Synthesis of WHO country programme evaluations

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Table of Contents

Figures

Tables

List of acronyms

AFR	WHO African Region
AFRO	WHO Regional Office for Africa
AMR	Antimicrobial resistance
BMGF	Bill and Melinda Gates Foundation
BCA	Bilateral Collaborative Agreement
CCS	Country Cooperation Strategy
CPE	Country Programme Evaluation
CSO	Civil Society Organization
EPI	Expanded Programme on Immunization
EQ	Evaluation Question
EUR	WHO European Region
EURO	WHO Regional Office for Europe
EVL	WHO Evaluation Office
FAO	Food and Agriculture Organization of the United Nations
FENSA	Framework of Engagement with Non-State Actors
GAVI	Gavi, The Vaccine Alliance
GER	Gender equality, human rights and equity
GFATM	The Global Fund to fight AIDS, Tuberculosis and Malaria
GPW	General Programme of Work
GSM	Global Management System
HDI	Human Development Index
HIS	Health information systems
HQ	WHO headquarters
HRH	Human Resources for Health
HSS	Health systems strengthening
IFI	International Financial Institutions
IHR	International Health Regulations (2005)
IOM	International Organization for Migration
JEE	Joint External Evaluation
LIC	Low-income country
LMIC	Lower-middle-income country
MAM	Moderate acute malnutrition
MIC	Middle-income country
MCH	Maternal and child health

MoH	Ministry of Health
MDG	Millennium Development Goal
MTE	Mid-term evaluation
NCD	Noncommunicable disease
NPO	National Professional Officer
NPSP	National Polio Surveillance Project
NSA	Non-State actor
NTD	Neglected Tropical Disease
ODA	Official Development Assistance
PB	Programme budget
PHC	Primary Health Care
PIP	Pandemic Influenza Preparedness
RMNCAH	Reproductive, maternal, newborn, child and adolescent health
RO	WHO Regional Office
SDG	Sustainable Development Goal
SEAR	WHO South-East Asian Region
SEARO	WHO Regional Office for South-East Asia
SSA	Special Service Agreement
STEPS	STEPwise approach to surveillance
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
UMIC	Upper-middle-income country
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNDS	United Nations Development System
UNEG	United Nations Evaluation Group
UNEP	United Nations Environment Programme
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
UNSDCF	United Nations Sustainable Development Cooperation Framework
WASH	Water, Sanitation and Hygiene
WCO	WHO Country Office
WHO	World Health Organization

Executive Summary

Introduction

In 2021, the WHO Evaluation Office commissioned a synthesis of the WHO country programme evaluations (CPEs) completed between 2017 and 2020. Introduced in 2017, CPEs seek to identify key achievements, challenges and areas for improvement, and to document best practices and innovations of WHO's work in a given country. They also generate evidence that sheds light on systemic issues that require attention at the corporate level with a view to contributing to organizational learning. In the specific case of CPEs, the focus on organizational learning has acquired heightened emphasis in light of the Organization's explicit commitment to achieving impact at country level – and to harnessing evidence both to help achieve and demonstrate such impact – in the Thirteenth General Programme of Work (GPW13).

CPEs cover the evaluation criteria of relevance, effectiveness (including a light touch on impact and sustainability), and efficiency. CPEs cover the work of WHO country offices undertaken in- country as part of the Country Cooperation Strategy (CCS)/Biennial Collaborative Agreement (BCA) and also examine the contribution of WHO headquarters and regional offices to the achievement of country results. CPEs use a standard methodology that address a common set of evaluation questions:

1. Were the strategic choices made in the Country Cooperation Strategy (CCS) or Biennial Collaborative Agreement (BCA) – and other relevant strategic instruments – the right ones to address the country's health needs and coherent with government and partners' priorities? *(Relevance)*
2. What is the contribution/added value of WHO towards addressing the country's health needs and priorities? *(Effectiveness, elements of Impact, progress towards Sustainability)*
3. How did WHO achieve results? *(Efficiency)*

As indicated in Table 1, the synthesis covers all seven CPEs conducted by EVL to date. These span three WHO regions, namely: Africa, Europe, and South-East Asia. The synthesis covers CCS/BCAs implemented between 2012-2019. In some cases (i.e. India, Myanmar), the synthesis also covers the design of the next generation of CCS, which were still in draft form when the CPE was completed. In addition, the synthesis considers the findings of the Independent Mid-term Evaluation of the WHO-Thailand Country Cooperation Strategy 2017-2021, which was conducted in 2020.[1]

Table 1. Country programme evaluations completed to date

Year	Country programme covered	Time period covered	WHO Region
2017	Thailand	2012-2016	South-East Asia
2018	Romania Rwanda	2014-2017 2014-2017	Europe Africa
2019	India Senegal	2012-2017 2016-2018	South-East Asia Africa
2020	Kyrgyzstan Myanmar	2014-2019 2014-2019	Europe South-East Asia

The CCS serve as the main strategic framework guiding the work of WHO at country level. Using a four- to five-year strategic cycle, the CCS offers a medium-term strategic vision in support of a country's

[1] Because this Independent Mid-term Evaluation was conducted using a light touch approach and does not answer the same evaluation questions as the CPEs, it was not possible to aggregate and code data from the Mid-term Evaluation following the same approach that was used for the CPEs. Nonetheless, the synthesis presents learning and good practices from this evaluation wherever possible.

national health agenda and articulates a set of priorities agreed upon by the Government and WHO. In the European Region, country offices use a slightly different instrument, the BCA, which has a two-year strategic cycle and includes a detailed budget portfolio. These instruments are aligned with the GPW, which defines WHO's Organization-wide strategic objectives.

The CCS/BCAs covered by this synthesis have been implemented during a time of profound organizational change within WHO and the broader development environment. In 2017, WHO launched the WHO Transformation, which is still ongoing, and seeks to make the Organization fit-for-purpose to deliver on the SDGs through the GPW13. The Transformation has taken place against the backdrop of – and has in fact been rooted in – the broader United Nations Development System reform, which calls for a new generation of United Nations country teams that work more strategically together through an empowered United Nations resident coordinator to implement the United Nations Sustainable Development Cooperation Frameworks in support of the SDGs. The main implication of these developments for purposes of this synthesis is that all of the CPEs evaluate the work of country offices as they were and are still operating at a time of profound change. This dynamic context underscores the formative scope of this synthesis and the tentative nature of its findings and recommendations.

Using basic descriptive statistics, the synthesis presents quantitative data on the number of CPEs that report on particular themes and a qualitative narrative that draws on country-specific examples of what has worked well and what has worked less well – and, critically, *why*.

Synthesis of CPE Findings

Relevance

CCS/BCAs generally include a comprehensive analysis of the health situation in-country informed by national health statistics, including demographic and health surveys and data from health management information systems. However, many lack a gender or equity-focused analysis explaining how specific vulnerable groups are affected by health inequities. In addition, most CCS/BCAs lack a clear justification for their selected priorities and lack strategic focus. Some CCS/BCAs address several outputs spanning multiple programme areas and their ambitious programme of work is often not commensurate with the financial and human resources available to the country office.

There has been strong alignment between CCS/BCAs and national health strategies in all countries and, even though the practice of formal revision during implementation has been rare, the CCS/BCAs nonetheless remained flexible instruments that allowed country offices to respond to emerging priorities. Strategic priorities have also been well aligned with health-related MDGs – and with SDG3, although in many cases CPEs have not clearly established the level of alignment with other health-related SDGs beyond SDG3. A key factor that has enabled strong alignment with Government priorities is the close relationship and periodic collaboration between the country offices and the ministries of health. While ministries of health have systematically participated in the conceptualization of the CCS/BCAs, however, ministries and development partners beyond the health sector have seldom been consulted except in the case of Thailand, where the country office has adopted a multi-stakeholder process for the design and governance of the CCS. The 2020 Guidelines for the next generation of CCSs outline the importance for country offices to adopt such consultative processes in an effort to promote intersectoral action and achieve all health-related SDGs, recognizing the mutually interdependent nature of SDGs.

Alignment between CCS priorities and those highlighted in the United Nations Development Assistance Framework has largely been sufficient. Linkages are even more explicit in the next generation of CCS, whose results framework and indicators align with the United Nations Sustainable Development Cooperation Framework. In some cases, however, competing priorities and different planning/monitoring structures across United Nations organizations have been key factors hindering greater collaboration within some United Nations Country Teams. This is a broader difficulty in the UN

that is not specific to WHO and is being addressed through the ongoing United Nations Development System reform.

GPW priorities are reflected well in CCS/BCAs, although the line of sight between CCS and GPW priorities has often not been explicit due to a disconnect in planning and monitoring systems and cycles at global and country level. Greater and more explicit alignment is evident in the new generation of CCSs.

WHO's role as a leader and convener in the health sector is well recognized, as is its comparative advantage in setting norms and standards and in providing policy support and technical expertise. As countries continue to develop, WHO has been called on to move away from technical assistance and further strengthen its role in providing strategic and policy dialogue support to governments on health-related issues. WHO has also played an increasingly important role in supporting middle-income countries and emerging economies in their role in global health, as has been the case in Thailand and India. Another external factor that is prompting WHO to rethink its role in recent years has been the emergence in several countries of new players in the health sector. This calls for WHO to put a greater emphasis on WHO's roles as a convener of traditional and non-traditional partners from and beyond the health sector to promote multisectoral action in support of all health-related SDGs. At the same time, a stronger strategic presence at decentralized level is emphasized as being necessary to further strengthen emergency preparedness and health systems to improve the quality of primary health care services in communities towards achieving universal health coverage.

In nearly all countries, WHO has facilitated multistakeholder processes supporting the development or revisions of national health strategies. In doing so, it has played an instrumental role in positioning key health issues that require further attention on national health agendas within the context of the 2030 Agenda, including universal health coverage, noncommunicable diseases and road safety, among others. Furthermore, in several countries, WCOs have supported countries to align their national health strategies to the SDGs. At the same time, however, WHO's role in fostering intersectoral action to address environmental health and the social determinants of health – both of which are key to achieving the SDGs – has not yet been fully exploited.

At corporate level, WHO has committed to addressing gender equality, human rights and equity in its GPW. Several CPEs confirm that country offices have addressed equity issues through their efforts to support universal health coverage, but also acknowledge that more could be done in the area of the social determinants of health to address structural barriers that exacerbate health inequities. Furthermore, gender equality has largely been addressed through gender-specific programming, mostly maternal health and gender-based violence, and more could be done by country offices to mainstream gender equality, human rights and equity in CCS/BCAs. At the same time, CPEs themselves provide a limited gender analysis, which is a missed opportunity to generate crucial lessons in this area and improve the integration of gender equality, human rights and equity in WHO country programming.

Effectiveness

Country programmes universally lack a clear theory of change, or "results roadmap," as a management tool to help WHO sharpen its focus, prioritize its work, manage toward targeted results, and monitor, evaluate and report on progress in a robust manner. Although this has hindered the ability of CPEs to provide a robust assessment of the extent to which results have been achieved in-country, CPEs were nonetheless able to find illustrative examples of results achieved. These results were achieved unevenly across programme budget category and programme areas, however.

Overall, strong achievements are observed across all programme areas of the communicable diseases category, with particularly strong results demonstrated in vaccine-preventable diseases. In most countries, WHO has also contributed significantly to the fight against noncommunicable diseases, most notably in tobacco control, cancer prevention and road safety. Achievements are also observed

in addressing moderate acute malnutrition, but results are mixed when it comes to addressing the double burden of malnutrition and obesity. In the noncommunicable diseases category, least results are observed in the areas of disabilities and rehabilitation as well as mental health and substance abuse. Overall, 'promoting health through the life-course' is the category area for which least results are reported, with significant variances across programme areas. Most results have been achieved in the area of reproductive, maternal, newborn, child and adolescent health, with fairly limited results in health and the environment, the social determinants of health, and ageing and health. As noted below, it is possible that the unevenness in achievements across various programmatic areas is at least partly rooted in the degree to which a programmatic area is funded through earmarked or unearmarked support.

Health systems strengthening has been a key priority featured in all CCS/BCAs, with notable results achieved in all countries. Even so, the majority of CPEs acknowledge that achieving universal health coverage will require continued support for long-term health sector reforms, with improvements needed in quality primary health care, human resources for health, health financing, and regulatory capacity, among others. Finally, CPEs report key results in 'emergency risk and crisis management', including strengthened country capacity to comply with International Health Regulations. In addition, country offices are recognized for having frequently supported the response of governments to disease outbreaks such as E-Coli, measles, and influenza.

Despite a lack of robust data to show the extent of WHO's contribution to long-term changes in the health status of the population, all CPEs provide concrete examples of plausible improvements in health outcomes. WHO's support to vaccination and disease surveillance has had a positive impact on the elimination or reduction of vaccine-preventable diseases. Although these results are visible in most countries, WHO's strong field-based workforce appears to have been a key factor facilitating the notable reduction in vaccine-preventable diseases in India and Myanmar. In some countries, impacts are also reported in reducing maternal and child mortality rates as well as major communicable diseases. In several countries, improvements in health governance and legislative frameworks are also expected to generate positive health benefits in the long term if implemented successfully.

CPEs also demonstrate the contribution of regional offices and headquarters to the achievement of results in-country. Country offices have benefitted frequently from technical assistance and initiatives spearheaded by regional offices and headquarters, often filling a gap in capacities or making additional resources available to the country programme. Likewise, CPEs underscore the importance of regional offices in supporting the exchange of experiences among countries, although some CPEs note that regional offices could further strengthen this role. Furthermore, some CPEs highlight country office concerns that the technical missions from the regional offices are sometimes too numerous and overly supply-driven.

The synthesis indicates that there is strong Government ownership of WHO activities across countries, with evidence of handover in some countries. A key factor facilitating strong ownership has been the strong relationship and continued collaboration between country offices and ministries of health. In addition, participatory processes spearheaded by country offices for the development of national health strategies have contributed to strong buy-in among government stakeholders. However, an important factor limiting the sustainability of results in some countries has been the high turnover of government officials, political instability, and shifting national priorities. In addition, a major factor hindering the sustainability of strategies developed with WHO's support in several countries has been the lack of resources for health to ensure their subsequent implementation. Some CPEs suggest that country offices could provide more support to convene partners and build an investment case for the implementation of these strategies.

Efficiency

Globally, WHO uses six core functions[2] to implement its GPW. CPEs demonstrate that all six functions have been applied in all countries, although some have been used more than others. Overall, policy options, capacity building, leadership and partnership as well as norms and standards have been among the WHO functions most commonly played by country offices. While there is evidence of knowledge generation in some countries, support to the national research agenda is a frequently-cited gap. Likewise, while WHO relied on the monitoring function to some extent, support to the surveillance of emerging diseases is an area for improvement.

In all countries, country offices have maintained a strong relationship with ministries of health characterized by a high level of trust and collaboration. This has been a key factor facilitating the achievement of results and ownership by the Government of WHO's programme of work. However, while there are some examples of collaboration with other ministries to address key issues such as antimicrobial resistance and road safety, most CPEs identify the need to strengthen partnerships with ministries beyond the health sector to foster greater multisectoral collaboration, especially in the areas of environmental health and the social determinants of health. In this respect, the innovative multisectoral approach to CCS governance in Thailand – which fosters the collaboration of multiple national and civil society stakeholders beyond the health sector – is promising. However, this approach also creates new challenges that adversely affect implementation, including the time that such stakeholders are able to dedicate to the development of the CCS and the monitoring of its implementation.

In addition, country offices have frequently partnered with United Nations organizations that traditionally work in the health sector to address issues such as immunization, sexual and reproductive health, gender-based violence, HIV and nutrition. Country offices have participated actively in the United Nations Country Team by chairing/co-chairing United Nations working groups and, in Kyrgyzstan and Myanmar, have acted as lead/co-lead of the health cluster. However, engagement with those partners that have a broader mandate remains limited. For instance, the Country Office in Senegal is the only one to have engaged in a partnership with an environmental organization (UNEP) to address issues of environmental health. Strong partnerships are observed with bilateral donors and global partnerships for health. However, several CPEs identify the need for greater collaboration with civil society organizations and academia. In Romania, the CPE confirms that the programme areas that have remained more stable overtime have benefitted from the involvement of professional associations and civil society. However, some CPEs note that a weak civil society has been a key factor hindering the ability of country offices to develop partnership with these actors. In addition, several CPEs identify opportunities for further collaboration with the private sector, which is considered essential to access medicines and achieve universal health coverage. WHO has taken some actions to enhance its engagement with these actors through the implementation of the 2016 Framework of Engagement with Non-State Actors.

The majority of CPEs identify funding constraints as a key factor hindering the ability of WCOs to implement their programme of work and potentially undermining their leadership role in the health sector. Only one country office (i.e. Kyrgyzstan) has developed a resource mobilization strategy informed by a mapping of donors to address shortages. To attract additional funding, CPEs also underline the importance for country offices to better report on their results. The earmarked nature and unpredictability of donor resources has often resulted in the uneven allocation of funding across

[2] 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.

strategic priorities and delays in implementation. To address this shortcoming, the country office in Thailand has piloted a flexible pooled funding mechanism. Although this innovative approach to CCS financial management is promising and has gained traction among WHO and national stakeholders in Thailand, challenges remain such as continued delays and high transaction costs.

CPEs recognize the strong dedication and expertise of country office staff. However, staffing shortages in specific programme areas are identified as a key factor limiting the achievement of results. In addition, vacant positions and high turnover of country office staff remain an issue caused in part lengthy recruitment processes and an over-reliance on Special Service Agreement contracts. Because of staffing shortages and the generally ambitious programme of work implemented by country offices, existing staff have had to take on additional tasks that are sometimes beyond their area of technical expertise. As a result, country office staff often manage a large portfolio spanning multiple CCS priority areas, resulting in a heavy workload. Staff shortages are also observed in the enabling functions, including planning and M&E, external communications/knowledge dissemination, and resource mobilization. CPEs also identify the need for a more appropriate balance between international staff and National Professional Officers to ensure WHO's leadership and expertise in-country. In some countries, some National Professional Officers have lacked the level of seniority and experience required to engage with high-level officials from the ministries of health, underscoring the need for more capacity development opportunities for national staff. In addition, some CPEs also outline the need for WHO to better define the roles and responsibilities of staff across WHO offices; for example, in some countries with United Nations regional presence, country office administrative staff have had to manage WHO's participation in regional events wherever WHO regional offices are located in other countries.

The lack of a theory of change or "results roadmap", accompanied by a results framework with indicators, baseline and targets to monitor and report on progress toward CCS/BCA results, represents a universal gap in all of the country offices covered by the synthesis. In addition, CPEs report a disconnect between the results defined in the CCSs and the workplans used to implement the country office programme of work, which are linked to GPW outputs and outcomes through the WHO Global Management System. Systemic issues in monitoring mechanisms are being addressed in the GPW13, and the next generation of CCS is expected to be better positioned to monitor health outcomes. The GPW13 is accompanied by the WHO Impact Framework, which includes a menu of 46 outcome indicators from which country offices can choose, and through which results in-country can be aggregated to measure WHO's overall contribution to health outcomes. A review of the draft of the next generation of CCSs for Myanmar and India confirms the presence of a results framework. In addition to internal monitoring, the 2020 guidance for the next generation of CCSs underlines the importance for country offices to monitor jointly with the Government progress in the implementation of the CCS. Several CPEs identify this as an important gap. In Thailand, the country office has developed an innovative participatory M&E mechanism involving the country office and the Ministry of Health but in practice it has only been partially functional.

