Country Office Evaluation: India

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Acronyms

AMR	Antimicrobial resistance
BMGF	Bill & Melinda Gates Foundation
BWP	Biennial workplan
CCS	Country Cooperation Strategy
COE	Country office evaluation
DFID	UK Department for International Development
EQ	Evaluation question
Gavi	The Vaccine Alliance
GDP	Gross domestic product
GFATM	The Global Fund to fight AIDS, Tuberculosis and Malaria
GoI	Government of India
GPEI	Global Polio Eradication Initiative
GPW	General Programme of Work
GSM	Global Management System
HQ	WHO headquarters
ICMR	Indian Council of Medical Research
IHIP	Integrated Health Information Platform
IHR	International Health Regulations
IUATLD	International Union Against Tuberculosis and Lung Disease
MDG	Millennium Development Goal
MoHFW	Ministry of Health and Family Welfare
MSF	Médecins sans Frontières
NCDC	National Centre for Disease Control
NCD	Noncommunicable disease
NIHFW	National Institute of Health and Family Welfare
NPO	National professional officer
NPSP	National Polio Surveillance Project
NRA	National Regulatory Authority
NTD	Neglected tropical disease
PB	Programme budget
RMNCAH	Reproductive, maternal, neonatal, child and adolescent health
SDG	Sustainable Development Goal
SEARO	WHO Regional Office for South-East Asia

SSA	Special Service Agreement
UNDAF	United Nations Development Action Framework
UHC	Universal health coverage
UIP	Universal Immunization Programme, Ministry of Health and Family Welfare
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNSDF	United Nations Sustainable Development Framework
USAID	US Agency for International Development
US CDCVHAI	US Centers for Disease Control
WCO	Voluntary Health Association of India
WFP	WHO Country Office
	World Food Programme
WHO	World Health Organization

Executive Summary

Country office evaluations are included in the WHO Organization-wide evaluation workplan for 2018-2019, approved by the Executive Board in January 2018. The workplan clarifies that country office evaluations "*will focus on the outcomes/results achieved by the country office, as well as contributions through global and regional inputs in the country. In addition these evaluations aim to analyse the effectiveness of WHO programmes and initiatives in the country and assess their strategic relevance within the national context*". They encompass the entirety of WHO activities during a specific period. The country office evaluations aim to provide findings, recommendations and lessons that can be used in the design of new strategies and programmes in-country.

This country office evaluation was the second of this type undertaken in the South-East Asia Region by the WHO Evaluation Office. Its main purpose was to identify achievements, challenges and gaps and document best practices and innovations of WHO in India. These include not only results of the WHO country office (WCO) but also contributions at the regional and global levels to the country programme of work. As with all evaluations, this country office evaluation meets accountability and learning objectives and it will be publicly available and reported on through the annual Evaluation Report.

Covering the period of the Country Cooperation Strategy (CCS) 2012-2017, this evaluation built on an analysis of relevant existing documents and data, complemented by the perspectives of key stakeholders, to:

a. Demonstrate achievements against the objectives formulated in the CCS 2012-2017 (and other relevant strategic instruments) and corresponding expected results developed in the WCO biennial workplans, while highlighting the challenges and opportunities for improvement.

b. Support the WCO and partners to operationalize the various priorities of future CCSs (and other relevant strategic instruments) based on independent evidence of past successes, challenges and lessons learned.

c. Provide the opportunity to learn from the evaluation results at all levels of the Organization. These can then usefully inform the development of future country, regional and global support through a systematic approach to organizational learning.

The main expected use for this evaluation is to support the WCO, especially as it considers the implementation of the CCS 2019-2023 and for future planning. Other main users of the evaluation are the WHO Regional Office for South-East Asia and WHO headquarters in order to enhance accountability and learning for future planning. The Government of India, as a recipient of WHO's actions, as well as the people of India and other organizations, including donors, partners, national institutions and civil society, have an interest to be informed about WHO's achievements and be aware of best practices. Also, the Executive Board has direct interest in learning about the added value of WHO's contributions in India. Finally, over the medium-term, this evaluation will contribute to build a body of evidence around possible systemic issues to be addressed corporately, such as the development of models of WCOs work/presence in countries.

Guided by the WHO evaluation practice handbook, the evaluation was based on a rigorous and transparent methodology to address the evaluation questions in a way that serves the dual objectives of accountability and learning. The methodology demonstrated impartiality and lack of bias by relying on a cross-section of information sources (from various stakeholder groups) and using a mixed methodological approach (e.g. quantitative and qualitative data) to ensure triangulation of information through a variety of means.

Relevance of the strategic choices

The CCS was developed to reflect the situation at a point in time as well as anticipated changes over a six-year period. Given that India has a growing economy and is undergoing rapid development, the relevance of the CCS was affected over that period due to a variety of factors including: emerging health issues; new policies and programmes introduced by the Government of India; evolving strategies within WHO; the shift from Millennium Development Goals to Sustainable Development Goals; and opportunities to access new skills and technologies that could not have been foreseen. The WCO was able to accommodate those changes in its biennial workplans. Long-term strategies such as the CCS must strike a balance between clarity of plans and targets on the one hand and flexibility to accommodate external changes on the other. The CCS 2012-2017 is effective in doing so.

The priorities identified during the development of the CCS 2012-2017 were relevant to addressing India's major health needs and were consistent with government and partners' priorities. They were also coherent, in terms of health needs and alignment, with WHO's high-level strategic vision as set out in the relevant General Programmes of Work and Regional priorities. The CCS reflects the significance of India to the overall work of WHO, as well as the pivotal role played by WHO in supporting the Government of India as it pursues its health goals.

It is clear that preparation of the CCS 2012-2017 was guided by dialogue with Ministry of Health and Family Welfare and reflects input from all levels of WHO. Less clear, however, is the extent to which there was active engagement of other partners such as the United Nations and civil society organizations in preparation, endorsement and subsequent promulgation of the Strategy and its key messages.

The health priorities identified in the CCS 2012-2017 are appropriate in light of the health challenges facing India at the time, and the health status of the country's population. However, the underlying evidence that was used to identify those priorities (and, by implication, reject others) could have been better elaborated and the consideration of health inequalities together with their causes/correlates and approaches to address gender, equity and human rights could have been better articulated.

The CCS 2012-2017 identifies support for India's role in global health as one of its three strategic priorities. Within that priority there is appropriate emphasis on the need to ensure implementation of commitments to International Health Regulations and improve system-wide stewardship. The third aspect, which seeks to strengthen drug regulatory capacity, contributes to the strengthening of India's role as a major producer and exporter of generic medical products. This also contributes to access to generic medicines and medical devices in India

Despite the broad scope of the CCS 2012-2017, some issues which are clearly relevant in the Indian context are not adequately addressed. They include the role played by the private sector in delivery of health services; articulation of WCO's approach to working with state governments; and the growing human resource challenges confronting India's health sector. In addition, although the CCS includes a good discussion of internal and external implications for the WHO Secretariat, there is only limited explicit consideration of financial or human resource requirements.

WHO's contribution and main achievements

There is a clear and strong consensus view among Government of India officials and development partners that WHO made a significant positive contribution to health policy and programmes across a wide range of issues in India during the period covered by the CCS 2012-2017.

With regard to Strategic Priority 1 of the CCS 2012-2017 (Supporting an improved role of the Government of India in global health) WHO supported pioneering health research to inform policy and programmes both in India and globally. Primary research from India guided the global switch from the trivalent to bivalent oral polio vaccine. WHO's support for India's regulatory systems contributed to

the success of Indian pharmaceutical industry as a source of medicines used globally in disease control programmes.

Achievements in respect of Strategic Priority 2 (Promoting access to and utilization of affordable, efficiently networked and sustainable quality services by the entire population) include support for high level policy dialogue on universal health coverage with the Ministry of Health and Family Welfare, NITI Aayog and selected states prior to introduction of a National Health Protection Scheme and the creation of Health and Wellness Centres to enhance primary healthcare in communities under the *Ayushman Bharat* initiative.

In the areas of concern under Strategic Priority 3 (Helping to confront the new epidemiological reality), WHO technical assistance, normative support, and on-the-ground implementation support contributed to major improvements of health status. Polio, yaws, and maternal and neonatal tetanus were eradicated in India over the CCS period. WHO experts also provided evidence and inputs in innovative treatment and control strategies for TB, HIV and hepatitis and WHO contributed to important national strategies and action plans, including for antimicrobial resistance and noncommunicable diseases. The National Polio Surveillance Project experience of transitioning to provide implementation support for routine immunization has been very successful in India, resulting in improved immunization coverage rates and strengthened surveillance for vaccine-preventable diseases.

WCO's increasing effectiveness over the period of the CCS 2012-2017 as a partner to MoHFW in respect of policy analysis and development was notable and its capacity is now better aligned with the needs of the Government of India. Increasing demand for support, as well as Government funding in the areas of routine immunization and TB could be considered recognition of the contribution, although it requires careful consideration of the workload of the staff involved.

There were some areas where WHO's achievements fell short of what was anticipated. While there was obvious progress in respect of enhanced regulatory capacity building for pharmaceuticals and medical devices, relatively little appears to have been accomplished in respect of regulation for health care practitioners and facilities. There is also scope for greater leadership role specifically for intersectoral actions and development of human resources and institutional capacity to tackle noncommunicable diseases. While implementation research in polio was seen as a valuable contribution, support towards health systems implementation research is an area for further work.

Ways of working and programme management challenges

Key contributions of core functions: All WHO core functions demonstrated their relevance for WHO's work in India over the CCS period, but it was noted that the relative contributions of the six functions has evolved, and will need to continue to evolve, as India continues its own rapid development. In particular, and especially towards the later years of the CCS period, there was growing focus on policy dialogue and work on norms and standards with a relative reduction in technical support requirements. Those trends are likely to continue.

With the Indian health sector's growing technical capacity and increased domestic financing for health, the nature of WHO support will gradually shift from providing strong technical support to an increased focus on policy and advocacy support. This will require WHO to address a broader set of issues and to work with a range of sectors and partners, many outside of the health sector.

Partnerships: While there are clear indications that the WCO strengthened its partnership base in the recent years, the India WCO would benefit from strengthening its leadership role, its capacity to engage in partnerships and its convening power in support of joint action. Noncommunicable diseases is one area where more could have been achieved by better deployment of that particular function.

The growing interest and investment in health by the Government of India has resulted in a wider range of ministries and other Government agencies working in the sector. The WCO appears to have

gained the respect of key stakeholders, most notably the NITI Aayog and the National Health Authority (which manages the *Ayushman Bharat* Initiative).

The partnership with other United Nations agencies in India is strong with a good delineation of respective roles. The United Nations Development Action Framework outputs to which WHO contributes were well-coordinated in the development of the CCS 2019-2023 and clearly focus on the promotion of intersectoral actions, which are extremely important in the context of addressing noncommunicable diseases.

While the Government of India and, more specifically, the Ministry of Health and Family Welfare is the principal partner of WCO, it is also increasingly requested to collaborate with state-level health administrations, especially those where health status is poor or health inequalities are great. Such collaboration may need to be undertaken in consultation and agreement with the Union Government.

The recent establishment of the Health Partners Group, and its potential to become a key forum for collaboration on strategic issues, is a notable and promising indicator of progress. WCO has become more adept at using high-level diplomacy and influencing skills, and more able to engage constructively at the highest levels of government, in support of its strategic priorities.

Given the increasing role of the private sector in universal health coverage and the potential of civil society engagement in the area of gender, equity and rights, stronger partnerships with these sectors can strengthen WHO's contribution toward achieving better health outcomes in India.

Funding: Overall, the work of WCO over the CCS period was well funded with significant voluntary contributions and support through the Global Polio Eradication Initiative. The Government of India also provided substantial funds, partly from domestic sources and partly from 'third party' grants, e.g. Bill and Melinda Gates and Bloomberg foundations. While there is confidence that historic funding sources and levels can be maintained for the next 2 to 3 years the longer-term situation is less clear and efforts should be made to adequately fund all areas of work as budgeted in workplans. In light of that uncertainty, as the WCO implements the new CCS 2019-2023, a more strategic focus towards resource mobilization and reporting is needed.

Staffing was a challenge for WCO throughout the CCS period and continues to be so. A number of key positions have proved difficult to fill and heavy reliance on Special Service Agreement contracts generates significant administrative workloads. At the same time, Government of India officials who are often highly skilled and experienced typically place high expectations on counterparts. As India continues to develop, and to build its own human capital, there are strong expectations on the part of the Government of India to receive innovative solutions and highly-skilled and politically astute support from WHO.

The presence of the South-East Asia Regional Office in the same city as the WCO presents opportunities as well as challenges for both offices. Relationships between the offices are generally good and examples were cited of very effective collaboration among their staff but it is apparent there is also a risk that poor communication and ambiguous role definitions can lead to negative outcomes. Similarly, Government of India officials and development partners value the ability to reach out to both WCO and the Regional Office but are not always clear as to the appropriate protocols. There is need for greater clarity on how the relationship should be managed.

Monitoring: The difficulty in measuring results against planned targets and assessing WHO's contributions to the same are indications of a number of systemic challenges in planning and monitoring processes within WHO at both corporate and country levels. The main monitoring mechanisms adopted were internal mid-term and end-of-biennium programme budget performance assessment reports and an internal review of the CCS carried out at the end of its coverage. The internal review provided valuable inputs for the development of the CCS 2019-2023 and highlighted the importance of monitoring and evaluation of a country cooperation strategy.

Recommendations

1. The head of the WHO Country Office and the Country Office should maximise the effectiveness and impact of Country Cooperation Strategy 2019-2023 as a key strategic instrument. It is recommended to:

   i. ensure close alignment of all planning and implementation activities with the Country Cooperation Strategy, including mid-term and end-of-biennium programme budget reviews and during the formulation of country-level workplans;
   ii. develop a theory of change which shows the anticipated causal path from all country-level activities and outputs specified in the Country Cooperation Strategy to expected outcomes and impact (in relation to achieving WHO's 'triple billion' goals);
   iii. seek to strategically use the Country Cooperation Strategy in its engagement with the Government of India and development partners; and
   iv. set up a monitoring and evaluation framework to measure WHO's progress towards targets over the Country Cooperation Strategy implementation period, including a mid-term evaluation of the Strategy. The framework should also consider the role of gender, equity and human rights as social determinants of health.

