved in the development of normative products may influence the degree of ownership of those products by users (see Box 1).
Several country respondents commented that feedback loops from users’ experience into WHO normative product development were insufficiently developed. The Quality Assurance, Norms and Standards (QNS) impact cycle (see Figure 4) outlines how global normative products should be updated and planned based on outcomes from implementation. From the diagram, it seems that evaluation of impact and monitoring of health outcomes should influence priority setting. But it is not clear that learning or user feedback influences product development or revision.

Box 1. Using country-generated evidence in the development of guidelines: the example of Malaria treatment guidelines in Uganda

Uganda malaria programme experts have extensive experience in conducting innovations on malaria control. However, country stakeholders consider that these efforts and expertise are not always acknowledged by WHO. The need for WHO to validate evidence at the global level is seen as sometimes hampering the use of locally generated evidence into national policies, since other donors such as the Global Fund will only fund the national malaria response to the extent that it follows WHO standards.

Stakeholders highlighted that in some instances WHO had demonstrated good reactivity to country-generated evidence. For example, WHO has been able to fast track the integration of country level learning on long-lasting treated nets into global guidelines: "WHO has become more adaptive, they listen to country experiences. In Uganda’s case WHO listened when we told them that mosquito nets lasted for less than the stated three years. WHO requested evidence before changing the three-year timeframe. Uganda and Tanzania brought the evidence, we did durability studies. The validity of the study was not doubted, it was done with the Liverpool School of Tropical Medicine. WHO accepted the results that mosquito nets last less than three years, they dropped the mention of long-lasting treated mosquito nets (LLTNs) and moved to Insecticide treated nets (ITNs).”

However, country stakeholders point to the need for WHO to be more responsive in identifying and responding to country-generated evidence. A national level stakeholder commented: "We want flexibility from WHO for countries to study and include new evidence in national policies directly. WHO needs to allow countries to respond to certain issues and later validate. For example, we need to pick up asymptomatic patients, especially the asymptomatic malaria in pregnant mothers. Uganda is piloting the use of multiple test trips in ante-natal care visits, including malaria and not just HIV. Otherwise, we are distributing nets for mothers to sleep under with malaria. What are the avenues for WHO to collect information from countries?" Although WCO attend technical working groups where emerging evidence is shared, stakeholders consider that WCO is too thin on the ground to pick up the innovations from countries and advocate for them to be taken up at the global level. There may be opportunities for this process to be supported from the regional level. In particular, national stakeholders from Uganda considered that the RO could facilitate experience sharing between countries based on the WHO annual report on malaria. Country respondents asked: “Is WHO using that report to discuss regional specific findings with Ministries of Health and countries regionally?” Another key role for the regional office would be to advocate for other partners such as the Roll Back Malaria initiative to support countries where innovations are taking place.

59. Several country respondents commented that feedback loops from users’ experience into WHO normative product development were insufficiently developed. The Quality Assurance, Norms and Standards (QNS) impact cycle (see Figure 4) outlines how global normative products should be updated and planned based on outcomes from implementation. From the diagram, it seems that evaluation of impact and monitoring of health outcomes should influence priority setting. But it is not clear that learning or user feedback influences product development or revision.
60. The QNS Department encourages those who develop normative products to consider the perspective of users during guideline development, but according to HQ respondents this does not seem to be an enforced requirement. This view was supported by country respondents, for example a WCO respondent considered that guideline steering groups may sometimes include a country’s Ministry of Health representative in a rather token manner.

Finding 5. Depending on the normative products, timeliness can be key to ensuring that they are relevant to their intended users.

61. The way feedback loops take place may vary widely between technical products, and this may argue against setting a single protocol for stakeholders’ engagement applying to all normative products. In particular, to maximize the relevance of normative products, the requirement for consultations and country-level engagement must be balanced with the need for timeliness. This factor may be particularly critical for guidelines that respond to an emergency, such as COVID-19. When developing the COVID-19 intra action review (IAR) guidelines, priority was given to developing a tool for countries to review their COVID-19 response from the onset of the pandemic, rather than adhering to a lengthy consultative development and validation process before issuing guidelines. The COVID-19 IAR guidance was then revised based on the experience of countries using the first version.

62. An excessively lengthy process for WHO to develop normative guidelines can undermine their usefulness. For example, regarding the norms related to travel during the COVID-19 pandemic, a Ministry of Health stakeholder commented: “WHO takes some time to build consensus on guidelines, so we first looked to CDC for guidance. At first WHO did not provide clear guidelines on travel, CDC provided clear guideline on air travel first. In an emergency we need guidelines quickly. With WHO there are protocol challenges between offices, so it takes time to retrieve information from Geneva for the country office. With CDC we get answers more quickly, it is more responsive.” The issue of the timeliness of WHO guidelines has been highlighted by many country level actors even
in non-emergency contexts, since countries may require specific input at the time of revising their treatment protocols or in response to their epidemiological situation, or as part of a health system reform process.

63. Technical departments in WHO are increasingly exploring ways of applying a living guidelines approach, although some technical products are updated according to a set calendar, like the Model List of Essential Medicines (EML) every two years. However, fully implementing living guidelines may not be cost effective or affordable, since this requires important resources to constantly review upcoming evidence. In addition, there is a risk of contradictory messages being sent if emerging evidence is not sufficiently consolidated and consistent, and successive recommendations provide conflicting messages to users. A HQ technical department stakeholder explained that they were seeking a balance between up-to-date guidance and having a strong process and a solid evidence base before updating their guidance. From a country perspective, disseminating new recommendations from WHO and training relevant stakeholders to follow them is also a lengthy and costly process.

Finding 6. Where country level stakeholders and users provide input in normative products, they have greater ownership and products are more adapted to their intended audiences.

64. Integrating users’ feedback in guideline development has been a way for technical departments to increase uptake of their products. The second version of the mhGAP implementation guide, for example, was developed following a thorough review and engagement process with implementers of the first version. It was judged more user-friendly than the first version by several in-country stakeholders who had been trained on both instruments.

65. The QNS department conducted consultations in 2021 with end users to understand their perspectives on the usability of WHO products. The HIV department also conducted a survey to understand expectations from Ministry of Health counterparts on a range of topics related to the normative products that they issue, such as the preferred format, frequency and means of dissemination. Recommendations from those consultations were echoed by country level respondents. These revolved around the need to better consider the needs and characteristics of different end users in the development of normative products. Key elements to take into account include:

- **Dissemination and information sharing.** New guidance is shared via the three levels of the Organization. Some strategies allow securing a better uptake of normative products, such as including mention of the product in the WHO Director General’s speeches, having scientific publications in high impact journals, or having the normative product promoted at specific platforms, such as the International Health Regulations Committee.

- **Format of normative products.** Country stakeholders may refer to online versions or printed copies depending on their preferences and internet access. In the case of clinical guidelines, health professionals appreciate normative products when they come as toolkits with charts and visuals that are easily referred to. Respondents to the HIV department’s survey mentioned a preference for consolidated guidelines. In the QNS consultation, users mentioned the complexities of navigating publications on the WHO website and identifying the latest version of the guidelines. Some technical departments are implementing innovative solutions to address these issues, such as the Global Malaria Programme, with an app available for health workers to access (see Box 2). The NCD programme has created virtual health workers providing recommendations directly to the public, Florence for tobacco and Pahola, developed by PAHO to provide counselling and information on alcohol. While these products are at the frontier between normative recommendations and information provision, they illustrate how WHO uses technology and innovation to increase the reach of its normative products to a wider audience beyond traditional channels.
Box 2: Global Malaria Programme Malaria Toolkit App

The Malaria programme’s Toolkit on Magic App provides all up-to-date recommendations in one place for easy access, not only by policy makers and programme managers, but also for health workers to be able to refer to directly. The evaluation found that although some country stakeholders working on malaria knew about this platform, none were using it to access WHO guidelines. A WCO respondent considered that they required more support to promote the use of such tools: “HQ is moving to apps and online format for their guidelines, so we need online courses to keep the country offices updated on this.” Moreover, in Uganda the Malaria Control Programme had set up its own app for health workers to access national treatment guidelines, and issues of interoperability with the WHO Malaria Toolkit App had not been addressed. This reflects the need for field-testing any dissemination and operationalization mechanisms with the same rigor as technical aspects to ensure that they fulfill their purpose. This also reflects the need to update WCO staff as the primary port of entry in countries regarding newly available normative products and accompanying tools developed at the other levels of the Organization.

• Other issues for normative products to be adapted to the needs of their audiences include accessibility for people with disabilities that do not seem to be considered in the sampled normative products, and translation into languages other than English. The issue of the availability of guidelines in Arabic was mentioned by stakeholders in Jordan. Translation of WHO normative products is often left to the responsibility of Ministries of Health – although, in some instances, WCO may be able to dedicate resources to this.

Finding 7. Normative products do not consistently provide guidance on how to implement and monitor them.

66. Guidelines tend to focus on technical aspects, and do not always provide much in the way of ‘how’ to implement and monitor progress, although this seems to have improved in recent years. In terms of the normative products included in the sample, there were uneven levels of guidance on how to implement and monitor use and contribution to public health outcomes. Table 8 shows that normative products and their accompanying documents have included elements of operational and monitoring guidance. The extent to which those are field tested, disseminated and used to support implementation in a country may however be limited. A WCO staff member commented: “Do colleagues in HQ understand the continuum from guidelines to implementation? Most WHO guidelines are purely clinical, they do not provide guidance on how to track how they are used.”

67. Crucially, where M&E guidance is provided, it does not often include objectives describing what success looks like nor give measurable targets that may be used to track progress against WHO result frameworks. There are however examples of this in the sample of normative products considered. The AWaRe (Access, Watch, Reserve) Access group of medicines, which has been developed by the EML unit, has an associated target in the GPW13 of 60% of national antibiotic use from the list. The Clean Household Energy Solutions Toolkit (CHEST) M&E module indicators, as part of the technical package of the Indoor Air Quality Guidelines, have been used to develop Demographic Health Survey indicators and report on SDG 7 Indicator 7.1.2 in all case study countries.

68. Information alone is, in most cases, not sufficient for Ministries of Health or other targeted audiences to implement WHO recommendations. Providing guidance goes beyond information sharing, to explain how recommendations can be turned into a programme. This needs to indicate what steps implementation should follow, what resources may be needed for this and where those may come from, and what success would look like. In this respect, the HEARTS package constitutes a good example of guidance that integrates implementation
guidance. By contrast, the Model EML is a rigorously developed instrument that has been widely disseminated, but that does not provide much guidance in the way of how to use it in practice so as to contribute to progress on Universal Health Coverage and essential services package agendas.
### Table 8. Monitoring guidance within the normative products included in the evaluation

<table>
<thead>
<tr>
<th>Normative product</th>
<th>Includes guidance on implementation?</th>
<th>Details of implementation guidance</th>
<th>Includes guidance on monitoring?</th>
<th>Details of monitoring guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>mhGAP-IG</td>
<td>YES</td>
<td>The manual includes a short section on the use of the guide. The section briefly describes intended users. It mentions that implementation of mhGAP-IG ideally requires coordinated action by public health experts and managers, and dedicated specialists with a background in public health. Therefore, training in the use of mhGAP-IG is best done as part of a systems approach involving health planners, managers and policy makers so that the interventions proposed are supported by necessary infrastructure/resources, e.g., availability of essential medicines. Training for mhGAP-IG also needs to be incorporated in an ongoing manner with mechanisms in place to ensure adequate support, supervision and refresher training for the healthcare providers. More details on the implementation process are provided in the mhGAP Operations manual (2018).</td>
<td>YES</td>
<td>Proposes facility level and system-level indicators that can be used to monitor mhGAP-IG implementation. The mhGAP Operations manual includes a proposed M&amp;E framework.</td>
</tr>
<tr>
<td>Malaria TG</td>
<td>YES on specific recommendations</td>
<td>The treatment guidelines offer little if any guidance on how to implement the recommendations. The final section, National Adaptation of the Generic Framework for Malaria diagnosis and Treatment and Implementation, offers some guidance on how to adapt the treatment guidelines to the national context, but the steps on how to implement the recommendations are very limited. There are field guides on specific recommended interventions, such as on Seasonal malaria chemoprevention with sulfadoxine–pyrimethamine plus amodiaquine in children (2023).</td>
<td>YES</td>
<td>Detailed guidance available in WHO Malaria surveillance, monitoring &amp; evaluation: a reference manual (2018) which includes forms to be adapted within countries’ surveillance systems.</td>
</tr>
<tr>
<td>Indoor air quality guideline</td>
<td>YES</td>
<td>The CHEST toolkit is intended to help professionals and policy-makers implement the recommendations of the Guidelines on indoor air quality. In includes modules on stakeholders mapping,</td>
<td>YES, but not detailed</td>
<td>The CHEST module on M&amp;E proposes core questions covering: primary and secondary fuels and technologies used for cooking, heating, and lighting; costs and availability of fuel; time spent using devices; time spent collecting fuel;</td>
</tr>
</tbody>
</table>
| Model EML | YES, on some aspects | The **Selection of essential medicines at country level manual** (2020) includes a section on “Monitoring utilization and expenditure on essential medicines” that provides some information on practical applications of monitoring essential drugs, such as evaluating top-selling and top-used drugs, monitoring antimicrobial medicine consumption, providing feedback to prescribers, deriving measures that reflect quality use of medicines and comparing prescribing choices to guideline recommendations or prescribing protocols. However, how to use the NEML to guide procurement of essential drugs and ensure their availability and affordability as part of the UHC agenda is not covered in the manual, although it is mentioned that “there are important real-world implications when a medicine is listed in the Model List, as it becomes a priority for access and reimbursement”.