Synthesis of CPE recommendations and management responses

All CPEs include recommendations calling on the country office to develop a theory of change and results framework as a management tool to help them prioritize their work, monitoring, and report on results. Several CPEs also recommend stronger partner engagement, in particular with non-State actors (i.e. civil society organizations, private sector) and national entities beyond the health sector in an effort to promote multisectoral action and help countries achieve all health-related SDGs. In addition, the majority of CPEs propose recommendations aimed at improving financial resources management, including the development of resource mobilization strategies and flexible funding mechanisms that promote the strategic use of resources. Similarly, recommendations frequently address the need to improve human resources through a revision of available skillset vis-à-vis

workplans, capacity building opportunities for staff, and a greater balance between international and local staff, among others.

An analysis of management responses[3] reveals that all 25 recommendations – with the exception of one sub-recommendation – have been accepted by country offices. The participatory approach used by the WHO Evaluation Office throughout data collection and reporting has likely contributed to ensuring that CPE recommendations are utilization-focused. As of 2021, a total of six recommendations have been implemented, 17 are in progress, and two have not yet been initiated. Several management responses identify the COVID-19 pandemic as a factor delaying the implementation of some recommendations.

Lessons emerging from the synthesis

The synthesis raised a number of lessons that can be used to improve the design and implementation of future WHO country programmes:

Lesson 1: Involving ministries from multiple sectors in the conceptualization, management and governance mechanisms of the CCS has the potential to increase government ownership and intersectoral collaboration. Careful consideration in the selection of participating entities is essential.

Lesson 2: Developing partnerships with United Nations organizations that do not have a traditional health mandate is essential for WHO to support the achievement of SDGs beyond SDG3 and to further address the social determinants of health and the health/environment nexus.

Lesson 3: Engaging in strategic partnerships with non-State actors such as civil society organizations, academia, and professional associations is a good strategy to increase sustainability, especially in contexts of political instability and high turnover. Developing a strong network of civil society organizations is also key to enhance WHO's presence at local level.

Lesson 4: Combining different types of support (e.g. policy support, capacity building) and outputs focused on a few areas is more effective in contributing to outcome-level results than a thinly scattered set of divergent programmes.

Lesson 5: Having well-resourced enabling functions is important to ensure adequate administrative and communications capacity, which are essential to increase the visibility and attract additional funding.

The synthesis also generated lessons that can be used to inform the design of the next generation of CPEs. These are as follows:

Lesson 6: CPEs can help country offices to define their comparative advantage vis-à-vis that of partners and become more strategically focused in a context where new players are emerging in the health sector. To do so, it would be important for CPEs to fully examine the evaluation criteria of coherence.

Lesson 7: Including a separate section on lessons learned in the CPEs can help evaluation users to identify more clearly the lessons on what has worked well and what has worked less well in country programme implementation.

Lesson 8: Designing gender-responsive methodologies requires that gender equality, human rights and equity be mainstreamed across all evaluation criteria and that gender-sensitive indicators be integrated in the evaluation matrix. This is key to ensure that CPEs generate learning aimed at improving to integration of gender equality, human rights and equity in country programming.

[3] Six management responses were analysed as the management response for the Myanmar CPE was not yet available at the time of writing this synthesis.

Recommendations

The synthesis proposes four recommendations aimed at addressing systemic issues identified in the CPEs. These are targeted at WHO headquarters, regional offices and country offices.

1. In keeping with the emphasis on the achievement of impact at country level embodied in the GPW13, WHO should ensure that its next generation of CCS/BCAs includes robust theories of change, which should serve as useful management tools to help guide the Organization toward this goal in each country context. Each CCS/BCA should be accompanied by a strategy for achieving targeted impacts and by a results-monitoring framework that includes baselines and targets as a means of monitoring and demonstrating progress toward heightened impact. To help maximize the likelihood that results will be achieved at country level, the Organization's Country Focus Policy should be reviewed and strengthened as necessary. With respect to the time frames covered by the CCS/BCA, heightened emphasis should be placed on ensuring maximum alignment with the current GPW as well as with the corresponding national health plan, wherever this is possible.

2. Pursuant to the impacts targeted for action in the CCS/BCAs, WHO should develop or strengthen its strategic partnerships beyond the health sector and with non-State actors in order to foster multisectoral approaches to achieving the SDGs.

3. WHO must ensure that country offices are sufficiently equipped with the predictable and sustainable resources – both financial and human – needed to address the priorities identified in the CCS, as well as the guidance and support, to achieve the ambitious goals of the GPW13 and SDGs.

4. WHO should take stock of progress in achieving greater impact at country level and feed this learning into the GPW14 development process as well as the next generation of CCS/BCAs.

1. Introduction

1. This report presents the findings of a synthesis of country programme evaluations (CPEs) conducted by the WHO Evaluation Office (EVL) between 2017 and 2020. Formerly called country office evaluations (COEs)[4]. CPEs are country-focused corporate evaluations conducted by EVL. They focus on the results achieved by a given WHO country office (WCO) and with the contribution of WHO headquarters (HQ) and the regional office (RO). In addition to analyzing the effectiveness of WHO programmes and initiatives at country level, CPEs seek to assess their strategic relevance within the country context[5]. CPEs cover all WHO activities carried out during the specific timeframe defined at the outset of the evaluation.

2. All CPEs address the United Nations Evaluation Group (UNEG) evaluation criteria of relevance, effectiveness and efficiency, and lightly touch upon elements of impact and sustainability. CPEs answer a common set of evaluation questions and sub-questions and use a standard methodology to collect, triangulate an analyze information. All CPEs address the following evaluation questions:

- **Were the strategic choices made in the Country Cooperation Strategy (CCS) or Biennial Collaborative Agreement (BCA) – and other relevant strategic instruments – the right ones to address the country's health needs and coherent with government and partners' priorities? (Relevance)**
- **What is the contribution/added value of WHO towards addressing the country's health needs and priorities? (Effectiveness, elements of Impact, progress towards Sustainability)**
- **How did WHO achieve results? (Efficiency)**

3. A detailed overview of evaluation questions and sub-questions is provided in Annex 2.

4. As Table 1 indicates, since CPEs were first introduced in 2017, seven such evaluations have been completed across three WHO regions. In addition, an Independent Mid-term Evaluation of the WHO-Thailand Country Cooperation Strategy 2017-2021 was conducted in 2020 and brings additional insights to the learning that emerged from the Thailand CPE completed in 2017. Over the 2020-2021 biennium, EVL planned to conduct at least seven[6] additional CPEs. No CPE was initiated during this period, however, owing to the COVID-19 pandemic and its ramifications for the work of the EVL and the Organization more broadly (e.g. with respect to travel restrictions, the additional evaluation work commissioned by Member States and others, and the effect of the pandemic response on WCOs' ability to engage in CPEs).

Table 2. Country programme evaluations completed to date

Year	Country programme covered	Time period covered	WHO Region
2017	Thailand	2012-2016	SEAR
2018	Romania Rwanda	2014-2017 2014-2017	EUR AFR
2019	India Senegal	2012-2017 2016-2018	SEAR AFR
2020	Kyrgyzstan Myanmar	2014-2019 2014-2019	EUR SEAR

[4] In 2020 the 'country office evaluation (COE)' exercise was renamed 'country programme evaluation (CPE)'. The purpose, scope, and methodological approach remain unchanged, however.

[5] Evaluation: update and proposed workplan for 2020–2021. Document EB 146/38.

[6] As per the evaluation workplan for 2020-2021, EVL plans to carry out CPEs in Afghanistan, China, Jordan, Morocco, Mongolia, Nigeria and Timor-Leste, with others to be defined.

5. The main purpose of these evaluations is to identify key achievements, challenges and areas for improvement, and to document best practices and innovations of WHO's work in a given country. In addition, CPEs generate evidence that sheds light on systemic issues that require attention at the corporate level. In recent years, EVL has redoubled its emphasis on the utility and utilization of evaluations and their contribution to organizational learning. In the specific case of CPEs, the focus on organizational learning has acquired heightened emphasis in light of the Organization's explicit commitment to achieving impact at country level – and to harnessing evidence both to help achieve and demonstrate such impact – in the Thirteenth General Programme of Work (GPW13).

6. It is within this context that EVL, in its evaluation workplan for 2020-2021, sought to complete a synthesis of CPEs.[7] The synthesis generates lessons on key achievements as well as recurrent issues that can be used by WHO management to improve corporate processes and guidance.

2. Methodology

2.1 Overall methodological approach

7. This synthesis was conducted by an external consultant under the guidance and supervision of EVL. It covers all seven CPEs conducted to date and also draws on learning that has emerged from the Independent Mid-term Evaluation of the WHO-Thailand Country Cooperation Strategy 2017-2021[8]. Its approach was characterized by the following features:

- **Synthesis of findings:** Aggregation and synthesis of the reports was greatly facilitated by the standardized approach of the CPEs themselves: the CPEs use a standard methodology to collect and analyze data and follow a standard format. This synthesis therefore structures its findings around the three main evaluation questions and accompanying sub-questions. For each sub-question, data was synthesized from all seven CPEs and coded in Excel using a series of themes (grouped around strengths, weaknesses, and their underlying explanatory factors). Using basic descriptive statistics, the synthesis presents quantitative data on the number of CPEs that report on particular themes and a qualitative narrative that draws on country-specific examples of what has worked well and what has worked less well – and, critically, why. The synthesis also identifies good practices and innovations wherever feasible.
- When presenting performance information on effectiveness, data is presented around the main categories that frame WHO's programme budgets (PBs) from PBs 2014 to 2017, namely: 1. Communicable diseases; 2. Noncommunicable diseases; 3. Promoting health through the life-course; 4. Health systems; 5. Preparedness, surveillance and response. Although the precise wording of these categories varies somewhat in the PB 2012-2013 and PB 2018-2019, programme areas can generally fit within these broad categories.
- Synthesis of CPE recommendations and corresponding management responses: A synthesis of the recommendations contained in the CPEs was completed as a means of identifying frequently recurring areas requiring action. By extension, a synthesis of the management responses corresponding to these recommendations was undertaken as a means of

[7] Evaluation: update and proposed workplan for 2020–2021. Document EB 146/38.

[8] Because this Independent Mid-term Evaluation was conducted using a light touch approach and does not answer the same evaluation questions as the CPEs, it was not possible to aggregate and code data from the Mid-term Evaluation following the same approach that was used for the CPEs. Nonetheless, the synthesis presents learning and good practices from this evaluation wherever possible.

identifying the extent to which the Organization had acted on the areas identified, and how it had done so.[9]

- Synthesis of lessons and generation of high-level recommendations: The main purpose of this CPE synthesis is to contribute to organizational learning above and beyond the country- and WCO-specific learning generated in the individual CPEs. Toward this end, this synthesis report includes a separate section on key lessons emerging from the CPEs – what has worked well and what has worked less well, with a view to improving WHO programming beyond the country operations evaluated to date. In addition, the synthesis raises a set of additional recommendations – over and above those identified in the CPEs themselves and borne out in them collectively – that elevate areas for action by the Organization on systemic issues not yet addressed (or not yet sufficiently addressed) more broadly.

2.2 Limitations

8. Although this synthesis of the CPEs is a straightforward undertaking, three limitations associated with the nature of CPEs themselves are noteworthy. These limitations are as follows:

- **Heavy reliance on qualitative data:** Owing to the state of results-based management practices in the Organization, none of the WCOs whose work was evaluated possessed as yet a theory of change or corresponding logical framework and indicators by which to monitor and measure progress. Therefore, the CPEs included in the synthesis are largely based on qualitative data. It is therefore difficult to draw conclusions about the achievement of country-level results based on a robust triangulation of quantitative data as well as qualitative data. This said, CPEs nonetheless do provide the most robust analysis of organizational performance possible using the best available data at the time they were conducted.
- **Small number of CPE reports:** Compared to most evaluation syntheses, which typically draw on a large number of evaluations, the number of CPEs included in this synthesis is quite small. This small number reflected the relatively recent institutionalization of CPEs as a key evaluation modality within WHO. In this vein, it is important to underscore that the main thrust of this synthesis is formative by design – that is, to harvest key takeaways for organizational learning and action based on this first-generation round of CPEs. Annex 1 provides a list of documents reviewed in this analysis.
- **CPE recommendations made in parallel to broader organizational changes underway:** The CPEs were conducted at a time of profound organizational change in WHO, including the implementation of the WHO Transformation Agenda and the development of the GPW13. Accordingly, many of the areas identified for improvement in this CPE synthesis have already been addressed or are being addressed as part of these broader organizational change efforts. Wherever possible, these improvements were considered in the analysis. However, as the synthesis methodology did not rely on additional interviews as a data source, the extent to which the outstanding systemic issues raised in this synthesis have been addressed as part of ongoing organizational reforms – or how adequately they have been addressed – was not assessed. This synthesis therefore represents an unfiltered set of takeaways emerging from the synthesis itself; whether they have already been sufficiently addressed or whether they require further attention rests with WHO management itself.

[9] At the time of writing, the management response for the Myanmar evaluation was not available. Therefore, whereas seven CPEs were analyzed, only six corresponding management responses were analyzed.

3. Context

9. As implied in Table 1 above, the implementation of CCS/BCAs (and the other strategic documents guiding the work of the WCOs) covered by the synthesis spans multiple GPW cycles, with the earliest CPEs covering a CCS/BCA that began under GPW11[10], and most taking place during the GPW12 time frame[11]. Some CPEs also covered draft CCSs that initiated under the GPW13[12].

10. This section provides an overview of the GPW and CCS/BCA as strategic instruments. In addition, it presents the objectives of the WHO Transformation and briefly discusses the evolution within the broader development environment, namely the United Nations Development System (UNDS) reform. Finally, this section presents an overview of the diversity of country contexts within which the seven CPEs were implemented.

3.1 WHO Strategic Instruments

11. At corporate level, the GPW defines WHO's Organization-wide strategic objectives. The Country Cooperation Strategy (CCS) serves as the main strategic framework guiding the work of WHO at country level. Using a four- to five-year strategic cycle, the CCS offers a medium-term strategic vision in support of a country's national health agenda and articulates a set of priorities agreed upon by the Government and WHO. In the European Region (EUR), WCOs use a slightly different instrument, the Biennial Collaborative Agreement (BCA), which has a two-year strategic cycle. In most countries the CCS/BCA is the main vehicle through which WCO supports the implementation of the GPW and contributes to the achievement of health-related SDGs, although in many countries it is complemented by additional strategic documents that guide the work of WHO in support of the Government. In 2020, WHO produced a revised version of the Country Cooperation Strategy Guide to support WCOs in the development of a new generation of CCS/BCAs.[13] Compared to previous iterations, this new generation of CCS/BCAs is intended to be a results-oriented instrument in its explicit support to the implementation of the GPW13 Triple Billion targets[14], in its focus on ensuring CCS/BCA alignment with the new United Nations Sustainable Development Cooperation Frameworks (UNSDCFs)[15] within the context of the UNDS reform, and in its increased emphasis on intersectoral action to support the achievement of the health-related SDGs in coordination with the wider United Nations Country Team (UNCT).

12. With the GPW12 representing the main implementation period covered by most of the CPEs included in this synthesis, Table 2 provides an overview of its five programme categories and corresponding programme areas, which are echoed in the PB 2016-2017.

[10] India, Thailand.

[11] Kyrgyzstan, Myanmar, Romania, Rwanda, Senegal.

[12] India, Myanmar.

[13] WHO. (2020). Country Cooperation Strategy Guide 2020: Implementing the Thirteenth General Programme of Work for driving impact in every country. https://apps.who.int/iris/handle/10665/337755.

[14] These are: 1) One billion more people are benefiting from universal health coverage; 2) One billion more people are better protected from health emergencies; 3) One billion more people are enjoying better health and well-being.

[15] According to the UN Sustainable Development Group, there are three important elements that describe the UNSDCF in relation to the UNDAF: "1) the UN Development 'Assistance' Framework has been renamed the UN 'Sustainable' Development 'Cooperation' Framework to more accurately reflect the contemporary relationship between governments and the UN development system in collaborating to achieve the SDGs; 2) the Cooperation Framework begins and ends with an analysis of the national development landscape and SDG priorities; 3) the UN Common Country Analysis, which underpins the Cooperation Framework, shifts from being a one-off event, as was the case with UNDAF, to a 'real-time' core analytical function." Source: SDG Knowledge Hub Website: UN Publishes Guidance on Revamped UNDAF: https://sdg.iisd.org/news/un-publishes-guidance-on-revamped-undaf/, accessed on 25 June 2021.

Table 3. GPW12 programme areas (and corresponding categories in Programme Budget 2016-2017)[16]

1. Communicable diseases	2. Noncommunicable diseases	3. Promoting health through the life course	4. Health systems	5. Preparedness, surveillance and response
❖ HIV and hepatitis ❖ Tuberculosis ❖ Malaria ❖ Neglected tropical diseases ❖ Vaccine-preventable diseases ❖ AMR *(PB 2018-2019 only)*	❖ Noncommunicable diseases ❖ Mental health and substance abuse ❖ Violence and injuries ❖ Disabilities and rehabilitation ❖ Nutrition	❖ Reproductive, maternal, newborn, child and adolescent health ❖ Ageing and health ❖ Gender, equity and human rights mainstreaming ❖ Social determinants of health ❖ Health and the environment	❖ National health policies, strategies and plans ❖ Integrated people-centred health services ❖ Access to medicines and other health technologies and strengthening regulatory capacity ❖ Health systems information and evidence	❖ Alert and response capacities ❖ Epidemic- and pandemic-prone diseases ❖ Emergency risk and crisis management ❖ Food safety

13. Approved at the Seventy-first World Health Assembly in May 2018, the GPW13 focuses on driving impact at country level, seeking to ensure that one billion more people benefit from universal health coverage, one billion are better protected from health emergencies, and one billion enjoy better health and well-being. Although CPEs provide limited data on results achieved under GPW13, in keeping with the formative purpose of this synthesis they nonetheless offer important insights into strategic priorities of the GPW13, and organizational reforms enacted by WHO to support its implementation.

3.2 Evolution within WHO and the broader development environment

14. At roughly the midpoint in the CCS/BCA period covered by the various CPEs (i.e. 2017), the WHO Transformation was launched. The Transformation, which is still ongoing, seeks to make the Organization fit-for-purpose and enable it to deliver on the SDGs through the GPW13 (whose sharpened focus is itself an important element of the Transformation). With the overarching goal of transforming the Organization into "a modern WHO working seamlessly to make a measurable difference in people's health at country level," the Transformation is structured around three strategic objectives:

- **Fully focused and aligned for impact:** This objective focuses on driving impact at country level and becoming a results-oriented Organization by establishing and operationalizing an impact-focused and data-driven strategy. This entails fully embedding GPW13 outputs and outcomes in country workplans and developing measurement tools, metrics and mechanisms to measure progress toward the achievement of results at country level. As part of this objective, WHO developed the WHO Impact Measurement Framework, which constitutes the corporate results framework that accompanies the GPW13.
- **Enabling the full potential of the Organization:** This objective entails optimizing and harmonizing key processes across WHO's major offices to enable the Organization to deliver high-quality normative and technical work supported by the latest technology, innovation and

[16] The programme areas were largely the same in the PB 2016-2017 and PB 2018-2019, with slight modifications. Namely, in the PB 2018-2019, AMR was added as a new programme area and food safety was moved from PB Category 5 to PB Category 2. In addition, in the PB 2018-2019, PB Category 5 was re-named 'WHO Health Emergencies Programme'. For the purpose of this synthesis, the language of the PB 2016-2017 is used.

science. This also entails a redesign of business and administrative processes such as supply chain management, recruitment and performance management. Likewise, this objective seeks to streamline external relations processes, including external and internal communications as well as resource mobilization. This strategic objective also aims to ensure an aligned operating model with clearer definition of the roles and responsibilities of major WHO offices at country, regional and headquarters level.