2. To enhance the relevance and effectiveness of WHO's involvement in India, it is recommended that the WHO Country Office with support from the Regional Office for South-East Asia and headquarters as appropriate:

   i. continue to support the Government of India' efforts within the framework of universal health coverage, such as *Ayushman Bharat*, and promote inclusion of neglected health issues, such as noncommunicable diseases;
   ii. support implementation research studies with respect to implementation of universal health coverage/*Ayushman Bharat* and provide necessary expertise to facilitate emerging Government priorities, such as digital health;
   iii. develop a strategy, in consultation with Ministry of Health and Family Welfare and other Union and state government agencies as appropriate, for working with state government counterparts and contributing to state-level health issues; and
   iv. develop a strategy for collaboration with private sector and civil society organisations, as appropriate to support the Government of India, guided by the Framework for Engagement with Non-State Actors.

3. The WHO Secretariat should ensure adequate and sustainable human and financial resources to implement WHO's work in India and respond to the specific emerging needs of India. It is recommended to:

   i. develop a resource mobilisation strategy which assesses future funding needs and identifies specific actions to address any potential shortfalls and improve donor relationships;
   ii. conduct a functional review of the WHO Country Office and ensure that the new Country Cooperation Strategy priorities and the emerging needs of the Government of India are adequately supported in a timely manner with the necessary financial and human resources (including through short-term external high-level expertise); and
   iii. assess the current WHO Country Office staffing and skills mix in the light of the new Country Cooperation Strategy priorities, addressing gaps for relevant areas and providing capacity building opportunities to existing staff in order to be better prepared and respond more effectively to the needs of the country.

4. As part of the planned joint consultation for the National Polio Surveillance Project transition plan and mid-term review of the Country Cooperation Strategy during the second half of 2020, the following should be considered in the terms of reference :

   i. lessons learned from polio transition;
   ii. relevance of current and planned activities beyond polio transition;
   iii. the management and funding of the National Polio Surveillance Project, including the engagement of SSAs; and
   iv. recommendations for the way forward.

5. The planned corporate mid-term evaluation of the polio transition plan to be conducted by the WHO Evaluation Office should consider lessons learned and best practices from the National Polio Surveillance Project model.

1. Introduction

1. Country office evaluations (COEs) are included in the WHO Organization-wide evaluation workplan for 2018-2019, approved by the Executive Board in January 2018.[1] The workplan clarifies that COEs "*will focus on the outcomes/results achieved by the country office, as well as contributions through global and regional inputs in the country. In addition, these evaluations will aim to analyse the effectiveness of WHO programmes and initiatives in the country and assess their strategic relevance within the national context"*. They encompass the entirety of WHO activities during a specific period. The COEs aim to provide findings, recommendations and lessons that can be used in the design of new strategies and programmes in-country.

1.1 Evaluation features

2. **Purpose.** This COE was the second of its type undertaken in the South-East Asia Region by the WHO Evaluation Office. Its main purpose was to identify achievements, challenges and gaps and document best practices and innovations of WHO in India. These include not only results of the WHO country office (WCO) but also contributions from the regional and global levels to the country programme. As with all evaluations, this COE meets accountability and learning objectives. It will be publicly available and reported on through the annual Evaluation Report.

3. **Objectives**. This evaluation built on an analysis of relevant existing documents and data, complemented by the perspectives of key stakeholders, to:

a. Demonstrate achievements against the objectives formulated in the Country Cooperation Strategy (CCS) 2012-2017 (and other relevant strategic instruments) and corresponding expected results developed in the WCO biennial workplans, while highlighting the challenges and opportunities for improvement;

b. Support the WCO and partners to operationalize the various priorities of future CCSs (and other relevant strategic instruments) based on independent evidence of past successes, challenges and lessons learned; and

c. Provide the opportunity to learn from the evaluation results at all levels of the Organization. These can then usefully inform the development of future country, regional and global support through a systematic approach to organizational learning.

4. **Expected use**. The main expected use for this evaluation is to support the WCO as it considers the implementation of the CCS 2019-2023 and for future planning. Other main users of the evaluation are the WHO Regional Office for South-East Asia (SEARO), and WHO headquarters (HQ) in order to enhance accountability and learning for future planning. The Government of India (GoI) as a recipient of WHO's actions, as well as the people of India, and other organizations, including donors, partners, national institutions and civil society, have interest to be informed about WHO's achievements and be aware of best practices. Also, the Executive Board has direct interests in learning about the added value of WHO's contributions in India. Finally, over the medium-term, it will contribute to build a body of evidence around possible systemic issues to be addressed corporately, such as the development of models of WCOs work/presence in countries.

5. **Scope**. The evaluation covered all activities undertaken by WHO (WCO, SEARO and HQ) in India, as framed in the CCS 2012-2017 and other strategic documents covering activities not part of

[1] Evaluation update and proposed workplan for 2018-2019. Document EB142/27 (http://apps.who.int/gb/ebwha/pdf_files/EB142/B142_27-en.pdf).

the CCS that took place over that period. In addition, it also included the development process of the CCS 2019-2023.

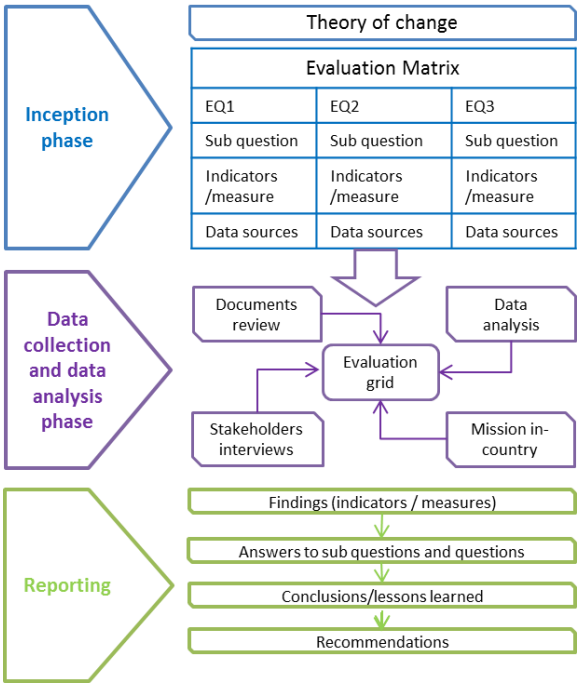
6. **Evaluation questions**. All COEs address the 3 main evaluation questions (EQ) identified below. The sub-questions are then tailored according to country specificities and detailed in an evaluation matrix (see Annex 2).

- **EQ1 - Were the strategic choices made in the CCS** (and other relevant strategic instruments) **the right ones to address India's health needs and coherent with government and partners' priorities**? (relevance) This question assessed the strategic choices made by WHO at the CCS design stage and its flexibility to adapt to changes in context.
- **EQ2 - What is the contribution/added value of WHO towards addressing the country's health needs and priorities**? (Effectiveness/elements of impact/progress towards sustainability) To address this question, the evaluation built on earlier analyses of results per programme area of the CCS 2012-2017 and focused on best practices and innovations observed.
- **EQ3 – How did WHO achieve the results**? (efficiency) In this area the evaluation sub-questions covered the contribution of the core functions, the partnerships and allocation of resources (financial and staffing) to deliver the expected results and, for each, sought to identify best practices and innovations.

1.2 Methodology

7. Guided by the *WHO Evaluation Practice Handbook*, the evaluation was based on a rigorous and transparent methodology to address the evaluation questions in a way that serves the dual objectives of accountability and learning. The methodology (summarized in Figure 1 below and developed further in Annex 2) demonstrated impartiality and lack of bias by relying on a cross-section of information sources (from various stakeholder groups) and using a mixed methodological approach (e.g. quantitative and qualitative data) to ensure triangulation of information through a variety of means.

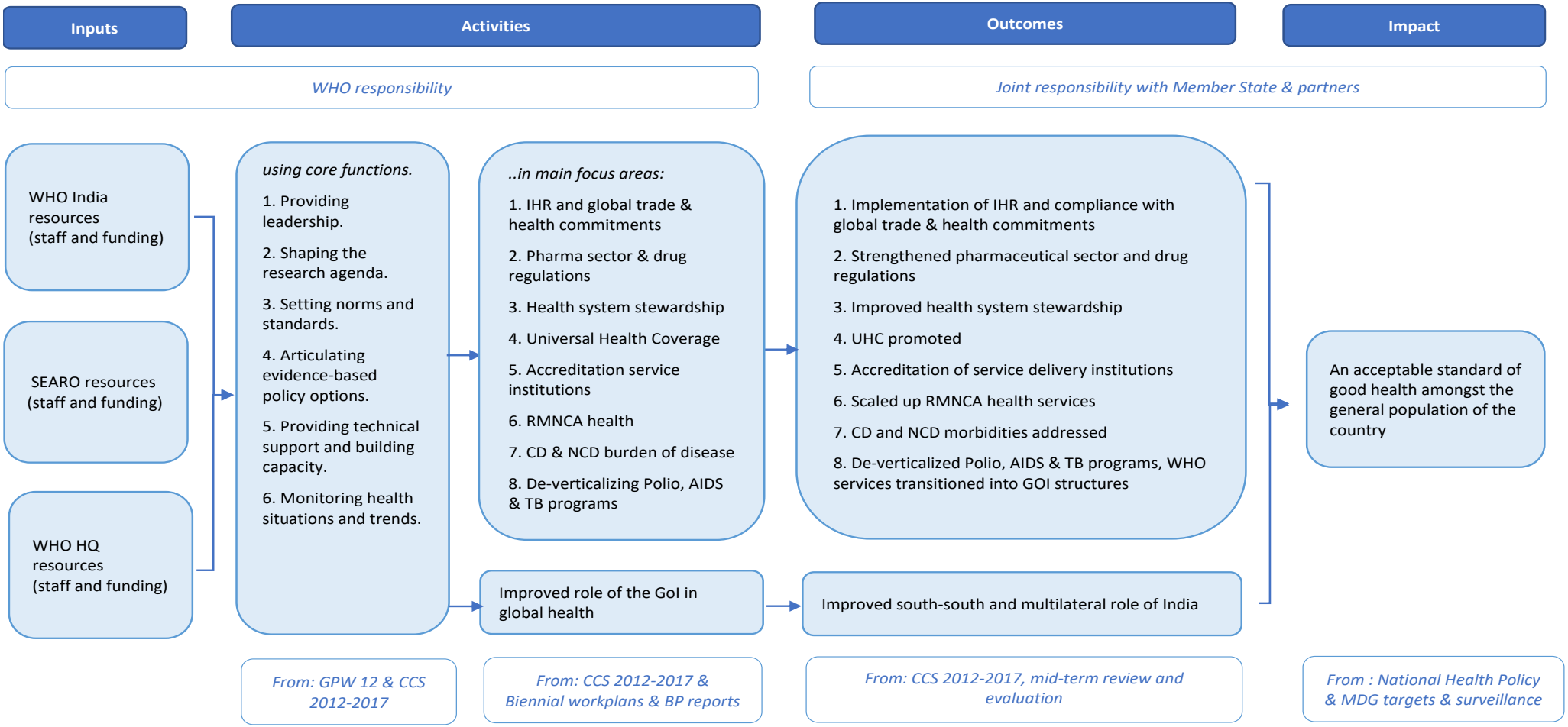
Figure 1: Methodological approach



8. The evaluation was conducted between January and April 2019 by a core team from the WHO Evaluation Office supported by two external consultants. The evaluation adopted the CCS as a primary criterion for the evaluation. However, in the absence of an explicit logic model or theory of change to frame the contributions of WHO in India over the evaluation period, during the inception phase the evaluation team proposed a retrospective theory of change (see Figure 2). This theory of change describes the relationship between the CCS strategic priorities, the focus areas and the activities and budgets as envisaged in the biennial workplans; clarifies the linkages with the General Programme of Work (GPW) and programme budgets; and identifies the main assumptions underlying it. The theory of change is aligned with the one validated by WHO in the context of the evaluation of WHO's presence in countries[2] and in previous COEs. Using the theory of change, the team developed an evaluation matrix, unpacking for each evaluation question the specific indicators/measures for assessing each sub-question, as well as the data collection method and data sources used. The evaluation mainly used existing data collected by WHO and partners, complemented with direct feedback from Ministry officials, WHO staff and other development partners, during the timeframe evaluated. After a comprehensive document review, the team conducted a two-week mission in-country, including visits to regional sub-offices in Bangalore and Lucknow, during which time it conducted a large number of interviews (list available in Annex 5). All the data were then analysed to produce the present report.

[2] WHO (2015). Evaluation of WHO's presence in countries (http://www.who.int/about/evaluation/prepublication-country-presence-evaluation.pdf?ua=1).

Figure 2: Theory of Change – WHO contributions in India 2012-2017



Assumptions

GOI funding
Donor funding
Other partners funding

Effective collaboration WHO (HQ, RO & WCO) with health/other ministries, development partners and civil society.

GOI willing and able to accept and use WHO products and services
Programme budget outputs/outcomes support CCS focus areas

Responsive to priority health needs of population, considering gender, equity & human rights.

1.3 Country context

9. India's economic performance has been strong, but development has been uneven, with the gains of economic progress and access to opportunities differing between population groups and geographic areas. India is already the world's third largest economy in purchasing parity terms and aspires to become a high-middle income country by 2030. Long-term gross domestic product (GDP) growth has become more stable, diversified, and resilient. Whilst extreme poverty dropped from 46% to an estimated 13.4% over the two decades before 2015, India is still home to 176 million poor people. The country's human development indicators - ranging from education outcomes to a low and declining rate of female labour force participation - underscore its substantial development needs.[3]

10. India's twelfth National Plan (2012-2017) aimed at an economic growth of 8% and reduction of poverty by 10% and contained specific goals on malnutrition and water safety. Since 2015, the NITI Aayog (National Institution for Transforming India) developed several national strategies with the aim to achieve Sustainable Development Goals (SDGs),[4] including the Three-year Action Agenda (2017-2020). These strategies address health goals directly and through social determinants of health.