Yes, on some aspects | The **Selection of essential medicines at country level manual** (2020) offers guidance on how to evaluate medicines at country level for their inclusion in the national list of essential medicines. The tracking of use of essential medicines on the NEML is covered by the ATC/DDD (Anatomic Therapeutic Chemical (ATC) and Defined Daily Dose (DDD)) methodology, referred to in the manual as the gold standard tool for producing good quality, usable and comparable drug utilization statistics. |
| HEARTS | YES | The HEARTS **Implementation module** outlines the steps to follow to implement the HEARTS package: engaging stakeholders, selecting a demonstration site, planning implementation, implementing and monitoring, and evaluating and scaling up. However, the question of the resources needed and where to find them is not dealt with in the guide.

Yes | The Implementation module includes guidance on implementation process and monitoring. It refers to PAHO’s additional guidance on monitoring which includes five recommended key indicators. |
| COVID-19 IAR | NO | The guidance focuses on how to conduct the review itself but does not provide detail on how to use the exercise as part of the COVID-19 response, beyond generating recommendations for use.

No | Although the guidance stipulates that there is the need to set up a follow up team after the review to track the implementation of activities, there is little guidance on how this team should function. In practice, none of the country case studies documented that such a process had been set up; rather, countries tended to use their existing mechanisms to track overall COVID-19 response implementation. |
Evaluation Question 2: Use of the normative products at the country level

Introduction

69. This section considers the extent to which WHO normative products have been used at the country level. It looks at this overall, drawing on the experience of using six normative products in seven case study countries. Then looks at different types of use before considering the roles of different actors in using these products. It examines the role of WHO at country level in supporting the use of normative products. The section concludes by looking at factors that might facilitate or hinder use of WHO normative products at country level.

70. Key findings under Evaluation Question 2 are as follows:

- WHO normative products in the sample have been widely used at country level, with the exception of the Indoor Air Quality Guidelines, which have been used to a very limited extent. The Model EML has been used to develop national EMLs.

- The first step in using WHO normative products often involves adapting them to a specific country context. WHO normative guidance has also been used commonly to build country capacity, in particular technical areas, and to develop and strengthen health systems. In some cases, WHO normative guidance has been used to improve or extend health services and programmes. There was no example of WHO normative guidance used specifically to promote gender equality and health equity.

- The assumption that national governments, alone and unaided, can and will apply normative guidance provided by WHO is not verified.

- While Ministries of Health are key actors in using WHO normative guidance, a wide range of other actors is needed to participate in its implementation, but they are not sufficiently engaged with.

- Normative functions of WHO at country level go beyond supporting the dissemination and adoption of global normative products.

- The implementation of normative products is not always well-integrated in overall country planning. Resources are not aligned to the ambitions of WHO in terms of its normative role at country level.

- Key factors facilitating and hindering the use of WHO normative guidance relate to country health system maturity, congruence with opportunities and events in countries, level of resources of the WCO and other contextual factors.

- WHO does not currently systematically monitor the use of its normative guidance.

Finding 8. WHO normative products have been widely used at country level.

71. From the case studies conducted for the evaluation, there is strong and consistent qualitative evidence that almost all the normative products considered in the sample had been widely used at country level. The only exception is the WHO Guidelines for Indoor Air Quality: Household Fuel Combustion (2014). Beyond feeding into the design of national surveys such as Demographic Health Surveys, these guidelines have either not been used, such as in Jordan, Pakistan and Uganda or have only been used to a very limited extent, for example in Rwanda. While there has been some limited use of the guidelines in Rwanda, work in this area has stalled due to limited human resources in the WHO country office (see Box 3).
Finding 9. **WHO does not currently systematically monitor the use of its normative products.**

72. The QNS Department is currently investigating how to monitor normative guidance reach, uptake, use and impact at country level. A theory of change model for WHO’s normative work is under development by the Department at the time of this evaluation. This model aims to clarify what is expected to happen to achieve results, how to measure impact, and outlines a number of assumptions and practical considerations relating to the nature of normative products, country-level health systems, and the contribution of WHO to the implementation of specific normative products at country level. At the time of this evaluation however, there is no corporate theory of change model for WHO’s normative work endorsed by the Organization to form the basis of a monitoring and evaluation framework for this function.

73. An ongoing research project by the University of Montreal in Canada aims to assess what WHO’s normative influence is. To understand how and when WHO norms are adopted by different countries to guide their health policy efforts, the research team is conducting an in-depth analysis of domestic law in sampled countries, and identifying where WHO norms are cited in legislation. This will provide an indication of uptake of WHO’s normative guidance by countries and of both hindering and facilitating factors.
While there is interest among HQ stakeholders in developing a measure of “uptake” (corresponding to countries adopting and adapting WHO normative products), it is likely that such measures would be difficult to interpret. Indeed, normative products have different intended audiences. Also, the fact that a normative product is not directly translated into the national framework may be due to different reasons, including the fact that some countries may already have systems and norms in place that do not require additional input from WHO. The need for a tailored approach is well captured in the QNS background document for an internal workshop held on 4 May 2023 with technical and corporate departments on monitoring, evaluation and learning from the implementation of WHO guidelines and other normative and standard setting products at country level. The document refers to the need for a tailored approach, while tentatively defining common dimensions.

Monitoring the use of WHO normative products at country level is key to understanding the Organization’s normative role and contribution at country level. However, there is currently no strong requirement or guidance from WHO on how to include the monitoring of normative product use at country level. The way in which the use and implementation of normative products are monitored is likely to be specific to each of them. As outlined in Finding 7, normative products included in this evaluation do not systematically include guidance on how to monitor their implementation.

**Finding 10. The first step in using normative products often involves adapting them to a specific country context.**

In general, WHO normative products are rarely used directly at country level. First there is usually a process of adaptation or contextualization. There are, however, some exceptions. For example, the United Nations Relief and Works Agency (UNRWA) reports that it uses WHO’s List of Essential Medicines directly rather than national lists produced by a particular country. One reason for this is that UNRWA works with Palestinian refugees in five “fields” – Gaza, Jordan, Lebanon, Syria and the West Bank.

In most other cases, the first step when using a WHO normative product is to adapt or contextualize it to the national context. This is especially the case with the WHO List of Essential Medicines (EML). All countries considered as case studies for this evaluation have used this as a basis for developing their own national EMLs (see Box 4). Respondents in the Philippines noted that using the WHO EML in this way results in substantial efficiency gains compared to if they had to develop and update their own national EML in isolation. This would also likely be the case for other countries. In Ethiopia, each of the approximately 4000 health facilities in the country is supposed to develop its own EML based on the national EML, which results in a time and resource intense process.

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ix Background document on monitoring, evaluation and learning from the implementation of WHO guidelines and other normative and standard setting products at country level (2023), QNS Department of WHO.
Box 4. Countries use the WHO Model EML to develop their own national EML.
All countries included as case studies for this evaluation reported that they use the WHO EML as the basis for developing their own national EMLs. However, the extent to which this is done in these or other countries is not tracked systematically. An exercise was conducted in 2017 which was used to construct a database of essential medicines for 137 countries. This is currently in the process of being updated by the EML unit. An article based on this work was published in BMJ Open in 2022. The database lists the number of essential medicines on the national list and the percentage that are on the WHO EML. On average, two thirds (66%) of medicines on the national EML are also on the WHO EML. This figure is highest in Pakistan (93%), Haiti (92%), Bangladesh (91%) and Mozambique (90%) and is lowest in Portugal (28%). Table 9 shows figures from this database for the seven countries included as case studies in this evaluation. There is considerable variation between national EMLs and the WHO EML. Jordan, Maldives and the Philippines have fewer than average of their national EML medicines on the WHO EML. Uganda has about the average and Rwanda and Pakistan have more than the average. Some, but not all, of this may be explicable in terms of national context.

Table 9: Number of medicines on national EML and percentage on WHO EML: Case study country examples (Source: WHO database 2017 data)

<table>
<thead>
<tr>
<th>Country</th>
<th># of medicines on NEML</th>
<th>% of medicines on NEML on WHO EML</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethiopia</td>
<td>707</td>
<td>45%</td>
</tr>
<tr>
<td>Jordan</td>
<td>590</td>
<td>49%</td>
</tr>
<tr>
<td>Maldives</td>
<td>535</td>
<td>45%</td>
</tr>
<tr>
<td>Pakistan</td>
<td>373</td>
<td>93%</td>
</tr>
<tr>
<td>Philippines</td>
<td>519</td>
<td>56%</td>
</tr>
<tr>
<td>Rwanda</td>
<td>284</td>
<td>76%</td>
</tr>
<tr>
<td>Uganda</td>
<td>363</td>
<td>68%</td>
</tr>
</tbody>
</table>

As this information is somewhat dated, the evaluation team repeated the analysis for two countries, Jordan and Maldives. This analysis is shown in Table 10.

Table 10: Number of medicines on national EML and percentage on WHO EML: Examples of Jordan and Maldives (figures in brackets for Jordan are for the rational drug list)

<table>
<thead>
<tr>
<th>Country</th>
<th>% of medicines on WHO EML which are also on NEML</th>
<th>% of medicines on NEML which are also on WHO EML</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jordan</td>
<td>91% (58%)</td>
<td>78% (35%)</td>
</tr>
<tr>
<td>Maldives</td>
<td>53%</td>
<td>59%</td>
</tr>
</tbody>
</table>

8. Other normative products have also been adapted for specific national contexts, for example mhGAP in Maldives, Pakistan, the Philippines and Uganda. This adaptation was considered particularly important in Maldives, where some of the material was not considered relevant to the country and there were key gaps, for example on anxiety. Adaptation was also considered important in Uganda in relation to epilepsy and self-care for health workers during COVID-19 (see Box 5). In Maldives, the number of questions proposed in the COVID-19 IAR guidelines was considered overwhelming. The IAR there consequently conducted a SWOT analysis, which was found to be a simple way of gaining answers to many of the most relevant questions.
A particular type of adaptation and use is when a country takes a part or parts of WHO guidance and incorporates it into policy and/or strategy, for example as has happened in some countries with mhGAP and HEARTS. However, this was reported relatively infrequently.

Finding 11. WHO normative guidance has been used commonly to build country capacity in particular technical areas.

There are many examples when guidance has been used to build capacity, such as by providing training. This is particularly the case for mhGAP, where training has been provided in all case study countries, and for HEARTS where training has been a key focus in, for example, Jordan and the Philippines. However, while training and capacity building are important, they are not sufficient to promote change alone, and there are many examples of training being provided that fail to lead to any tangible change. It is essential that training focus not only on technical content but also on how practice can change. Where this has been done successfully, it has involved additionally training health centre managers and administrators, ensuring the regular support and follow-up of those trained, and ensuring that referral mechanisms are in place and that they work.