- **Leveraging the global community:** This objective seeks to leverage WHO partners to achieve health outcomes, including through the establishment of new partnerships. For example, WHO supported the development in 2019 of the Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP), which brings together 13 organizations[17] to accelerate progress on the health-related SDG indicators by 2030. This strategic objective also supports resource mobilization initiatives to enhance predictability of financial resources.

15. Underpinning the strategic objectives of the Transformation are efforts to build a workforce that is motivated and fit-for-purpose to implement the GPW13.

16. The Transformation has taken place against the backdrop of – and has in fact been rooted in – the broader UNDS reform, which calls for a new generation of UN country teams that work more strategically together through an empowered UN resident coordinator to implement the UNSDCFs in support of the SDGs. It is within this context of organizational change, both within WHO and in the wider UN system of which it is a part – that the WCOs covered by the CPEs included in this synthesis were operating. Figure 1 plots each of the WCOs and their corresponding CCS (or BCA) against key developments within WHO and in the wider UN system.

[17] These are: Gavi – The Vaccine Alliance, the Global Financing Facility, The Global Fund, UN Women, the Joint United Nations Programme on HIV and AIDS (UNAIDS), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), Unitaid, the World Bank, World Food Programme (WFP), the World Health Organization (WHO) and, as of February 2021, the International Labour Organization (ILO).

Figure 1. Timeline of CCS developments, internal, and external events

Country level CCS/BCAs	Developments within WHO			Developments within the UN system
	GPW11 (2006-2015)	**2006**	**2006**	
India CCS (2012-2017)		**2012**	**2012**	
Thailand CCS (2012-2016)				
		2013	**2013**	
Romania BCA (2014-2015)	GPW12 (2014-2019)	**2014**	**2014**	
Kyrgyzstan BC (2014-2015)				
Rwanda CCS (2014-2018)				
Myanmar CCS (2014-2018)				
		2015	**2015**	Sustainable Development Goals
Romania BCA (2016-2017)		**2016**	**2016**	
Kyrgyzstan BCA (2016-2017)				
Senegal CCS (2016-2018)				
Thailand CCS (2017-2021) – DRAFT	WHO Transformation	**2017**	**2017**	
Kyrgyzstan BCA (2018-2019)		**2018**	**2018**	UNDS Reform
India CCS (2019-2023) – DRAFT	GPW13 (2019-2023)	**2019**	**2019**	Launch of the Global Action Plan for Healthy Lives and Well-being for All
Myanmar CCS (2019-2023) – DRAFT				
	Release of guidance on the new generation of CCSs	**2020**	**2020**	

17. The main implication of these developments for purposes of this synthesis is that all of the CPEs evaluate the work of WCOs as they were and are still operating at a time of profound change. Indeed, both the Transformation and the UNDS processes are still ongoing. This dynamic context underscores the formative scope of this synthesis and the tentative nature of its findings and recommendations.

3.3 Diverse country contexts

18. The broad range of country contexts represented in the seven CPE countries further shaped the synthesis and the generalizability of its findings and recommendations. The seven countries span three WHO regions (Africa [AFR]; South-East Asia [SEAR]; Europe [EUR]) and represent a diverse typology of socio-economic status and demographic characteristics. The synthesis covers countries with very large and far smaller populations (e.g. India, with 1.3 billion inhabitants compared to Kyrgyzstan, with 5

million inhabitants), and where demographic trends are also divergent, from a two-decade long demographic decline in Romania to cases like Rwanda, where over 40% of the population is younger than 15 years of age. Across these countries, life expectancy is also vastly different: women and men in Thailand and Romania outlive their peers in Myanmar, Senegal and Rwanda by over a decade.

19. The seven countries also reflect different levels of socio-economic development. For instance, Romania occupies the 52nd position globally (out of 189 countries) on the Human Development Index (HDI), placing it in the very high human development category. On the other end of the spectrum, Senegal ranks 166th placing it in the low human development category. Likewise, country classification by income level differs significant among CPE countries, from low-income country (LIC) (i.e. Rwanda), to lower middle-income country (LMIC) (i.e. India, Kyrgyzstan, Myanmar, Senegal), and upper-middle income country (UMIC) (i.e. Thailand, Romania). This also means that the flow of Official Development Assistance (ODA) for health has remained stable or increased over time in some countries (e.g. Rwanda, India) while it has been has decreased in others (e.g. Kyrgyzstan).

20. As summarized in Table 4, these differences are even more pronounced on a range of heath indicators. For instance, the neonatal mortality rate in Romania and Thailand is low with only 3.4 and 5.3 deaths per 1,000 live births, respectively, while it is above the global average of 17 deaths per 1,000 live births in three countries (India, Senegal, Myanmar). Similarly, the maternal mortality ratio[18] varies across countries, with very low rates in Romania, Thailand and Kyrgyzstan, low rates in Rwanda, India and Myanmar, and high rates in Senegal. Likewise, the majority of CPE countries[19] experience an epidemiological transition toward noncommunicable diseases with a growing incidence of cardiovascular diseases and cancer due to an ageing population and unhealthy lifestyles. At the same time, communicable diseases remain a major concern in many countries like Myanmar, Senegal, Kyrgyzstan, Thailand, and India. For example, Myanmar and Thailand are among the 30 high burden countries for tuberculosis and antimicrobial resistance (AMR) is a growing concern. Access to primary health care (PHC) also varies significantly among countries. For instance, physician density is below the global average of 1.556 physician per 1,000 inhabitants in five countries, ranging for 0.064 physician per 1,000 in Senegal to 2.669 physician in Romania. Similarly, national expenditures for health as a total of government expenditures ranges from 3.49% in Myanmar to 15.03% in Thailand. In some countries there are also important inequities in accessing health, with high out-of-pocket expenditures as a major contributor to poverty: in four countries (i.e. Myanmar, India, Senegal, Kyrgyzstan), such expenditures are significantly above the global average of 18.12% of total health expenditures.

21. All told, despite this wide variation in country contexts, and despite the period of change in which the WCOs covered by the CPEs were operating, it was nonetheless possible to extract a range of common findings. The remainder of this report highlights these findings, structured according to the three evaluation questions covered in the CPEs (and enumerated in Section 1 above).

[18] UNICEF categorizes the maternal mortality ratio (maternal deaths per 1,000 live births) as follows: 1) very low (<100); 2) low (100-299); 3) high (300-499); 4) very high (500-999); 5) extremely high (>1,000)

[19] India, Thailand, Kyrgyzstan, Myanmar, Senegal.

Table 4. Health statistics in the seven CPE countries[20]

Health indicators	Thailand	Romania	Rwanda	India	Senegal	Kyrgyzstan	Myanmar
Population (in million) total	68.86 (2016)	19.78 (2016)	11.92 (2016)	1,324.17 (2016)	15.41 (2016)	5.96 (2016)	54.4 (2020)
Population proportion under 15 (%)	17.7 (2016)	15.3 (2016)	40.5 (2016)	28.2 (2016)	43.0 (2016)	31.5 (2016)	25.5 (2020)
Life expectancy at birth (years) – Female	81.0 (2019)	79.3 (2019)	69.2 (2016)	70.3 (2016)	69 (2016)	75 (2016)	69 (2020)
Life expectancy at birth (years) – Male	74.4 (2019)	72.0 (2019)	65.0 (2016)	67.4 (2016)	65 (2016)	68 (2016)	64 (2020)
Socioeconomic							
Income status	UMIC	UMIC	LIC	LMIC	LMIC	LMIC	LMIC
Human development index rank *[source UNDP]*	77 (2018)	52 (2018)	157 (2018)	129 (2018)	166 (2018)	122 (2018)	145 (2018)
Gender inequality index rank *[source UNDP]*	84 (2018)	69 (2018)	95 (2018)	122 (2018)	125 (2018)	87 (2018)	106 (2018)
Health							
Neonatal mortality rate (per 1000 live births)	5.3 (2019)	3.4 (2019)	15.9 (2019)	24.0 (2017)	20.5 (2017)	10.7 (2017)	22.4 (2019)
Under-five mortality rate (probability of dying by age 5 per 1000 live births)	9 (2019)	7 (2019)	34.3 (2019)	39.4 (2017)	45.4 (2017)	20 (2017)	44.7 (2019)
Maternal mortality ratio (per 100 000 live births)	37 (2017)	19 (2017)	210 (2014-15)	174 (2015)	315 (2015)	76 (2015)	250 (2017)
Infants exclusively breastfed for the first six months of life (%)	23.1 (2015)	15.8 (2004)	248 (2017)	54.9 (2015)	36.4 (2016)	40.9 (2014)	51.2 (2015)
Health systems							
Physicians density (per 1000 population)	0.47 (2015)	2.669 (2013)	0.064 (2015)	0.758 (2016)	0.068 (2016)	1.854 (2014)	0.677 (2018)
Nursing and midwifery personnel density (per 1000 population)	2.294 (2015)	6.415 (2013)	0.832 (2015)	2.094 (2016)	0.309 (2016)	6.429 (2013)	0.999 (2018)
Births attended by skilled health personnel (%)	99 (2016)	97 (2018)	91 (2014-15)	85.7 (2016)	68.4 (2017)	100 (2018)	60 (2016)
(DTP3) immunization coverage among 1-year-olds (%)	97 (2019)	88 (2019)	98 (2019)	88 (2017)	93 (2017)	92 (2013)	90 (2019)
Health financing							
Total expenditure on health as % of GDP	3.79 (2018)	5.56 (2018)	7.54 (2018)	3.54 (2018)	3.98 (2018)	6.53 (2018)	4.79 (2018)
Out-of-pocket expenditure (% of current health expenditure)	11.01 (2018)	19.46 (2018)	10.52 (2018)	62.67 (2018)	55.89 (2018)	52.44 (2018)	76.45 (2018)
General government expenditure on health as % of total government expenditure	15.03 (2018)	12.69 (2018)	8.88 (2018)	3.39 (2018)	4.26 (2018)	8.39 (2018)	3.49 (2018)

[20] Global Health Observatory WHO, WHO, http://apps.who.int/gho/data.

4. Findings

4.1 Synthesis of CPE findings linked to the relevance of WHO's strategic choices – EQ1

22. This section presents a synthesis of the relevance of strategic choices in the seven CPE countries. It examines whether CCS/BCAs are based on a comprehensive health diagnosis, and the extent to which they align with national priorities, the United Nations Development Assistance Framework (UNDAF), and WHO's corporate strategic priorities and international commitments. In addition, this section discusses the role of WHO and its value-add at country level. Finally, it examines the extent to which CCS/BCAs have integrated considerations of gender equality, human rights and equity (GER).

4.1.1 Evidence base and strategic focus of the CCS/BCAs

Finding 1: CCS/BCAs generally include a comprehensive analysis of the health situation in-country. However, many lack a gender or equity-focused analysis explaining how specific vulnerable groups are affected by health inequities, and most lack strategic focus in the form of a clear justification for their selected priorities.

23. All seven CPEs conclude that CCS/BCAs have provided a comprehensive overview of the health situation in the country. Situation analyses have consistently been informed by national health statistics, including demographic and health surveys, health management information systems data, STEPwise approach to surveillance (STEPS) surveys that identify risk factors associated with noncommunicable diseases (NCDs), and sentinel data, among others. In addition, more than half of the CPEs[21] confirm that situation analyses have made some reference to health inequalities, especially across geographic areas. However, these also note that a more systematic equity-focused analysis describing how specific vulnerable groups are affected by health inequities was warranted. Likewise, four CPEs[22] reveal that situation analyses lacked a gender analysis describing how women and men are affected differently by health issues. That said, two CPEs note a better integration of equity (i.e. Kyrgyzstan) and gender (i.e. Thailand) in the most recent generation of CCS/BCAs, suggesting that some WCOs are making progress in this area. The 2020 CCS guidance, which underlines the need to include disaggregated data in health situation analyses, might help ensure that CCS/BCAs are grounded in a strong evidence base that adequately reflects elements of equity.

24. While all CPEs find that CCS/BCAs have made reference to the burden of diseases, it is not always clear how evidence has informed the selection of CCS/BCA priorities. Only one CPE (i.e. Thailand) confirms the conduct of a formal needs assessment to justify the selection of CCS priorities. In addition, five CPEs [23] express concerns that CCS/BCAs lack strategic focus; their ambitious programme of work spanning multiple programme areas has often not been commensurate with the financial and human resources available to the WCO (see Findings 15 and 16 for further information on funding and staffing shortages). For example, three CPEs note that CCS/BCAs had addressed multiple outputs (up to more than 40) and highlight the importance for WCOs to adopt strategic priorities that are based on a clearer analysis of the comparative advantage of WHO in relation to that of other health partners in the country.

[21] Thailand, India, Kyrgyzstan, Myanmar.

[22] Thailand, India, Kyrgyzstan, Myanmar.

[23] Romania, Rwanda, India, Senegal, Kyrgyzstan.

4.1.2 CCS/BCA alignment with national health strategies and country priorities

Finding 2: There has been strong alignment between CCS/BCAs and national health strategies in all countries and, even though the practice of formal revision during implementation has been rare, the CCS/BCAs nonetheless remained flexible instruments that allowed WCOs to respond to emerging priorities. Strategic priorities have also been well aligned with health-related MDGs – and with SDG3, although in many cases CPEs have not clearly established the level of alignment with other health-related SDGs beyond SDG3.

25. All CPEs confirm that CCS/BCAs priorities have been strongly aligned with national health strategies. In all cases, CPEs find that the CCS/BCAs have been developed in consultation with ministries of health (MoHs), which has been a key factor in ensuring alignment. One CPE (i.e. Thailand) also confirms that the CCS has been developed on the basis of extensive consultations with public health agencies, line ministries, academia, civil society organizations (CSO) and other UN agencies, although the 2020 Mid-term Evaluation (MTE) of the WHO-Thailand CCS (2017-2021) provides additional insights regarding the effectiveness of such consultative processes (see textbox). Conversely, CPEs in three countries[24] note that the consultation process has not involved ministries beyond the MoH and that it is unclear whether the process has been sufficiently consultative. The 2020 CCS guidance underscores the importance of conducting broad consultations beyond the health sector and with non-State actors (NSAs) prior to developing the CCS so as to foster national ownership and intersectoral approaches to achieve health-related SDGs beyond SDG3. In this vein, all CPEs find CCS/BCAs to be generally well aligned with the MDGs and SDGs, especially the health-related goals such as MDG3 on infant, under-five and maternal mortality rates and MDG6 on HIV, and SDG3 on health and well-being. However, CCS have not presented a comprehensive analysis of CCS alignment with the SDGs, especially beyond SDG3. This might be explained by the fact that CCS/BCAs have not sufficiently detailed their expected contribution to SDGs. In fact, only the Romania and Kyrgyzstan CPEs find explicit linkages between BCA outputs and SDG targets, which is specific to the Regional Office for Europe (EURO) and is considered good practice.

Learning from the 2020 MTE of the WHO-Thailand CCS 2017-2021

The MTE finds that there has been a systematic process to identify CCS priority areas that has involved a range of stakeholders. However, some stakeholders have been left out of the consultations, which has resulted in some key health priorities not covered by the CCS, including: tuberculosis, HIV/AIDS, dengue hemorrhagic fever, sexual and reproductive health.

26. Another a key factor enabling CCS alignment with government priorities is the presence of a strong national vision in the health sector, as identified in the Rwanda CPE. Conversely, the lack of a long-term vision and shifting government priorities have made it more difficult for WCOs to align their CCS to government priorities (e.g. Romania). This is also reiterated by the MTE of the WHO-Thailand CCS 2017-2021, which confirms that alignment with national priorities has been a straightforward process in areas where the Government already has a national plan (i.e. AMR, NCD), but has been more difficult in areas where such plans do not exist (i.e. migrant health, road safety).

27. Similarly, five CPEs[25] identify the rapidly evolving context and the emergence of new players as a key factor potentially affecting the relevance CCS/BCAs. In this respect, the 2020 CCS guidance confirms the need for WCOs to revise the CCS when changes in the external context occur. Although few CCS/BCAs have undergone a formal revision process at key points in the strategic cycle, all but one CPE observe that the CCS/BCA has remained a flexible instrument and that WCOs have demonstrated a high degree of responsiveness by frequently adapting their workplan to emerging needs. CPEs provide several examples of workplans being adjusted to address emerging priorities, (e.g. digital health and AMR). CPEs identify the strong relationship between the WCO and the MoH as

[24] Romania, India, Myanmar.

[25] Rwanda, India, Myanmar, Senegal, Thailand.

a key factor facilitating this flexibility. However, these recognize that this has also resulted in WCOs responding to ad hoc requests, which has further expanded the scope of their programme of work.

28. Overall, all CPEs find that the strategic priorities outlined in the CCS/BCAs have responded to major health needs in-country. For example, CPEs frequently comment on the high relevance of CCS/BCA priorities addressing Universal Health Coverage (UHC), NCDs, and AMR. However, despite CCS/BCA covering a broad range of priorities, several CPEs find cases of neglected needs. For instance, two CPEs[26] identify decreased attention to communicable diseases compared to previous CCS/BCAs despite a continued high prevalence of tuberculosis. Likewise, two CPEs[27] find room for future CCSs to further address health challenges related to the ongoing demographic and epidemiological transition, including NCDs and healthy ageing. Likewise, three CPEs[28] identify gaps in addressing environmental health despite increased recognition by the Government of its importance. Furthermore, even though CCS/BCAs strongly emphasize UHC, all CPEs outline that more efforts could be deployed to address the social determinants of health to ensure equitable access to quality PHC.

4.1.3 CCS/BCA alignment with UNDAF

Finding 3: Alignment between CCS priorities and those highlighted in the UNDAF has largely been sufficient. In some cases, however, competing priorities hindered greater collaboration within some UNCTs in practice.

29. All but one CPE[29] find alignment between CCS/BCA priorities and specific outcomes of the UNDAF to be sufficient. In Romania, there is no UNDAF due to lack of presence of UN agencies. Four CPEs[30] identified the active participation of WHO in the development of the UNDAF as a factor ensuring alignment. Reflecting more recent developments on this front, the draft CCS for India (2019-2023) includes a results framework with results statements and indicators that are aligned with UNSDCF results. The India CPE also indicates that UN agencies are expected to play a role in monitoring progress against the CCS. These efforts are in line with the broader UNDS reform, which calls for a greater alignment between the strategic instruments of respective UN organizations and the UNSDCF, and efforts to monitor joint results. This new way of working jointly is also emphasized in the new CCS guidance.

30. That said, nearly half of CPEs identify shortcomings in terms of joint work among UN agencies. One of the main hindering factors has been competing priorities and different planning/monitoring structures across UN organizations. This is a broader difficulty in the UN that is not specific to WHO and is being addressed through the ongoing UNDS reform.

31. Collaboration with UN agencies is further discussed in Finding 14.

4.1.4 CCS/BCA alignment with GPW and international commitments

Finding 4: GPW priorities are reflected well in CCS/BCAs, with greater and more explicit alignment being evident in the new generation of CCSs.

32. Overall, CPEs find that priorities outlined in the GPW12 (i.e. 1. communicable diseases; 2. NCDs; 3. health in the life course; 4. health systems; and 5. preparedness, surveillance and response) have been used to shape overall priorities outlined in the CCS. However, as noted in Finding 17, the line of sight between CCS and GPW priorities has often not been explicit due to a disconnect in planning and monitoring systems at global and country level. Conversely, there appears to be greater alignment

[26] Thailand, Kyrgyzstan.