11. India is experiencing a rapid health transition, due to changes in the socio-economic context. First, the health priorities are changing from maternal and child mortality towards a growing burden of noncommunicable diseases (NCDs) and some infectious diseases. Second, the Indian health care industry is robust and growing rapidly. Third, catastrophic health care expenditures are a major contributor to poverty. Finally, rising economic growth enables enhanced fiscal capacity.[5]

[3] World Bank, India (http://www.worldbank.org/en/country/india/overview , accessed 28 November 2018).
[4] United Nations Resident Coordinator's Office, India (2018). Government of India and United Nations Sustainable Development Framework 2018-2022.
[5] Ministry of Health and Family Welfare, Government of India. National Health Policy 2017.

Table 1: India health statistics[6]

Population (in thousands) total (2016)	1,324,171
Population proportion under 15 (%) (2016)	28.2
Life expectancy at birth (years) (2016)	70.3 (Female)
	67.4 (Male)
Socioeconomic	
Gender inequality index rank (2014)	130
Human development index rank (2014)	130
Health	
Neonatal mortality rate (per 1000 live births) (2017)	24.0
Under-five mortality rate (probability of dying by age 5 per 1000 live births) (2017)	39.4
Maternal mortality ratio (per 100 000 live births) (2015)	174
Infants exclusively breastfed for the first six months of life (%) (2015-2016)	54.9
Health systems	
Physicians density (per 1000 population) (2016)	0.758
Nursing and midwifery personnel density (per 1000 population) (2016)	2.094
Births attended by skilled health personnel (%) (2010-2016)	85.7
(DTP3) immunization coverage among 1-year-olds (%) (2017)	88
Health financing	
Total expenditure on health as a percentage of GDP (2014)	4.69
Private expenditure on health as % of total expenditure on health (2014)	69.96
Out-of-pocket expenditure as % of total health expenditure (2015-2016)[7]	60.59
General government expenditure on health as % of total government expenditure (2014)	5.05

12. The GoI accepts only direct Overseas Development Assistance from a small number of donors and under specific conditions, for socially relevant purposes, including health. International agencies and partners are expected to provide only state of the art evidence, methodological inspiration and high-level support.[8] Overall Overseas Development Assistance increased from US$ 1.7 billion to almost US$ 2.7 billion from 2012 to 2016.[9] Whilst a large proportion of foreign funding is allocated for health, foreign aid forms a minimal fraction (less than 1% in 2012)[10] of health expenditure by the Union and state governments. The main development partners for health in India during the period were the US Agency for International Development (USAID), Japan, the UK Department for International Development (DFID), the European Commission, the UN system and global health partnerships such as the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) and the Vaccine Alliance (Gavi).[11]

13. The UN system efforts in India have been guided since 2013 by the UN Development Action Framework (UNDAF) 2013-2017, focusing on Millennium Development Goals (MDGs) including health-related targets. Health was covered under UNDAF Outcome 4, Equitable Access to Quality Basic Services.[12] The current GoI-UN Sustainable Development Framework (UNSDF) 2018-2022 aims to

[6] Global Health Observatory, WHO (http://apps.who.int/gho/data/node.cco.ki-IND?lang=en, accessed 28 November 2018).

[7] National Health Systems Resource Centre (2018). National Health Accounts Estimates for India (2015-16). New Delhi, Ministry of Health and Family Welfare, Government of India (p. 11) (accessed 14 May 2019).

[8] WHO, India (2012). WHO Country Cooperation Strategy India 2012-2017 (https://apps.who.int/iris/bitstream/handle/10665/161136/B4975.pdf;jsessionid=2A5663A82506C16B5350CEC565FD1A87?sequence=1).

[9] OECD data on Word Bank (https://data.worldbank.org/indicator/DT.ODA.ALLD.CD?contextual=default&end=2016&locations=IN&start=2012&view=chart, accessed 28 November 2018).

[10] Economic survey of India 2011-12 (http://indiabudget.nic.in/ accessed 31 March 2012), quoted in the CCS 2012-2017.

[11] WHO, India (2012). WHO Country Cooperation Strategy India 2012-2017 (https://apps.who.int/iris/bitstream/handle/10665/161136/B4975.pdf;jsessionid=2A5663A82506C16B5350CEC565FD1A87?sequence=1).

[12] United Nations Resident Coordinator's Office, India (2012). United Nations Development Action Framework 2013-2017.

support India to reach the SDGs. It groups health, water and sanitation as one of eight priorities, alongside priorities related to social determinants of health, e.g. poverty, education, climate change, disaster resilience and gender equality.[13] The UN system has a geographical focus on states with the highest proportion of people living in poverty.[14] Key UN agencies working with WHO in India are the World Bank, UNICEF, UNFPA, UNAIDS and UNDP.[15]

1.4 WHO activities in India

14. The WCO is based in New Delhi, with roughly 110 staff. WHO works at national level, but also through 273 field offices of the WHO Public Health Surveillance Project (formerly the National Polio Surveillance Project (NPSP)), with over 1700 NPSP staff (about 850 Special Service Agreement (SSA) holders and 900 field monitors recruited through an outsource mechanism). In addition, WHO India employs around 80 TB consultants, 12 state and zonal coordinators for neglected tropical diseases (NTDs) and 20 cardiovascular health officers and 40 cardiovascular senior treatment supervisors through outsourcing.

15. The WCO's partners include the Union Ministry of Health and Family Welfare (MoHFW), the Indian Council of Medical Research (ICMR) and other entities, including the NITI Aayog, non-health ministries, academic institutions and nongovernmental organizations/civil society organisations.

16. The work of the WCO is guided by a CCS (i.e. CCS 2012-2017 and CCS 2019-2023[16]); the National Health Policy (updated in 2017); the WHO GPWs (i.e. 11th, 12th and 13th GPWs), and WHO Regional priorities. The aim of the CCS 2012-2017 was to contribute to improving health and equity in India by helping to develop inter-sectoral actions on the broad determinants of health while providing the appropriate individual and population services. The three strategic priorities were:

1) Supporting an improved role of the GoI in global health (ensuring implementation of international health regulations (IHR), strengthening the pharmaceutical sector, and improving stewardship of the India health system);
2) Promoting access to and utilization of affordable, efficiently networked and sustainable quality services by the entire population (providing universal health service financing and accreditation of service delivery institutions); and
3) Helping to confront the new epidemiological reality (scaling up reproductive, maternal, newborn, child and adolescent health services, addressing combined morbidities and transferring WHO services to the Government).

17. In 2017, the WCO undertook an internal review of the CCS, assessing relevance, efficiency and effectiveness. The main conclusions were that the strategic focus of the CCS became less relevant with the changing national, regional and global priorities, necessitating increasing programming (and expenditure) outside CCS priorities through biennial workplans. Strategic revision could have been addressed through a mid-term review and mid-course correction of the CCS focus areas. This calls for establishing a robust monitoring and evaluation system to oversee the implementation of the CCS. Recommendations for strategic priorities for the next CCS included: 1) emergency and NTDs (including malaria) as they are priorities in the National Health Policy, Regional flagships and the Regional Director's four strategies; 2) further alignment with National Health Policy focus areas: antimicrobial resistance (AMR), mHealth, integration and continuum of care, neonatal mortality and stillbirth,

[13] United Nations Resident Coordinator's Office, India (2018). Government of India and United Nations Sustainable Development Framework 2018-2022.
[14] For UNSDF Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Maharashtra, Odisha, Uttar Pradesh & North-East region; UNDAF also targeted Rajasthan and in the North-East, specifically Assam.
[15] WHO, India (2019). The WHO India Country Cooperation Strategy 2019-2023: a time of transition.
[16] The CCS 2019-2023 was approved by the Ministry of Health and Family Welfare in May 2019.

adolescent health, violence against women, health care of the elderly, environmental health, mental health, and viral hepatitis; and 3) improved ownership/engagement of other ministries.[17]

18. The CCS 2019-2023, developed based on lessons and experience of the earlier CCS, has several strategic priorities, each with focus areas for WHO collaboration:

1) Accelerate progress on universal health coverage;
2) Promote health and wellness by addressing determinants of health;
3) Better protect the population against health emergencies; and
4) Enhance India's global leadership in health.

19. The WCO implements its work through biennial workplans and budgets. The biennial workplans reflect the corporate strategic objectives of the WHO biennial programme budget. The twelve strategic objectives for the Programme Budget 2012-2013 were reduced to five categories from 2014 onwards, as reflected in the table below.

Table 2: Links between CCS India priorities and WHO programme budget priorities

India CCS priorities 2012-2017	Programme Budget strategic objectives 2012-2013	Programme Budget categories 2014-2017
1.1 Ensuring the implementation of IHR	5. Emergencies, disasters, crises and conflicts	5. Preparedness, surveillance and response *(IHR)*
1.2 Strengthening the pharmaceutical sector including drug regulatory capacity and trade and health	11. Medical products and technologies	4. Health Systems *(Access to medicines and health technologies)*
1.3 Improving the stewardship of the entire Indian health system	12. Leadership, governance and partnership	4. Health Systems *(National health policies, strategies and plans; Health systems information and evidence)*
2.1 Promoting universal health service coverage so that every individual would achieve health gain from a health intervention when needed	10. Health governance, financing, staffing and management, and research	4. Health Systems *(Integrated people-centered health services)*
2.2 Properly accrediting service delivery institutions (primary health care facilities and hospitals) to deliver the agreed service package	10. Health governance, financing, staffing and management, and research	4. Health Systems *(Integrated people-centered health services)*
3.1 Scaling up reproductive, maternal, newborn, child and adolescent health services	4. Pregnancy, childbirth, the neonatal period, childhood and adolescence, sexual and reproductive health, and ageing	3. Promoting health through the life-course *(Reproductive, maternal, newborn, child and adolescent health)*
3.2 Addressing the increase in combined morbidities due to combinations of communicable and noncommunicable diseases	3. Noncommunicable diseases, mental disorders, violence and injuries and visual impairment 6. Tobacco, alcohol, drugs, unhealthy diets 7. Social and economic determinants of health 8. Environmental threats to health. 9. Nutrition, food safety and food security	2. Noncommunicable diseases 1. Communicable diseases
3.3 De-verticalizing polio, AIDS and TB programmes and transitioning WHO service delivery in them to Government structures	1. Communicable diseases (p*olio*) 2. HIV/AIDS, tuberculosis and malaria	1. Communicable diseases (*HIV/AIDS, TB, vaccine-preventable diseases)* 5.Preparedness, surveillance and response (polio)

[17] WHO, India (2016). Internal review of Country Cooperation strategy 2012-2017 (draft).

2. Findings

20. The findings of the evaluation are presented following the three main evaluation questions and sub-questions identified in the Terms of Reference (see Annex 1 for the full list).

2.1 Relevance of WHO's strategic choices

Are the CCS (and other relevant strategic instruments) based on a comprehensive health diagnostic of the entire population and on India's health needs?

21. Both CCSs are based on a comprehensive analysis of the health situation in India, including social and economic determinants of health, at the time of their preparation. The instruments build on a range of national and international research and other sources to provide a sound evidence base for their development. Furthermore, the situation analysis underpinning the CCS 2019-2023 draws on work undertaken in support of the MoHFW's 2017 National Health Policy, thus ensuring a common foundation for both documents.

22. While both CCS make references to the burden of disease attributable to various conditions it is not clear that priority-setting was consistently evidence-based. The CCS 2019-2023, while still lacking any detailed references to burden of disease as a planning tool, does note that India plans to adopt regular monitoring of burden of disease (at both national and state levels) by 2022.

23. The CCS 2012-2017 makes explicit reference to health inequalities, and includes examples relating to variations in infant mortality (among states) and under-nutrition (among income quintiles). Nevertheless, the focus is relatively narrow and there are no references in the document to health and other inequalities between rural and urban communities, or those linked to other determinants of health. Although gender is mentioned in the CCS, it does not contain an analysis of gender issues or broader inequalities.

24. There are no direct references to health or other inequalities in the CCS 2019-2023. Possibly such issues are now included within the broader agenda of universal health coverage (UHC).

Are the CCS (and other relevant strategic instruments) coherent with the National Health Policy, any other relevant national health strategies and the MDG/SDGs targets relevant to India?

25. The priorities set out in both CCS appear to be well-aligned with those of India. As noted by the MoHFW Secretary in his foreword, the CCS 2012-2017 was developed jointly by the Ministry and the WCO, 'in line with national priorities and health policy' at the time. In the case of the CCS 2019-2023, priorities reflect those set out in the 2017 National Health Policy. Indeed, finalisation of the new CCS was delayed in part to ensure such alignment could take place.

26. The CCS 2012-2017 prioritised India's MDG targets at the time, especially in respect of maternal and neonatal morbidity and HIV/AIDS. Since the 2017 National Health Policy 'recognises the pivotal importance of Sustainable Development Goals' there is also good alignment between the the CCS 2019-2023 and the SDGs. The WCO also contributed more broadly to the SDG agenda, and its alignment to WHO actions, by organising a National Consultation on Transitioning from MDGs to SDGs in 2016 and by supporting state-level planning for SDGs.

27. The CCS 2019-2023 is consistent with India's health priorities elaborated in the Strategy for New India@75 which was published in November 2018 by the National Institution for Transforming India, also known as NITI Aayog. That document highlights several health-related areas as priorities under the broad heading of 'Inclusion': public health management and action (with a focus on human resource and institutional aspects); comprehensive primary health care; human resources for health; UHC; nutrition; and gender.

28. It is difficult to assess the extent of external input to the 2012-2017 document due to staff changes among GoI and partner counterparts. The process for developing the CCS 2019-2023 was widely viewed as having been 'participatory' in nature, however relatively few key informants reported that they personally had been actively engaged. Most stakeholders external to the WCO were aware of the CCS as a key document underpinning the work of WHO in India.