Finding 12. WHO normative guidance has been used to develop and strengthen health systems.

WHO guidance has been used by countries to develop and strengthen health systems particularly related to primary health care. Examples include the roll out of mhGAP in the Philippines, for example, through Regional Mental Health Committee Councils. Maldives does not have an up-to-date primary health care system, with patients often accessing secondary or tertiary services without referral, particularly in Male. For this reason, HEARTS and mhGAP implementation is being piloted in Faafu atoll as a way of deliberately strengthening primary health care.
health care in the country. However, there are concerns in some countries, such as Uganda, that HEARTS could be implemented in a way that undermines health systems and that promotes vertical, disease-based programming. Efforts to introduce HEARTS in Uganda have to date been unsuccessful due to limited resources. One proposal is to seek to introduce HEARTS through HIV clinics, which are better-funded. While this may be a pragmatic approach, it presumably may create health systems issues.

Finding 13. In some cases, WHO normative guidance has been used to improve or extend health services and programmes.

82. There is evidence in some countries that guidance has been used to improve or extend health services and programmes. For example, in Jordan, mental health services are now estimated to be available in 30% of Ministry of Health primary health centres because of mhGAP. The mhGAP has also been used to promote mental health services in facilities operated by UNRWA and International Medical Corps (IMC). There is also strong qualitative evidence from the Philippines that mhGAP roll out has strengthened the provision of mental health services there. Evidence of the use of COVID-19 IARs is mixed. There was relatively little evidence of use in Jordan. However, in Maldives the two IARs, which each focused on a single pillar, led to concrete action in each case. For example, the COVID-19 vaccine post-introduction review (c-PIE) led to adding two permanent staff, including a cold chain manager, replacing all domestic fridges in health facilities, and expanding the electronic data reporting system beyond COVID-19 to cover other forms of vaccination. In Uganda, two IARs were used to develop national response and stabilisation plans. However, in Rwanda, the COVID-19 national plan was not updated although the review recommended this. Nevertheless, stakeholders commented that the review had been useful for improving aspects of the COVID-19 response, such as confinement and ensuring continuity of care for chronic patients. Much of the evidence on improved health services and programmes is, in the absence of robust systems to collect quantitative data, qualitative and anecdotal.

Finding 14. No example was presented to the evaluation of a WHO normative product used specifically to promote gender equality and health equity.

83. No examples were encountered of WHO guidance being used specifically to promote health equity or gender equality. Some WCO and other country respondents have argued that actions that develop primary health care would be expected to have a positive effect on equity by improving access to services for all. While this may hold true for the general population, in the absence of dedicated efforts to gather evidence, to understand and address barriers to accessing healthcare for different sections of the population, it is unlikely that entrenched inequalities and discrimination against specific groups will be reduced by population-wide interventions.

Finding 15. The assumption that national governments can and will apply normative guidance provided by WHO is not verified.

84. The draft QNS handbook contains a pathway for normative products after publication (Figure 1). The theoretical model developed during the inception phase of the evaluation, reflecting the implicit theory of change for WHO’s normative work, largely aligns to the phases of the pathway for normative products after publication⁴. This pathway implies that if WHO develops and positions normative products for use then policymakers will then adopt and adapt these products in their context, then the target audience will use the normative products to inform their knowledge, they will change their practice and behaviour based on the normative product, and policy makers and health professionals will influence changes in service delivery and changes in community practice. Although the

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⁴ At the time of the evaluation, the QNS Department was in the process of developing a theory of change model for WHO normative function, which aims to provide more details on impact measurement and practical aspects for WHO to enhance the contribution of its normative work.
pathway does not explicitly identify assumptions, it appears to assume that WHO’s input focusses on developing and positioning products and that other actors will then be able to make the changes envisaged, in other words they know how to do this, they have the resources to do so and are able to monitor the changes that occur.

85. Overall, the implicit assumptions within this model place a great deal of emphasis on national governments, and Ministries of Health in particular, implementing the guidance provided by WHO at scale. While national governments accept this responsibility in general, there is recognition that, in many countries, health services and other activities may be provided by a range of actors and not only by national government. In addition, respondents expressed a strong preference for normative products that not only say what should be done with evidence but which also give guidance on how this should be done. There is also a preference for ongoing support from WHO, particularly from country offices, for translating the guidance into action. This often requires producing adapted or contextualized guidance and countries often seek technical assistance from WHO country offices for this. Another area where governments appreciate support is in identifying the resources needed. There are many costs associated with the roll-out of technical guidance in the health system, for example the training of a health workforce, revision of HMIS tools for collection of patient and other health systems information, the printing and dissemination of the revised tools to all health facilities, etc. This does not mean that Ministries of Health are always looking to WHO to provide that support, but they would like WHO to work with them to identify where resources might come from. In low-income countries, it is likely that additional resources would need to be found from external sources.

86. In many countries, there is a national regulatory authority for medical products or Chief Pharmacist who has responsibility for developing national EMLs based on the WHO EML. In general, they have well-developed systems for doing this. However, those actors have been less active in promoting essential medicines use, for example through training policy makers, prescribers and the general public or by introducing measures to ensure essential medicines are procured or prescribed. In some cases, such as Maldives, where the Food and Drug Administration has tried to introduce regulations on generic prescribing and maximum prices, this was successfully opposed by other stakeholders.

Finding 16. While Ministries of Health are key actors in using WHO normative products, it is necessary to involve a wide range of other actors.

87. Other government ministries may also have a key role to play in using WHO normative guidance, particularly in areas beyond health service delivery. For example, other ministries, such as the Ministries of Energy, Environment or Climate Change may have a key role in relation to indoor air quality and air pollution. However, their main focus may be on ambient air pollution, and it may not be clear which ministry has the lead responsibility for indoor air quality. Indeed, in some countries, such as Jordan, there may not be a ministry with lead responsibility for this area. Similarly, in some countries, the Ministry of Health may not have been the lead ministry in relation to the response to COVID-19. This may have been handled by a body responsible for emergencies or there could have been a special body established specifically for COVID-19, like the National Command and Operation Centre in Pakistan.

88. There are other development partners who may play an active role in promoting the use of WHO normative guidance. Positive examples include the Global Fund on malaria, various NGOs in relation to mhGAP and the United States Agency for International Development (USAID) and Chemonics International as regards essential medicine lists. However, there may be cases where there could be competition between WHO and other development agencies in relation to normative guidance. Examples given to the evaluation team included the Centers for Disease Control and Prevention (CDC), Gavi, the Vaccine Alliance and Partners in Health. In Jordan, there were three COVID-19 intra-action reviews. Each was associated with a different development partner (WHO, Civilian Research and Development Foundation [CRDF] and the World Bank), which resulted in some duplication and redundancy.
89. One shortcoming of much of the WHO normative guidance, particularly in areas relating to the provision of health services, is that it appears to assume a somewhat unified health system or service. This is not the case in many countries, for example Jordan. Overall, WHO normative guidance is not readily applicable to private providers, particularly for-profit providers. This is problematic in countries where such providers deliver a large proportion of health services. This is not to argue for separate guidance for the private sector but for WHO normative guidance to recognize that private providers are important health service providers in many contexts. One positive example of private sector engagement comes from the Philippines where it is reported that doctors from private clinics have organized lectures and capacity building.

90. There are examples where Non-State Actors have played an important role in supporting the use of WHO guidelines. For example, in the Philippines, grants have been provided to NGOs and academic organizations to contextualize components of mhGAP, and to academic organizations to integrate mhGAP into pre-service training. In Jordan, mhGAP training has been provided to IMC facilities. In Uganda, both the Tropical Health Education Trust (THET) and Jhpiego have been involved in disseminating mhGAP to regional hospitals.

Finding 17. While normative products are key in supporting WCO’s efforts to strengthen a country’s health system, the implementation of those products is not always well integrated in overall country planning.

91. Country Cooperation Strategies set out the priorities for WHO’s support in country, at the intersection between the country’s priorities and the maturity of its health system and WHO’s global normative guidance. These strategies thus reflect where the WCO’s normative role is situated on a continuum from policy guidance to direct service delivery in some specific cases, as outlined in the Country Cooperation Strategy Guide (2020)24. The CCS is delivered through biennial Country Support Plans (CSP) that articulate the required support from the three levels of the Organization to deliver the strategy, and to specify what normative products will be disseminated and supported at country level in the biennium.

92. WHO has been working on improving alignment of the normative products cycle with the WHO corporate operational planning cycle, particularly integrating the implementation of normative products in country support plans (CSPs). This alignment has been conceptualised for the last programme budget cycle in the technical product guide, as outlined in Figure 6.
93. In practice, however, some WCO stakeholders interviewed for this evaluation consider that a level of confusion exists about how to select products within the list of available products and how to include those in their workplans and budgets. This may hinder the ability of WCO and national counterparts to keep abreast of updated guidance and identify the normative products that are relevant to their needs. WCO respondents have thus expressed the need for better and more tailored dissemination of information on available normative products to support their planning. In addition, where resources are available, technical departments may promote their normative products to be taken up by specific countries in parallel to the corporate planning process. This may result in a disconnect with country level processes and capacity levels to implement and track normative products use and contribution.

94. Conversely, it is noteworthy that normative product use in countries may differ from the planned uptake by WHO technical product developers. For example, in the selected sample of countries, only two (Ethiopia and Philippines) are considered ‘implementation countries’ by the WHO NCD department. However, other countries in the sample such as Maldives and Uganda have attempted to introduce the package through mobilising other partners. Rwanda is not one of the twenty-five target malaria elimination countries for WHO; however, national stakeholders considered that efforts should be dedicated to achieving malaria elimination before 2030 in the country. While the main stakeholder for the use of Indoor Air Quality Guidelines is expected to be the Ministry of Energy, there seemed to be very little contact between them and the WCO in the sampled countries. Conversely, other Ministries such as the Ministry of Climate Change in Pakistan or the National Environment Management Authority in Uganda have been working on household air quality standards.

95. The way that the normative function of WHO is conceptualized from a HQ perspective seems to be that once normative products are developed in response to country needs, countries become recipients of WHO’s normative work and WCO plays a facilitation role in the process of adapting and implementing them. However, this linear process does not reflect the fact that country office planning is largely driven by a country’s evolving priorities. A
review of Country Cooperation Strategies for the seven case study countries reveals that they appear largely demand driven and mainly refer to national policy framework documents rather than specific WHO normative products. From a country perspective, normative products are a tool to be adopted as and where relevant, to support the broader normative function of the WCO in country. Interestingly, the CCS sometimes are also involved in supporting the adoption of normative products that are relevant but not directly authored by WHO, such as the DCP3 in the Pakistan CCS.

96. This tension is well-articulated in the 2018 Rwanda Country Office Evaluation, which describes the challenges for WCO to respond to both shifting country demands and the strategic agenda of WHO, which is set at the global level: “WHO is strongly driven by a highly ambitious and dynamic national counterpart and work planning is also done within the context of guidance by the GPW and biennial programme budgets. The WCO therefore faces twin challenges: from the Government, which is dynamic and ambitious, to address rapidly evolving national priorities; and from WHO itself to meet wide-ranging global and regional targets.”

97. The issue of bottom-up planning and ensuring that there is one integrated planning process driven at country level by WCO is not new. MOPAN assessment in 2017–2018 emphasised that: “Resources will continue to need to shift from headquarters to some country offices, with GPW13 in principle allowing greater focus at country level through a more bottom-up approach.” More recently, the need for more country-driven planning was highlighted by the Evaluation of WHO’s results based management framework: “There is lack of support for implementation and guidance on how the global, regional and country plans can be translated into implementation in countries. Country offices’ delivery capacity needs to be strengthened to act as a health delivery unit/catalyst in their country.” In relation to normative product use and implementation, bottom-up planning remains complex to implement.

98. Specific normative products tend to be mentioned more in the CSPs than in the CCS, as illustrated in the example of Jordan in Table 11.