[27] Senegal, Rwanda.

[28] Rwanda, Senegal, Kyrgyzstan.

[29] Romania.

[30] Rwanda, India, Senegal, Myanmar.

between priorities outlined in the GPW and the BCAs, which have been linked explicitly to programme areas of the GPW. The development of the majority of draft CCSs coincides with the GPW13. These new CCSs align more intentionally their priorities and expected results to the strategic priorities outlined in GPW13.

4.1.5 WHO's role and value added at country level

Finding 5: WHO's role as a leader and convener in the health sector is well recognized, as is its comparative advantage in setting norms and standards and in providing policy support and technical expertise. As countries continue to develop, WHO has been called on to move away from technical assistance and further strengthen its role in providing strategic support to governments on health-related issue. Likewise, a stronger strategic presence at decentralized level is emphasized as being necessary to further strengthen health systems to improve the quality of PHC services in communities towards achieving UHC.

33. Overall, CPEs find that WHO's role and comparative advantage in-country have been well defined. CPEs frequently refer to WHO's strong comparative advantage in providing technical support and capacity building (two countries) [31], setting norms and standards and supporting policy development (five countries[32]), and supporting research and evidence generation (three countries[33]). All but one CPE make explicit reference to WHO's brand value, its neutrality and credibility as strong attributes that make it a partner of choice in the health sector. Furthermore, five CPEs[34] underscore that WHO has been highly valued for its strong expertise in technical areas and highly qualified staff.

34. Five CPEs[35] also underscore the strong leadership role played by WHO in the health sector and its comparative advantage in convening government and development partners on health-related matters. In four countries[36], WHO either chairs or co-chairs the health sector working group, a national platform that brings together the Government and development partners on health-related matters. In two countries[37], WHO's leadership in HIV has also been exerted by co-chairing the Global Fund Country Coordination Mechanism.

35. That said, CPEs identify a number of external factors that are prompting WHO to rethink its role in-country. Four CPEs[38] underline that, as countries' technical capacity has grown – and in some cases as domestic resources for health have increased – the role of WHO is increasingly moving away from that of technical assistance provider to that of strategic catalyst that provides policy advice. In addition, CPEs observe that the emergence of new actors in the health sector calls for WHO to play an even more prominent convening role to bring together traditional and non-traditional health actors in support of the SDGs. In this respect, the 2020 MTE of the WHO-Thailand CCS 2017-2021 finds that the WCO in Thailand has used its social capital to provide national and international visibility, which has helped to attract partners to support CCS priority programmes. Likewise, WHO has played an increasingly important role in supporting middle-income countries (MICs) and emerging economies in their role in global health, including through the strengthening of regulatory frameworks to enable exports of medical supplies to other countries. In this respect, the CPEs in India and Thailand underscore that WHO's added value lies in its ability to link national health actors to the regional and international domain.

[31] Rwanda, Kyrgyzstan.

[32] Rwanda, India, Senegal, Kyrgyzstan, Myanmar.

[33] Rwanda, India, Senegal.

[34] Thailand, India, Kyrgyzstan, Senegal, Myanmar.

[35] Thailand, India, Kyrgyzstan, Senegal, Myanmar.

[36] Rwanda, India, Senegal, Kyrgyzstan.

[37] Senegal, Rwanda.

[38] Thailand, India, Senegal, Kyrgyzstan.

36. Finally, in countries where WHO implements large programmes (e.g. India, Myanmar), CPEs recognize the important value-add of WHO technical staff on the ground, especially in the area of polio eradication, vaccination, and other areas. However, nearly half of CPEs[39] also note that WCOs maintain relationships with health authorities overwhelmingly at the national level, with limited strategic presence at the sub-national level. Increased presence at this level is perceived as an important means of strengthening health systems at decentralized level and further improving the quality of PHC services to achieve UHC.

Finding 6: WHO has played an instrumental role in positioning key health issues that require further attention onto national health agendas within the context of the 2030 Agenda. However, its role in fostering intersectoral action to address environmental health and the social determinants of health – both of which are key to achieving the SDGs – has not yet been fully exploited.

37. In all countries, WHO has used its technical leadership and convening power to place health priorities on the national agenda. For example, in six countries[40], WHO has provided technical support and facilitated multi-stakeholder processes for the development and/or revision of national health strategies (see textbox). The majority of CPEs also acknowledge that WHO has played a key role in positioning emerging priorities on the national agenda, including NCDs (i.e. Kyrgyzstan), road safety (i.e. Thailand, India), border and migrant health (i.e. Thailand), Universal Health Coverage (i.e. Kyrgyzstan, India, Rwanda, Senegal), community health (i.e. Romania), AMR (i.e. India) and environmental health (i.e. India). In four countries[41], WHO has also provided support to the Government to align its national health agenda with the SDGs. For example, in India, the WCO spearheaded national consultations on the transition from MDGs to SDGs and supported state-level planning for the achievement of SDGs, while in Kyrgyzstan the WCO provided support to align the 2030 National Health Strategy to the SDGs.

National health strategies developed with WHO support
-Romanian National Health Strategy (2014-2020)
-Third Rwandan Health Sector Strategic Plan – HSSP III (2012-2018)
-Kyrgyzstan 2030 National Health Strategy
-Myanmar National Health Plan (2017-2021)
-India National Health Policy (2017) and the National UHC Strategy
-Plan National de Développement Sanitaire et Social Sénégal (PNDSS)

38. At the same time, all CPEs recognize the important role that WHO can play in convening stakeholders beyond the health sector to achieve the breadth of health-related SDGs, this in recognition of the mutual interdependence of the SDGs generally and intersection of health and other sectors specifically. In particular, five CPEs[42] identify the need for WCOs to further address the social determinants of health as a prerequisite to make progress towards UHC. Likewise, while two CPEs[43] recognize the increased emphasis placed on environmental health during the course of the CCS to respond to emerging threats such as air pollution, three CPEs[44] acknowledge that further support in this area is needed to achieve health-related SDGs. However, as further detailed in Finding 13, CPEs also identify WCOs' limited partnership with non-health actors as being a critical gap. There is an effort within WHO to support multisectoral action, as evidenced by the guidance for the new generation of CCSs, which emphasizes the need to support actions beyond the traditional health sector.

[39] Senegal, Myanmar, India.

[40] Romania, Kyrgyzstan, Rwanda, India, Myanmar, Senegal.

[41] Rwanda, India, Romania, Kyrgyzstan.

[42] Rwanda, Romania, Senegal, Kyrgyzstan, Myanmar.

[43] India, Myanmar.

[44] Kyrgyzstan, Rwanda, Senegal.

4.1.6 Gender equality, human rights, and equity

Finding 7: CCS/BCAs do not adequately address issues of gender equality, human rights and equity as key social determinants of health. In addition, CPEs provide limited gender analysis, which is a missed opportunity to generate crucial lessons in this area.

39. At corporate level, WHO has committed to addressing GER through dedicated programme areas in the GPW12 on social determinants of health and gender equity and human rights mainstreaming. This commitment has carried over into GPW13.

40. Four CPEs[45] outline that equity issues are often addressed through efforts deployed by the WCOs to achieve UHC. For example, in Romania, the BCAs have recognized the reduced access of vulnerable groups to health care and included priorities to address health issues in the Roma population. However, CPEs generally identify the need for CCS/BCAs to better articulate their approach to equity as a social determinant of health. Likewise, five CPEs[46] reveal that these considerations have not been adequately mainstreamed in CCS implementation or that they have largely been addressed through gender-specific programming, mostly maternal health and gender-based violence. Conversely, two CPEs[47] find that WCOs have adequately integrated gender during implementation, although these do not provide further detail on precisely how it was integrated.

Findings of the MOPAN 2017-18 assessment on gender equality and equity

The MOPAN assessment found that there is a heightened focus in the GPW13 to address cross-cutting issues such as gender equality and equity. However, the assessment noted that "cross-cutting issues are integrated more at a strategic level than operationalized, but this is improving". The Gender, Equity and Human Rights team, supported by a network of gender focal points in regional offices, provide support when possible, although the MOPAN assessment also acknowledged that human and financial resources are not always available to fully address gender in all cases.

41. This analysis suggests that corporate commitments on GER are not yet fully reflected in country programming. This issue was also highlighted in the 2017-2018 MOPAN Assessment of WHO (see textbox).[48] The new CCS guidelines emphasize the need for CCSs to integrate these cross-cutting issues, although a lack of staff capacity at country level could hinder the ability of WCOs to put this guidance into practice.

42. In addition, CPEs themselves provide a limited analysis of GER, making it difficult to fully understand the strengths and weaknesses of CCS/BCAs in integrating these aspects. With more explicit guidance on this area now on hand for the next generation of CCS/BCAs, future CPEs should be better positioned to apply a correspondingly more explicit lens related to GER in their analyses moving forward.

43. An evaluation of the integration of gender, equity and human rights in the work of the Organization was completed in September 2021.

4.2 Synthesis of CPE findings linked to WHO's contribution and added value (effectiveness and progress towards sustainability) – EQ2

44. This section presents an analysis of the effectiveness of WHO's work in the seven CPE countries. First, it provides an overview of the results achieved by WCOs across WHO categories and programme areas as presented in the GPW12, as well as the factors enabling or hindering effectiveness. In doing so, it also examines the role of WHO regional offices and headquarters in supporting the achievement of results. In addition, it provides a synthesis of WHO's contribution to long-term changes in the health

[45] Romania, India, Senegal, Myanmar.

[46] Thailand, India, Senegal, Kyrgyzstan, Myanmar.

[47] Romania, Rwanda.

[48] MOPAN (2019). MOPAN 2017-2018 Assessments: World Health Organization (WHO).

of the population in CPE countries. Finally, this section discusses the sustainability of results achieved with WHO support.

4.2.1 Achievement of results

Finding 8: Country programmes universally lack a clear theory of change, or "results roadmap," as a management tool to help WHO sharpen its focus, prioritize its work, manage toward targeted results, and monitor, evaluate and report on progress in a robust manner. Despite the absence of such a tool, CPEs were able to find illustrative examples of results achieved in-country; these results were achieved unevenly across PB category and programme areas, however.

45. As further explained in Finding 17, all CPEs report that country programmes lack a clear theory of change and results framework that translate PB corporate outcomes and outputs as measurable outcomes and outputs at country level. The absence of such a management tool has made it difficult for WCOs to prioritize their work and has hampered the ability of CPEs to fully assess the extent to which WHO has achieved targeted results at country level.

46. Even so, all CPEs report on illustrative examples of WHO's contribution toward the achievement of results in countries and provide an indication of programme areas where most and least results have been achieved. As indicated in Section 2.2 above, the CPEs largely relied on qualitative data to validate these results. This finding presents an overview of results achieved per PB category and programme area in the seven CPE countries.[49] Overall, results have been achieved unevenly across PB category and programme areas. Greater contribution to outcomes is observed when several types of support (e.g. policy support, capacity building) have been combined in a given area.

Communicable diseases

47. Overall, strong achievements are observed across all programme areas of the communicable diseases category, with particularly strong results demonstrated in vaccine-preventable diseases. Despite important results, a decline in the attention paid to some major communicable diseases is noted in a few countries.

48. All CPEs underscore the contribution of WCOs in developing or improving national strategies, programmes, and action plans to address ***HIV and hepatitis, tuberculosis (TB) and malaria***. For example, in Thailand, the WCO led a review of the national malaria programme and provided advice that fed into the development of the National Strategic Plan for Malaria Elimination (2017-2026). In India, WHO contributed to the creation of a National Viral Hepatitis Control Programme, which provides free treatment for hepatitis B and C. In four countries[50], WHO has also provided normative guidance for the review of guidelines and protocols for case management of major communicable diseases. For example, in Kyrgyzstan, the new TB clinical guidelines and the introduction of WHO testing procedures led to an increase in the detection of TB cases. Despite these achievements, two CPEs[51] note decreased attention to major communicable diseases despite continued needs, this in tandem with correspondingly greater attention paid to NCDs in recent years.

[49] When presenting performance information on effectiveness, data was presented around the main PB categories (i.e., 1. Communicable diseases; 2. non-communicable diseases; 3. promoting health through the life-course; 4. health systems; 5. preparedness, surveillance and response) identified in the PBs 2014-2017. Although categories are somewhat different in PB 2012-2013 and PB 2018-2019, programme areas can generally fit within these broad categories.
[50] Senegal, Rwanda, Kyrgyzstan, Myanmar.
[51] Thailand, Kyrgyzstan.

49. Four CPEs[52] highlight the efforts that have been deployed by WCOs to combat ***neglected tropical diseases (NTDs)***, including soil-transmitted diseases, schistosomiasis, onchocerciasis, and human African trypanosomiasis. Key activities have included mass drug administration campaigns, research and surveillance, and support for the development of a national plan to fight NTDs. In India, increased attention has been paid to NTDs in the past few years with the recent contracting of 12 state and zonal NTDs coordinators to support field-level implementation. Conversely, despite some results achieved in Senegal in the fight against NTDs, the CPE reports an 80% decrease in funding in this area over the course of the CCS.

Soil-transmitted helminth infections in Kyrgyzstan

In Kyrgyzstan, deworming campaigns led to a reduction of soil-transmitted helminth infection rates among school aged children, from 56% to 13.2%.

50. ***Vaccine-preventable diseases*** is among the programme areas where most results are observed, with all seven CPEs reporting significant achievements. Support to expand routine immunization coverage and conduct mass vaccination campaigns (e.g. measles, Japanese encephalitis, polio) are commonly reported.[53] WCOs have also contributed to strengthening national immunization programmes through improved surveillance systems, training for Expanded Programme on Immunization (EPI) staff, capacity assessments, and other means. Furthermore, in Senegal and Kyrgyzstan, WHO has provided support to improve the cold chain and vaccine stock management. In four countries[54], WHO has also contributed to the introduction of new vaccines such as the Rotavirus vaccine, the Human Papilloma Virus vaccine, the Conjugate Pneumococcal vaccine, and others. In addition, WHO has provided assistance to India in its role in global health by, for example, supporting research that guided the global switch from the trivalent to bivalent oral polio vaccine and the development of new devices for measles surveillance.

51. Five CPEs[55] report increased efforts to address ***AMR*** in the 2018-2019 biennium, an area that governments have further prioritized in recent years. In all five countries, results are mostly reported in the area of evidence-based policy making, including the development of national strategies and action plans to combat AMR. In Senegal, Myanmar and Kyrgyzstan, CPEs also underline the contribution of WCOs to the adoption by the Government of the One Health approach and increased collaboration between the health and agricultural sectors to address AMR.

Noncommunicable diseases

52. Overall, five CPEs[56] report notable results in the area of ***NCDs*** with room for further improvement identified in two countries[57]. In many cases, WCOs have generated evidence on NCDs through the conduct of the STEPS surveys and other studies to support the development of evidence-based policies and strategies that consider the four risk factors of NCDs.[58] WCOs have also provided tools and built the capacities of government partners to address NCDs. For example, the WHO Package of Essential Noncommunicable Disease interventions (WHO-PEN) protocols[59] was introduced to the health care system in both Myanmar and Kyrgyzstan. In addition, in Myanmar and Romania, WCOs have provided technical support to strengthen cervical cancer prevention activities. Important achievements in tobacco control are also reported by the majority of CPEs[60]. These include the

[52] Rwanda, India, Senegal, Kyrgyzstan.
[53] Senegal, Romania, Myanmar, Kyrgyzstan.
[54] Rwanda, India, Myanmar, Kyrgyzstan.
[55] Thailand, India, Senegal, Kyrgyzstan, Myanmar.
[56] Thailand, Romania, India, Kyrgyzstan, Myanmar.
[57] Rwanda, Senegal.
[58] The four risk factors of NDCs include: 1) Tobacco use; 2) physical inactivity; 3) the harmful use of alcohol; 4) and unhealthy diets.
[59] The WHO-PEN protocols is a set of NCD prevention tools provided to primary health care facilities in low-resource settings for the early detection and management of cardiovascular diseases, diabetes, chronic respiratory diseases and cancer.
[60] Thailand, Romania, Rwanda, India, Kyrgyzstan, Myanmar.

development of legislation for tobacco use in five countries[61] and increased awareness on the importance of smoke-free environments as a result of health promotion activities in three countries[62]. For example, the WCO in Kyrgyzstan successfully positioned the issue of tobacco control in the 2018 Nomad Games. In addition, the WCO in Myanmar has provided technical and financial support for the implementation of the FCTC 2030 initiative, which helps a select number of countries advance tobacco control.

53. With respect to ***nutrition***, WHO plays a key role in addressing the double burden of malnutrition, with a comparative advantage in treating moderate acute malnutrition (MAM) and in addressing obesity by promoting healthy lifestyles. In Myanmar and Senegal, CPEs report notable results in addressing MAM through the development of strategies and guidelines, nutrition surveillance, and the training of community health workers. However, CPEs report mixed results in addressing the double burden of malnutrition. In Myanmar and Romania, the CPEs acknowledge the efforts deployed by the WCOs to promote physical activity and a healthy diet. However, three CPEs[63] find that more could be done in the area of nutrition to promote healthy lifestyles and address growing levels of obesity as a contributing factor of NCDs.

54. In the programme area ***violence and injuries***, four CPE [64] report on the achievement of results in road safety, including the development of national strategies in line with UN recommendations on road safety in all four countries, increased awareness on the importance of road safety as a result of awareness-raising campaigns spearheaded by the WCOs in two countries[65], and strengthened institutional capacity to address this issue in two countries[66]. Greater impact was observed in Kyrgyzstan, where multiple types of support were combined. For example, the WCO in Kyrgyzstan supported the development of a draft legislation on road safety, strengthened the capacity of the Ministry of Interior's Department of Road Safety through south-south cooperation, and conducted road safety advocacy activities in collaboration with UNDP and UNICEF throughout the country. These efforts likely contributed to a reduction in mortality caused by traffic injuries, from 22 deaths (per 100,000) in 2013 to 15.4 in 2016. Also in the area of violence and injuries, some activities were implemented to address domestic and gender-based violence in three countries[67]; however, the extent to which these have contributed to outcomes is unclear.

55. Likewise, with the exception of some scattered outputs in ***disabilities and rehabilitation*** in two countries[68] and ***mental health and substance abuse*** in four countries[69], CPEs do not report any meaningful contribution to results in these programme areas.

Promoting health through the life-course

56. Overall, 'promoting health through the life-course' is the category area for which least results are reported, with significant variances across programme areas. Most results have been achieved in the area of reproductive, maternal, newborn, child and adolescent health (RMNCAH), with fairly limited results in ageing and health. Likewise, CPEs highlight that more efforts are needed in the areas of ***health and the environment*** and the ***social determinants of health,*** and call for a stronger intersectional approach to achieve the mutually interdependent SDGs, as already discussed in Finding 6. In some cases (e.g. Kyrgyzstan, Senegal), these two programme areas have been identified as CCS priorities but CPEs report that limited funding and staff capacity hindered the achievement of results.

[61] Thailand, Romania, Rwanda, India, Kyrgyzstan.
[62] Romania, Rwanda, Kyrgyzstan.
[63] Rwanda, Senegal, Kyrgyzstan.
[64] Thailand, Rwanda, Kyrgyzstan, Myanmar.
[65] Rwanda, Kyrgyzstan.
[66] Kyrgyzstan, Myanmar.
[67] India, Romania, Myanmar
[68] Thailand, Myanmar.
[69] Romania, Rwanda, India, Kyrgyzstan.