29. A specific strategic theme which is common to both CCSs is support for the role India plays in global health. The 2012-2017 document defines a strategic priority of 'Supporting an improved role of the GoI in global health' while the 2019-2023 version commits to 'Enhance India's global leadership in health'. Those priorities also relate to WHO's support to India in its role as a major producer and exporter of generic medicines and, increasingly, medical devices. They also reflect the part that India plays in global health governance, south-south cooperation (in areas such as polio transition and disease control) and development of innovative technologies in digital health and other fields. Inclusion of such priorities in both CCSs is further evidence of alignment between WHO and GoI priorities.

Box 1 – WHO's support for India's role in global health

WHO supports India not only for domestic health improvements, but also to play a bigger role internationally. One of the three priorities in the CCS 2012-2017 was 'supporting an improved role of the GoI in global health'. Also the CCS 2019-2023 commits to 'enhance India's global leadership in health'.

Many WHO CCSs recognize the interconnectedness of national, regional and global health, and include cross border collaboration in disease control, south-south sharing of experience and innovation, and other forms of regional collaboration. All the above are in line with the theory of change of the GPW and CCS which contributes to health impact at country level.

Besides the above issues, the India CCS 2012-2017 specifically mentions the global impact of India's contribution in the area of biotechnology, for example the production and global export of generic drugs and vaccine development. The WCO's comparative advantage is to support India to strengthen the pharmaceutical sector including drug regulatory capacity and trade & health, in cognizance of intellectual property rights issues and international covenants. WHO's support also contributes to public health impact outside India's borders.

India's case study illustrates the evolving opportunities and needs of countries transitioning from low to middle income status, where speed of economic growth is contrasted by a lag in reduction of disease burden and other inequities in health. WHO has a unique role to play in such countries.

Are the CCS coherent with the UN Development Action Framework 2013-2017/UN Sustainable Development Framework?

30. The UNDAF covering 2013-2017 was built on a foundation of extensive consultation and strategic discussions among UN agencies and relevant GoI bodies. In the case of WHO, the UNDAF 2013-2017 and the CCS 2012-2017 were 'developed in tandem'. Relevant UNDAF outputs were incorporated into the CCS, specifically: promotion of inter-sectoral actions; multilevel advocacy; development of evidence-based policy options; and enhanced capacity for decentralized planning, delivery, monitoring and evaluations of interventions. WHO also contributed to work related to health and social determinants of health for inclusion in the UNDAF.

31. In the case of the CCS 2019-2023, the proposed monitoring framework utilises indicators which are described as being 'aligned to' the UNSDF 2018-2022. It is also intended that UN agencies will play a part in monitoring progress against the CCS 2019-2023 while WHO will continue to act as the lead UN agency for health matters. Again, there is evidence of good coherence between the CCS and the UNDSF.

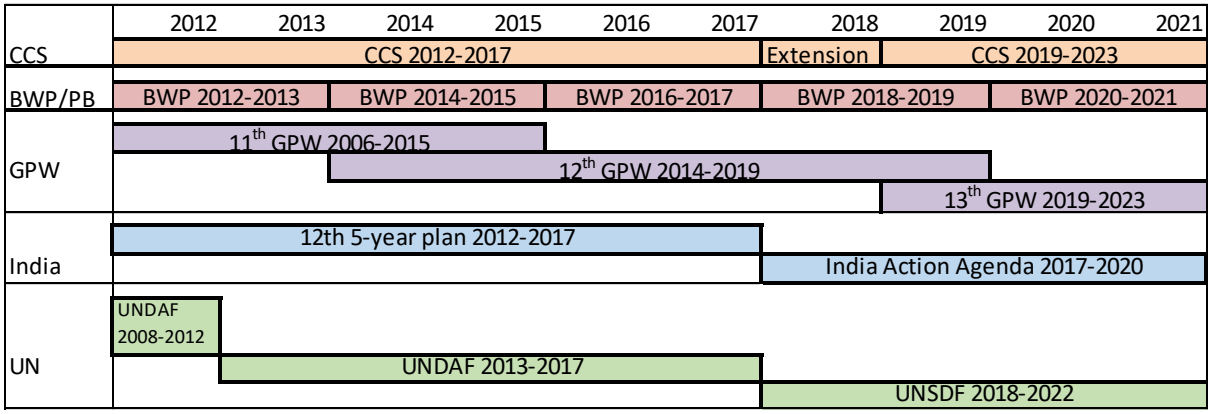
32. The coherence between WHO and the wider UN system in India which emerges from review of documentation is also apparent from key informants within the WCO, other UN agencies and partners who confirmed that WHO's strategic choices are relevant to the broader UN agenda.

33. In practical terms, it is also clear that there is good collaboration and a sound understanding of agencies' respective roles among WHO and its UN partners in India. In the case of NPSP, for example, WHO, UNICEF and UNDP have collaborated for many years, with UNICEF providing social mobilization and cold chain support and UNDP assisting with IT support to the materials supply chain. Stakeholders considered that UN agencies' respective roles are clear, appropriate to their areas of comparative advantage and well executed.

Are the CCS coherent with the WHO General Programme of Work and aligned with WHO's international commitments?

34. The CCS 2012-2017 was developed during the development of WHO's 12th General Programme of Work (GPW12) at a time when WHO reform was also gathering pace. The CCS makes reference to the five 'programmatic categories' set out in GPW12 (communicable diseases; noncommunicable diseases; health through the life course; health systems; preparedness, surveillance and response). While it is apparent that those categories shaped the overall approach set out in CCS 2102-2017, they are not used as a result framework.[18] The work of WHO in India is guided by a range of national policies and priorities as well as associated WHO planning documents. Figure 3 presents the main internal planning instruments that sit alongside India's own national strategies to frame WHO's action in India. The associated challenges these instruments present are further elaborated in Annex 3.

Figure 3. WHO's main planning instruments in India



35. The reform agenda that is elaborated in GPW12 is also reflected in the CCS 2012-2017 which notes that 'WCO seeks to reposition itself by fostering health policy dialogue and technical advice in strategic priority areas of collaboration'.

36. The 2017 audit of the Country Office concluded that the 'CCS is aligned and harmonized with the GPW and country's key international commitments'. That view is also borne out by the internal review of the CCS 2012-2017 which found that there was generally good alignment between the CCS and GPW12 while noting that the former did not make explicit reference to social determinants of health which was an issue addressed in the GPW.

37. Finalisation of the CCS 2019-2023 was delayed for two principal reasons. Firstly, in order to take into account a number of major policy developments in India, including *Ayushman Bharat* that

[18] The difficulty in measuring results against planned targets and assessing WHO's contributions to the same are indications of a number of systemic challenges in planning and monitoring processes within WHO at both corporate and country levels. This weakens WHO's capacity to demonstrate results and contribution to health improvements in any given country.

was announced early in 2018 and launched later in the same year. Secondly, in order to ensure it fully reflected the strategic priorities of WHO's 13th General Programme of Work (GPW13): to have one billion more people benefitting from UHC; one billion more people better protected from health emergencies; and one billion more people enjoying better health and well-being.

38. The CCS 2019-2023 makes explicit reference to the three strategic priorities of GPW13 and, in contrast with the previous CCS, the proposed monitoring framework for the CCS 2019-2023 also uses indicators that are aligned to GPW13 targets. As such, the CCS 2019-2023 will enable 'measurement of the contribution of the India CCS to achieving the triple billion goals of the GPW13'. It is also noted that India's size means that the country will be an important contributor to achieving the GPW13 targets.

39. There is also evidence of coherence between the CCS and Regional priorities. While the CCS 2012-2017 does not refer to SEARO policy documents or strategies, having been developed before the Regional Director articulated her 1 by 4 strategic vision,[19] there is alignment between the two.

40. Reporting in 2016, the Independent Expert Oversight Advisory Committee (IEOAC)[20] also noted they had observed 'strong alignment between regional and [India] country office in priorities, objectives, reporting and governance'.

41. The analytical chapter of the CCS 2012-2017 mentions inequalities in health, such as gender and rural-urban disparities. However, there is no evidence WCO used or commissioned detailed analysis on gender, equity and human rights. Gender is viewed primarily through a relatively narrow (but important) lens of maternal health and gender-based violence. However, the 2017 audit of the Country Office concluded that the Office 'integrates equity, gender, human rights and social determinant into its work'.

42. UHC and the need to address inequalities in general is also a prominent theme throughout the CCS 2012-17. The focus on stewardship under Strategic Priority 1 could also be viewed as a move to enhance governance.

43. Similarly, the CCS 2019-2023, while again emphasising all aspects of UHC does not explicitly refer to gender, human rights, social determinants of health, or good governance. It is notable, however, that the CCS 2019-2023 M&E framework proposes to monitor equity in population health gains, by disaggregating indicators based on gender, age, geography and socio-economic factors, at the national and sub-national level.

44. Key informants did not raise any significant concerns regarding the WCO's adherence to WHO's international commitments, including those set out in the relevant GPW. The general consensus appears to be that WHO works consistently in support of global priorities although it was suggested that WHO could better employ the Organization's strength and profile to advocate for rights-based approaches to health.

Has WHO learned from experience and changed its approach in view of evolving contexts between both CCSs or during the course of the CCS 2012-2017?

45. The internal review of the CCS 2012-2017, which was carried out in 2017, notes that the strategic focus of the CCS became less relevant as national, regional and global priorities evolved during the CCS period. As priorities changed, the country programme budget and operational workplans also diverged from what was anticipated by the CCS. Such responses are considered to be appropriate and reflect the challenges of longer-term planning in a country which is undergoing rapid development.

[19] See http://www.searo.who.int/mediacentre/features/2014/flyer_1by4.pdf?ua=1
[20] See http://apps.who.int/gb/ieoac/PDF/20/20th_Report.pdf

46. Additionally, a number of important strategic documents and other initiatives were launched while the CCS 2012-2017 was current. They include the 2017 National Health Policy, the Regional Flagship Priority Areas (defined in 2014) and the Regional 1 by 4 Strategic Vision (announced in 2013). Biennial workplans were revised to take account of new priorities stemming from such developments.

47. The WCO leadership acknowledge that long-term strategies like CCSs are useful planning tools, but also recognise that plans need to be reviewed and revised as context and needs evolve. That view is echoed by the internal review of the CCS 2012-2017 which recognises that, while all planned CCS priorities remained relevant, mid-course review and revision of the CCS focus areas would be useful.

48. Other changes to WHO's approach which were reportedly made during the course of the CCS 2012-2017 included increases in the emphasis placed on sanitation (stimulated by a Government initiative - *Swachh Bharat*), environmental health (in response to emerging health threats due to growing air pollution) and hepatitis (thanks to the availability in-country of WHO staff with relevant expertise, coupled with the production in-country of new, generic medicines to treat the condition).

49. More recently, the high-level, national initiative to progress towards UHC through increased access to services, improved referral processes and better financial protection (*Ayushman Bharat*) has served to engage WHO actively and reinforce the WCO's focus on such issues, and was a key factor in shaping priorities for CCS 2019-2023.

50. Ministry counterparts indicated their appreciation for WHO's ability to adjust its plans in response to emerging national needs and opportunities. On the other hand, there is no clear evidence that such increases in effort were offset by reductions in efforts in other areas.

51. The internal review carried out in 2017 sought to identify achievements, challenges and lessons learned during the course of the CCS 2012-2017 in order to guide the development of the next CCS . The review considered the relevance of the CCS 2012-2017, the efficiency of its implementation and its effectiveness in terms of achievements on expected outcomes. It concludes by presenting a series of seven 'Strategic Recommendations for the new CCS' which appear to have been adopted in developing the CCS 2019-2023.

52. Further evidence of learning and experience being deployed to guide future plans is offered by the Executive Summary of the CCS 2019-2023 which indicates that it 'builds upon the work that WHO has been carrying out in the last several years, but also expands its support in certain areas to meet new or growing health challenges, such as air pollution, increasing suicide rates and the challenge of making UHC a reality'.

53. The CCS 2019-2023 also addresses issues which were not apparent when the previous CCS was developed. It is, for example, clear in its intent to reflect the GoI priorities as set out in the 2017 National Health Policy, the *Ayushman Bharat* initiative and the strong focus of the GoI on digital health, including the Integrated Health Information Platform (IHIP). It also provides an indication of the way forward in respect of transferring the NPSP from the Global Polio Eradication Initiative (GPEI) and WHO to the GoI during the polio transition.

54. A further significant change between the CCS 2012-2017 and the CCS 2019-2023 is the commitment in the latter for WHO and the MoHFW to conduct an extensive review midway through the CCS, in order to guide any necessary 'mid-course' adjustments to workplans and staffing for later years. The CCS 2019-2023 also includes a detailed monitoring framework. Both these changes are indicative of a willingness on the part of the WCO to build upon lessons learned.

Are the CCSs strategic regarding identification of WHO's comparative advantage and clear strategy to maximise it and make a difference?

55. WHO's comparative advantages appear to be widely acknowledged among GoI, partners and other stakeholders, which include skilled and experienced technical staff; good working relationships

with MoHFW; access to regional and global expertise; neutrality; credibility; and strong 'convening' power.

56. It was also noted that WHO in India has a well-recognised, respected and hence influential 'brand' although it was argued that WHO is not using its 'brand' proactively enough at country level.

57. The CCS 2012-2017 seeks to capitalise upon on those advantages and thus enable WHO to contribute meaningfully to and influence national health policy processes and the GoI's health agenda. Specifically, the CCS proposes:

i. a shift from budgetary support to health policy dialogue and technical advice;
ii. a shift from replacing Government services to strengthening the country's own capacity;
iii. a shift to impact-ensuring practices instead of high-labour, low-impact activities and small-dose cash transfers;
iv. stronger interlocution with and presence across the country; and
v. inter-sectoral action and engagement with various stakeholders in fostering health actions.

58. The CCS 2019-2023 defines the added value and role of WHO in India as:

i. a reliable and credible source of high-quality data and information - to influence and advocate for policy change and program improvements (both with the Government and with other development partners);
ii. the lead UN technical agency for health - to convene and work across a range of Government ministries and agencies; and
iii. a source of expertise in a range of technical areas, drawing upon experts from HQ, SEARO, and the network of WHO Collaborating Centres.