Table 11. Normative products inclusion in CCS and CSP: the example of Jordan

<table>
<thead>
<tr>
<th>Normative Product</th>
<th>CCS 2021-25</th>
<th>CSP</th>
</tr>
</thead>
<tbody>
<tr>
<td>EML</td>
<td>Jordan has a comprehensive national drug policy, an essential medicines list and standardized treatment protocols supported by a regulatory body, but it is not completely utilized at health facility level. High levels of expenditure on pharmaceuticals can be partially explained by the prescribing behaviour of physicians and pharmacists, insufficient regulation of prescribing practices, self-medication by consumers, and the relative presence and influence of the pharmaceutical industry that promotes products without adequate control.</td>
<td>Activity under Outcome 1.3 1. Provide technical assistance to JFDA to routinely update the National Essential Medication List (EML)</td>
</tr>
<tr>
<td>HEARTS</td>
<td>Not specifically mentioned although there is reference to NCDs and risk factors</td>
<td>Included as output under outcome 1.1.1 NCD Integration in PHC: NCD prevention and management of technical packages (including HEARTS), M&amp;E and other mechanisms supported and implemented, as part of people-centred PHC strategies</td>
</tr>
</tbody>
</table>
Activities include:
1. Supporting MOH to implement and monitor the HEARTS technical package, to strengthen response to cardiovascular disease risk factors at PHC level;
2. Capacity building and learning for impact - Supporting MOH towards building national capacities to effectively prevent and manage NCDs;
3. Supporting MOH to strengthen the integration of NCDs into PHC and priority benefit packages;
4. Support for strengthening NCD surveillance, and supporting MOH to monitor NCDs;
5. Supporting MOH to assess, early detect and respond to rheumatic heart diseases in both host and refugee communities;
6. Promoting the integration of NCDs’ programme at MOH by assessing the adoption and implementation of PEN at PHC level

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>mhGAP</td>
<td>Included in the list of acronyms but not mentioned elsewhere. Mental health is mentioned a lot.</td>
</tr>
<tr>
<td>Malaria TG</td>
<td>Not relevant</td>
</tr>
<tr>
<td>Indoor Air Quality</td>
<td>Air pollution recognized as health risk factor. Clean air identified as essential ingredient of good health. No specific mention of indoor air quality</td>
</tr>
<tr>
<td>COVID-19 IAR</td>
<td>While COVID-19 is covered, no specific mention of IARs</td>
</tr>
</tbody>
</table>

Finding 18. Normative functions of WHO at country level go beyond supporting the dissemination and adoption of global normative products.

99. The GPW13 describes how WHO intends to tailor its normative work and the level of support it provides for the implementation of normative products according to country capacity and need: “In all countries WHO will engage in policy dialogue, tailored to country needs and context, as the basis for the Organization’s collaboration with countries and as the means of ensuring that WHO’s normative work is implemented by countries. The WHO Secretariat may also provide strategic support to countries in implementing WHO’s normative guidance, and technical assistance to help build institutions and capacity. In a small subset of countries WHO will also, for a limited time period, strengthen service delivery principally to coordinate and convene the health sector response.” This graduated response is translated in practice to the categorisation of countries by the County Support Unit Department according to the level of support provided, as presented in the Methods section. The third-party evaluation of the adoption of WHO written standards for quality, safety and efficacy of medical products (2023) also recommends: “Develop[ing] guidelines that take into consideration the state of certain Member States that don’t have capacity to implement (adopt and adapt) WHO norms and standards (coming out of conflicts, fragile states).”
100. Other normative roles of WCO, beyond supporting the dissemination and adoption of global normative products at country level, include:

- Supporting country use and impact on normative products,
- Supporting the development, analysis and feedback of country-generated evidence and data and their use so as to inform national policies and programmes,
- Supporting the capacity of countries to better adapt global guidance into their national context beyond the use of particular normative products. In this respect, the QNS Department has piloted a project in Ethiopia and Uganda to assess current systems that are in place to do this at country level, and to identify potential entry points for WHO to support country capacity in this respect.

101. In practice, WHO country offices are much more active in supporting and facilitating the use of WHO normative guidance at country level than might be implied by the post-publication pathway in the draft QNS handbook. WHO country offices often introduce national governments to relevant WHO guidance. They actively promote it through engagement with and within decision-making bodies in country. WHO country offices often provide technical assistance to adapt guidance to specific national contexts. In emergency settings, such as in Pakistan, the WHO country office may assume a more operational role than might be usual in non-emergency settings. In terms of specific normative products, while WHO country offices have not been particularly active in the adaptation of WHO EML to develop national EMLs – not least because this is a long-established process in which most countries have experience and capacity – there are examples of WHO country offices supporting a country’s regulatory function in other ways, for example in the Philippines. WHO country offices have been active in supporting NCD surveillance efforts, such as STEPwise surveys. These have been influential in some countries, including Jordan and Maldives, in terms of providing data to justify the introduction of the HEARTS programme.

**Finding 19. WCO resources are generally not aligned to ambitions and expectations in terms of supporting the implementation of normative products.**

**Box 6. Pakistan and the use of Malaria treatment guidelines in the flood emergency**

In the context of Pakistan’s flood emergency in 2023, WHO has shifted to an emergency type of response to malaria, in order to rapidly identify and address outbreaks. WHO hired 57 malaria experts to support the emergency malaria response during the floods. They worked to strengthen the health information system with daily reporting of cases from facilities and health camps and set up an automatic incidence warning system. Mass Drug Administration to children under the age of five was applied where increased transmission of malaria was observed.

102. Country office capacity to support the use of WHO normative products is mixed. Some WHO country offices have sub-national offices, meaning they may be better able to support the use of WHO normative guidance throughout the country.

103. Most technical staff in WCO must cover multiple roles. There are some specific areas where human resource capacity in country offices is especially inadequate, for example mental health in Pakistan or Rwanda. In general, NCDs, mental health and environmental health technical areas appear to be under-resourced at WCO level. Respondents from HQ believe that this situation has worsened as time from technical staff is increasingly dedicated to reporting or undertaking managerial tasks required by both HQ and regional offices.

104. Some topical areas, although nominally prioritized within WHO, have been under-resourced. Such areas include NCDs, mental health and indoor air quality. There is a lack of resources to support activity implementation in the technical areas related to the HEARTS package, the mhGAP and the indoor air quality guidelines. Respondents from Ministries of Health have often commented that they do not expect WHO to have sufficient resources to fund health services delivery at scale, often contrasting WHO’s role with that of UNICEF. However, when introducing a normative product to stakeholders in a country, WHO has sometimes stopped short of supporting the necessary activities to ensure its use. The Uganda case study documents several instances of programmes where support from WHO has stopped after a pilot training (on HEARTS in three districts, mhGAP in one district), but no further
follow-up was provided to either document the pilot or to use learning as part of a scaling up to plan. Another example of this is the Indoor Air Quality Guidelines training workshop that took place in Rwanda, where a multi-stakeholder process was started by WHO identifying community health workers to be trained, but then the process was abandoned for lack of resources and human resources at WCO level. This seems to assume that the onus of ensuring follow up and implementation from the pilot would be on the Ministry of Health or another Ministry. These short-term, small-scale interventions can create frustrations in national counterparts, for example a high-level Ministry of Health stakeholder considered that the country suffered from “pilotitis”. A clinician that was trained as a Master Trainer on mhGAP as part of a WHO-led pilot also requested that trainings not be organised unless there were resources in place for follow up.

105. In contrast, there are areas where more implementation resources are enabling WHO to play an active role in supporting the implementation of normative products, as is the case for mhGAP in Jordan.

106. This is particularly marked in emergencies, where WHO may play a ‘first respondent’ role and gets directly involved in services delivery. In Jordan, Pakistan and the Philippines, there are examples of the use of mhGAP among refugees and in situations of civil unrest and natural disasters, such as typhoons, floods and earthquakes. In some cases, for example in relation to malaria during flood emergencies in Pakistan (see Box 6.), the WHO country office has used the emergency response to build the provincial health system’s capacity. Concerns were raised in the Pakistan case study that while the response to malaria in emergency settings was very strong, malaria control, surveillance, and resistance monitoring outside the emergency context seemed insufficient. This may explain why malaria cases are falling in some provinces, such as Punjab, but rising elsewhere.

Finding 20. Key factors influencing the use of WHO normative products relate to country health system maturity, whether the introduction of a normative product/package coincides with key opportunities or events in a country, on the level of resources of the WCO and other contextual factors.

107. The level of political commitment in a country to a particular topic or issue may affect the extent to which the use of WHO guidance is facilitated or hindered. For example, political commitment to mental health in the Philippines was high and this helped the successful roll out of mhGAP. In Ethiopia, in the case of the COVID-19 IAR, the Ethiopian Public Health Institute spearheaded the IAR at three administrative levels based on a strong government commitment. Timing of the introduction of a normative product/package with country processes such as health system reforms or policy reviews is also a facilitating factor.

108. The existence of champions and/or opponents may facilitate and/or hinder the use of WHO guidance. This has proved an important issue relating to mhGAP with some psychiatrists championing the programme, for example in Maldives, while others have been strong opponents, such as in Jordan and the Philippines.

109. The content and nature of the guidelines themselves may facilitate or hinder their use. For example, one reason given for not using the indoor air quality guidelines in some countries, such as Jordan, is that they do not cover the issue of smoking, which is considered a main cause of poor indoor air quality. Also, use may be hindered where guidelines are too theoretical and/or focus solely on providing up-to-date evidence. This was reported to be the case with mhGAP guidance. While the mhGAP package includes an operation manual, respondents considered that the package was strong on mental health content but weaker on processes related to both training and programme delivery. Respondents expressed the need for more practical information on how to translate guidance into action.

110. Key factors that facilitate or hinder the use of WHO guidelines are: the level of national government capacity in terms of the technical area covered; the ability to adapt guidelines; and the ability to translate norms and guidance into practical programme delivery. In some areas, such as translating WHO EML into national EMLs, some
countries have established capacity and a long track record, for instance Uganda. Overall, however, there are problems of national capacity, with shortages and high turnover of staff in many areas and these problems profoundly affect the ability of a country to use WHO normative products. One specific example is that follow-up of mhGAP training in Pakistan relies on Provincial Health Departments and they have huge human resource issues.

111. A factor that has facilitated the use of WHO guidelines at country level has been the strong and long-standing relationship between WHO country offices and Ministries of Health. In some countries like Maldives and the Philippines, the offices are co-located. While this close relationship helps to promote the use of guidelines in most cases, it may sometimes mean that WHO feels unable to challenge the Ministry of Health when that is needed.

112. Use of WHO guidelines may be hindered in situations where the Ministry of Health is not the main or only government actor, particularly where a Ministry of Health and WHO country office have limited skills and experience in promoting multisectoral working. This may mean that it is easier to promote the use of guidelines in areas of health service delivery, such as malaria, mhGAP and HEARTS, than in other areas, such as indoor air quality. It may also mean that the WHO country office finds it easier to work with the Ministry of Health than across government more broadly. For example, this may be one factor explaining why the WHO-supported COVID-19 IAR in Jordan focused almost entirely on the Ministry of Health rather than having a multisectoral focus as recommended in the guidance. It may also partially explain the lack of action on the review’s recommendations as the Ministry of Health’s Crisis Management Directorate had been largely marginalized with the national response to COVID-19 being coordinated by the National Centre for Security and Crises Management (NCSCM). However, in Rwanda, the convening role of WHO in the IAR was greatly appreciated. In the Philippines, it is reported that NGOs, including the Philippines Society of Hypertension, have been positively involved in the roll out of HEARTS.

113. The presence or absence of mechanisms to translate guidance into practical actions may facilitate or hinder the use of guidance. For example, there may have been limited use of national EMLs to make the prescribing and procurement of medicines more rational because of a lack of training of policy makers, prescribers and the general public, the lack of treatment protocols for different conditions and the absence of requirements on funders to procure only or preferentially essential medicines. Conversely, where such mechanisms are in place, national EMLs are likely to lead to more rational medicine use. The CVD module has been more easily adapted in the Philippines within the broader package of HEARTS, which includes an implementation guide and is designed in such a way as to enable country actors to adapt it flexibly to their context.