57. Five CPEs report contribution to results in the area of ***reproductive, maternal, newborn, child and adolescent health (RMNCAH)***. CPEs outline the support provided by WCOs for the development of strategic plans, action plans, and guidelines on maternal and child health (MCH), and their alignment with international norms and standards. For example, the WCO in Rwanda supported the development of the Maternal, Newborn and Child Health Strategic Plan 2018-2024 and the WCO in Senegal contributed to the elaboration of the Maternal, Newborn, Child and Adolescent Health Plan (2016-2020). In several countries, efforts have also been deployed to reduce maternal and neonatal mortality. For example, in Rwanda and Myanmar, WHO provided technical support for the implementation of a maternal death surveillance and response system. In Kyrgyzstan, WHO supported the introduction of perinatal audit, which has contributed to a reduction in maternal mortality. In addition, in three countries[70], the WCOs have provided capacity building support and tools to improve MCH. For instance, in Myanmar, the WCO supported the development of an essential package of interventions on maternal and reproductive health and, in Kyrgyzstan, it trained health workers on reproductive health services, including perinatal care. In Senegal, WHO has also engaged in a joint programme on MCH in collaboration with UNICEF, UNFPA, and UN Women through the French Muskoka Fund. Four of the five CPEs[71] confirm that WHO's work in this area contributed to improvements in related health indicators. Despite some results, the CPE in Senegal outlines that continued support is needed to address high rates of neonatal, infant, and maternal death.

58. With respect to ***ageing and health***, only two CPEs (i.e. Thailand and Senegal) report on the implementation of activities in this area. Both these CPEs acknowledge that there have been limited results in this area, highlighting the needs for more efforts to address an issue of growing importance to Governments in the context of an ageing population. CPEs in Rwanda and Myanmar also identify health concerns related to the demographic transition but this has not been addressed as a CCS priority.

59. Six CPEs discuss the performance of WHO in the area of ***health and the environment***, with five presenting examples of results.[72] In four countries[73], the WCO has provided policy advice for the development of strategies, action plans, or national standards related to health and the environment. Three CPEs[74] also report the achievement of results in WASH and water safety. For example, in Rwanda and Senegal, WHO has supported the participation of the Government in the UN-Water Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS). In Senegal, WHO has also provided technical assistance to the Ministry of Water and Sanitation for the production of WASH accounts using WHO's Tracking Financing to WASH (TrackFin) approach. In addition, the WCO in Myanmar contributed to the creation of a water surveillance system. In Myanmar, the WCO has also started to address air pollution. Despite these achievements, CPEs largely agree that environmental health is an area that requires further attention.

60. Similarly, CPEs report few results in the area of the ***social determinants of health***, even though it has been identified as a strategic priority in several CCS/BCAs. These emphasize the need for WCOs to increase their efforts in this area in order to address gender inequalities and broader health inequities.

Health systems

61. ***Health systems*** strengthening has been a key priority featured in all CPEs, with notable results achieved in all countries. Even so, the majority of CPEs acknowledge that achieving UHC will require continued support for long-term health sector reforms.

[70] Rwanda, Kyrgyzstan, Myanmar.
[71] Rwanda, India, Kyrgyzstan, and Myanmar.
[72] The WCO performance in health and environment was discussed in all CPEs but Thailand. Specific examples of results were reported in Romania, Rwanda, India, Senegal, and Myanmar. The CPE Kyrgyzstan did not provide examples of results in this area.
[73] Romania, Rwanda, India, Myanmar.
[74] Rwanda, Senegal, Myanmar.

62. All CPEs report significant contributions to results in the programme area ***national health policies, strategies and plans***. For example, WCOs have supported the development of sectoral strategies on HIV, TB, AMR and NCDs, among others. In addition, as mentioned in Finding 6, WHO has played a key role in the development of national health strategies that set the stage for important reforms to strengthen PHC and achieve UHC. In six countries[75], WHO also supported the review of health strategies and programmes to identify key gaps in the health system and guide Health Systems Strengthening (HSS) efforts. Four CPEs[76] also identify results in health financing (see textbox for an example of good practice in Senegal) and the introduction of health insurance schemes.

63. In *Kyrgyzstan*, advice from the WCO has been instrumental in strengthening the governance of the Mandatory Health Insurance Fund. In addition, the WCO provided technical assistance to improve the hospital payment system.

64. In *India*, the WCO supported the introduction of the National Health Protection Scheme.

Good practice in Senegal: WHO support to the health financing strategy

The WCO in Senegal supported the development of the National Financing Strategy towards Achieving Universal Health Care and its accompanying investment plan. It also provided advocacy support at a national forum on health financing. Given the emergence of new partners in the health sector, this support helped to determine how different partners would contribute to the health financing strategy.

65. In *Rwanda*, technical assistance from the WCO has contributed to the development of the health insurance policy and Community-Based Health Insurance.

66. In *Senegal*, the WCO contributed to the institutional strengthening of the Agency for Universal Sickness Coverage, which offers a health insurance scheme to vulnerable groups in particular.

67. Furthermore, WHO has supported the production of national health accounts in three countries[77] to help governments monitor financial investments in the health sector. Despite these achievements, two CPEs acknowledge that the lack of WCO funding has been a key factor hindering progress toward results in health financing. As noted in Finding 12, support in this area is key for achieving UHC as most governments still struggle to ensure adequate resources for health.

68. Central to achieving UHC is the availability of quality ***integrated people-centered health services.*** Although the majority of CPEs report some achievement of results in this programme area, nearly all acknowledge that continued efforts are required to ensure that populations have access to quality care, especially vulnerable groups. Nearly all CPEs recognize the efforts made by WCOs to improve the quality of care and strengthen community-based health systems. For instance, in India the WCO supported the creation of national multi-sectoral expert group on patient safety to improve quality care and community-based wellness centers to increase access to PHC. In Myanmar, the WCO trained community-based health workers and, in Senegal, the WCO built the capacities of social development committees to improve the quality of PHC services in communities. However, three CPEs[78] note that the quality of care remains one of the weakest points of the national health system. Furthermore, two CPEs[79] outline that the limited presence of WHO at decentralized level is an important factor limiting its ability to enhance the quality of PHC services in support of UHC. A key issue hindering access to care is also the lack of human resources for health (HRH), due to outward migration of qualified healthcare professionals and low wages. CPEs recognize the efforts made by WCOs to raise awareness on this issue, which has contributed to the development of national HRH strategies in four countries[80]. In India, the WCO also contributed to the establishment of a dedicated HRH cell responsible for policy

[75] Rwanda, Kyrgyzstan, Romania, Thailand, India, Senegal.
[76] Rwanda, India, Senegal, Kyrgyzstan.
[77] Rwanda, India, Senegal.
[78] Romania, Rwanda, Myanmar.
[79] Senegal, Myanmar.
[80] India, Myanmar, Romania, Kyrgyzstan.

making, strategic planning and monitoring in this area. Even so, three CPEs[81] acknowledge that HRH is an area that requires further attention.

69. In the programme area ***Access to medicines and other health technologies and strengthening regulatory capacity,*** all CPEs report at least some progress toward ensuring high quality and affordable medicine and medical devices. Four CPE[82] outline WHO's contribution to the development of legislation and regulatory frameworks in the area of access to medicine and/or medical devices. In Romania and Senegal, support from WHO has contributed to enhancing efficiencies in the drug supply chain, resulting in cost-savings and a reduction in medicine shortages. Two CPEs also report improvements in national regulatory capacity through the establishment of a Food and Drug Regulatory Authority (i.e. Rwanda) and the introduction of WHO's model System for computer-assisted medicines registration (SIAMED), a system to monitor the traceability of imported medicine (i.e. Senegal). Despite some achievements, three CPEs [83] identify room to further strengthen regulatory systems.

70. In addition, WHO has supported Thailand and India in their role in global health, which has resulted in greater availability of affordable vaccine and drug supplies in other countries (see textbox). WHO's support to global health has therefore contributed to the control of diseases beyond borders and the achievement of global public health impact.

WHO support to global health in India and Thailand

WHO has supported India in its role as a producer and exporter of generic medicine by strengthening its drug regulatory capacity. Globally, 70% of prequalified medicines, 65% of prequalified vaccines and 59% of active pharmaceutical ingredients originate from India.

In Thailand, global health diplomacy has been a key priority of the CCS 2017-2021. Thanks to WHO's support, Thailand now has the capacity to support neighboring countries respond to disease outbreak by providing them with vaccine and drug supplies.

71. As for the programme area ***health systems, information and evidence,*** nearly all CPEs [84] find evidence of contribution to the development and/or strengthening of health information systems (HIS). For example, the WCO in Thailand supported the creation of a health information system for migrants along the Thai/Myanmar border. In Rwanda and India, WHO has contributed to enhancing civil registration and vital statistics systems by introducing records on the cause of death. Despite these achievements, three CPEs[85] underscore the need for continued support to further strengthen data quality and HIS. In addition, four CPEs[86] outline that digital health is becoming a key priority for governments and will require more attention going forward; in some cases, this is already a focus area of the new generation of CCSs.

Preparedness, surveillance, and response

72. With respect to ***alert and response capacity,*** six CPEs[87] underscore WHO's contribution to strengthening national capacities to comply with International Health Regulations (IHR). In four countries[88], WHO has conducted in collaboration with the Government and key experts a Joint External Evaluation (JEE) of IHR core capacities[89], and has provided targeted support for the implementation of JEE recommendations. For example, in Myanmar, the WCO supported the

[81] Romania, Senegal, Kyrgyzstan.
[82] Myanmar, Kyrgyzstan, Thailand, Senegal.
[83] Myanmar, Rwanda, Senegal.
[84] Rwanda, Romania, Thailand, Myanmar, India, Kyrgyzstan.
[85] Rwanda, Kyrgyzstan, Myanmar.
[86] Kyrgyzstan, Rwanda, Myanmar, India.
[87] Romania, Rwanda, India, Senegal, Kyrgyzstan, Myanmar.
[88] Rwanda, Senegal, Kyrgyzstan, Myanmar.
[89] WHO defines a joint external evaluation (JEE) as a "voluntary, collaborative, multisectoral process to assess country capacities to prevent, detect and rapidly respond to public health risks whether occurring naturally or due to deliberate or accidental events. The JEE helps countries identify the most critical gaps within their human and animal health systems in order to prioritize opportunities for enhanced preparedness and response." It assesses 19 core national capacities.

elaboration of a costed National Action Plan for Health Security (2018-2022) and, in Kyrgyzstan, the WCO supported the implementation of several simulation exercises to address capacity gaps identified in the JEE. In addition, CPEs commonly report that WHO has strengthened surveillance and early warning systems, laboratory and biosafety capacity, and case detection. Finally, in Senegal, the WCO has played a pivotal role in influencing the Government to adopt a One Health approach to combat zoonotic and food-borne diseases as well as AMR.

73. In the area of ***emergency risk and crisis management***, WHO has actively supported country preparedness and response to disease outbreaks in five countries[90] through the elaboration of national plans for outbreak response, the development of training curricula, and mass vaccination campaigns, among others. For example: in Kyrgyzstan, the WCO conducted an after-action review of a measle outbreak; in Romania, the WCO provided assistance to the Government in the area of risk communication in food safety during the 2016 E-coli outbreak; and, in Myanmar, the WCO provided support to control the 2017 H1N1 Influenza outbreak. In addition, in both Myanmar and Kyrgyzstan, the WCO has supported efforts on emergency preparedness and response through its role as the chair/co-chair of the health cluster. In Kyrgyzstan, the WCO has played a key role in reinvigorating the health cluster, which has been dormant for several years. Although there was no active emergency in Kyrgyzstan at the time of the CPE, WHO has been working actively with the Government and development partners on emergency preparedness and risk management activities, which is considered good practice.

74. Finally, four CPEs[91] report results in the area of ***food safety***. In three countries, the WCO has provided support for the development of national food safety standards that are aligned with the CODEX Alimentarius guidelines. In addition, the WCO in Romania has trained health care workers on food safety and the WCO in Senegal supported the development of a contingency plan in case of food intoxication. Both Senegal and Kyrgyzstan have received funding from the WHO/FAO CODEX Trust Fund; however, in Kyrgyzstan, this funding has come to an end and stakeholders report challenges in mobilizing additional resources for food safety.

4.2.2 Contribution to long-term health changes

Finding 9: WHO's support to vaccination and disease surveillance has had a positive impact on the elimination or reduction of vaccine-preventable diseases. In some countries, impacts are also reported in reducing maternal and child mortality rates as well as major communicable diseases. In several countries, improvements in health governance and legislative frameworks are also expected to generate positive health benefits in the long-term.

75. Despite a lack of robust data to show the extent of WHO's contribution to long-term changes in the health status of the population, all CPEs provide concrete examples of plausible improvements in health outcomes.

76. In most countries, WHO's efforts to raise awareness on the importance of vaccines and to strengthen national immunization programmes have contributed to increased routine immunization coverage and, despite a lack of data to show attribution, it is plausible that these efforts have contributed to a decrease in mortality from vaccine-preventable diseases. In this regard, five CPEs highlight WHO's contribution toward the eradication or reduction in the incidence of the following diseases. As indicated below, more results are reported in India and Myanmar; WHO's strong field-based workforce in these two countries appears to be a key factor of success.

- **Polio:** In *India* and *Myanmar*, WHO's National Polio Surveillance Project (NPSP) is largely credited for having contributed to the eradication of polio. In *Romania*, WHO contributed to

[90] Romania, Rwanda, Senegal, Kyrgyzstan, Myanmar.

[91] Romania, Rwanda, Senegal, Kyrgyzstan.

maintaining the country's polio-free status through capacity building to strengthen surveillance.

- **Measle and Rubella:** In *Rwanda*, WHO's support for surveillance and the capacity building of EPI personnel contributed to the elimination of measles. Likewise, *Kyrgyzstan* became a rubella free country in 2019. In *Myanmar* and *India*, support for routine immunization is believed to have contributed to a reduction in measles and rubella rates.
- **Maternal and neonatal tetanus:** With WHO support, *India* and *Myanmar* have both eliminated maternal and neonatal tetanus.
- **Malaria:** Following years of WHO support, *Kyrgyzstan* was declared a Malaria-free country in 2016. In *Myanmar*, the number of malaria cases and deaths decreased by 84% and 95% between 2012 and 2018, respectively.
- **Yaws:** In *India*, WHO's support contributed to the elimination of yaws in 2016.

77. Four CPEs[92] also report that WHO's efforts in the area of MCH likely contributed to reducing maternal and child mortality. Furthermore, two CPEs[93] outline WHO's important role in increasing treatment coverage for major communicable diseases (i.e., HIV and TB) and reducing their prevalence.

78. Furthermore, four CPEs[94] outline that the support provided by WHO to implement health reforms have or is expected to contribute to increased health coverage and access to medical care among the population. Finally, five CPE[95] underscore that new legislations developed with WHO support are expected to generate important health benefits for the population if implemented successfully (see Finding 11 on challenges related to the sustainability of legal frameworks).

4.2.3 Contribution of headquarters and regional offices to the achievement of results

Finding 10: WCOs have benefitted frequently from technical assistance and initiatives spearheaded by regional offices and headquarters, contributing to the achievement of results in multiple areas. Likewise, CPEs underscore the importance of regional offices in supporting the exchange of experiences among countries, although some CPEs note that regional offices could further strengthen this role. Other CPEs highlight WCO concerns that the technical missions from the ROs are sometimes too numerous and overly supply-driven.

79. One of the main contributions of WHO HQ and ROs cited by all CPEs is the regional and international expertise that they provide to WCOs and governments, often filling capacity gaps in technical areas at country level. For example, the ided targeted support in Rwanda and Senegal, including on matters related to UHC and for the development of national health strategies. Likewise, WHO's regional emergency hubs in Dakar and Bishkek have provided support on emergency preparedness and response, not only to the Governments of Kyrgyzstan and Senegal but also to other countries of the region. CPEs overwhelmingly agree that technical missions from ROs have been of high quality and have contributed to the achievement of important results in-country. However, two CPEs[96] also note that such missions sometimes appear to be supply-driven or too numerous, creating unwarranted burden on country offices.

80. In addition, three CPEs[97] outline that the programmes and initiatives managed by ROs or HQ have benefited country offices. For instance, the Myanmar WCO has benefited from yearly grants for

[92] Rwanda, India, Kyrgyzstan, Myanmar.
[93] Rwanda, Myanmar.
[94] Rwanda, Senegal, Kyrgyzstan, Myanmar.
[95] Thailand, Romania, Senegal, Kyrgyzstan, Myanmar.
[96] Kyrgyzstan, India.
[97] Thailand, Senegal, Myanmar.

anti-TB drugs from the Global Drug Facility hosted at headquarters. In AFR, the Intercountry Support Team has been providing support to Senegal on health financing through a multi-country programme on UHC under the umbrella of Partnership for Health.

81. Furthermore, four CPEs[98] underscore the ability of WHO to foster regional cooperation to address cross border health challenges, including through surveillance and the sharing of information between countries on the outbreak of diseases. For example, the CPE of Rwanda report cross-border collaboration to address the resurgence of malaria and the CPE of Myanmar identifies examples of cross-border initiatives in the areas of polio immunization and malaria surveillance. However, the CPE for Thailand also highlight that cross-regional collaboration in the Mekong sub-region has sometimes been hampered by the fact that only Myanmar and Thailand are part of SEAR while other Mekong countries[99] are associated to the Western Pacific Region of WHO.

82. In addition, six CPEs[100] recognize that the ROs have played a key role in the sharing of experiences and lessons learned among countries by supporting their participation in regional events, study tours and south-south cooperation. For example:

- In *Senegal*, MoH representatives visited neighbouring countries to learn about their experiences in UHC and the drug supply chain. Learning informed Senegal's reform to achieve UHC. Likewise, Senegal shared its experience implementing the One Health approach with neighbouring countries.
- In *Kyrgyzstan*, health officials have shared their experience on Pandemic Influenza Preparedness (PIP) with other countries.
- In *Myanmar*, the RO has initiated dialogue between Myanmar health officials and Thailand on nutrition.
- In *Thailand,* WHO has supported the country's role as a knowledge broker in global health, using its convening power to connect Thailand health officials with those of other countries.

83. Despite positive support from regional offices, three CPEs[101] find that even more efforts could be deployed to support knowledge exchanges and the sharing of experiences among countries.

4.2.4 Sustainability

Finding 11: CPEs confirm that there is strong Government ownership of WHO activities with evidence of handover in some countries. In addition, participatory processes spearheaded by WHO for the development of national health strategies have led to strong buy-in among government stakeholders. In several countries, however, the sustainability of these efforts has been hampered by a lack of resources to ensure their subsequent implementation. Some CPEs suggest that WCOs could provide more support to convene partners and build an investment case for the implementation of strategies. Another key factor hindering sustainability in some countries has been the high turnover of government officials and political instability.

84. CPEs in all countries confirm that WHO has supported government-led processes in the health sector, resulting in strong national ownership of WHO's programme of work. A key enabling factor is the strong relationship between WCO staff and MoH officials, who have met regularly to plan activities jointly. In addition, two CPEs confirmed that the Government has committed resources to the implementation of WHO activities, which is a strong indication of sustainability:

[98] Rwanda, Senegal, Myanmar, India.

[99] Mekong countries include: Cambodia, China, Laos, Myanmar, Thailand, Vietnam.

[100] Thailand, Romania, Rwanda, Senegal, Kyrgyzstan, Myanmar.

[101] Senegal, Romania, Myanmar.