59. The large, field-based workforce available through WHO's network of regional and sub-regional offices in-country is also a clear source of comparative advantage which is being used to provide support to state governments including via the NPSP, TB Technical Support Network, NTD coordinators and India Hypertension Management Initiative. The CCS 2019-2023 proposes a stronger focus on state-level support via such modalities.

60. India's significant, and growing, role in global health is reflected in the priorities of both CCSs. WHO's ability to support that role through its authority to endorse and certify health-related products and services is a further unique advantage.

61. In contrast, while WHO's global reach was seen as a strength it was suggested that WHO's traditional role in translating international guidelines for national adoption may be one which will increasingly be subsumed under MoHFW's own capacity.

Are the CCSs strategic regarding capacity of WHO to position health priorities in the national agenda and in those of the national partners in the health sector?

62. Both CCSs build on several factors which strengthen WHO's ability to position health priorities in national and partners' agendas.

63. WHO has excellent access to knowledge and expertise and both CCSs indicate an important role for WHO in intellectual leadership and policy development supported by evidence generation and high-level international expertise. This role is most strongly articulated in the CCS 2019-2023.

64. The WCO also has formal standing within the development partner community as a result of its role in convening and chairing the Health Partners Forum which seeks to enhance coordination among UN, development agencies, and other key stakeholders. In addition, the 2017 audit of the Country Office found that WCO coordinates closely with GoI, UN, and non-State actors to promote

multisectoral approaches to other health challenges including road safety, environmental health and AMR. WHO is seen by many as a 'neutral arbitrator' in those roles.

65. Stakeholders also remarked about the strong relationships that exist between WHO staff and senior MoHFW personnel. It was noted that WHO's effectiveness in supporting particular GoI health agendas, for example UHC, benefitted greatly from its credibility with the Ministry.

66. The CCS 2012-2017 signals an aspiration to 'influence the Government's health agenda' and many of the initiatives set out in the CCS were designed with that aim in mind. WHO's contribution in this regard is noted in the CCS 2019-2023.

67. Several key informants suggested that WHO should be credited with helping to focus political attention, and resources, at national level on health – i.e. the aspiration of the CCS 2012-2017 had been achieved. Other factors will doubtless also have been relevant, for example growing GDP resulting in a larger fiscal envelope for health, but it seems reasonable to assume that WHO's strategic role did play a part.

68. It is also apparent that WHO faces, and will continue to face, some challenges to its ability to influence and contribute to the national agenda:

i. It was noted on a number of occasions that there are many Indian nationals, within and outside GoI, with high levels of health expertise (some of whom are relied upon by WHO to provide input to global policy deliberations). When providing technical expertise, WHO will thus need to ensure the availability of top-level expertise to add value.
ii. GoI views the private sector as an important partner in the country's health system and measures such as PM-JAY (as a component of the Ayushman Bharat initiative) will fund private providers for delivery of secondary and tertiary care. Almost half of the empanelled hospitals are classed as private for-profit or not-for-profit. The CCS 2019-2023 indicates a role for WHO to act as a bridge between the public and private sectors (as it did for new TB service models). Some stakeholders indicate WHO could do more in this area, as it is crucial for the design and implementation of UHC initiatives.
iii. International philanthropies and other development partners are also pursuing opportunities to serve as alternative sources of advice and support to GoI.

Are the CCS strategic regarding the partnership between WHO and the Government of India?

69. The CCS 2012-2017 indicates the WCO's intention to reposition itself by providing health policy advice to the GoI and advancing health policy dialogue. The CCS proposed major adaptations in the way the WCO plans, runs its budgets, works and organizes itself, to achieve this repositioning.

70. The CCS 2019-2023 is more explicit regarding the role of WHO in supporting GoI in enacting health reforms and reaching key goals of the 2017 National Health Policy. Building upon WHO's earlier work, it proposes to expand support to meet new or growing health challenges such as UHC.

71. The CCS and NPSP Transition Planning Framework (2018-2026) propose a significant change in WHO's role in supporting the GoI. Most of the financing and eventually the management of the NPSP will be transferred to the GoI. WHO will gradually shift focus from providing on-the-ground support in planning, implementing and monitoring programs (NPSP, TB control and integrated hypertension management initiative) to providing high-level policy guidance and advocacy. This shift should also allow WHO to address a broader set of issues as they arise and requires WHO to work with a broader range of sectors and partners in and outside the health sector.

72. There is broad support among stakeholders for this shift of WHO's emphasis away from on-the-ground support. It is argued that WHO ought not take on roles that GoI could and should be doing themselves – and which are already funded by GoI. At the same time others, including WCO and

government stakeholders, caution that a rapid transfer may result in reduced effectiveness. It has also been proposed that important support skills and functions should not get lost but could instead be used in other programmes.

73. From a Constitutional perspective, responsibility for health in India rests primarily with state governments although responsibility for some aspects, on the so-called 'concurrent list', is shared between both levels of government and some matters which impact directly or indirectly on health (such as quarantine, tobacco excise and foreign affairs) are handled by the Union (national) government. Some key health initiatives including, as recent examples, *Ayushman Bharat* and *Swachh Bharat* are also led from national level. According to the CCS 2012-2017 state governments, in total, spent more than twice as much on health as the Union Government in 2010.

Box 2 – Working in a federated country

The federated nature of the GoI offers worthwhile opportunities in areas such as policy innovation and learning, but may also pose challenges for WHO. While GoI and, more specifically, MoHFW is the principal partner of WCO, there are requests for WHO also to collaborate with state-level health administrations – especially those where health status is poor or health inequalities are great. While directly partnering with the Union Government for evidence generation, policy support, and technical assistance, WCO has been providing extensive support to various states based on the varying needs of the states in concurrence with the Union Government. Those include implementation support, capacity strengthening, monitoring and technical assistance.

74. The federated nature of GoI can offer worthwhile opportunities in areas such as policy innovation and exchange of best practices and lessons learned in different states and levels but this may also pose strategic challenges for WHO. While GoI and, more specifically, MoHFW is the principal counterpart organisation to WHO there are requests for WHO also to collaborate with state-level health administrations – especially those where health status is poor or health inequalities are great. Any such collaboration may need to be undertaken in consultation and agreement with the Union Government.

75. The CCS 2012-2017 also refers to work to increase the policy-making and planning capacity of some states as well as support for inter-state and state/Union exchange of experience. The CCS 2019-2023 notes that WHO has provided technical support to states in areas such as viral hepatitis control and AMR and suggests there will be ongoing collaboration with States in many areas, including institutional strengthening for regulatory functions.

2.2 WHO's contribution and added value (effectiveness and progress towards sustainability)

To what extent were the country biennial work plans (2012-2017) articulated with the focus areas as defined in the CCS (and other relevant strategic instruments) or as amended during the course of implementation?

76. The internal review of the CCS 2012-2017 provides a retrospective analysis of the extent to which biennial workplans were aligned with the CCS. Since polio expenditure represents a large component of biennial workplans, data are presented with and without the inclusion of NPSP.

77. If polio-related outputs and products are excluded the proportion of outputs that were not reflected in the CCS doubled over the three biennia from 24% in 2012-2013 to 48% in 2016-2017. That may reflect the fact that the WCO was adjusting workplans to respond to changes in national needs and priorities over the course of the CCS period.

78. In financial terms the trends are less clear with the proportion of total spending allocated to non-CCS outputs and products falling between the first and second biennia but then rising again between the second and third biennia.

79. Considering successive workplans in more detail suggests that a number of CCS priorities were reflected in all three biennial workplans (see Table 3).

Table 3: CCS 2012-2017 priorities consistently reflected in biennial workplans during CCS period

Category	Priorities
1	TB HIV immunization
2	Multisectoral actions Primary health care approach
3	Quality of care Gender equity
4	Clinical Establishment Act Health intelligence Advocacy on UHC Primary health care Health financing Licensing, accreditation, certification and quality of care Human resources for health Access to medicines Support to pharmaceutical sector of GoI Supply chain management
5	IHR Polio

80. Several priority areas were not covered explicitly or in detail by the CCS 2012-2017 but gained prominence during the period, generally in response to emergence of issues stemming from the 2017 National Health Policy, SEARO strategies or WHO's GPW. Those areas included NTDs, measles, mental health, social determinants of health and neonatal health.

81. Beyond immediate national-level concerns (and the biennial workplans), the WCO also supported the WHO Ebola response in West Africa and provided assistance in the form of post-disaster surveillance, outbreak response and immunization campaigns in Cox's Bazar, Bangladesh.

What were the main results achieved for each CCS priority and other key activities within and outside the CCS?

82. Objective assessment of achievements is problematical since the CCS 2012-2017 does not have a result framework which specifies indicators, including targets and baselines, for each objective. The CCS 2019-2023 addresses that issue by including indicators for success and a results framework for each of its four strategic priorities.

83. Apart from the regular internal mid-term and end-of-biennium programme budget performance assessment processes, WCO did not review progress of implementation of the CCS during the period 2012-2017, but undertook an internal review in 2017, as part of the planning process for the CCS 2019-2023.

84. With regard to Strategic Priority 1 of the CCS 2012-2017 (Supporting an improved role of GoI in global health), WHO supported pioneering health research to inform policy and programmes both in India and globally. Primary research from India guided the global switch from the trivalent to bivalent oral polio vaccine (OPV). Ongoing research projects will inform implementation of the Polio Endgame Strategy, including a trial of a fractional dose of inactivated polio vaccine (IPV), and a trial combining use of a monovalent OPV (MOPV1) with IPV. WHO is also supporting clinical trials of typhoid conjugate vaccine and of new devices and diagnostics for measles surveillance. WHO's support for India's regulatory systems contributed to the success of Indian pharmaceutical industry as a source of medicines used globally in disease control programmes.

85. Achievements in respect of Strategic Priority 2 (Promoting access to and utilization of affordable, efficiently networked and sustainable quality services by the entire population) include support for high level policy dialogue on UHC with MoHFW, NITI Aayog and selected states prior to introduction of a National Health Protection Scheme and the creation of Health and Wellness Centres to enhance primary healthcare in communities under the *Ayushman Bharat* initiative.

86. In the areas of concern under Strategic Priority 3 (Helping to confront the new epidemiological reality) several reports suggest, and stakeholders agree, that WHO technical assistance, normative support, and on-the-ground implementation support contributed to major improvements of health status. Polio, yaws, and maternal and neonatal tetanus were eradicated in India over the CCS period. WHO experts also provided evidence and inputs in innovative treatment and control strategies for TB, HIV and hepatitis and WHO contributed to important national strategies and action plans, including for AMR and NCDs.

87. Annex 4 summarizes in more detail the results that were identified by the internal review and other WCO reports, and validated during the evaluation, as having been achieved in relation to each strategic objective identified by the CCS 2012-2017.

Box 3 – Field-level implementation support

Apart from its normative role and convening capacity, WHO's comparative advantage in India includes the catalytic role of its extensive field-based workforce in support of disease control programmes such as polio and TB and, more recently, NTDs and the hypertension management initiative. In addition to its central-level staff in New Delhi, WHO provides on-the-ground implementation support to states in India through its field-based networks. As a result of their understanding of local realities, these networks are able to rapidly reach out to populations and provide necessary support on the ground, including through strengthened surveillance, monitoring of epidemics and capacity building.

It is widely recognized that the eradication of polio in India and the achievements of the TB programme would not have been possible without such networks.

88. India achieved significant improvements in health outcomes over the period of the CCS 2012-2017. Most stakeholders agreed that WHO had contributed significantly to those improvements although the lack of a robust results framework and theory of change in the CCS 2012-2017 makes attribution difficult.

89. Much of the work at country level to implement the CCS 2012-2017 was undertaken against the backdrop of GPW12 which does itself define a clear results chain. The internal review of the CCS 2012-2017 therefore took the opportunity to consider achievements in India in relation to the GPW12 goals and noted that India achieved GPW outcome targets by 2015 in a number of CCS priority areas, such as: percentage of HIV+ pregnant women provided with antiretroviral treatment; introduction of rotavirus vaccine; having a comprehensive national health sector strategy; having a national strategy for major epidemics and pandemics; and polio eradication.

90. India missed the GPW outcome indicators for DTP[21] vaccine coverage, measles elimination and postnatal care visits within two days of delivery.

91. Review of progress reports and key informant interviews also suggest a number of other positive changes in India in respect of CCS priorities over the period 2012-2017 and beyond to which WHO contributed significantly (see Table 4).

Table 4: WHO contribution to achievements in India in respect of CCS priorities

Priority 1: Improved role of GOI in global health
Objective 1.1: Ensuring the implementation of IHR and similar commitments • Development of IHIP enabling collection of surveillance data from public and (several) private health facilities, including outbreaks, health workforce, essential medicines and commodities, and diagnostic equipment • Cause of death registry as a "game changer" in the generation of reliable mortality statistics • Adoption of India National Action Plan on AMR • International Conference on AMR and 'Delhi Declaration'
Objective 1.2: Strengthening the pharmaceutical sector, including drug regulatory capacity and trade & health • India declared functional to meet international indicators for a functional vaccine regulatory system • Generic industry very robust in India – Indian Pharma massive contribution to containing HIV/AIDS, TB, malaria, reproductive health, hepatitis and others (70% of prequalified medicines, 65% of prequalified vaccines and 59% of active pharmaceutical ingredients come from India) • WHO is the most credible partner in India for pharmacovigilance • India declared Centre of Excellence for good manufacturing, clinical and distribution practices (GMP, GCP) for the Region • India participation in annual global forum on access issues and recommendations are followed through at national level • Annual national regulators conference, with recommendations implemented swiftly • India first country to issue an essential diagnostic list • Development of pharmacovigilance programme for traditional medicines at the Ministry of AYUSH

[21] This is now being tracked under pentavalent vaccine expansion, which includes antigens for DTP, Haemophilus influenzae type b and hepatitis B.