114. The availability of financial resources is a key facilitator of guideline use, while their lack clearly hinders use. Lack of financial resources appears to have been a particular issue in Rwanda and Uganda, affecting progress on indoor air pollution, procurement of essential medicines, roll out of mhGAP and roll out of HEARTS (in Rwanda). The same applies to the procurement of essential medicines in Ethiopia. Conversely, a key reason for the success of HEARTS in Jordan has been the availability of EU funds for this purpose through Spanish Cooperation. Lack of resources was cited in Jordan as a reason why the Ministry of Health had not been able to act on recommendations arising from COVID-19 IARs.

115. The availability and supply of medicines is a key facilitating factor for the use of those guidelines that require medicines, such as malaria, mhGAP and HEARTS. For example, in Pakistan, shortages of psychotropic medicines at primary health care level, have hindered the roll out of the mhGAP programme. In Uganda, a pilot of the HEARTS programme in the Masaka region faced challenges due to lack of training, medicines and basic equipment. As a result, the pilot was not scaled up. In Ethiopia, limitations in the national budget and security issues affected the availability of drugs and medicines listed on the EML in community health facilities. This is compounded by the fact that 80% of communities are in rural settings, where access limitations are more acute than in urban settings.

116. The strength and capacity of the health system may facilitate or hinder the use of WHO guidelines. For example, taking a health systems approach to mhGAP in the Philippines meant involving Regional Mental Health Committee
Councils to reach the entire country. In Jordan, limitations in physical infrastructure and staff shortages have hindered efforts to change patient flow pathways as part of the HEARTS programme, so that new patients have their vital signs checked before seeing a doctor. In Maldives, the absence of a re-organized primary health care makes it difficult to introduce any programme that relies on primary care. This explains why HEARTS and mhGAP are being used as a way of establishing a functioning primary health care system in one atoll in the country.

117. The creation and provision of incentives may facilitate the use of WHO guidelines. For example, in the Philippines, an incentive for mhGAP training is that this is necessary to qualify as a medicine access site.

118. Monitoring data is crucial in facilitating the use of WHO normative guidance, since it provides information on what progress has been made and what the situation is currently. The absence of such monitoring data, for example in relation to EMLs, is a major factor hindering the use of WHO normative guidance. This data, however, is costly to gather and track, and the task goes beyond available resources of the EML unit in WHO. Similarly, the absence of monitoring data in relation to mhGAP hinders understanding of whether training activities are resulting in improved programme and health service delivery. Patient-based monitoring systems, such as registries, help to ensure continuity of care for patients who move from one area to another. In some cases, weak, fragmented and incomplete health information systems have hindered the collection and reporting of key data, for instance on HEARTS programme implementation in Jordan, Maldives and Uganda.

119. Surveillance data has in some cases been an impetus to action for particular WHO guidance. For example, in Jordan and Maldives, the results of a STEPwise survey were identified as crucial for promoting uptake of the HEARTS programme. In some cases, epidemiological data is quite out-of-date. For example, the latest NCD Epidemiological data from Uganda is almost ten years old.

120. External factors can facilitate or hinder the use of guidelines. The disruptive effect of COVID-19 and measures to control it are well-known, such as on the roll out of HEARTS in the Philippines. However, the pandemic also brought more focus on mental health, and this led to an increased use of mhGAP guidelines, for example in the Philippines. Also in the Philippines, the occurrence of typhoon Haiyan was a trigger to accelerate an mhGAP training rollout.
Evaluation Question 3. Results achieved at country level

Introduction

121. The proposed Quality Assurance, Norms and Standards Handbook has a draft chapter entitled, “Impact of Normative Products at Country Level”. This notes that the 2017 evaluation of WHO’s normative function argued for a shift away from assessing the quality of normative products and their recommendations to documenting effects. This is in line with the third strategic shift of GPW 13 and its focus on “documenting impact”. Key principles underlying this documentation include the idea that normative products should be based on country needs and that impacts that occur may be long-term in nature.

122. The results framework in GPW 13 identifies 12 outcomes grouped around the triple billions and the outcome of a more effective and efficient WHO providing better support to countries (see Figure 7).

Figure 7. Extract from WHO results framework showing 12 outcomes (Source: GPW 13)

123. The extent and nature of outcomes and the impact that WHO normative products contribute to may depend on the nature and category of specific normative products. Of the six normative products selected for this evaluation, four might be expected to contribute mainly to outcomes in the “first billion”, in other words to increase the number of people benefiting from universal health coverage (UHC). One product might be expected to contribute mainly to the “second billion”, that is to increase the number of people protected from health emergencies. Finally, one product might be expected to contribute mainly to the “third billion”, that is to increase the number of people enjoying better health and well-being.

124. Key findings related to Evaluation Question 3 are:

- Guidance for conducting a country COVID-19 intra-action review (IAR).
The evaluation found evidence of contributions of the sampled normative products to the triple billion goals and related outcomes. Three of the products (malaria treatment guidelines, mhGAP and HEARTS) reviewed for the evaluation are likely to be contributing to improved access to quality essential health services. While the evaluation did not encounter explicit evidence of a reduced number of people suffering financial hardship it is likely that implementation of PHC-based guidelines will have that effect. There is little evidence however that national essential medicine lists lead to more rational drug use in countries. While it is likely that COVID-19 IARs have contributed to better responses, there is no clear evidence that more people are protected as a result. As the Indoor air quality guidelines have not been widely implemented in case study countries, it is not possible for the evaluation to comment on their impact in terms of contributing to a healthier environment to promote health and sustainable societies.

While WHO normative products may be seen to contribute to health equity as part of efforts to promote primary health care and universal health coverage, there is no other evidence from the evaluation of their impact on improving gender equality and health equity or reducing discrimination.

Monitoring and impact evaluation of WHO normative guidance at country level has been extremely weak.

The main factors influencing normative products’ contribution to impact have been identified as the extent to which the product has been used in a country and external factors such as the COVID-19 pandemic.

Finding 21. Three of the products reviewed for the evaluation are likely to be contributing to improved access to quality essential health services

125. Many normative products reviewed for the evaluation might be expected to contribute to improved access to quality essential health services (outcome 1.1 under the first billion goal), including the guidelines on malaria, mhGAP and HEARTS.

126. The Worldwide Antimalarial Resistance Network (WARN) note that WHO’s malaria guidelines have been published in a context where there has been a dramatic decline in the number of cases and deaths related to malaria. They also note that the aim of the revised guidelines is “to promote the optimal use of safe and effective antimalarial treatments to cure and protect patients, and to slow drug resistance.” However, published studies do not really distinguish between contributions made by the guidelines and other initiatives. Part of the problem may be that the malaria guidelines are not really a branded programme in the same way as mhGAP and HEARTS are. One respondent from Rwanda commented that “to eliminate malaria, we need more than clinical guidelines”. They argued for WHO treatment guidelines that focused more on the contextual determinants of the disease including poverty. Nevertheless, malaria treatment guidelines, based on WHO guidance, have been widely applied in Rwanda and Uganda, including the latest treatment recommendations, such as mass drug administration during outbreaks and a new treatment regimen in the first trimester of pregnancy.

127. mhGAP is a longstanding and well-branded programme that is well-documented in academic literature. For example, in 2021, Keynejad and others published a study that synthesized experiences of using the mhGAP implementation guide drawn from 162 new papers which had been published since an earlier systematic review published in 2017. There have been studies from a wide range of settings including Small Island Development States and particular countries, such as Ethiopia and Nigeria. However, although there is strong evidence that mhGAP training improves the knowledge, attitudes and confidence of those trained, including when applied to pre-service training, there is less systematic evidence of mhGAP resulting in changes in clinical practice. However, some studies have shown benefits for patients including greater utilisation of services, improvement of symptoms, improved ability to work, fewer discriminatory experiences and greater satisfaction and engagement with care following mhGAP implementation. Key factors identified in ensuring that the training of staff produced tangible benefits for patients included political commitment to mental healthcare, leadership, coordination of services, continued monitoring and supervision, and availability of medication. In a 2019 comment, Hughes and Thomson expressed the view that “supervision is the lynchpin of sustainability of the mhGAP training”. Innovative approaches may also be helpful. For example, a study in Nigeria commented that the electronic version of the...
implementation guide (emhGAP-IG) may be “a viable way to embed clinical guidance and decision-making tools in the management of people with mental health conditions in Nigerian PHC”.

128. This evaluation’s country case studies reinforce many of the findings in the academic literature, namely that mhGAP is an effective way of building knowledge, skills and confidence among those trained but that ongoing support and supervision is required for that to be translated into improvements for patients (see Box 7).

Box 7. Effects and benefits of mhGAP: examples from this evaluation’s country case studies

In countries where training is backed up with ongoing support and supervision, there is evidence of emerging benefits for patients.

For example, in Jordan, it is reported that people are being seen faster and closer to home, more people are being reached and there is more appropriate use of secondary and tertiary services. In addition, stigma may be being reduced although some respondents reported that stigma in local communities may mean some people are reluctant to seek help for mental health issues in primary care centres.

In the Philippines, ongoing support has included supervision sessions, hotlines, an outpatient referral service and a mental health coordinator in each region. Benefits of mhGAP include improved accessibility for mental health services closer to patients’ homes. The implementation of mhGAP is monitored through a system of programme implementation reviews. In regions affected by Taifun Haynan, the number of patients registered for mental health services rose from around 1,000 to 7,717.

Where training is not yet being backed up with ongoing support and supervision, for instance Maldives, Rwanda and Uganda, or where such supervision is weak, such as Pakistan, there is a risk of mhGAP becoming a training programme only with little, if any, tangible benefit for patients or clinical practice.

129. While there are fewer published studies relating to the HEARTS programme, extensive experience in the Region of the Americas has been reported to improve the detection, treatment and control of hypertension in the populations served. A pilot study in Jordan, published in 2022, showed that among 852 patients with hypertension, rates of uncontrolled blood pressure fell over four months from 71.5% to 29.1%. Older patients (less than 50 years old) were more likely to have controlled blood pressure after four months than younger patients.

Box 8. Effects and benefits of HEARTS: examples from this evaluation’s country case studies

In a number of countries, HEARTS has been implemented as a way of promoting or improving primary health care. For example, in Jordan the focus has been on Ministry of Health services particularly trying to change patient flow in health centres so that those attending have their vital signs checked before seeing a doctor. In Maldives, the primary health care system is not reorganized so it was decided to implement HEARTS in one atoll initially first. There are anecdotal reports from healthcare workers from Faafu atoll that they have begun to observe an increase in the early diagnosis of some NCDs. There are also anecdotal reports from the Philippines of improved availability of anti-hypertensive medications and that, as a result, health outcomes are improving at a small scale.

While there are well-defined indicators for tracking the benefits and effects of HEARTS in relation to hypertension (diagnosed, treated, with blood pressure controlled), it has proved difficult to monitor these effectively in countries, such as Jordan, Maldives and Uganda, that lack a comprehensive and interconnected health information system.

In both Rwanda and Uganda relatively little information is available about the benefits of implementing the HEARTS programme. Factors include partial/incomplete implementation, little involvement by the WHO country office in Rwanda and problematic implementation in Uganda.
Examples of the benefits and effects of the HEARTS programme from the evaluation’s case studies are presented in Box 8.

Finding 22. While the evaluation did not encounter explicit evidence of a reduced number of people suffering financial hardship, it is likely that implementation of PHC-based guidelines will have that effect.

In its 2020–21 results report, WHO noted that the Outcome 1.2 on Reduced number of people suffering financial hardship under the first billion, as well as other outcomes, were adversely affected by the COVID-19 pandemic. While WHO has supported numerous initiatives related to this outcome, none appear directly related to the six normative products reviewed for the evaluation.