- **India:** The Government showed willingness to deploy national resources to fund important elements of WHO's programme of work, in particular the NPSP and TB.
- **Thailand:** The immunization and vaccine development programme, previously supported by WHO, is now entirely funded by the Government. In addition, while government funding for the CCS 2012-2016 amounted to only 1.9%, the CCS 2017-2021 was expected to be almost entirely funded by the Government. This is a strong indication of sustainability and government ownership of the CCS.

85. In addition, a Polio Transition Plan has been drafted for the handover of the Polio programme to the Government in Myanmar. Though the transition had not yet happened at the time of the evaluation, the CPE finds early evidence that the Government has adequate capacity to sustain the programme without technical support from WHO.

86. CPEs also reveal that the process facilitated by WCOs for the development of national health strategies was government-driven and highly consultative, bringing together multiple national actors. CPEs note that this process has resulted in strong ownership by government stakeholders of national health strategies developed with the support of WHO. In addition, three CPEs[102] underscore that advocacy efforts and high-level policy dialogue spearheaded by the WCO have resulted in increased commitment and additional funding for the implementation of national health strategies. In this respect, the support of the WCO in Senegal to the health financing strategy was identified as a good practice to support financing for health. However, four CPEs[103] underline that the lack of funding has been an important factor limiting the implementation of national health strategies and programmes developed with the support of WHO. To address this issue, some CPEs suggested that WHO could: 1) make greater use of its leadership function to convene development partners in support of resource mobilization for the national health agenda; 2) support the inclusion of health in national budgets by helping the government to demonstrate the cost-effectiveness of health investments in order to build an investment case. Another challenge highlighted by the CPE of Kyrgyzstan – and likely faced by other countries transitioning to MIC status – is the decrease of ODA in the health sector, pointing to a need for WHO and its partners to support countries transition from an ODA-reliant health systems to self-financed health systems.

87. Nearly half of the CPEs identify changes in government and shifting national priorities as a key factor limiting the sustainability of WHO's contribution. Three CPEs note that high turnover of government officials has hindered the relationship between WCO staff and national counterparts (i.e. India), have led to delays or discontinuity in the implementation of the WCO programme of work (i.e. Romania), or have hindered the sustainability of national capacities developed with WHO support (i.e. Kyrgyzstan). Of particular interest is the CPE of Romania, which confirms that the programme areas that have remained more stable overtime have benefitted from the involvement of professional associations and civil society. This likely points to the importance of working with NSAs as a strategy to increase sustainability, especially in contexts of political instability. (See Finding 14 for more information on partnerships with NSAs).

4.3 Synthesis of CPE findings linked to how WHO achieved results (elements of efficiency) – EQ3

88. The report provides a synthesis of efficiency by examining how WCOs have achieved results. Specifically, it looks at the key core functions used by WCOs during CCS/BCA implementation. It also examines the adequacy of partnerships with the government, UN agencies and NSAs such as CSOs and the private sector. This section also reports on the extent to which funding levels and human resources enabled the achievement of results. Finally, it discusses CCS/BCA monitoring mechanisms.

[102] Romania, India, Senegal.

[103] Romania, Rwanda, Senegal, Kyrgyzstan.

4.3.1 WHO functions

- **Finding 12: Policy options, capacity building, leadership and partnership as well as norms and standards have been among the WHO functions most commonly played by country offices. While there is evidence of knowledge generation in some countries, support to the national research agenda is a frequently-cited gap. Likewise, while WHO relied on the monitoring function to some extent, support to the surveillance of emerging diseases is a common gap. Also identified by several CPEs is the need for WCOs to move away from pure technical assistance to a more strategic role as countries continue to develop.**

89. CPEs assess the extent to which WCOs have used the six WHO core functions[104] to achieve results, as set forth in the GPW12 and GPW13. As depicted in the figure below, all six functions have been applied in all countries, although some more than others. All CPEs report a strong use of the capacity-building function, with technical support provided in multiple programme areas. As mentioned in Finding 5, all CPEs also recognize the strong leadership of WCOs in convening the Government and development partners around health matters. Likewise, all CPEs report frequent use of the norms and standards function across CCS priorities, including but not limited to: major communicable diseases, MCH, road safety, and emergency preparedness and response. All CPEs also confirm a consistent use of the policy option function to support the development and review of national health policies and strategies. However, while several CPEs indicate that WCOs have supported the generation of knowledge products – particularly to support evidence-based policy making – some[105] also note that WCOs could have done more to support the national health research agenda and to create opportunities to disseminate the production of knowledge to other countries[106]. Likewise, all CPEs acknowledge the support provided to establish national health observatories or strengthen surveillance systems in areas such as maternal death, TB, and vaccine-preventable diseases; however, CPEs also outline the need to further support the surveillance of emerging diseases (e.g. dengue and NCDs).

Table 5. Prevalence of WHO function in CPE countries

WHO Function / Country	Thailand	Romania	Rwanda	India	Senegal	Kyrgyzstan	Myanmar
Leadership and partnership							
Research and knowledge							
Norms and standards							
Policy options							
Capacity building							
Monitoring							

Legend

Strongly featured

Featured to some extent, but gaps in function's presence in country noted

90. In addition, four CPEs[107] underline that, as countries develop increased technical capacity – and in some cases more domestic resources for health – the role of WHO is increasingly moving away from a technical assistance provider to a strategic catalyst that provides policy advice and helps bring together traditional and non-traditional health actors to address global public health issues.

[104] 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.

[105] India, Senegal, Kyrgyzstan.

[106] Romania, Rwanda.

[107] Thailand, India, Senegal, Kyrgyzstan.

4.3.2 Partnerships

Finding 13: All CPEs report strong partnerships between WCOs and ministries of health. However, most CPEs identify the need to strengthen partnerships with ministries beyond the health sector.

91. All CPEs confirm the existence of a strong working relationship between WCOs and MoHs characterized by a high level of trust and collaboration, with some CPEs even reporting that WCOs are almost regarded as part of the MoH. All CPEs also report some examples of collaboration with ministries beyond the health sector. For example, in Kyrgyzstan the WCO has established a partnership with the Ministry of Agriculture in an effort to control AMR and with the Ministry of Interior to promote road safety. In Myanmar, the WCO has collaborated with the Ministry of Education on health promotion in schools in the areas of tobacco control, road safety and sexual education, among others. In Rwanda, the WCO has worked jointly with the Ministry of Infrastructure to address water and sanitation.

92. Despite these examples, nearly all CPEs[108] reveal that partnerships beyond the health sector have been limited overall. These underline the importance of greater multisectoral collaboration to address issues related to environmental health and the social determinants of health, among others, and identify the need for WCOs to further engage in strategic partnerships with ministries from other sectors. There is an effort within WHO to support multisectoral action, as evidenced by the guidance for the new generation of CCS, which emphasizes the need to support actions outside the traditional health sector by further involving ministries across key sectors in the conceptualization and monitoring of the CCS. Thailand is an example of efforts made by the WCO to engage in intersectoral action, not only by fostering the engagement of multiple ministries in the design of the CCS, but also by involving them in managing and overseeing the implementation of the CCS (see textbox). The Thailand experience brings important lessons on the benefits of intersectoral collaboration, especially in terms of addressing the socio-determinants of health, and the challenges linked to inclusive multi-stakeholder governance mechanisms. One of the challenges identified by the 2020 MTE of the WHO-Thailand CCS 2017-2021 is that government participants in the CCS are involved part-time and that they have sometimes not been able to dedicate enough time to CCS programmes and activities. The MTE concludes that considerable time and efforts are required to manage the CCS governance mechanisms and that dedicated human resources are required.

Good practice in Thailand: Multi-sectoral approach to CCS governance

To foster multisectoral collaboration, the CCS 2012-2016 introduced a new governance mechanism whereby each of the five CCS priorities were managed by a sub-committee overseen by a lead public agency. A steering committee was also created to oversee the implementation of the entire CCS. This approach has had varying degrees of success depending on the CCS priority area. Multisectoral collaboration was further strengthened in the CCS 2017-2021, with 66 ministries, agencies and organizations expected to participate directly in CCS implementation at the time of writing the Thailand CPE in 2017.

Finding 14: WCOs have frequently partnered with UN organizations that traditionally work in the health sector, although engagement with those partners that have a broader mandate remains limited. Strong partnerships are also observed with bilateral donors and global partnerships for health. However, several CPEs identify the need for greater collaboration with CSOs, academia and the private sector. WHO has taken some actions to address this gap.

93. CPEs generally report a good level of collaboration between WHO UN organizations, especially those working in the health sector, although areas for improvement have been identified in some countries. Five CPEs[109] highlight frequent collaboration with UN organizations that have a health

[108] Rwanda, Senegal, India, Myanmar, Romania, Kyrgyzstan.

[109] Thailand, Rwanda, India, Senegal, Kyrgyzstan.

mandate, namely UNICEF, UNFPA and UNAIDS on issues such as immunization, sexual and reproductive health, gender-based violence, HIV and nutrition. Though less frequently, collaboration is also identified with UNDP (three countries) on tobacco control and road safety, IOM (one country) on border and migrant health, and FAO (one country) on food safety. The CPE of Senegal is the only CPE to report the existence of a strategic partnership between WHO and a UN agency specialized in environment to address the health/environment nexus (see textbox).

94. In addition, three CPEs[110]report that WCOs have participated actively in the UNCT by chairing/co-chairing UN working groups (e.g. UNDAF results groups, health-related technical working groups, communications group, among others). The 2020 MTE of the WHO-Thailand CCS 2017-2021 also notes that a UN Thematic Working Group on NCDs has been established to promote the participation of UN partners in the implementation of the CCS programme on NCDs. In two countries[111], WHO has also acted as the lead/co-lead of the health cluster. Despite evidence of collaboration, three CPEs [112] identify competing priorities among UN agencies as well as different governance mechanisms and organizational processes as key factors that have hindered joint work under the UNDAF. This challenge is not unique to WHO and is being addressed as part of the broader UNDS reform, which advocates for greater collaboration among UN organizations through a new resident coordinator system and common business operations to implement the UNSDCF.

Good practice in Senegal: Partnering with non-health UN actors to address health and the environment

The WCO in Senegal is part of a five-year regional partnership with UNEP on chemical waste management. In addition, under the umbrella of UN-Water, the WCO implements a joint programme with UNICEF to monitor water quality.

The new CCS guidance emphasizes the importance of positioning as many CCS priorities as possible in the UNSDCF as this is expected to enable WHO to generate a multisectoral response to CCS priorities. As per the guidance, UN partners can "use their convening power to influence sectors where WHO's relationship are not so strong".

95. All CPEs report strong partnerships with the US Centres for Disease Control and Prevention (six countries) and global partnerships such as the Vaccine Alliance (GAVI) and the Global Fund to Fight AIDS Tuberculosis and Malaria (GFATM) (four countries) on issues related to major communicable diseases, immunization and surveillance. Likewise, partnerships with foundations, most commonly the Bill and Melinda Gates Foundation (BMGF), are identified in three CPEs[113].

96. However, only two CPEs reported on partnerships with International Financial Institutions (IFIs). In Kyrgyzstan, WHO has maintained a strong partnership with the World Bank, which has been a key player in the health sector. In India, WHO has partnered with the World Bank mostly on health systems, but the CPE finds opportunities for further collaboration in other areas such as air pollution and NCDs.

97. Overall, the majority of CPEs identify opportunities for WCOs to further engage with NSAs. Five CPEs[114] reveal that partnerships with CSOs have been limited, with some evidence of collaboration in specific areas such as Polio, NCDs (i.e. India) and emergencies (i.e. Kyrgyzstan). In two countries, a weak civil society is identified as a key factor limiting such collaboration. In addition, four CPEs[115] identify opportunities for further collaboration with the private sector, which is considered essential to access medicine and achieve UHC. In fact, only one CPE (i.e. Senegal) reports a partnership with the pharmaceutical industry for the mass distribution of medicines to fight NTDs. Overall, CPEs provide

[110] India, Kyrgyzstan, Myanmar.

[111] Kyrgyzstan, Myanmar.

[112] Thailand, Rwanda, Senegal.

[113] India, Rwanda, Kyrgyzstan.

[114] Romania, Rwanda, India, Kyrgyzstan, Myanmar.

[115] India, Romania, Myanmar, Kyrgyzstan.

limited insights on the extent of partnerships with academia, with one CPE (i.e. India) identifying existing collaboration and two CPEs[116] acknowledging that this is an area for improvement. In addition, the 2020 MTE of the WHO-Thailand CCS 2017-2021 provides interesting insights with respect to partnering with CSOs. It reveals that the partnership with CSOs, which have not typically been involved in WHO country programming in other countries, have supported outreach at provincial and local levels, where WHO has less presence. In 2016, WHO adopted a Framework of Engagement with Non-State Actors (FENSA)[117]. A 2019 Evaluation of WHO's FENSA concluded that the framework has resulted in some positive changes but lacks concrete actions to foster partnerships with NSAs.[118] Recognising the importance of partnerships with these actors to implement the GPW13, WHO is in the process of developing an engagement strategy and indicators to operationalize and monitor partnerships with NSAs, in particular with CSO and the private sector.[119] The new CCS guidance also emphasizes the importance for CCSs to identify synergies with CSOs and academia and establish a roadmap for such engagement.[120]

4.3.3 Funding

Finding 15: Funding constraints have affected the work of all WCOs included in the analysis, with only one WCO having developed a resource mobilization strategy to address shortages. To attract additional funding, CPEs also underline the importance for WCOs to better report on their results. The earmarked nature and unpredictability of donor resources has often resulted in the uneven allocation of funding across strategic priorities and delays in implementation. To address this shortcoming, the WCO in Thailand has piloted a flexible pooled funding mechanism.

98. Figure 2 provides an overview of overall expenditures, including staff time, by WCO over the period assessed by the CPEs[121]. Because CPEs present budget information differently, it was not possible to present overall figures disaggregated by PB category. However, CPEs[122] indicate that PB categories such as promoting health through the life course – and more particularly areas such as the social determinants of health and health and the environment – and NCDs tend to receive less funding than other categories. Likewise, three CPEs[123] also reported that NCDs received little funding. Conversely, despite some funding gaps in areas such as TB and hepatitis in countries such as India and Kyrgyzstan, health systems and communicable diseases tend to be better funded overall.

[116] Romania, Senegal.

[117] Non-state actors covered by the FENSA include: Civil society organizations, the private sector, philanthropic foundations and academic institutions.

[118] WHO (2019). Initial Evaluation of the Framework of Engagement with Non-State Actors (FENSA)

[119] WHO (2020). Initial Evaluation of the Framework of Engagement with Non-State Actors (FENSA): Management Response.

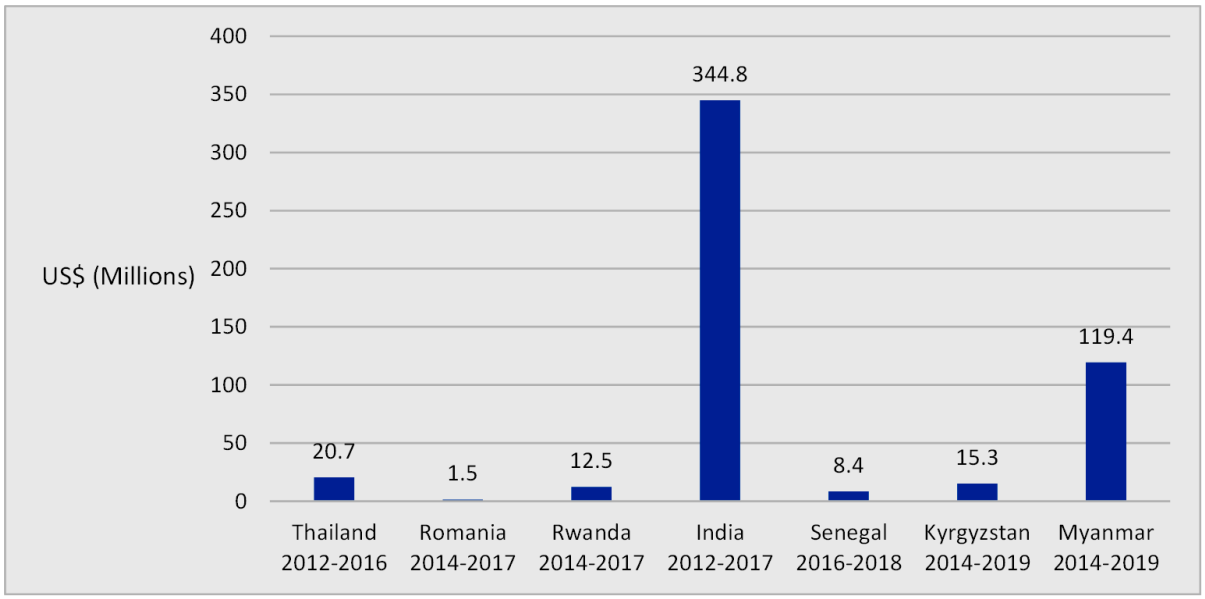
[120] WHO (2020). Country Cooperation Strategy Guide 2020: p.10.

[121] Financial figures are often reported per PB biennium. Therefore, financial figures do not always match the timeline of the CCS. For example, in Myanmar, the CCS under review covers 2014-2018, but the financial figures also include 2019. Because some evaluations were undertaken during the last year of the CCS/BCA, expenditures for that last year were not available at the time of writing the CPE.

[122] India, Romania, Kyrgyzstan, Myanmar.

[123] India, Romania, Myanmar.

Figure 2. Overall budget expenditure over the CCS/BCA period evaluated



99. Six CPEs[124] identify funding constraints as a key factor hindering the achievement of results and potentially undermining the ability of WCOs to maintain a leadership role in the health sector. Only one of the seven CPEs report the development of a resource mobilization strategy to attract additional donor resources in response to funding shortages. Indeed, the Kyrgyzstan WCO developed an ambitious resource mobilization strategy informed by a comprehensive donor mapping, which has contributed[125] to a significant increase in expenditures, from US$ 3.3 million in 2014-2015 to US$ 7 million in 2018-19.

100. In addition, although all WCOs have been funded through assessed contributions (i.e. flexible funding), five CPEs [126] comment that WCOs have also relied to variable extents on voluntary contributions. The earmarked nature of donor funding has resulted in the uneven allocation of resources across some programme areas, making it difficult for WCOs to move away from project-based resource allocation to a more strategic use of resources. To that end, the Thailand WCO has been piloting a new funding mechanism whereby un-earmarked funding is to be pooled annually to fund each of the CCS priorities (see textbox). In addition, the Myanmar CPE confirms that pooled funding is a potential new approach considered by the WCO.

Finding from the 2020 MTE of the WHO-Thailand CCS 2017-2021

The MTE concludes that pooled funding is a promising and innovative approach to CCS financial management. It uses a common bank account and joint financial reporting. This new approach has fostered country ownership, alignment with national priorities and harmonization with partners. The majority of stakeholders are in favor of this approach, although some challenges are observed, including delays in the release of funds and high transaction costs.

101. Three CPEs [127] also identify the importance for governments and donors to have a better understanding of how WHO resources contribute to impact at country level. This is particularly important in cases where new financing mechanisms (e.g. Thailand) link funding disbursements to the achievement of outcomes. Systemic difficulties in reporting on WCO's contribution to outcomes and

[124] Thailand, Romania, Rwanda, Senegal, Kyrgyzstan, Myanmar.

[125] BMGF funding received from the HQ-driven Transformation Process also contributed to a significant increase in resources for the WCO in Kyrgyzstan.

[126] Thailand, Rwanda, Senegal, India, Myanmar.

[127] India, Thailand, Myanmar.

Organization-wide efforts to improve impact measurement at country level are further discussed in Finding 17 on monitoring and evaluation.