Objective 1.3: Improving stewardship of entire Indian health system

- Adoption of National Health Policy
- Health has become a priority for GOI top leaders, including the Prime Minister, and GOI has committed to double government health expenditure from 1.2 to 2.5% of GDP by 2025
- Development of Health Financing chapter in National Health Profile, feeding into National Health Accounts
- Increased perceived and real professional recognition for the ICMR

Priority 2: Promoting access to and utilization of affordable, efficiently networked and sustainable quality services by the entire population

Objective 2.1: providing UHC so that every individual would achieve health gain from a health intervention when needed

- Increased WCO engagement with policy-makers at Union and State levels, and increased contributions to policies
- Establishment of UHC as a key goal for the Indian health system
- Endorsement of National UHC Strategy (*Ayushman Bharat*): National Health Protection Scheme and creation of Health and Wellness Centres to enhance primary healthcare (2018)

Objective 2.2: properly accrediting service delivery institutions (PHC facilities and hospitals) to deliver the agreed service package

- Improved MoHFW awareness about service delivery, regulation and accreditation, human resources for health, health financing, and quality of care shortfalls and sustained policy engagement in these areas
- Establishment of national multi-sectoral expert group on patient safety for improving quality of care
- Establishment of dedicated Human Resources for Health Cell at the national level for policy, strategic planning and monitoring

Priority 3: Helping to confront the new epidemiological reality

Objective 3.1: scaling up RMNCAH services

- Elimination of maternal and neonatal tetanus in 2015
- Progress towards MDGs for maternal and neonatal mortality
- GOI and Government of Ethiopia co-hosted 3rd global call to action for ending preventable child and maternal deaths
- GOI commitment to reintroduce cadre of midwives
- Adoption of WHO Global Indicators for RMNCAH, Early Child Development community implementation model
- Adoption of India Newborn Action Plan in selected states

Objective 3.2: addressing increased combinations of communicable and noncommunicable diseases

- India and South-East Asia Region certified polio-free in 2014
- Maintenance of polio-free status supported with introduction of inactivated polio vaccine and trivalent to bivalent OPV switch
- Elimination of yaws in 2016
- Enhanced political commitment for ending TB in India by 2025: 1) National Strategic Plan based on WHO's End TB Strategy: 2) fully funded by MoHFW, and 3) a five-fold increase in budget allocation for TB
- Adoption of innovative strategies to reach the "90-90-90" targets nationwide, and over 900,000 people receive ART
- Adoption of National Viral Hepatitis Control Programme including a policy decision to provide free treatment for hepatitis B and C
- Introduction of safety-engineered reuse prevention syringes for therapeutic injections adopted in Punjab and elsewhere
- Introduction of new vaccines in the routine immunization programme (pneumococcal conjugate vaccine and rotavirus vaccine, while HPV vaccine introduced in a few states)
- Adoption of national roadmap for Kala Azar, MOUs with neighbouring countries and other organizations
- Endorsement of National Multisectoral Action Plan for NCD by cabinet and NITI Aayog
- India signed the FCTC, established Inter-ministerial committee of Secretaries for Tobacco Control, reduction of 6% in smoking prevalence among young Indian adults since 2010-2016
- Adoption of National Action Plan on Climate Change and Human Health
- Adoption of National Sanitation (*Swachh Bharat*) Mission
- Approval National Mental Health Act on World Health Day

Objective 3.3: gradual phased "transfer strategy" of WHO services to the national, state and local authorities with the sine qua non condition that no erosion of effectiveness occurs during the transition period. Such transition strategy will be developed through a consultative process.

- Currently 94% of AFP investigated by MoHFW
- Polio funding from MoHFW has increased towards less dependence on GPEI funds

What has been the added value of regional and headquarters contributions to the achievement of results in country?

92. WCO staff generally report that they have experienced good collaboration with both SEARO and HQ in developing and delivering joint workplans. Specific areas that were highlighted include leprosy and other NTDs, communicable diseases, NCDs, UHC, health information systems, health financing, pharmaceuticals, and environmental health (air pollution). Prior to development of capacity within the WCO, SEARO also provided significant assistance in relation to hepatitis.

93. Many Ministry and civil society counterparts appear not to differentiate between the specific contributions of WCO, SEARO or HQ personnel. They tend to communicate primarily with WCO staff and view all support as emanating from WHO as a single body. In the same vein, when individual Ministry personnel have personal relationships with SEARO or HQ counterparts they are happy to establish informal contact on technical matters of mutual interest.

94. Ministry officials did comment specifically on the support provided by HQ for development of the national UHC program and the roles played by SEARO and HQ to support the WCO in respect of malaria.

95. In some cases, it was suggested, support from SEARO and HQ might be 'supply driven' as opposed to being a response to a specific need or request from country level. Such unsolicited inputs may, on occasion, place additional demands which WCO staff and/or Ministry counterparts sometimes struggle to meet.

What has been the contribution of WHO results to long-term changes in health status in India?

96. As noted above (paragraph 88) India has achieved significant, long-term, positive changes in health status and WHO's contribution to those achievements is seldom disputed. In the eyes of the WCO leadership team, their role is to provide GoI with the best possible evidence and advice which the Government may or may not choose to accept and act upon.

97. The CCS 2012-2017 internal review notes that in CCS priority areas, India achieved the MDG targets for HIV and TB, but narrowly missed them for under-five mortality, infant and maternal mortality in the period 2012-2017 (see Table 5)

98. All respondents credit WHO for its significant contribution towards the elimination of polio from India with acknowledgment in particular for the polio transition model and the NPSP for this success. WHO is also viewed as having contributed to eradication of maternal and neonatal tetanus, and yaws as well as reductions in measles and rubella rates though support for routine immunization.

Table 5: India's achievement of MDG targets (1990-2015)[22]

MDG	Indicator	Baseline (1990)	Achievement	Year
4: Reduce Child Mortality	Under-five mortality rate	125	49	2013
	Infant mortality rate	80	40	2013
5: Improve Maternal Health	Maternal mortality ratio	437	167	2011-2013
6: Combat HIV/AIDS, malaria and other diseases	HIV prevalence among population aged 15-24 years	0.89 (2005)	0.32	2012-2013
	Incidence rate associated with tuberculosis	216	171	2013
	Prevalence rate associated with tuberculosis	465	211	2013
	Death rate associated with tuberculosis	38	19	2013

Is there national ownership of the results and capacities developed?

99. Most respondents agreed that WHO's advocacy and strategic support had contributed to health becoming recognised as a government priority and attracting additional funding. As a result, the Ministry's demands for more sophisticated technical and normative support were increasing: a fact which is recognised in the CCS 2019-2023.

100. SEARO and WCO leadership see further evidence of national ownership in the willingness of GoI to deploy domestic and grant resources to fund substantial elements of the WCO workplan, most notably NPSP and TB.

[22] Source: WHO, India (2016). Internal review of Country Cooperation Strategy 2012-2017 (draft).

101. WCO staff indicate that participation and inclusive consultations further increase MoHFW ownership of technical strategies, for example development of the national NCD agenda. They also noted that, by focusing efforts on development of national strategies and plans (as opposed to delivering short-term inputs, implementation support or other technical assistance) the longer-term impact and sustainability of WHO's inputs was likely to be greater.

2.3 How did WHO achieve the results? (Elements of efficiency)

What were the key core functions[23] most used to achieve the results?

102. The CCS 2012-2017 refers to the WCO 'striving to reposition itself' to concentrate on areas where WHO has comparative advantage, as characterised by the six core functions set out in GPW12. The strategy does not indicate which specific functions will be adopted in support of each of the CCS strategic priorities or individual focus areas, but retrospective reviews and analyses confirm that all six core functions were used by the WCO over the period covered by the CCS.

103. The 2017 audit of the Country Office commented positively on 'comprehensive implementation of core functions of WHO' and results of a survey undertaken as part of the audit reveal consistent agreement among respondents at all levels of WHO as well as UN agencies, other development partners and GoI that the WCO performed well in respect of all six functions.

104. Both the Internal review of the CCS 2012-2017 and the biennial workplan progress reports suggest that all functions were applied (with additional inputs from SEARO and HQ in some cases).

105. Table 6 (below) indicates the role played by each function in support of the CCS focus areas within each strategic priority.

Table 6: Level of contribution of the core functions to the results of the 2012-2017 period

CCS objectives	Core functions					
	Leadership & partnerships	Research & knowledge	Norms & standards	Policy options	Capacity building	Monitoring
1.1: IHR and similar commitments	X		X		XX	XX
1.2: Strengthening regulatory capacity	X		XX	X	XX	X
1.3: Improving stewardship	XX	X			X	
2.1: UHC	XX	X		XX		X
2.2: Accrediting service delivery	XX			XX		
3.1: RMNCAH services	X	XX	XX	X	X	X
3.2: Communicable diseases & NCDs	X	XX	XX	X	XX	X
3.3: Transfer WHO services					XX	
Polio transition	XX	XX	XX	XX	XX	XX

Note: rating relates to information available on the contribution of core functions and this is reflected as follows: xx substantial contribution and x some contribution. The intent is not to be exhaustive but to reflect where emphasis was laid during the 2012-2017 period.

106. While stakeholders generally do not classify WHO's contributions by reference to the six core functions, it was clear, however, that all functions had impacted positively across a wide spectrum of GoI and other partners' activities.

107. Views varied on the WCO's effective use of WHO's convening power, an element of the 'leadership and partnership' function which captures the ability to bring diverse players and interests together to address specific issues. Several stakeholders identified it as a strength while others

[23] The six core functions of WHO are: (i) providing leadership on matters critical to health and engaging in partnerships where joint action is needed; (ii) shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge; (iii)setting norms and standards and promoting and monitoring their implementation; (iv)articulating ethical and evidence-based policy options; (v)providing technical support, catalysing change, and building sustainable institutional capacity; and (vi) monitoring the health situation and assessing health trends.

considered more could have been done by WHO to align interests and activities in some areas such as NCDs.

108. Other functions which were highlighted include provision of technical support, which was seen as bringing rigour to research (especially implementation research), and WHO's role in setting norms and standards, although it was suggested that, in the case of the latter, more could have been done in respect of 'follow-up' activities to monitor compliance with norms and standards. While implementation research in polio was seen as a valuable contribution, support towards health systems implementation research was highlighted as an area for further work.

109. The NPSP is a major, long-standing, collaborative project of WHO and the GoI which has been instrumental in providing the MoHFW and the donor consortium with technical guidance for conducting polio immunization campaigns. NPSP has, for many years, accounted for the majority of WHO budget/expenditure in India and its extensive network of field workers is the largest staff cohort in the WCO and WHO globally. All stakeholders agree on the quality and effectiveness of the NPSP and the value of staff understanding of local realities. This network has been re-purposed to address the immunization agenda more broadly and supports other health priorities.

110. Given the impending phase-out of GPEI support for this initiative at the end of 2019, the WCO and the GoI developed a NPSP Transition Planning Framework 2018-2026, which proposes limited phase out of field operations while broadening the scope of NPSP to support routine immunization and surveillance of vaccine preventable diseases and other public health initiatives.

111. Since the eradication of polio in India, the NPSP has transitioned into a 'Public Health' surveillance project, providing implementation support for routine immunisation (including introduction of new vaccines) and national immunisation campaigns. All stakeholders agree on the need to support the transition from polio to routine immunization and surveillance support.

112. NPSP staff are also increasingly requested to provide support for outbreak control and other emergencies (in India and abroad). Some stakeholders question the appropriateness of WHO broadening the scope of NPSP beyond polio transition into such areas and there is recognition that NPSP field-level operations are not sustainable in their current form.

Box 4 – Polio transition

Even before India was certified polio-free in 2014, it was at the forefront of polio transition efforts, the core objectives of which are to mainstream functions needed to maintain a polio-free world after eradication into ongoing public health programmes; transition of non-essential capabilities and processes to support other health priorities; and share knowledge generated and lessons learned.

The NPSP experience of transitioning to provide implementation support for routine immunization (including introduction of new vaccines) has been very successful in India, resulting in improved immunization coverage rates and strengthened surveillance for vaccine preventable diseases and adverse events following immunization. WCO also worked closely with the government to support high-priority national immunization campaigns.

In anticipation of the phase-out of GPEI funding for polio activities in India at the end of 2019, and in line with the joint WCO/GoI NPSP Transition Planning Framework 2018-2026, the GoI has already assumed funding of most of the national polio laboratory network with the ultimate goal of absorbing the broadened programmatic activities of NPSP into the GoI public health systems by 2026.

113. In addition, replicating the successful NPSP model, WHO also employs field-level support staff in other programmes (TB, NTDs and hypertension management). Their role includes local advocacy together with capacity building and supervision of programme managers and health workers. There is a wider debate about WHO's mandate for, and involvement in, extensive field-level implementation support to states in general, especially since this involves well over half of WCO's expenditure and human resources. The

contrasting (and arguably more common) view was that WHO's role in field activities was focused on setting norms, monitoring their implementation, building sustainable institutional capacity and disseminating knowledge and, as such, was well-aligned with a number of the core functions.

How did the strategic partnerships contribute to the results achieved?

114. It is clear that strategic partnerships have contributed significantly to the results achieved by WHO in India. The CCS 2012-2017 identifies key partners in heath, including donors (DFID, the European Commission, Japan and USAID), UN partners (UNICEF, World Bank), international initiatives (Gavi, GFATM, Roll Back Malaria, Stop TB), foundations (the Bill and Melinda Gates, Bloomberg, Clinton, Norway India Partnership and Sasakawa Foundations) and international nongovernmental organizations (Action Aid, Oxfam and Red Cross).

115. The WCO budget centre review 2016-2017 notes that WCO also worked closely with other key institutions including Ministries beyond health, NITI Aayog, state governments, academic bodies, nongovernmental organizations, and civil society. In the case of civil society however, evidence from WCO staff and stakeholders suggest that the extent of collaboration was limited.