However, it is likely that implementation of those guidelines, for example, mhGAP and HEARTS, which mean that people can be treated more frequently in primary health centres close to where they live rather than travelling to more distant secondary or tertiary centres, will reduce the number of people suffering financial hardship in terms of health and illness. Similarly, the implementation of guidelines that promote preventive measures, for instance HEARTS and household air quality, could reduce the incidence of serious illnesses, such as cardiovascular and respiratory diseases, with the associated high costs of curative treatment. Finally, if the WHO EML and national EMLs result in the greater use of essential and cost-effective medicines, it is likely that people will recover more quickly and may avoid more serious complications, giving both health and financial benefits. However, relatively little evidence related to this outcome was collected by this evaluation.

Finding 23. There is little evidence that national essential medicine lists contribute to more rational drug use in countries.

Clearly, part of the aim of the WHO List of Essential Medicines is to contribute to improved access to essential medicines, not least by defining what they are, and ensuring that their definition is up to date. This may be achieved in conjunction with other WHO units, such as those responsible for developing clinical guidelines that feed into the EML, and other units within the UHC department. In reviewing progress towards the outcome of improved access to essential medicines, vaccines, diagnostics and devices for PHC (outcome 1.3 under the first billion in Figure 7), WHO notes that the latest WHO EML included a number of new treatments such as antimicrobials, medicines for cancer and diabetes and products to assist those who wish to stop smoking. An infographic on the role of the WHO EML highlighted a number of successes, among them the provision of antiretroviral treatment, increasing the selection of medicines for cancer classified as essential, and promoting the AWaRe system for classifying antibiotics.

However, these claims somewhat assume that countries develop essential medicine lists based on WHO EML and these are then used to improve access to essential medicines. On the first point, while most countries do have national essential medicine lists, the extent to which these reflect the WHO EML is unclear since this is not systematically monitored (See Box 4).

Second, there are also issues about how national EMLs are used to promote access to essential medicines. Ideally, they would be used to educate policy makers, prescribers, and the public, to inform national treatment protocols and to guide procurement and prescribing. However, the evaluation identified several concerns in this area. For example:

- No country reported any training of policy makers, prescribers or the public in relation to essential medicines.
- The national health insurance scheme in Maldives, Aasandha, does not provide essential medicines only or preferentially. In the Philippines, not all medicines in the Philippines National Formulary are covered by the Philippines Health Insurance. In Uganda, a key challenge is that funds available for drug procurement are...
insufficient. In Ethiopia, the Pharmaceutical Procurement Supply Service, part of the Ministry of Health, has its own procurement list, which is not identical to the national EML, reflecting internal inconsistencies in the Ministry concerning EML use.

• However, in Pakistan, key essential medicines are reported to be part of the UHC essential service package. Steps have been taken to promote procurement of essential medicines, and WHO coordinates with the government, development partners and disease programmes to ensure this. Also, WHO plays an active role in procuring medicines for emergencies and vaccine campaigns.

• Maldives lack up-to-date clinical protocols aligned to the national EML for most diseases. However, some treatment guidelines aligned to the national EML are in place in Pakistan and Rwanda. In Uganda, there are relevant clinical guidelines but the extent to which these are captured in the national EML is unclear.

136. In general, essential medicine lists are not seen as relevant to the private sector although requirements for registration of medicines (safety, quality, efficacy, etc.) do apply to that sector.

• Despite laws to the contrary, medicines can be purchased from pharmacies without prescription in Jordan, Maldives and Pakistan.

• There has been little education or training on essential medicines for policymakers, prescribers or the general public.

• Systems to monitor the extent of use of essential or non-essential medicines are weak or entirely absent.

137. Overall, systems to translate national EMLs into more rational drug use have been weak. In Maldives, a 2014 study43 concluded that, although there is a national EML, “it is not actively used or promoted”. It is therefore unsurprising that, in 2021, a study44 was published which failed to show a statistical association between the extent to which essential medicines were listed on national EMLs in 131 countries and their healthcare access and quality (HAQ) scores in certain disease areas. Partly, this may be because other factors are of more importance, but it may also reflect the absence of mechanisms to translate listings of medicines in national EMLs into greater use of and access to essential medicines. Clearly, issues relating to essential medicine use are complex and interdependent, as confirmed in a qualitative evidence synthesis45 published in 2022. This concluded that just listing essential medicines was unlikely to be sufficient but “to maximize the value of national medicines lists, greater investments should be made in processes and institutions that are needed to support various stages of the implementation pathway from global norms to adjusting prescribed behaviour”.

Finding 24. While it is likely that COVID IARs have contributed to better responses, there is no clear evidence that more people are protected as a result.

138. The second billion goal is to increase the number of people better protected from health emergencies, and the COVID-19 IAR are expected to contribute to this goal. In 2022, WHO published a global analysis46 of COVID-19 intra-action reviews (IARs). This analysis was based on consideration of 83 reports of IARs conducted, as of 2 March 2022, in 57 countries; interviews with 27 key individuals; and 29 country responses to an online survey. The analysis identified themes, key messages and considerations across 13 health response pillars. It also identified common challenges and crosscutting themes. Timing was identified as critical to the IAR. One benefit identified from IARs was bringing stakeholders together. Critical success factors for the response to COVID-19 identified by IARs included early decisive action from senior leadership; speed and efficiency; agility; transparent information exchange; and real-time data.

139. The analysis report contained a section (4.2) on the impact of IARs based on interviews and survey responses. Factors affecting impact included the composition of the coordination team, the stakeholders invited, the timing of

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Ischaemic heart disease, cerebrovascular disease and hypertensive heart disease.
the IAR and the effectiveness of the follow-up process in implementing IAR recommendations. The analysis also identified seven critical areas for strengthening the IAR methodology.

140. Perceived benefits were that:

- The IAR provided a collaborative context to allow the space and time for multisectoral stakeholders to come together and discuss strategies to combat the ongoing pandemic.
- The IAR was perceived as a useful and timely methodology that could be used for COVID-19 and other public health emergencies.
- IAR recommendations were integrated into national plans and strategies to contribute to long-term system strengthening.
- IARs conducted at the local level were both useful and effective since recommendations could be immediately acted upon to make a difference in the response, requiring less bureaucratic administration.
- The IAR process provided a flexible and useful approach that could be tailored to conduct focused reviews of any aspect of the response, especially when reviewing specific elements of a single pillar.

141. Evidence of these benefits was also identified in the case studies conducted for this evaluation.

142. Most of the IARs reviewed did provide a collaborative context for multisectoral stakeholders to come together. However, this was not the case for the first IAR conducted in Jordan which only involved WHO and the Ministry of Health. The subsequent review, facilitated by the Civilian Research and Development Foundation (CRDF) was better in this regard.

143. The country case studies conducted for this evaluation confirmed IARs as a useful and timely methodology. However, in some cases, such as Jordan, agency specific IARs were conducted rather than coming together for a coordinated review. In many cases, for example Jordan and Maldives, the IARs were large and time-consuming affairs. The suggestion, in the global analysis of IARs, that reviews would be strengthened if there was a “swift and efficient review process with minimal disruption to the actual response” is supported by the findings of this evaluation.

144. While one of the benefits identified in the global analysis report was that recommendations could be integrated into plans and strategies, this was not the case in Rwanda where national COVID-19 plans were not updated as a result. One challenge identified in Rwanda and in Jordan, was a lack of resources to implement the IAR recommendations. However, in Uganda, the two IARs that were conducted were used to develop national response and stabilization plans.

145. The evaluation documented many cases where immediate actions were taken as a result of the IAR. This was possible in some national-level IARs and not just in more local IARs. For example, in Maldives, following the COVID-19 vaccine post-introduction review (c-PIE), actions were undertaken for five areas as per the review’s recommendations, namely the human resource gap; cold chain management; digital data reporting; SOPs and guidelines; and waste management. In Rwanda, the IAR was not only conducted at national level but also at sub-national levels with more than 300 participants. Specific actions following that review included some on confinement and ensuring continuity of care for patients with chronic diseases.

146. While some IARs covered the whole of the COVID-19 response, such as, in Jordan, there were examples of single pillar reviews. For example, in Maldives there were two IARs looking at vaccination and laboratory services respectively. In Pakistan, the IAR also focused on laboratory systems. Issues identified with single pillar reviews included the fact that they may focus on areas where a country is doing well, with other less well-performing areas overlooked, or on areas identified primarily by funders, for instance as a prerequisite for funding.
147. One challenge identified in relation to many IARs was that follow-up was not always as systematic as it was advised in the guidelines. For example, in Jordan and Rwanda, the specific follow-up group mandated by the guidelines was not established.

Finding 25. Since the 'Indoor air quality guidelines: Household fuel combustion' has not been widely implemented in case-study countries, it is not possible for the evaluation to comment on its impact in terms of contributing to a healthier environment to promote health and sustainable societies.

148. According to WHO's 2022 results report, issues relating to air quality are covered under this outcome. While Bruce and others expressed the hope, in their 2014 paper, that the WHO indoor air quality guidelines would address household air pollution and reduce the risk of multiple child and adult diseases, the extent to which this has occurred has not yet been systematically assessed and evaluated.

149. Although the guidelines and related literature focus primarily on the use of polluting fuels for cooking, there are concerns in countries that primarily use non-polluting fuels for cooking, for instance Jordan, that there may be other factors that affect household air quality, such as fuels used for heating and particularly indoor smoking. However, these aspects are not covered under the indoor air quality guidelines, as they relate to other evidence bases and/or other WHO departments.

150. In general, it has not been possible to document evidence of the impact of these guidelines in the country case studies conducted for this evaluation. In some cases, such as Jordan, the guidelines have not yet been used or applied.

151. In Uganda, they have not received a great deal of emphasis. Although the country's ambient air quality policy guidelines are informed by WHO guidelines, these are currently in draft form only, and indoor air quality is not yet addressed. Responsibility for this issue is shared across several ministries and there have been very limited efforts even from some of those ministries with line responsibility. In addition, there has not been much emphasis from the WHO country office in this area. In particular, the WHO country office has not yet supported adaptation of the WHO guidelines.

152. In Pakistan, there has been a strong focus on climate change and the environment, which are national priorities. WHO has supported policy development at the federal level. However, there has been little, if any, specific focus on indoor air pollution. The Ministry of Health’s capacity on environment is weak and the level of coordination between the Ministry of Health and the Ministry of Climate Change, which is the one spearheading questions of air pollution, is low.

153. Even in Rwanda, where the energy/clean fuels agenda is a national priority, progress has been limited. Case reports have been published concerning the health effects of indoor air pollution. WHO facilitated a multi-stakeholder workshop, and a report was produced on the Benefits of Action to Reduce Household Air Pollution (BAR-HAP). However, it is not clear the extent to which this report has been followed up. WHO and the Rwanda Biomedical Centre (RBC) have conducted awareness campaigns in five districts. Community-based health workers have been identified for training. However, progress has been hindered by lack of human and financial resources.

Finding 26. While WHO normative products may be seen to contribute to health equity, there is scant evidence of their impact on gender equality and health equity.

154. Several of the normative tools reviewed do not specifically consider issues of equity or gender equality. For example, although principles of equity might be deemed to underpin the concept of essential medicines, in other words making them available to everyone at all times, the list itself does not specifically discuss equity or gender
equality. Similarly, the mhGAP intervention guide does not specifically mention equity or gender equality. Gender is only mentioned once in relation to NGOs working on gender-based violence.

155. Neither equity nor gender equality are mentioned explicitly in the guidelines for treatment of malaria, although these concepts may be implied in other concepts such as equal access to prevention and treatment, involvement of women in decision-making processes, incorporation of gender perspectives into malaria programme and strengthening health systems. The only mention of gender is in relation to the effects of gender on different antimalarials. However, the Roll Back Malaria Partnership and the Global Fund do have a specific equity assessment tool to improve the effectiveness of malaria programmes. This is called the Malaria Matchbox Tool.

156. The HEARTS technical package affirms that an approach based on primary health care improves coverage and equity and states that: “the equity of any impacts will be monitored and, in particular, WHO will support pilot countries to assess programme effectiveness by sex and for different socioeconomic groups”. However, it is unclear the extent to which such equity monitoring has taken or is taking place. Gender is only mentioned in the HEARTS technical package in relation to cardiovascular risk assessment.

157. The guidance for conducting a COVID-19 IAR identifies gender, equity and human rights as possible topics cross-cutting for a review. Yet there is nothing to indicate that these should be included, and no specific guidance on how this might be done.