102. Finally, timeliness of funding is identified as problematic by four CPEs[128]. Cumbersome disbursement mechanisms have resulted in delays in the disbursement of funds to the Government. In addition, the unpredictability of donor resources is identified as a key factor delaying implementation.

4.3.4 Human resources

Finding 16: Despite efforts deployed by some WCOs to strengthen their workforce, staffing shortages are a key factor limiting the achievement of results. Vacant positions and high turnover of WCO staff remain an issue caused in part by lengthy recruitment processes and an over-reliance on SSAs. CPEs also identify the need for a more appropriate balance between international staff and NPOs to ensure WHO's leadership and expertise in-country. Some CPEs also outline the need for WHO to better define the roles and responsibilities of staff across WHO offices.

103. Three CPEs[129] commend the efforts made by WCOs to enhance their human resources. In Thailand, international positions more than doubled over the CCS period. In Kyrgyzstan and Romania, the position of Head of Office – which was previously assumed by a national staff with support from EURO – was for the first time entrusted to an international staff as part of an Organisation-wide effort to increase WHO's international presence. In the case of Kyrgyzstan, the WCO embarked on a transformation process which has been key to strengthen the capacity of its workforce and enhance the visibility of WHO in the country (see textbox). Still, all CPEs with the exception of Thailand note that WCOs have relied heavily on National Professional Officers (NPOs) and that the number of international staff has been insufficient. Furthermore, three CPEs[130] find that some NPOs lack the level of seniority and experience required to engage with high level officials from health ministries and successfully position WHO's leadership in national health fora. Those CPEs further note that, as countries become increasingly developed, they require high-level expertise, which is why it is important that WCOs have the ability to draw on international experts and NPOs who have the right skillset. CPEs therefore identify the need to increase capacity-building opportunities for NPOs. In this regard, efforts made by the WCO in Kyrgyzstan to strengthen its workforce as part of the transformation process is considered good practice.

Good practice in Kyrgyzstan: Transformation process of the WCO

In 2017, the WCO in Kyrgyzstan participated in the transformation process, a pilot programme funded by the Bill and Melinda Gates Foundation (BMGF) to make country offices more efficient and effective. As part of the transformation process, the WCO has invested in training opportunities for national staff. The WCO has also invested substantially in its enabling functions, which increased by more than four-fold between 2014-2015 and 2018-2019. Resources have been used to fill administrative positions and to recruit a communications officer, which has helped increase the visibility of WHO in the country.

104. Despite the strong dedication of WCO staff, all CPEs report varying degrees of understaffing issues limiting the ability of WCOs to cover all CCS priorities and/or fulfil enabling functions. Limited and unpredictable funding combined with lengthy hiring procedures are identified as key factors explaining high staff turnover and vacant positions. Gaps are observed in the following priority areas: NDCs (two countries); health systems (two countries); health in emergencies (two countries); health and the environment, social determinants of health, and health promotion (two countries); MCH (one country) and communicable diseases (one country). This has meant that existing staff have had to take on additional tasks that are sometimes beyond their area of technical expertise. Therefore, WCO staff

[128] Rwanda, India, Senegal, Myanmar.

[129] Thailand, Kyrgyzstan, Romania.

[130] Rwanda, India, Myanmar.

often manage a large portfolio spanning multiple priority areas, resulting in a heavy workload. Two CPEs report that understaffing in some technical areas (i.e. NCDs and health systems) has resulted in other organisations taking the lead in an area where WHO normally has a comparative advantage. In terms of the enabling functions, four CPEs[131] pointed to gaps in staffing in the following areas: planning and M&E, external communications/knowledge dissemination, and resource mobilization. These functions are perceived as essential to ensure the visibility of the WCO in-country and mobilize resources for the implementation of the WCO programme of work. In the case of Kyrgyzstan, these gaps have been largely addressed through the transformation process.

105. In large country offices like India and Myanmar, overreliance on Special Service Agreements (SSAs) is a significant problem. In both countries, a large proportion[132] of the workforce is contracted through SSAs – a short-term contractual modality – in part because of the unpredictability of funding. CPEs emphasize that this not only poses a legal risk to the Organization as staff have sometimes occupied the same position for over 15 years, but it also contributes to high staff turnover and job insecurity because SSA holders do not enjoy the same benefits as staff. In addition, the annual renewal of SSA contracts creates an important workload for administrative staff and is therefore inefficient.

106. Furthermore, four CPEs identify the need to define more clearly the roles and responsibilities of certain staff, especially in country offices with more complex structures and/or functions. Myanmar is the third largest WCO in the South-East Asia Region (SEARO), with offices in Yangon and Naypyidaw. Due to the large size of the WCO, a new position of Deputy WHO Representative was created in 2019 in the Naypyidaw office. However, the CPE notes that the division of labour between the WHO Representative and the Deputy WHO Representative has not clearly been defined. As for India, it is home to both a WHO country office and the regional office (SEARO). The CPE finds that although this has created some opportunities, there has also been confusion in the roles and responsibilities of staff regarding communication with government and other partners. Finally, Kyrgyzstan and Senegal host regional meetings regularly and CPEs find that the roles and responsibilities of WCO and regional staff in preparing those meetings is not well defined which has created an additional burden for national administrative staff.

4.3.5 Monitoring mechanisms

Finding 17: The natural accompaniment to a theory of change or "results roadmap" – that is, a results framework with indicators, baseline and targets to monitor progress toward CCS/BCA results – represents a universal gap in all of the WCOs included in the analysis. Systemic issues in monitoring mechanisms are being addressed in the GPW13, and the next generation of CCS is expected to be better positioned to monitor health outcomes. Likewise, periodic review of progress is identified as an area for improvement by most CPEs.

107. All CPEs reveal that none of the CCS/BCA have been accompanied by a theory of change or results framework with baseline data and targets. In addition, five CPEs[133] also outline a disconnect between the results defined in the CCSs and the workplans used to implement the WCO programme of work, which are linked to GPW outputs and outcomes through the WHO Global Management System (GSM). WCOs report periodically on activities through the corporate monitoring tool in GSM, but CPEs explain that reporting has been very much activity-based, rather than focused on outputs and outcomes. As mentioned in Finding 8, CPEs acknowledge that these systemic issues have limited their ability to assess the extent to which WCOs achieved their expected results.

[131] Thailand, Senegal, Rwanda, Kyrgyzstan.

[132] In Myanmar, 66% of the workforce is contracted through SSAs. Exact figures are not available for India, though they are reported to be significant.

[133] India, Thailand, Rwanda, Senegal, Myanmar.

108. There is a broader effort within WHO to measure more effectively the impact of the Organization on people's health at country level. As result, the GPW13 is accompanied by the WHO Impact Framework, which includes a menu of 46 outcome indicators from which WCOs can choose, and through which results in-country can be aggregated to measure WHO's overall contribution to health outcomes. The new CCS guidance emphasizes the need for the next generation of CCSs to develop results frameworks with targets and indicators that are aligned with the Impact Framework of the GPW13 and designed to collect disaggregated data. CPEs in India and Myanmar confirm that draft CCSs (2019-2023) include a results framework with indicators, baselines and targets that are aligned with the GPW13. These also note that indicators are disaggregated (e.g. by sex, age, and geography) to monitor gains in health equity. This said, the ability of WCOs to monitor equity gains will be contingent upon the availability of national disaggregated data, hence the importance of continued support to help countries improve their HIS. Indeed, the availability of disaggregated data remains a challenge in monitoring progress toward gender equality and equity not only for WHO but for all UN organizations and development partners.

In Thailand: Participatory M&E mechanisms

In *Thailand*, a monitoring and evaluation sub-committee composed of the MoH and the WCO was set up to oversee the implementation of the CCS-2021. This represents an innovative and participatory mechanism that has the potential to increase ownership of the CCS and its continued alignment with national priorities. However, the 2020 MTE of the WHO-Thailand CCS 2017-2021 reveals that there have been delays in setting up this M&E sub-committee and that it has only been partially functional.

109. Likewise, CCS guidance stipulates that "progress in CCS implementation should be reviewed at country level at least once every year." Although some WCOs have conducted reviews or evaluations at some point in the programme cycle, these rarely assess progress toward the achievement of results periodically. The exception is Kyrgyzstan, where the WCO has reviewed the implementation of the BCAs jointly with the MoH every six months to adjust programming as required. In addition, the WCO has instituted an internal practice whereby all staff members discuss progress and challenges in implementing the BCA bi-weekly. In addition, in Thailand, a formal M&E committee was set up to monitor progress in implementation; however, there have been challenges in its implementation.

4.4 Synthesis of CPE recommendations and management responses

110. This section presents an aggregate overview of the recommendations offered by the CPEs and their accompanying management responses.

4.4.1 Synthesis of CPE recommendations

111. All CPEs offer recommendations directed to HQ, ROs and WCOs. The WHO Secretariat is called on to ensure sufficient capacity of WCOs to implement CCS/BCAs and other strategic agreements. The ROs for Africa, Europe and South-East Asia are also called to ensure adequate coverage of financial and human resources and in general to strengthen those core functions that would help WHO deliver more effectively.

112. These are accompanied by a series of recommendations targeted at WCOs. These most commonly relate to current country engagement with partners, the alignment of CCS/BCAs to country priorities, and the strategic focus of the WHO country programme through management tools such as a theory of change and monitoring framework. All seven CPEs provide recommendations to improve partnerships, including strategic engagement with national partners beyond the health sector to foster multisectoral action in support of the SDGs, the development of partnership with NSAs (i.e. civil society, private sector), and the creation of coordination mechanisms to bring key stakeholders together around health issues.

113. Six CPEs[134] provide recommendations on the alignment to country priorities, calling on WCOs to ensure the alignment of the CCS/BCAs with the priorities set forth by the Government, and ensure a good strategic fit with current unmet needs. In India and Myanmar, where WHO has a large programme, CPEs recommend that WCOs articulate the strategic role of WHO at the State level by focusing on areas where the WHO has a competitive advantage and develop strategies in consultation with local Ministries and state government agencies as appropriate. In addition, in Romania and Kyrgyzstan, a revision of the current timeframe for strategic planning is also recommended in order to address long-term health needs. A new, longer-term, 4–5-year strategic planning instrument to address the more systemic and long-term needs that goes beyond the short-term (2-year) planning timeframe, taking into account long-term joint commitments and outcomes and medium-term WHO strategies, is proposed.

114. Six CPEs[135] call for the development of a theory of change that identifies a clear pathway for change, from country-level activities and outputs to expected outcomes and impact, with linkages to the GPW13 'triple billion' goals. CPEs recommend that WCO use the theory of change for priority-setting to ensure that CCS/BCAs are strategically focused. In addition, six CPEs[136] recommend that WCOs develop a monitoring and evaluation framework to measure progress toward the achievement of CCS targets, taking into consideration gender and the social determinants of health, with some CPEs also recommending the conduct of a mid-term evaluation. Several recommendations speak to improving the WCO's financial and human resources as well as technical capacity to implement its programme of work. Six CPEs[137] provide recommendations to ensure adequate financial resources, including through the development of resource mobilization strategies as well as funding mechanisms that are sustainable and promote the strategic use of resources rather than a project-by-project approach. Likewise, all CPEs provide recommendations to improve human resources and ensure adequate technical capacity of staff. In general, recommendations include actions to build the capacity of technical professionals, and a revision of current available team skillset vis-à-vis implementation. In some cases, these include a balance between international and local staff, availability of support staff, or a rationalization of the burden of work of WCO staff.

4.4.2 Synthesis of management responses

115. Upon completion of a CPE, the WCO is expected to develop a management response explaining whether it accepts the recommendations, the actions proposed to implement the recommendations, and their status of implementation. The synthesis analyzed the management responses of six CPEs. At the time of writing this synthesis, the management response for the Myanmar CPE had not yet been approved. All 25 recommendations made by the six CPEs have been accepted by the WCOs, with the exception of one sub-recommendation in India. This indicates that WCOs are largely in agreement with the findings and recommendations of the CPEs. The highly participatory approach used by the EVL team throughout data collection and reporting likely contributed to ensuring that CPE recommendations are utilization-focused.

116. As of 2021, a total of six recommendations have been implemented, 17 are in progress, and two have not yet been initiated. The 25 recommendations have been broken down into 87 actions, of which 35 have been implemented, 40 are in progress, and 12 have not yet started. Table 5 indicates the level of implementation of recommendations and their corresponding actions for each of the six countries. Several management responses identify the COVID-19 pandemic as a major factor delaying the implementation of recommendations.

[134] India, Kyrgyzstan, India, Romania, Senegal, Myanmar.

[135] Thailand, Romania, India, Senegal, Kyrgyzstan, Rwanda.

[136] Thailand, India, Senegal, Kyrgyzstan, Rwanda, Myanmar.

[137] Thailand, India, Senegal, Romania, Rwanda, Myanmar.

Table 6. Level of implementation of CPE recommendations and corresponding actions

CPE	Recommendation			Action		
	Implemented	In progress	Not initiated	Implemented	In progress	Not initiated
Thailand	4	0	0	10	0	0
Romania	1	3	0	7	5	1
Rwanda	0	4	1	3	8	7
India	1	3	1	6	3	3
Senegal	0	3	0	2	13	1
Kyrgyzstan	0	4	0	7	11	0
Total	**6**	**17**	**2**	**35**	**40**	**12**

117. **TOC/prioritization process:** One WCO[138] has developed a theory of change and undergone a priority-setting process. This process is in progress in two countries[139] and not yet initiated in one country[140]. In two countries[141], the WCO accepts the recommendation to develop a TOC but does not propose concrete actions for doing so and, therefore, progress remains unclear. Actions linked to the development of a results framework with measurable indicators have been completed in two countries[142], in progress in one country[143], and not yet initiated in another country[144].

118. **Partnerships:** Three WCOs[145] have fully implemented actions related to partnerships while actions are partially implemented in three countries[146]. For example, in India, the WCO developed a strategy for collaboration with the private sector and CSOs. In Kyrgyzstan, Rwanda and Romania, WCOs have started to develop strategic partnerships with ministries beyond the health sector with the objective to foster intersectoral action, although this is still a work in progress.

119. **Financial resources/human resources:** Financial resources is where most progress has been made, with related actions fully implemented in three countries[147] and partially implemented in two[148]. For instance, in India, the WCO developed a resource mobilization strategy while the WCO in Senegal jointly analyzed with AFRO the funding of the workplan to identify and fill gaps. The unpredictability of resources remains an issue, however, pointing to a broader increasing trend of donor earmarking. Some progress has also been made in the area of human resources, with two WCOs[149] fully implementing related actions and the implementation of actions is in progress in four countries[150]. In particular, functional reviews with an assessment of HR needs to fulfil the workplan of WCOs are ongoing or expected to be completed in the near future.

[138] Thailand.

[139] Rwanda, Senegal.

[140] India.

[141] Romania, Kyrgyzstan.

[142] Thailand, Senegal.

[143] India.

[144] Rwanda.

[145] Thailand, India, Romania.

[146] Kyrgyzstan, Rwanda, Senegal.

[147] Thailand, India, Senegal.

[148] Rwanda, Romania.

[149] Thailand, India.

[150] Rwanda, Romania, Kyrgyzstan, Senegal.

5. Lessons

120. Above and beyond the conclusions and recommendations, this synthesis raised a number of lessons on what has worked well and what has worked less well in the design and implementation of CCS/BCAs. This section presents these lessons, which WCOs may consider improving the relevance, effectiveness and efficiency of their country programme. In addition, the section reflects on lessons that could be used to improve the design of the next generations of CPEs.

Lessons emerging from the implementation of CCS/BCAs:

Lesson 1: Involving ministries from multiple sectors in the conceptualization, management and governance mechanisms of the CCS increases government ownership, which may in part help to increase health financing. It also has the potential to foster the intersectoral collaboration needed to address broader health issues, including the social determinants of health and environmental health. However, it is important to ensure that the right stakeholders are involved in consultation processes. In addition, involving multiple stakeholders in the day-to-day management of the CCS poses operational risks and requires careful consideration in the selection of entities responsible for implementation.

Lesson 2: Developing partnerships with UN organizations that do not have a traditional health mandate is essential for WHO to support the achievement of SDGs beyond SDG3 and to further address the health and environment nexus.

Lesson 3: Engaging in strategic partnerships with NSAs such as academia, CSO and professional associations is a good strategy to increase sustainability, especially in contexts of political instability and high turnover. In addition, CSOs typically have extensive presence at province and local levels and strategically engaging with CSOs can help WHO strengthen its presence at these levels. However, developing these partnerships can prove challenging, especially in countries where NSAs are not well organized. Strengthening their institutional capacity is therefore essential to create an enabling environment.

Lesson 4: Combining different types of support (e.g. policy support, capacity building) and outputs focused on a few areas is more effective in contributing to outcome-level results than a thinly scattered set of divergent programmes. Developing a clear theory of change detailing the results chain between output and outcome-level results – based on an analysis of the comparative advantage of the WCO and that of other partners – is key to ensuring a focused programme that can contribute to health outcomes.

Lesson 5: The proportion of CCS funding dedicated to the enabling functions varies significantly depending on the country office. A well-resourced enabling function is important to ensure adequate administrative and communications capacity, which are essential to increase the visibility and reputation of the country office. This can in turn enhance the ability of the WCO to mobilize partners and attract additional resources to fund its programme areas.

Lessons to improve the design of the next generation of CPEs:

Lesson 6: This synthesis has shown that the emergence of new players in the health sector has prompted WCOs to rethink their role at country level based on their comparative advantage vis-à-vis that of partners, especially in the context of limited WHO funding. CPEs can help WCOs to define this role and become more strategically focused. However, to do so, it would be important for CPEs to fully examine the evaluation criteria of coherence[151], not as sub-set of the relevance criterion but as a separate criterion).

[151] Coherence is a standard OECD-DAC criterion since 2019. The definition of coherence as per OECD-DAC guidance is: "Internal coherence addresses the synergies and interlinkages between the intervention and other interventions carried out by the same institution/government, as well as the consistency of the intervention with the relevant international norms

Lesson 7: In tandem with their learning purpose, CPEs generate key lessons on what has worked well and what has worked less well in the implementation of country programmes. However, these are spread out throughout the findings are not always easily identifiable. Having a separate section on lessons learned – which is often done in evaluations conducted by other UN organizations – might help enhance clarity of key lessons and could be used to generate a compendium to promote continued learning across the Organization.

Lesson 8: Designing gender-responsive methodologies is key to ensuring that GER is fully mainstreaming in a CPE. To do so, it is important to mainstream GER across the evaluation criteria and develop specific indicators that are designed to collect data on gender equality as per UNEG guidance[152]. These should not only look at the achievement of gender equality results but also at organizational processes to mainstream gender equality, human rights and equity (for example, the availability of gender expertise in the WCO, the use of gender tools and guidance, and so on).

and standards to which that institution/government adheres. External coherence considers the consistency of the intervention with other actors' interventions in the same context. This includes complementarity, harmonisation and co-ordination with others, and the extent to which the intervention is adding value while avoiding duplication of effort." Source: https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm

[152] UNEG Guidance Integrating Human Rights and Gender Equality in Evaluations (2014) underlines the importance of integration GEHR across all evaluation criteria. It proposes a set of generic evaluation questions per OECD-DAC evaluation criterion that can be adapted during evaluation design. file:///C:/Users/esthe/Downloads/UNEG_HRGender_web_final.pdf (see pages 81-85).