116. Table 7 (below) summarizes the key partnerships in place which contributed to the CCS 2012-2017 objectives.

Table 7: key partnerships which contributed to CCS objectives

CCS objectives	**Key partnerships**					
	MoHFW	**Other GOI**	**UN**	**Development partners**	**Civil society**	**WHO**
1.1: IHR and similar commitments	NCDC			US CDC		SEARO, HQ
1.2: Strengthening regulatory capacity	NRA	NRA				SEARO, HQ
1.3: Improving stewardship	NIHFW					SEARO, HQ
2.1: UHC	NHA	NITI Aayog	UNDP UNICEF			SEARO, HQ
2.2: Accrediting service delivery			World Bank			SEARO, HQ
3.1: RMNCAH services			UNFPA, UNICEF	MacArthur Foundation BMGF		SEARO, HQ
3.2: Communicable diseases & NCD	Many depts	Environment Roads & transport	UNAIDS UNICEF UNDP WFP	US CDC BMGF USAID Gavi Bloomberg Nippon Sasakawa GFATM	VHAI (Tobacco) MSF, CARE, IUATLD	SEARO, HQ
3.3: Gradual, phased transfer strategy of WHO services to national, state and local authorities						SEARO, HQ
Polio transition	UIP		UNDP UNICEF	Gavi, BMGF	Rotary International Lions International	GPEI, SEARO, HQ

117. It is apparent that the relationship between WCO and MoHFW has evolved over time. That evolution was characterised by one source as progressing from a situation in the late 1990s where the Ministry regarded the WCO primarily as a source of flexible funds for activities it could not afford (with the exception of polio) to the current situation where WHO is recognised as a source of technical expertise, with a more sophisticated 'political' capability, that is a true ally of the Ministry. More generally, it was noted that the ability of senior staff in WCO to engage with, and understand the viewpoints and priorities of, senior government officials was a vital factor in ensuring effectiveness at country level in India.

118. WHO's strategic partnership with MoHFW is fundamental to achieving results in India. The fact that some Country Office staff are co-located with Ministry officials (an arrangement which is believed to be unique among UN agencies in India) is viewed as both a contributor to, and symbol of, the quality of the partnership. It was noted that good personal relationships, at all levels, can contribute significantly to the quality of the partnership.

119. The MoHFW was described on more than one occasion as having high expectations of professionalism and technical expertise from its partners. Against that backdrop, staff across a broad range of functions from both organisations observed that they enjoy a strong relationship of trust and credibility in which WHO is not perceived merely as a partner but almost regarded as part of the Ministry.

120. Specific factors which were seen as challenges to the quality of the relationship between WCO and MoHFW included frequent staff turnover among Ministry officials; a perception that WCO communication with MoHFW was reactive and ad hoc as opposed to regular and planned; and a lack of understanding about WHO's mandate and how to access WHO support among some Ministry personnel.

121. The growing interest and investment in health by GoI has resulted in a wider range of ministries and other government agencies working in the sector. The WCO appears to have gained the respect of the key stakeholders, most notably the NITI Aayog and the National Health Authority (which manages the *Ayushman Bharat* initiative). In contrast, some civil society representatives and counterparts from other Ministries suggested that WCO's collaboration with non-health ministries was limited.

122. The partnership between the WCO and other UN agencies is considered to be strong with WHO being viewed as a good 'team player'. Areas of collaboration include:

i. Water, sanitation and hygiene, nutrition and NPSP – with UNICEF;
i. NCDs and NPSP – with UNDP;
ii. Gender-based violence – with UNFPA; and
iii. HIV/AIDS – with UNAIDS.

123. There is little overlap in responsibilities or duplication of effort among UN agencies. The size and scope of work in India reduces the likelihood of agencies seeking to address the same issue(s) in the same location(s) while the strength of GoI institutions means that development partners' roles are usually well-defined.

124. WHO convenes the UN Results Working Group on Health, Water and Sanitation and also participates in UNDSF teams on environment, nutrition and HIV, thus reinforcing the One UN dimension at country level. Together with other UN agencies, WHO is represented on the GoI inter-ministerial committee for NCDs. The UN team as a whole holds quarterly coordination meetings.

125. WCO's only collaboration with World Bank in India to date has been in health systems strengthening. There may be future opportunities for strategic partnership between the World Bank and WHO in relation to air pollution and NCDs.

126. WHO also works in partnership with a range of national and international nongovernmental organizations to deliver results in India. During the CCS 2012-2017 period, partners included MSF, Caritas, and CARE all of whom collaborated with WCO in work to address communicable diseases. Rotary has been a strong partner in polio eradication efforts in India over several years and continues to maintain its relationship with NPSP.

127. The partnership between WCO, SEARO and HQ is also recognised as contributing significantly to the work of WHO in India. The fact that India is the largest country in the Region and a key player in global health means that it is a priority country for all levels of WHO.

128. As noted earlier, the fact that the Regional Office is based in the same country and city as the WCO can present challenges and opportunities for both offices.

129. From the WCO perspective, the proximity of SEARO is viewed positively. Personal relations, especially at senior levels, are believed to be crucial for effective collaboration and the fact that there is movement of staff at all seniorities between the offices has helped to build strong networks.

130. WCO staff consider SEARO to be responsive to their requests for support but report some frustration when they are not party to informal communication between SEARO and MoHFW. At the same time, some MoHFW staff indicated they felt the need for communication to SEARO having to go through WCO was cumbersome.

131. Other development partners cited examples of both good and poor communication between SEARO and WCO, including at least one where they considered that poor communication had delayed programme implementation. The evaluation did not find any evidence of commonly understood, protocols for communication and delineation of roles between WCO, SEARO and HQ vis-à-vis the GoI.

132. As an important development, towards the end of the CCS 2012-2017 period, the WCO established a Health Partners Group. The group, which is chaired by WHO, focuses on coordination and collaboration among UN agencies, key partners (including some national NGOs) and embassies working in health in India. The Group's objectives are to:

i. serve as a platform for information sharing, discussion and coordination;
ii. share best practices and lessons learned from ongoing or completed activities; and
iii. stimulate dialogue on global health agenda and its implication to India.

How did the funding levels and their timeliness affect the results achieved?

133. The WCO in India is one of the biggest budget centres in WHO with a biennial budget of around US$ 100 million.

Table 8: Funding sources for WCO India (US$ million)

1. Donor	PB 2012-2013	PB 2014-2015	PB 2016-2017
Member States – assessed	12.6	11.2	13.5
Member States – voluntary specified	39.3	46.2	43.4
(of which India)	*1.3*	*6.6*	*11.5*
Philanthropies	27	13.5	18
Partnerships	0.7	16	12.2
NGOs	13.6	4.1	4
Private sector	23.8	1	0.9
UN	4.2	1.4	1.6
Unspecified funding (PSC/CVCA)	0.5	2.5	2.3
TOTAL	**121.7**	**95.9**	**95.9**

Source: WHO Programme Budget Web Portal and GSM

134. As can be seen from Table 8 above, the WCO was relatively successful in diversifying its funding sources over the CCS 2012-2017 period with financial resources being contributed by

development partners (including increasingly significant contributions from GOI over the three biennia); philanthropic foundations (Bill and Melinda Gates, Bloomberg, Nippon and Sasakawa Foundations), partnerships (including Gavi and GFATM), nongovernmental organizations (including Rotary and the International Union Against Tuberculosis and Lung Disease), UN agencies and the private sector (in particular for the provision of medicines which, as from the 2014-2015 biennium, were considered as in-kind contributions and therefore no longer recorded within the programme budget).

135. Both WCO and MoHFW remarked that the reduced funding from GPEI for polio transition is compensated by increasing funding from GoI, which includes both domestic funding and grants from Gavi and the Bill and Melinda Gates Foundation. A possible challenge encountered in relying on funds from GoI could be delayed implementation of activities due to additional administrative processes. In turn, some MoHFW officials also noted that WCO funds are not always received in a timely fashion.

Table 9: WCO India: Trends in expenditure (US$ million)

	2012-13	2014-15	2016-17
Categories under Programme Budget	**Expenditure**	**Expenditure**	**Expenditure**
CATl: Communicable Diseases	30.50	12.89	18.15
CAT2: Non Communicable Diseases		2.20	2.28
CAT3: Health Through Life Course		1.39	2.03
CAT4: Health Systems		9.39	5.86
CAT6: Corporate Services and Enabling functions		4.01	4.02
CAT12: WHO Health Emergency Programme			0.30
Sub Total Base Budget	30.50	29.89	32.64
CATS: Mainly Polio	61.73	56.23	57.51
Sub Total Programme Budget	92.23	86.12	90.15
Non-PB Technical Assistance:			
In Kind Drugs/In kind Services	22.20	22.82	26.85
Reimbursable Purchases - TB Prevalence Survey			4.45
Sub Total Non-PB Programme Budget	22.20	22.82	31.30
Grand Total	114.43	108.94	121.45

Source: WCO

136. Expenditure data for the three biennia, as reported by the WCO, are presented in Table 9 above.[24] A comparison with the previous funding table shows a programme budget expenditure against available funds of 93% in 2012-2013,[25] 90% in 2014-2015 and 94% in 2016-2017.

137. The overall high-level funding and expenditure remained stable across the three biennia, i.e. around US$ 100 million. Of note is the significant expenditure over the three biennia on polio (a beyond CCS activity) and the very limited expenditure on NCDs and health through the life course, which was also confirmed by stakeholder interviews. In the area of communicable diseases, while relatively well funded, some stakeholders also noted the lack of external funding for malaria and hepatitis programmes, which resulted in them being funded from assessed contributions. Expenditure

[24] Expenditure for 2012-2013 was framed against strategic objectives while from 2014-2015 onwards expenditures are framed against categories.

[25] For comparability with the 2014-2015 and 2016-2017 biennium, total funds available as in-kind and in-services for the 2012-2013 biennium (US$ 24.3 million) were deducted from funds available.

on health systems was also reduced by nearly 40% between the 2014-2015 and 2016-2017 biennia. In addition, the 2017 audit of the Country Office highlighted that funding against the approved budget was low for infectious hazard management (28%), violence and injury prevention (46%), social determinants of health (53%) and access to medicines (56%).

138. Funding remans a perennial challenge with several programmes having no firm sources of finance identified beyond 2021. The 2017 audit of the Country Office mentions that sustainability of funding for previously well-funded programmes (such as TB) is an issue, yet a resource mobilization plan was not available. The need for WCO to improve its resource mobilisation efforts was also identified in the 2016-2017 biennial progress report and echoed by a number of partner organisations. The expected reduction in availability of flexible funds moving forward was a cause of concern. It was also suggested that, despite improvements over recent years, there was scope for WCO to further enhance its capacity to develop proposals and report on progress.

Was the staffing adequate in view of the objectives to be achieved?

139. Human resources are fundamental to achievement of CCS objectives. The WCO workforce is large, and staff are distributed throughout the country, with 6 regional offices, 36 sub-regional offices and 273 field offices The WCO in New Delhi is split over two different locations, one being in the MoHFW. Human resource management was thus one of the main challenges that confronted the leadership team during the CCS 2102-2017 period and continues to do so. The length of the recruitment process was highlighted as a source of particular frustration by internal and external stakeholders alike.

140. By far the largest component of the WCO staff are employed in the field (NPSP, TB, NTDs and hypertension), most of them on SSA contracts (NPSP and NTDs) or outsourced consultant contracts (TB, hypertension initiative and NPSP field monitors).[26] A high turnover of SSA holders was noted as a result of better conditions being offered by GoI and other entities.

141. The contribution of SSAs in the field, especially in the NPSP programme, has been widely recognized and appreciated. However, the extensive use of SSAs in the country office was identified by WCO staff as an important issue to be considered. From an administrative point of view, such contracts engender a significant workload on administrative staff as a result of the large number of contracts and the fact that they have to be renewed every year. In addition, it was noted that a significant proportion of NPSP field staff have been on SSA contracts for over 15 years, while there is a salary freeze after 10 years, and under such contracts they do not receive the same benefits as WHO staff (e.g. no benefits for their families and no pension or job security, lower per diem). The Organization has a duty of care to this group of very dedicated individuals and needs to find solutions that attend to their needs as well as those of the Organization.

142. Over the period under evaluation, there was an initial increase in the number of international professionals in the WCO and towards the end of the period the trend moved towards a greater reliance on National Professional Officers (NPOs) and a concurrent reduction in the number of international professionals. The GoI looks to the WCO to provide high-quality expertise and policy advice and WCO staff expressed the opinion that the recently introduced regional policy of recruiting all new NPOs at the lowest level runs contrary to this expectation. There was agreement from both WCO leaders and some MoHFW staff that junior NPOs lacked the technical and political skills to engage effectively with highly-experienced government counterparts. Stakeholders also mentioned that the WHO policy for recruitment of NPOs is not comparable with that of other UN agencies. The results of the ongoing evaluation of the role of NPOs in the Organization should provide useful guidance on the way forward.

[26] As an illustrative example, in November 2018, the total of SSAs and outsourced consultant contracts was 1998. Of this amount, the NPSP programme alone has 863 staff on SSAs and 964 field monitors on outsourced consultant contracts.

143. Skill shortages in areas such as health systems and IHR have persisted during and since the CCS 2012-2017 period. External partners also commented that a lack of staff capacity in NCD resulted in issues being addressed by other organisations that could not offer the levels of expertise and neutrality that would have been provided by WHO. A lack of WCO expertise on air pollution also resulted in inefficient processes for obtaining support from SEARO and HQ.

144. Several partners commented on the importance of interpersonal skills and relationships, notably among senior WCO staff, for the success of WHO's work. India's senior public servants are highly qualified and experienced, and they expect the same of those with whom they interact. Specific examples were cited where the ability of WCO leaders to understand and respond to the political environment had secured successful outcomes for WHO.

145. Looking forward, there is widespread agreement that WHO support to India will need to change in response to India's growing need for higher-level expertise for short-term expert inputs on specific issues.

What were the monitoring mechanisms to inform CCS implementation and progress towards targets?

146. The lack of a results framework, with indicators for success, targets and baselines, in the CCS 2012-2017 limited the opportunities for robust monitoring. Although the CCS proposed periodic (at least annual) progress reviews of CCS implementation involving WHO, MoHFW and 'other stakeholders as appropriate' there is no evidence of such reviews having taken place. The intention was that reviews would use indicators focused on outcomes and deliverables of the CCS priorities. The failure to implement a review process as envisaged thus represents a missed opportunity to undertake monitoring and evaluation and to reap the benefits of organisational learning.