158. The WHO indoor air quality guidelines (household fuel combustion) identify gaps relating to policies for achieving rapid and sustainable transitions to low emissions, efficient and safe options suitable for different population groups. One of the identified gaps relates to “impacts on equity of access”. There is specific consideration of equity issues affecting household uptake of cleaner cooking technologies. One of the key questions identified for a review is: “Can any specific lessons be derived with respect to scaling up programmes for cleaner and more efficient household energy technologies in equitable ways in relation to poverty, urban-rural location and gender?” The guidelines also specify that the composition of the Guideline Development Group considered the issue of gender balance.

159. Published literature has little to say about the extent to which the use of these products has promoted equity and gender equality. For example, the 2021 systematic review of experience of mhGAP mentions neither concept. The WHO global analysis of COVID-19 intra-action reviews did consider the topic of vaccine equity and also the extent to which the pandemic exacerbated health inequity. The report also noted that although there is a specific pillar on vulnerable and marginalized populations, none of the 83 IAR reports reviewed specifically addressed this pillar.

Box 9. Gender and health Equity in the Uganda country case study

In relation to essential medicines, women and youth living with HIV have noted that they were able to access their ARV treatment and co-trimoxazole free of charge at the public health facility without difficulty. However, for other health conditions, they faced economic barriers: "The government hospitals are presumed to be free, but unless a patient pays money, they will be neglected. Unfortunately, the payment is not standard, it is not known how much one should pay for what, how you pay it and to whom it is paid.” Patients mentioned other barriers, such as the fact that health workers do not have time to explain to them what the prescribed medicines are for and there are not opportunities to ask questions. There are also gender-related factors that influence access to essential medicines: "the hospital visits are a big inconvenience for women because they bear the burden of domestic work, businesses and children. In the end, many women tend to miss their appointments, and stay without pills because they have no time to go to hospital."
The Malaria programme has identified vulnerable groups, such as young pregnant mothers and children as well as people in refugee settlements. While women and children are particularly at risk, they also have better health seeking behaviours according to the programme. There are reported access issues in terms of outreach to rural communities and for people living with disabilities who are not targeted specifically. However, data is not disaggregated consistently in all data capture tools. Some tools capture and analyse data by gender and age while others do not identify disparities among groups. The DHIS 2 data is not disaggregated by gender, since only below /above five years old and pregnant women are captured. Women and youth living with HIV that were consulted identified economic barriers to accessing malaria care services. A woman testified that: “Some drug shops can offer you an under dose depending on the money you have, or they can offer treatment for one or two days only because that is the money a patient has.”

In relation to cardiovascular disease care, clinicians and patient groups highlighted equity issues in NCD services. A woman living with HIV who also suffered a stroke considered that quality CVD care was not accessible and affordable in public hospitals: “CVD treatment is very expensive, and it is not clear whether this is well managed in government hospitals. CVD attacks are very bad, they often need urgent care, which one cannot easily find in a government hospital.” A clinician from a Health Centre III confirmed, “For hypertension, the essential drugs should include bisoprolol and amlodipine. The patients buy for themselves, these are pills which patients have to take daily or their health could be compromised. On the open market, these drugs are very expensive for the common people”. Women and youth living with HIV that were consulted all reported having experienced mental health issues, but not seeking care. Female youth reported having experienced hating themselves, failing to sleep, failing to eat, and struggling to do their daily work. However, none had ever sought mental health care. They did not consider such signs warranted medical attention, and when they went for routine check-ups, these emotional issues were not asked about or attended to. They felt that health workers were focused on their daily tasks and not their emotional wellbeing. They also mentioned not having time to seek care for these issues.

The impact of measures recommended through the IARs on the health-related outcomes of the COVID-19 epidemic in Uganda were not specifically monitored. Gender, health equity and human rights implications of the COVID-19 pandemic and associated measures were not specifically considered in the IAR report recommendations.

In relation to indoor air quality guidelines, despite sensitization campaigns on clean and efficient cooking solutions, the cost of those technologies may not be affordable by many. In Kampala, a majority of the population resides in slums and cannot easily afford to use gas. This has warranted the Ministry of Energy’s project of purchasing and distribute gas cylinders to households free of charge, since what is expensive is the initial purchase of the cylinder, while refilling is relatively affordable. The Ministry has also partnered with Makerere University to conduct studies on the impact of household air pollution on children’s and women’s health. They documented that poor air quality affects children and women more than any other group, as women do the cooking while carrying their babies on their back. The study concluded that women should be given priority when discussing air quality policy issues.

160. The country case studies conducted for this evaluation failed to show much evidence that implementation of these products had had a substantive impact on equity or gender equality. The case study in Maldives noted that the mhGAP training materials did not focus much on gender. The case study in Jordan only referred to gender as a factor in cardiovascular risk assessment. In Pakistan, the evaluation found that health equity, gender equality and discrimination were addressed insufficiently in programmes. The Uganda case study highlighted some of the data gaps in relation to gender equality and health equity, contributing to programmes unevenly addressing those issues (see Box 9). Barriers affecting health service access reported by patients and healthcare workers included: discrimination and fear of stigma related to mental health issues, quality of NCD services at public facilities, long
waiting times in public hospitals that may discourage single working mothers from seeking care, work overload of health workers signifying that they were not able to implement mhGAP recommendations in their daily work, and the unpredictable and high cost of malaria treatment when going to private healthcare providers.

Finding 27. Monitoring and evaluation of the impact of WHO normative guidance at country level has been extremely weak.

161. In Rwanda, institutional respondents reported that the community-based insurance scheme put in place by the Government, together with specific programmes for people living with disabilities, refugees or widows adequately addressed equity issues. Gender equality was also considered to be addressed through mainstreamed services in the country. Respondents tended to feel that where people did not access health services, it was mostly a question of individual responsibility. This view is however mitigated by reports of low service coverage at primary health care level, especially for mental health and chronic and acute NCD care. Affordability of some essential medicines was also an issue, for example insulin was only provided for free for people under 25 years old. In 2021, the Malaria Matchbox Assessment in Rwanda highlighted a number of barriers to malaria prevention and treatment beyond service cost and availability. It noted that there were many gaps in the country's strategy for malaria control among vulnerable groups. While some of these related to knowledge, attitudes and behaviour of certain groups, there were also issues relating to physical and financial accessibility, negative experiences with health facilities and gender norms. Gender was identified as a key factor in determining who is most affected. Specific problems identified included:

- Insufficient involvement of vulnerable populations, particularly mine workers, refugees and rice farmers, in the effective implementation of malaria prevention and treatment measures.
- Limited commitment to addressing the use of self-medication and the traditional treatment of malaria.
- Limited material resources compared to the needs of vulnerable populations.
- Insufficient health personnel in terms of numbers compared to the demand for health care.

162. Where case studies documented that programmes were supporting implementation of primary care, such as HEARTS and mhGAP in Jordan, Maldives and Rwanda, there was anecdotal, qualitative evidence that people were able to access services faster and closer to where they live, and this is likely to have positive equity implications. In the Philippines, improved local mental health service access and delivery was documented. This meant that people with mental health issues no longer needed to make a trip to a hospital. Rather, they were able to access services through local rural health units. Another equity issue noted in the Philippines was that COVID-19 vaccinations requiring ultra-cold storage were not recommended for use in the Philippines based on equity considerations.

163. The proposed Quality Assurance Norms and Standards Handbook's draft chapter on "Impact of Normative Products at Country Level" recognizes the importance of monitoring and independent evaluation of the use and effects of normative products at country level. This is in line with the recommendations of the 2017 evaluation of WHO’s normative function and the general emphasis of GPW 13.

164. Other relevant documents provided to the evaluation included a note for the record of a workshop, held in May 2023, on monitoring guidelines and other normative-setting product uptake and use and evaluating their impact at country level. This provided a high-level summary of the workshop, links to video recordings of the workshop and a session-by-session description. In addition, there was a background document for this workshop. This covered a range of topics including proposals on approach (and tailoring that approach); setting objectives; dimensions for monitoring, evaluating and learning; mapping and analysing the stakeholders; and measurement metrics (although this part is outlined in very general terms).
165. Some of the products reviewed do not have a clear monitoring, evaluation and learning framework. For example, the WHO EML does not have a mechanism to monitor and evaluate its impact. See Finding 7. Finding 7 for more details on the content relating to monitoring in the sample of normative products.

166. The guidelines for the treatment of malaria do have a section on monitoring the efficacy and safety of antimalarial drugs and resistance. In addition, they specify that “a mechanism will be established for periodic monitoring and evaluation of use of the treatment guidelines in countries”. In 2018, WHO produced a very extensive *Malaria Surveillance, Monitoring and Evaluation Manual*. The bulk of the document focuses on disease surveillance but there is one chapter (no. 7) on monitoring and evaluation. The chapter covers the aims of monitoring and evaluation; types of information required for monitoring; role of routine systems and surveys; use of information at national level; use of information at regional and global levels; and a set of 46 recommended indicators on the continuum to elimination. Almost the entire chapter is about monitoring with very little about evaluations, particularly the practicalities of conducting an evaluation. Details of how the malaria programme is monitored in Uganda are presented in Box 10.

167. The HEARTS package places a strong emphasis on monitoring and evaluation. One of the six core modules of the package is “systems for monitoring”. Indeed, “systems for monitoring” is the origin of the “S” in HEARTS. This module provides an introduction; a list of five programme indicators with detailed descriptions; details of data collection and reporting tools; and analysing and reviewing data. There is an annex with an example of a recording tool. However, data systems for HEARTS are not fully established in any of the countries utilised as case studies for this evaluation. This is mainly because of the stage of implementation of HEARTS. In Jordan, where HEARTS has been relatively well-implemented, the absence of a functioning, inter-connected health information system has proved problematic.

168. Similarly, WHO’s health-based guidelines on clean fuels and technologies for household cooking, heating and lighting is supported by a *Clean Energy Solutions Toolkit* (CHEST). One of CHEST’s six modules is on monitoring and evaluation. This is structured around core questions of household energy use and also includes a pictorial guide for administering the core questions and a guide to collecting data using the core questions. CHEST questions (for example on the type of cooking fuel used) have been adapted in standard Demographic Health Surveys to report on SDG 7 Indicator 7.1.2, “Proportion of population with primary reliance on clean fuels and technology”. While these tools are useful to track the progress on global targets, they do not provide a monitoring and evaluation framework to guide programmes at country level. There are however plans to include a catalogue of methods for evaluating household energy interventions.

169. In particular, the evaluation did not find any assessments of normative products at country level, which is in line with one of the concerns of the 2017 evaluation of WHO’s normative functions and products, namely that there were very few evaluations of outcome or impact of products.

170. Factors which facilitated or hindered the use of normative products in a particular country have been considered elsewhere in this report (see Finding 20). This section briefly covers factors that have facilitated or hindered contribution to outcomes or impact once a particular normative product has been used. Clearly, the biggest factor that facilitates normative products contributing to country-level outcomes is the extent to which they are used in a country. It is unreasonable to expect that guidelines that have not been widely used, such as guidance on household air pollution in the seven country case studies for this evaluation, would have contributed to any country-level outcomes or impact.
171. Linked to this, the **type and extent of use** is likely to affect the extent of contribution to outcomes and impact. While the local adaptation of guidelines including incorporating them into local lists, guidelines, policies etc. is an important step, it is unlikely to contribute to outcomes or impact if that is the only way in which the guidelines are used. For example, while the development of national essential medicine lists is important, these need to be used in some way to change procurement and prescribing practice. Such usage might be the basis for educating policy makers, prescribers and the public and/or by requiring prescribers, health providers and health financers to provide essential medicines only or preferentially.

172. Similarly, although **building local capacity** is important, guidelines that are used only to provide training to staff, such as in some cases with mhGAP, are unlikely to have much practical effect unless concrete steps are taken to ensure that what is learned is applied in practice, for example through providing ongoing support and follow-up. For this to happen, human and financial resources need to be provided. While it may not always be appropriate for WHO to obtain or provide these resources, guidelines could contain more on how countries might mobilize the resources required.