Box 5 – Monitoring and evaluation of the CCS

The CCS 2012-2017 aimed to set up mechanisms for periodic joint progress review of CCS implementation, and includes an annex with expected outcomes for each of the strategic objectives.

The document does not contain an M&E chapter explaining how WCO would monitor progress, evaluate effectiveness or undertake mid-course corrections. In practice, WCO used the biennial workplans and the associated (programme budget) monitoring system to report on expenditure, activities, and corporate outputs/outcomes. There was no mid-term review or progress reporting on the CCS. In the last biennium (2016-2017) of the CCS, WCO undertook an internal review of the CCS, assessing continued relevance, effectiveness and efficiency of the CCS 2012-2017.

A lesson from the internal review was the importance of monitoring and evaluation of a CCS. This resulted in the CCS 2019-2023 containing an M&E chapter, articulating a result framework, with indicators for success, baselines and targets, aligned with GPW13 impact framework (to help alignment with corporate biennial workplan reporting requirements). The WCO also plans a review of major programmes (and the CCS) in 2020.

The broader lessons from the India experience (and several other countries) are:

i. The tendency for WCO to conduct insufficient reviews (and revision) of the CCS, due to increased focus on regular mandatory reporting as part of the biennial workplan and programme budget processes.
ii. The importance of a result framework as part of the CCS, to enable assessment of progress towards CCS objectives. Indicators that are measurable, have a baseline and are aligned with corporate outputs and outcomes are most useful.
iii. The importance of adopting and adapting the WHO theory of change into CCSs, to help articulate the relevance of WHO's strategic choices, articulate assumptions in the chain of results, and help articulate and manage associated risks.

147. The main monitoring mechanisms adopted were reports on implementation of the three biennial workplans (2012-2013, 2014-2015 and 2016-2017) using standard programme budget reporting formats coupled with several evaluations of individual projects and initiatives. In respect of the former, the 2017 audit of the Country Office found that the WCO excelled in various aspects of programme management, including programme budget monitoring and performance assessment.

148. Monitoring of the CCS at the end of its coverage was undertaken by means of an internal review, carried out in 2017 as preparation for the development of the CCS 2019-2023. The report of that review, which has been referenced extensively by this evaluation, provide a comprehensive analysis of achievements and issues arising during the implementation of the CCS 2012-2017.

3. Conclusions

149. Based on the findings presented in the previous section, the following conclusions are articulated around the three main evaluation questions all of which inform the recommendations presented in Chapter 4.

Relevance of the strategic choices

150. The CCS was developed to reflect the situation at a point in time as well as anticipated changes over a six-year period. Given that India has a growing economy and is undergoing rapid development, the relevance of the CCS was affected over that period due to a variety of factors including: emerging health issues; new policies and programmes introduced by GoI; evolving strategies within WHO; the shift from MDGs to SDGs; and opportunities to access new skills and technologies that could not have been foreseen. The WCO was able to accommodate those changes in its biennial workplans. Long-term strategies such as the CCS must strike a balance between clarity of plans and targets on the one hand and flexibility to accommodate external changes on the other. The CCS 2012-2017 is effective in doing so.

151. The priorities identified during the development of the CCS 2012-2017 were relevant to addressing India's major health needs and were consistent with government and partners' priorities. They were also coherent, in terms of health needs and alignment, with WHO's high-level strategic vision as set out in the relevant GPWs and Regional priorities. The CCS reflects the significance of India to the overall work of WHO, as well as the pivotal role played by WHO in supporting GoI as it pursues its health goals.

152. It is clear that preparation of the CCS 2012-2017 was guided by dialogue with MoHFW and reflects input from all levels of WHO. Less clear, however, is the extent to which there was active engagement of other partners such as the UN and civil society organizations in preparation, endorsement and subsequent promulgation of the Strategy and its key messages.

153. The health priorities identified in the CCS 2012-2017 are appropriate in light of the health challenges facing India at the time, and the health status of the country's population. However, the underlying evidence that was used to identify those priorities (and, by implication, reject others) could have been better elaborated and the consideration of health inequalities together with their causes/correlates and approaches to address gender, equity and human rights could have been better articulated.

154. The CCS 2012-2017 identifies support for India's role in global health as one of its three strategic priorities. Within that priority there is appropriate emphasis on the need to ensure implementation of commitments to IHRs and improve system-wide stewardship. The third aspect, which seeks to strengthen drug regulatory capacity, contributes to the strengthening of India's role as a major producer and exporter of generic medical products. This also contributes to access to generic medicines and medical devices in India

155. Despite the broad scope of the CCS 2012-2017, some issues which are clearly relevant in the Indian context are not adequately addressed. They include the role played by the private sector in delivery of health services; articulation of WCO's approach to working with state governments; and the growing human resource challenges confronting India's health sector. In addition, although the CCS includes a good discussion of internal and external implications for the WHO Secretariat, there is only limited explicit consideration of financial or human resource requirements.

WHO's contribution and main achievements

156. There is a clear and strong consensus view among GoI officials and development partners that WHO made a significant positive contribution to health policy and programmes across a wide range of issues in India during the period covered by the CCS 2012-2017.

157. With regard to Strategic Priority 1 of the CCS 2012-2017 (Supporting an improved role of GoI in global health) WHO supported pioneering health research to inform policy and programmes both in India and globally. Primary research from India guided the global switch from the trivalent to bivalent oral polio vaccine. WHO's support for India's regulatory systems contributed to the success of Indian pharmaceutical industry as a source of medicines used globally in disease control programmes.

158. Achievements in respect of Strategic Priority 2 (Promoting access to and utilization of affordable, efficiently networked and sustainable quality services by the entire population) include support for high level policy dialogue on UHC with MoHFW, NITI Aayog and selected states prior to introduction of a National Health Protection Scheme and the creation of Health and Wellness Centres to enhance primary healthcare in communities under the *Ayushman Bharat* initiative.

159. In the areas of concern under Strategic Priority 3 (Helping to confront the new epidemiological reality), WHO technical assistance, normative support, and on-the-ground implementation support contributed to major improvements of health status. Polio, yaws, and maternal and neonatal tetanus were eradicated in India over the CCS period. WHO experts also provided evidence and inputs in innovative treatment and control strategies for TB, HIV and hepatitis and WHO contributed to important national strategies and action plans, including for AMR and NCDs. The NPSP experience of transitioning to provide implementation support for routine immunization has been very successful in India, resulting in improved immunization coverage rates and strengthened surveillance for vaccine-preventable diseases.

160. WCO's increasing effectiveness over the period of the CCS 2012-2017 as a partner to MoHFW in respect of policy analysis and development was notable and its capacity is now better aligned with the needs of the GoI. Increasing demand for support, as well as Government funding in the areas of routine immunization and TB could be considered recognition of the contribution, although it requires careful consideration of the workload of the staff involved.

161. There were some areas where WHO's achievements fell short of what was anticipated. While there was obvious progress in respect of enhanced regulatory capacity building for pharmaceuticals and medical devices, relatively little appears to have been accomplished in respect of regulation for health care practitioners and facilities. There is also scope for greater leadership role specifically for intersectoral actions and development of human resources and institutional capacity to tackle NCDs. While implementation research in polio was seen as a valuable contribution, support towards health systems implementation research is an area for further work.

Ways of working and programme management challenges

162. **Key contributions of core functions:** All WHO core functions demonstrated their relevance for WHO's work in India over the CCS period, but it was noted that the relative contributions of the six functions has evolved, and will need to continue to evolve, as India continues its own rapid development. In particular, and especially towards the later years of the CCS period, there was growing focus on policy dialogue and work on norms and standards with a relative reduction in technical support requirements. Those trends are likely to continue.

163. With the Indian health sector's growing technical capacity and increased domestic financing for health, the nature of WHO support will gradually shift from providing strong technical support to an increased focus on policy and advocacy support. This will require WHO to address a broader set of issues and to work with a range of sectors and partners, many outside of the health sector.

164. **Partnerships**: While there are clear indications that the WCO strengthened its partnership base in the recent years, the India WCO would benefit from strengthening its leadership role, its capacity to engage in partnerships and its convening power in support of joint action. NCDs is one area where more could have been achieved by better deployment of that particular function.

165. The growing interest and investment in health by GoI has resulted in a wider range of ministries and other Government agencies working in the sector. The WCO appears to have gained the respect of key stakeholders, most notably the NITI Aayog and the National Health Authority (which manages the *Ayushman Bharat* Initiative).

166. The partnership with other UN agencies in India is strong with a good delineation of respective roles. The UNDAF outputs to which WHO contributes were well-coordinated in the development of the CCS 2019-2023 and clearly focus on the promotion of intersectoral actions, which are extremely important in the context of addressing NCDs.

167. While GoI and, more specifically, MoHFW is the principal partner of WCO, it is also increasingly requested to collaborate with state-level health administrations, especially those where health status is poor or health inequalities are great. Such collaboration may need to be undertaken in consultation and agreement with the Union Government.

168. The recent establishment of the Health Partners Group, and its potential to become a key forum for collaboration on strategic issues, is a notable and promising indicator of progress. WCO has become more adept at using high-level diplomacy and influencing skills, and more able to engage constructively at the highest levels of government, in support of its strategic priorities.

169. Given the increasing role of the private sector in UHC and the potential of civil society engagement in the area of gender, equity and rights, stronger partnerships with these sectors can strengthen WHO's contribution toward achieving better health outcomes in India.

170. **Funding**: Overall, the work of WCO over the CCS period was well funded with significant voluntary contributions and support through GPEI. GoI also provided substantial funds, partly from domestic sources and partly from 'third party' grants, e.g. Bill and Melinda Gates and Bloomberg foundations. While there is confidence that historic funding sources and levels can be maintained for the next 2 to 3 years the longer-term situation is less clear and efforts should be made to adequately fund all areas of work as budgeted in workplans. In light of that uncertainty, as the WCO implements the new CCS 2019-2023, a more strategic focus towards resource mobilization and reporting is needed.

171. **Staffing** was a challenge for WCO throughout the CCS period and continues to be so. A number of key positions have proved difficult to fill and heavy reliance on SSA contracts generates significant administrative workloads. At the same time, GoI officials who are often highly skilled and experienced typically place high expectations on counterparts. As India continues to develop, and to build its own human capital, there are strong GoI expectations to receive innovative solutions and highly-skilled and politically astute support from WHO.

172. The presence of SEARO in the same city as WCO presents opportunities as well as challenges for both offices. Relationships between the offices are generally good and examples were cited of very effective collaboration among their staff but it is apparent there is also a risk that poor communication and ambiguous role definitions can lead to negative outcomes. Similarly, GoI officials and development partners value the ability to reach out to both WCO and SEARO but are not always clear as to the appropriate protocols. There is need for greater clarity on how the relationship should be managed.

173. **Monitoring**: The difficulty in measuring results against planned targets and assessing WHO's contributions to the same are indications of a number of systemic challenges in planning and monitoring processes within WHO at both corporate and country levels. The main monitoring mechanisms adopted were internal mid-term and end-of-biennium programme budget performance assessment reports and an internal review of the CCS carried out at the end of its coverage. The internal review provided valuable inputs for the development of the CCS 2019-2023 and highlighted the importance of monitoring and evaluation of a country cooperation strategy.

4. Recommendations

1. The head of the WHO Country Office and the Country Office should maximise the effectiveness and impact of Country Cooperation Strategy 2019-2023 as a key strategic instrument. It is recommended to:

   i. ensure close alignment of all planning and implementation activities with the Country Cooperation Strategy, including mid-term and end-of-biennium programme budget reviews and during the formulation of country-level workplans;
   ii. develop a theory of change which shows the anticipated causal path from all country-level activities and outputs specified in the Country Cooperation Strategy to expected outcomes and impact (in relation to achieving WHO's 'triple billion' goals);
   iii. seek to strategically use the Country Cooperation Strategy in its engagement with the Government of India and development partners; and
   iv. set up a monitoring and evaluation framework to measure WHO's progress towards targets over the Country Cooperation Strategy implementation period, including a mid-term evaluation of the Strategy. The framework should also consider the role of gender, equity and human rights as social determinants of health.

2. To enhance the relevance and effectiveness of WHO's involvement in India, it is recommended that the WHO Country Office with support from the Regional Office for South-East Asia and headquarters as appropriate:

   i. continue to support the Government of India' efforts within the framework of universal health coverage, such as Ayushman Bharat, and promote inclusion of neglected health issues, such as noncommunicable diseases;
   ii. support implementation research studies with respect to implementation of universal health coverage/*Ayushman Bharat* and provide necessary expertise to facilitate emerging Government priorities, such as digital health;
   iii. develop a strategy, in consultation with Ministry of Health and Family Welfare and other Union and state government agencies as appropriate, for working with state government counterparts and contributing to state-level health issues; and
   iv. develop a strategy for collaboration with private sector and civil society organisations, as appropriate to support the Government of India, guided by the Framework for Engagement with Non-State Actors.

3. The WHO Secretariat should ensure adequate and sustainable human and financial resources to implement WHO's work in India and respond to the specific emerging needs of India. It is recommended to:

   i. develop a resource mobilisation strategy which assesses future funding needs and identifies specific actions to address any potential shortfalls and improve donor relationships;
   ii. conduct a functional review of the WHO Country Office and ensure that the new Country Cooperation Strategy priorities and the emerging needs of the Government of India are adequately supported in a timely manner with the necessary financial and human resources (including through short-term external high-level expertise); and
   iii. assess the current WHO Country Office staffing and skills mix in the light of the new Country Cooperation Strategy priorities, addressing gaps for relevant areas and

providing capacity building opportunities to existing staff in order to be better prepared and respond more effectively to the needs of the country.

4. As part of the planned joint consultation for the National Polio Surveillance Project transition plan and mid-term review of the Country Cooperation Strategy during the second half of 2020, the following should be considered in the terms of reference :

   i. lessons learned from polio transition;
   ii. relevance of current and planned activities beyond polio transition;
   iii. the management and funding of the National Polio Surveillance Project, including the engagement of SSAs; and
   iv. recommendations for the way forward.

5. The planned corporate mid-term evaluation of the polio transition plan to be conducted by the WHO Evaluation Office should consider lessons learned and best practices from the National Polio Surveillance Project model.