173. Where the use and effects of guidelines are monitored and evaluated at country level, not only will the extent of use and impact be known and evidenced, but it is likely that **use and effects will be magnified through positive feedback loops**. Effective monitoring and evaluation need a clear system described in the guidelines or supporting documents, for instance as has been done for malaria and HEARTS. Ideally, such systems should build on existing national health information systems rather than creating parallel structures. However, where countries lack comprehensive and interconnected health information systems, this lack is a major barrier to demonstrating the effects to which implementing certain guidelines have contributed.

174. Finally, there are many **external, contextual factors** that affect both the use of guidelines and the effects that using those guidelines might have or contribute to. For example, the recent COVID-19 pandemic adversely affected the use of some guidelines and may also have mitigated the benefits and positive effects of using those guidelines.
This section addresses the fourth evaluation question ‘How could WHO’s normative function be strengthened at country level?’ and draws on the findings presented under each of the three first evaluation questions relating to normative product development, use, and impact at country level.

Conclusions

**In relation to the Evaluation Question 1 on normative product development**

**Conclusion 1.** The prioritization process of normative product development has improved to align with Member State priorities but there are still bottlenecks to ensuring that it is effective.

The prioritization process has improved along with refined criteria and processes to align with Member State priorities and alignment with programme budget cycles. However, bottlenecks remain for selecting a manageable number of normative products for development in line with Organizational resources that develop and support the use of priority country-facing products/packages. Currently, many normative products do not go through the prioritization process, which potentially affects the relevance and contribution of WHO normative products at country level.

**Conclusion 2.** WHO normative products are seen as being of high quality and they are valued by stakeholders. However, in terms of positioning these products for use, feedback loops from country level stakeholders including WCO are insufficiently developed.

Involvement of WCO and other country level actors can be tokenistic rather than systematically integrated into the process of normative product development. There is a particular need for strengthening the feedback loops from country experience to global level, so as to reflect emerging evidence from implementation experience in the different technical areas. RO are well positioned to play a more active role in this process.

**Conclusion 3.** Normative products often do not sufficiently consider end-user needs, particularly in relation to guidance on implementation, resourcing and monitoring.

Normative products have tended to focus heavily on technical/clinical aspects, without sufficiently considering the needs of the different intended users in their formulation, content and presentation. Among the normative products included in the sample, guidance on how to implement, the resources required, what success looks like, and how to monitor progress is uneven.

**Regarding Evaluation Question 2 on normative product use:**

**Conclusion 4.** There is strong qualitative evidence that WHO normative products are being used at country level. Types of use include adaptation of national policy frameworks, building country capacity in particular technical areas, strengthening health systems, and improving the quality of health services. Normative products were not found to be specifically used to address gender and health inequities. The primary audience for WHO’s normative products is Ministries of Health, but other actors’ substantial roles are not always recognized in WHO normative products.

WHO appears to be the main source of normative guidance for Ministries of Health. A range of other stakeholders play a key role in either funding or implementing work related to WHO norms and standards. These stakeholders include government ministries beyond the Ministry of Health, civil society actors, other development partners and the private sector. The multi-sectoral involvement needed to implement WHO normative products (for instance adjustment to legislations and regulations in non-health sectors such as trade or environment) requires funds and expertise that WHO often does not possess at country level, and the roles of other actors beyond the health sector are generally not well-covered in WHO’s normative products.
Conclusion 5. Prioritization, implementation, monitoring and evaluation of WHO’s normative products are not well integrated into country planning and budgeting processes.

Normative product prioritization and use in specific countries is not systematically driven by WCO as part of their country strategy and planning. In some instances, where resources are available, technical departments may promote uptake of the normative products they develop by target countries. Hence, a disconnect can arise between country planning processes led by WCO and normative product planning and resourcing.

Conclusion 6. The normative function of WHO at country level does not stop at introducing and supporting adaptation of global normative products to country contexts. Rather, it also involves varying degrees of involvement in supporting the implementation and monitoring of progress, depending on the particular normative product and country context.

WCO use normative products as an integral part of their broader normative work in response to evolving needs and demands from a country. The role of WCOs in supporting the implementation of normative products at country level is more active and diverse than implied in the post-publication pathway of normative products. WHO may support the implementation of normative products in countries in a variety of ways, such as technical assistance, advocacy, capacity building at national and sub-national levels, without necessarily being directly involved in implementation or funding. The role also varies between countries and according to different normative products.

Conclusion 7. Resources for supporting the use and impact of normative products at country level are not aligned to WHO’s ambitions. While there are resources dedicated to implementation in emergency programmes, other core areas of the GPW13 such as mental health, NCDs and environmental health are not adequately resourced at country level.

It is to be expected that WHO play a more hands-on role in emergencies, in particular during the COVID-19 pandemic. By contrast however, WCO technical capacity appears insufficient to effectively support the use of normative products in other core areas. There seems to be a mismatch in terms of WHO’s ambitions at country level and the distribution of resources between strategic areas. There are examples of WCO successfully using emergency programmes to support the implementation of normative products in areas such as malaria prevention and treatment, or securing access to mental health and NCD services at PHC level in a health-system strengthening approach. Overall, however, WCOs have little room for manoeuvre to align resources with priority areas.

In relation to Evaluation Question 3 on normative product impact:

Conclusion 8. The expected use and impact of normative products is insufficiently integrated at the planning stage of normative products, and insufficiently monitored and evaluated at the implementation stage.

The evaluation has found evidence of normative products contributing to key WHO strategic results, relating especially to health system capacity and service delivery. Evidence relating to health outcomes has been documented in published studies relating to some of the normative products in the sample. However, there is little focus from WHO on documenting contribution of its work at country level in general, and of normative products in particular. Documenting and evaluating contribution at country level requires contextualisation to understand how the introduction of a normative product may interact with key events and opportunities in countries.

Conclusion 9. Gender equality and health equity are not prioritized explicitly in WHO’s normative work

Although normative products aim to contribute to reducing access barriers to health services, they do not specify how to address gender equality and health equity in their implementation or monitoring. WCO’s technical assistance to a country does not integrate a gender and equity lens, despite opportunities to strengthen data collection and an analysis of inequality and gender difference factors.
Recommendations

Recommendations directly follow from the evaluation conclusions above. The detail of these recommendations has been co-created between the evaluation team and key stakeholders in WHO, through a three-step process: emerging recommendations were discussed with WHO country offices at the end of data collection in case study countries when presenting emerging results; a workshop was held with key WHO stakeholders at the three levels of the Organization on 11 July 2023 to discuss draft recommendations; and further discussions took place with the QNS Department to refine some of the recommendations in order to enhance alignment with ongoing processes in the Department, in particular around the monitoring of normative products going forward.

Recommendation 1. Further improve the prioritization of normative products.

Addressed to: WHO Secretariat HQ, including QNS, PRP

- Prioritise the development of normative products based on agreed Member State priorities. In particular, an analysis of the strategic priorities and deliverables in Country Cooperation Strategies (CCS) should be conducted as part of a country-led approach to prioritisation.
- Ensure that the normative product prioritization process is more systematically implemented by: i) strengthening oversight and accountability of the normative product process centrally and ii) ensuring that country-facing normative products are prioritized in line with available resources to support their development and use.

Recommendation 2. Revisit the process of normative product development to include feedback loop mechanisms, and outline the role of regional offices and WCOs.

Addressed to: WHO Secretariat at the three levels, in particular the QNS Department

- Quality standards for normative product development should include the meaningful engagement of expected users and practitioners in countries from the design stage, including promoting the development of normative products by practitioners and experts in countries where they are meant to be implemented.
- Develop key principles to ensure the relevance and usefulness of normative products for their intended users.
- Further clarify the roles of the three levels of WHO in fostering participation of country level stakeholders in normative product development, including:
  - At global level, by developing avenues for country implementation experience to inform normative products development in a more systematic way
  - At regional level, by ensuring that RO support the analysis and sharing of country-generated evidence and facilitate the participation of country level stakeholders in normative products development
  - At country level, emphasizing the role of the WCO in supporting country capacity to gather, analyse and use evidence to inform policy and programme decisions at national level as well as global level.

Recommendation 3. Normative products to include mechanisms to support an implementation plan.

Addressed to: WHO Secretariat HQ (including QNS, technical departments responsible for developing normative products)
• Ensure that quality standards for normative products and accompanying products as part of guidance packages go beyond information provision to include guidance on how to implement, the resources needed and how to identify them, and what success looks like.

• Normative products/packages should include a monitoring framework that aligns with the WHO corporate result framework, outlining expected contribution at country level as well as contribution to WHO outcomes.

**Recommendation 4.** Incorporate the implementation of global normative products into Country Support Plans (CSP) based on country priorities and context. Normative work of WHO at country level to be planned as a process, beyond policy level, to include support for implementation and monitoring.

*Addressed to: WHO at three levels, in particular Country Support Unit at HQ and regional levels*

• Normative products should be emphasised to specific country offices and their counterparts in Ministries of Health, based on an analysis of their CCS priorities.

• CSP should include activities to support the use and impact of normative products at country level in line with the delivery of WCO’s strategic objectives.

• The monitoring and evaluation of normative product implementation should be integrated into the overall M&E framework of the CSP as part of the WHO corporate monitoring system.

• WCOs should identify and work with a wider range of stakeholders wherever possible, such as other sectors, civil society and private healthcare providers, as part of their implementation strategy for normative products, without undermining their relationship with Ministries of Health.

**Recommendation 5.** Resources in line with planned activities and expected results should be made available at country level to support the adoption and implementation of normative products, with sufficient flexibility for WCO to align resources with priority areas.

*Addressed to: WHO Secretariat management at three levels and Member States*

• Ensure that there are plans to resource the implementation and monitoring of normative products at country level. This may be achieved by ensuring that: i) the planning of normative products to be developed during a biennium is linked to resource allocation for their implementation; ii) there is funding available centrally to support the implementation of critical normative products in selected countries; iii) an increasing share of flexible funding be dedicated to developing WHO country capacity and normative work.

• Where it is not feasible for WHO to provide all the support needed for implementation, WHO should advocate to mobilise domestic funding and support the government to develop proposals and obtain the funding from other partners.

• Ensure that sufficient technical capacity is available in a country office in priority areas so that WHO is a credible partner for stakeholders implementing normative products, including by leveraging existing human resource policies and developing incentives to strengthen human-resource capacity at country level.

• Ensure that WCO can use resources more flexibly to support country capacity as needs arise.

• Ensure that emergency funding supports capacity development of the health system through continuity of support to the implementation of normative products.

**Recommendation 6.** Evaluation of WHO’s normative work implementation and contribution at country level should be strengthened.

*Addressed to: WHO Secretariat HQ and RO (including departments of QNS, PRP, and the Evaluation Office)*

• A cross-departmental, corporate theory of change outlining WHO’s normative function in different contexts should be designed as the basis for assessing the use and impact of normative guidance.
Based on this, WHO normative work use and contribution at country level should be better reflected in WHO’s corporate monitoring system, for example by leading indicators in the Output Score Card achievement of results dimension.

Once normative products have been identified for the biennium, WCO should report on how they have been used and what difference they have made over the expected timeframe. This monitoring should be streamlined into WHO’s corporate output and outcome level monitoring.

WHO should conduct more country-level evaluations, for example by selecting a sample of countries to be evaluated each biennium. This could be done by standard WHO contribution evaluations being integrated into the Country Cooperation Strategy cycles; and strengthening the methodology of country case studies.

Recommendation 7. Ensure that gender equality and health equity and human rights (GER) considerations are integrated into WHO’s normative work.

Addressed to: WHO Secretariat at three levels, in HQ particularly the QNS Department and GER Unit

- Ensure that the corporate theory of change of WHO’s normative function outlines how it intends to contribute to GER.
- Ensure that normative products indicate how to implement the recommendations in a way that promotes GER.
- Ensure that GER considerations are included systematically in the monitoring of the contribution that normative products make to outcomes and impact, with clear guidance on disaggregated data collection and analysis. This may be done as a collaboration between the GER Unit and QNS Department.
- Ensure all WCO staff have adequate awareness and capacity on gender equality, health equity and human rights.
REFERENCES


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