6. Conclusions

121. Overall, CCS/BCA are well aligned with national priorities, the UNDAF and broader WHO strategic priorities as outlined in the GPWs. In all CPEs countries, the CCS/BCAs have addressed important needs in the health sector. They have played a pivotal leadership role in the health sector by positioning key issues on national health agendas and by supporting evidence-based policy making in the health sector. Despite the universal lack of a theory of change and results framework, illustrative examples of results are evident in all GPW category areas, though with notable variances across programme areas. Particularly noteworthy is the progress made in combatting vaccine-preventable diseases, in all countries but even more so in countries where WHO has a field-based workforce. Good progress has also been made in the fight against NCDs, most notably in tobacco control, cancer prevention and road safety. Likewise, WHO has actively supported countries in their response to health emergencies and has successfully assumed its leadership role in the health cluster. Significant results have also been achieved in the area of RMNCAH, but less so in healthy ageing despite important demographic changes and an ageing population in several countries. Environmental health and the social determinants of health are also areas that are lagging behind. As these two areas address broader health issues and health inequities, accelerating progress in these areas will be key to achieve all health-related SDGs and UHC. Given their intersectoral nature, however, it is unlikely that WCOs can make further progress without broadening their partnership base beyond the health sector. In addition, addressing health inequities also requires addressing gender inequalities. However, the systematic lack of a gender analysis informing the design of CPEs have limited the ability of WCOs to address gender inequalities beyond the implementation of gender-specific programming (e.g. MCH). In the same vein, WCOs have made important contributions to health systems strengthening but, in all countries, gaps remain to achieve UHC. The lack of WHO presence at decentralized level is a notable factor hindering progress toward UHC and the availability of quality PHC in communities.

122. In addition, WCOs tend to spread themselves thin, with CCS/BCAs addressing several outputs and outcomes spanning multiple programme areas. This is particularly problematic considering the limited resources available to WCOs and staff shortages, which have hindered the ability of WCOs to fully implement their ambitious programme of work and achieve results across all programme areas. In many countries, the emergence of new players in the health sector constitutes an opportunity for WCOs to develop more strategic CCS/BCAs by focussing their programme of work on their comparative advantage in relation to that of other country partners. However, such a prioritization process calls for WCOs to develop a robust theory of change that demonstrates the pathways to change and show clear linkages between WHO activities, outputs and expected outcomes, also taking into consideration the contribution of partners to these outcomes. Ensuring that the conceptualization of the CCS/BCAs is truly informed by an analysis of what others are doing in the health sector will require WCOs to consult with stakeholders beyond the MoHs, which has until now been a gap in most countries.

123. This synthesis demonstrates that WCOs have nurtured a close relationship with MoHs, which has facilitated Government ownership and alignment with national priorities. In addition, WCO have collaborated regularly with UN organizations with a health mandate to address MCH, sexual and reproductive health, and nutrition. They have also participated actively in the UNCT by chairing UNDAF results groups, thematic groups, and others. However, different governance and management structures as well as competing priorities among UN agencies remain a key challenge to joint UN collaboration. WHO's continued efforts to implement the UNDS reform and streamline processes, including monitoring and reporting processes that align with UN Info, will be key to ensure WHO's successful engagement in the UNCT.

124. In addition, WCOs have had limited engagement with national ministries and UN organizations beyond the health sector. In this sense, there are opportunities for WHO to further strengthen partnerships beyond the health sector to address environmental health and the social determinants of health, which are central to achieve all health-related SDGs. WHO has made good progress in this

area with the adoption in 2019 of the Global Action Plan for Healthy Lives and Well-being for All and, going forward, it will be key for WCOs to develop a clear engagement roadmap at country level with national and development partners beyond the health sector. In this respect, WCOs may capitalize on the relationship of other UN organizations with ministries to broaden their own partnership base with government stakeholders. In addition, several CPEs identified the need to further strengthen partnerships with NSAs, including CSOs, academia, and the private sector. Doing so would help to create an enabling environment to contribute to more sustainable results especially in contexts of high turnover and political instability. In addition, considering the limited financial and human resources available to WHO, developing a network of CSO partners with strong field-based presence might increase WHO's visibility and influence at local level. Similarly, engaging with academia could help WCOs to make a stronger application of WHO's research function, which remains a gap in several countries.

125. The availability of WHO funding is a critical issue hindering the achievement of results in all countries. Indeed, adequate funding is important not only to fund programme areas but also to address staff shortages and ensure that existing staff have access to capacity development opportunities. The synthesis also demonstrates that adequately funding the enabling functions is key to ensure that the WCO is properly managed and to maintain WHO's visibility in-country, which is in turn crucial to mobilize donor resources. This has been a gap with only one country having developed a resource mobilization strategy. At the same time, increased donor earmarking is an external factor that hinders that ability of WCO to make strategic use of its resources; a challenge that not only affects WHO but the entire UN system.

126. Limited national resources for health – and in some countries decreasing ODA in the health sector – has also hindered the ability of countries to implement health strategies and programmes developed with WHO's support. As countries are developing more technical capacities and are seeing the emergence of new players in the health sector, WCOs are called to assume a more prominent leadership role in convening partners to support the implementation of these strategies. Likewise, this points the to increasingly important role that WCOs could play in supporting the integration of health in national budgets. Again, this would require WCOs to broaden their partnership base beyond the MoHs by forging strategic relationships with ministries of finance.

127. All CPEs identify important gaps with respect to planning and monitoring mechanisms, including alignment issues with global and country level results, the lack of theories of change and country results framework to monitor and report on WHO's impact at country level. Several mechanisms have been put in place to address these issues through the GPW13, its results framework, and the new CCS guidance. It will be increasingly important for WCOs to put in place these mechanisms as they develop their new CCS/BCAs, especially considering that donors are becoming increasingly results-focus and require the multilateral organizations they fund to develop strong accountability mechanisms. Donors are also increasingly paying attention to the integration of cross-cutting issues, such as gender equality, human rights and equity. Although new monitoring requirements set forth in the new CCS guidance identify the need to better monitor and report on WHO's contribution to gender equality and equity, the limited availability of disaggregated data at country level might hinder the ability of WCOs to report on equity and gender equality results going forward. Therefore, there are opportunities for WCOs to further support the availability of disaggregated data in the health sector through its work on HIS.

128. As for the CPEs themselves, these constitute an important learning tool to help WCOs improve their country programmes and to identify systemic issues requiring attention across WHO. However, the UNDS reform and the emergence of new players require WCOs to rethink their role and comparative advantage in relation to that of other partners. CPEs have the potential to help WCOs better define this role but currently only provide a partial analysis of coherence. In addition, CPEs only provide a limited gender analysis, which constitutes a missed opportunity to gender learning on the integration of GER in country programming.

7. Recommendations

129. This chapter presents a set of recommendations that are linked to the findings and conclusions of the synthesis. The recommendations are targeted at specific users and proposes specific actions to address systemic issues identified by the synthesis.

1. In keeping with the emphasis on the achievement of impact at country level embodied in the GPW13, WHO should ensure that its next generation of CCS/BCAs includes robust theories of change, which should serve as useful management tools to help guide the Organization toward this goal in each country context. Each CCS/BCA should be accompanied by a strategy for achieving targeted impacts and by a results monitoring framework that includes baselines and targets as a means of monitoring and demonstrating progress toward heightened impact. To help maximize the likelihood that results will be achieved at country level, the Organization's Country Focus Policy should be reviewed and strengthened as necessary. With respect to the time frames covered by the CCS/BCA, heightened emphasis should be placed on ensuring maximum alignment with the current GPW as well as with the corresponding national health plan, wherever this is possible.

Required actions:

I. In tandem with the 2020 CCS guidance, the next generation of CCS/BCAs should be accompanied by a robust theory of change, developed by country offices with the support of relevant regional offices and headquarters divisions and the input of relevant stakeholders, that clearly identify the pathways to achieving greater impact in-country. The theories of change should include the pathways by which targeted results will be pursued by specific interventions within each of the relevant WHO core functions (both individually and in mutually reinforcing ways). They should also include the assumptions underlying the path to results and the strategy for managing the work of the Organization toward results in light of these assumptions. In these ways, the theory of change should serve as a management tool to help guide the work of the Organization at all levels in achieving results in each country – e.g. by helping sharpen strategic focus within each country, ensure adequate resourcing of each country office in light of the scope and scale of the changes being sought, and other aspects of managing toward results.

II. Each CCS/BCA theory of change should be accompanied by a results framework that includes a finite number of targets and accompanying baselines as a means of monitoring and reporting on progress toward targeted results.

III. The CCS/BCA theory of change should also be accompanied by a strategy for achieving targeted results – e.g. the resource mobilization requirements; support required of regional offices and headquarters; any necessary functional reconfigurations with a clear definition of roles and responsibilities across major offices; partnerships to be pursued to maximize impact (including with non-traditional partners and including at the subnational level, as per Recommendation 2 below); and how the assumptions and risks identified will be managed.

IV. In this process, the ***WHO Gender Equity and Human Rights team*** should develop tools and guidance to support country offices to conduct gender analyses and integrate gender equality, human rights and equity into CCS/BCAs, and hold webinars with country offices to exchanges lessons learned regarding the application of tools. The WHO Gender Equity and Human Rights team should also develop a set of criteria that will be used to assess the integration of gender equality, human rights and equity into CCS/BCAs, and gender focal points/gender specialists in regional offices should

provide constructive feedback to WCOs to continuously improve the integration of gender equality, human rights and equity in CCS/BCAs.

V. Relevant regional offices and headquarters divisions should provide sufficient support to country offices in the development of their CCS/BCA and accompanying theory of change through templates, trainings, technical and strategic support and guidance on an ongoing basis, as required, to ensure that these CCS are based on WHO's comparative advantage and are as robust and useful as management tools as possible.

VI. To help maximize the likelihood that results will be achieved at country level, the Organization's Country Focus Policy should be reviewed and strengthened as necessary.

Recommendation linked to: *Findings 1, 7, 8 and 17.*

2. Pursuant to the impacts targeted for action in the CCS/BCAs, WHO should develop or strengthen its strategic partnerships beyond the health sector and with non-State actors in order to foster multisectoral approaches to achieving the SDGs.

Required actions:

I. ***WHO's External Relations and Governance Division*** should develop strategic partnerships with UN organizations and funds that have mandates beyond the health sector, including in the areas of the social determinants of health as well as environmental health. To do so, ***WHO headquarters*** should clearly define its niche beyond the health sector and identify potential areas of synergy with UN organizations that have mandates beyond the health sector as well as non-State actors – including civil society organizations and the private sector.

II. ***WHO regional offices*** should consider developing Memorandums of Understanding with international nongovernmental organizations that could translate into the development of strategic partnerships with civil society at country level. In addition, regional offices should also consider implementing joint regional/multi-country office programmes with UN organizations that have a mandate beyond the health sector.

III. When developing their CCS, ***WHO country offices*** should consider developing strategic partnerships beyond the health sector in support of all health-related SDGs, particularly in the context of the implementation Global Action Plan for Healthy Lives and Well-being for All. This would entail a careful analysis of what partners are doing, including UN partners in the context of the United Nations Sustainable Development Cooperation Framework, and identify leverage points for intersectoral action. The roles and responsibilities of WHO vis-à-vis that of partners should be well defined, with clear accountability for implementation. In this respect, it will be important for WHO to implement Recommendation 3[153] from the Joint Evaluability Assessment of the Global Action Plan for Healthy Lives and Well-being for All. ***WHO country offices*** should also develop partnerships with government entities beyond health in collaboration with the Ministry of Health. In addition, in line with Recommendation 6[154] of the evaluation of the Framework of Engagement with Non-State Actors, ***WHO Country Offices*** should develop country action plans to engage with non-State actors

[153] Recommendation 3 – Make the GAP more concrete and accountable by: a) accelerating progress on mapping out the agreed activities for GAP partners; b) restarting the process on indicator development; and c) strengthening accountability through consistent involvement of senior leaders across all 12 agencies and following through into workplans and time allocations of their staff.

[154] Recommendation 6 – Develop a corporate WHO engagement strategy with non-State actors, including specific strategies for nongovernmental organizations and for private sector entities.

in line with the upcoming Engagement Strategy. In doing so, they should consider conducting a mapping of civil society organizations and other non-State actors in-country, identifying areas of collaboration, and conduct activities to build the capacities of these actors – in particular civil society organizations. The development of strategic partnerships with local actors, including civil society organizations, could also be used by country offices to strengthen their field presence.

IV. ***WHO headquarters,*** *with support from the* ***Gender, Equity and Human Rights team,*** should develop a strategic partnership with UN-Women to support countries to develop information systems that collect disaggregated data on health indicators. This could be integrated as an integral part of the work that WHO does on health information systems.

Recommendation linked to: *Findings 2, 6, 8, 13, 14 and 17.*

3. WHO must ensure that country offices are sufficiently equipped with the predictable and sustainable resources – both financial and human – needed to address the priorities identified in the CCS, as well as the guidance and support, to achieve the ambitious goals of the GPW13 and SDGs.

Required actions:

I. In keeping with the recommendations emerging out of the 2021 evaluation of the WHO Transformation, WHO must ensure that country offices are equipped with the human and financial resources to achieve greater impact. Toward this end, country offices, regional offices and headquarters should work together to identify resource needs and, as necessary, ensure that country offices are allocated the human and financial resources at a level commensurate with the scope and scale of the changes they are targeting.

II. As part of this resource allocation process, and similarly in keeping with a recommendation emerging out of the 2021 evaluation of the WHO Transformation, WHO should explore various resourcing modalities for ensuring adequate resources beyond the creation of new posts – e.g. greater staff mobility, temporary staff reassignments to country offices, more flexible working arrangements, and so on.

Recommendation linked to*: Findings 15 and 16.*

4. WHO should take stock of progress in achieving greater impact at country level and feed this learning into the GPW14 development process as well as the next generation of CCS/BCAs.

Required actions:

I. In the short-term, the WHO Evaluation Office should continue to conduct CPEs to harvest lessons and good innovative practices that can inform the development of CCSs across the Organization. In particular, the CPEs should identify key factors contributing to the implementation of innovations (e.g. inclusive governance mechanisms, pooled funding, and others) as well as challenges.

II. Linked to the previous action, the ***WHO Evaluation Office*** should ensure that WHO evaluations generate learning on gender equality, equity and human rights. The ***WHO Evaluation Office*** should develop a guidance note on gender equality, human rights and equity in health-related evaluations to support the adoption of gender-responsive methodologies in WHO evaluations, drawing on the UNEG Guidance *Integrating Human Rights and Gender Equality in Evaluation.* In addition, the ***WHO Evaluation Office*** should appoint a gender focal point to support the integration of gender equality, human rights and equity in WHO evaluations.

III. In the short, medium and long term, ***WHO headquarters*** and ***regional offices*** should ensure that the next generation of CCS/BCAs are informed by state-of-the-knowledge learning. This entails producing and disseminating relevant knowledge (e.g. research, lessons learned) through briefs. ***Regional offices*** could also facilitate cross learning through webinars and other means. Corporate accountability mechanisms could be developed to monitor the percentage of new CCS/BCAs that are informed by relevant knowledge.

IV. In the medium term, ***the WHO Evaluation Office*** should conduct a follow-up synthesis on what has worked well and what has worked less well in the implementation of the new generation of CCS. Lessons emerging from this synthesis could contribute to shape GPW14.

Recommendation linked to*: Findings 1, 7, 13 and 15.*

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Annex 2: Evaluation matrix

Evaluation sub-questions	Indicator/measure
EQ1 - Were the strategic choices made by WHO in the CCS/BCA (and other relevant strategic instruments) the right ones to address the country's health needs and coherent with government and partners priorities? (relevance)	
1.1 Are the CCS/BCA and other relevant strategic instruments based on a comprehensive health diagnostic of the entire population and on the country's health needs?	Availability in the CCS/BCA of a comprehensive health diagnostic inclusive of gender-related issues and covering all population (minorities, migrants) living in the country and based on evidence-based data available such as data from the Global Health Observatory or other reliable and valid sources (e.g. Demographic and Health Survey)
1.2 Are the CCS/BCA and other relevant strategic instruments coherent with the country's National Health Plan and any other relevant strategies, as well as the MDG and SDGs targets relevant to the country?	Level of alignment of health priorities identified in the CCS/BCA, and other relevant strategic documents, with - Priorities of the National Health Plan - MDG targets in the country - SDG targets in the country
1.3 Is the CCS/BCA coherent with relevant UN Strategic Frameworks?	- Level of alignment of the CCS/BCA with relevant UN Strategic Frameworks
1.3.1 Are the key partners clear about WHO's role in the country?	- Level of clarity among partners about the role of WHO in the country
1.4 Is the CCS/BCA coherent with the WHO General Programme of Work and aligned with WHO's international commitments?	Level of coherence between the CCS/BCA and - GPW12 and/or GPW13 - MDG and/or SDG targets
1.4.1 Does the CCS/BCA support good governance, gender equality and the empowerment of women?	Availability of explicit reference in the CCS/BCA to - good governance, - gender equality and empowerment of women - equity concerns and human rights
1.5 Has WHO learned from experience and changed its approach in view of evolving contexts (needs, priorities, etc.) during the course of the CCS/BCA	- Changes or orientation in the implementation of the CCS/BCA and rationale for these changes - Consider changes with regard to the SDG agenda
1.6 Is the CCS/BCA strategically positioned when it comes to:	- Indication of best practice in terms of strategic positioning
1.6.1 Clear identification of WHO's comparative advantage and clear strategy to maximise it and make a difference?	- Explicit elements of WHO's comparative advantage identified in the CCS/BCA - Explicit strategy to value the comparative advantages identified
1.6.2 Capacity of WHO to position health priorities (based on needs analysis) in the national agenda and in those of the national partners in the health sector?	- Clear linkages between CCS/BCA priorities and most important health needs in the country as identified in the health diagnostic (see 1.1)

Evaluation sub-questions	Indicator/measure
	- Indication of role played by WHO in the development of the national health agenda - Indication of role played by WHO in development of main national partners in the health sector
1.6.3 Specificities of the partnership between WHO and the Government of the country?	- Indication of partnerships elements in the CCS/BCA - indication of evolution in the CCS/BCA - Reasons for change in partners - Reasons for evolution within continuing partners
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)?	
.1 To what extent were the country biennial workplans (operational during the evaluation period) based on the focus areas as defined in the CCS/BCA (and other relevant strategic instruments), or as amended during course of implementation?	- Availability of explicit linkages between the workplans and the focus areas described in the CCS/BCA - Weight (and trend) of activities in workplans not included in the CCS/BCA and rationale for their inclusion in the workplans
2.2 What were the main results achieved for each outcome, output and deliverable for the WCO as defined in the country biennial workplans?	- Level of achievement for each CCS/BCA priority and any other key activities within and outside the CCS/BCA - Identification of key results and best practices - Identification of added value of WHO contributions
2.3 What has been the added value of regional and headquarters contributions to the achievement of results in-country?	- Indication of HQ/RO contribution to CCS/BCA development and to the design of other strategic documents - Indication of HQ/RO contribution to specific activities in the country - Indication of participation of national partners in regional or global initiatives/capacity development opportunities directly linked to CCS/BCA priorities - Identification of added value from key results and best practices
2.4 What has been the contribution of WHO results to long-term changes in health status in-country?	- Indication of long term WHO engagement in selected areas or work - Perception of stakeholders on WHO's role to changes in these areas - Identified key results and best practices
2.5 Is there national ownership of the results and capacities developed?	- Indication of key areas of national capacities developed - Indication of changed practices among partners following WHO support and capacity development activities - Indication of continued activities by national partners following end of WHO support - Identified key results and best practices

Evaluation sub-questions	Indicator/measure
EQ3 – How did WHO achieve the results? (efficiency)	
3.1 For each CCS/BCA priority, what were the key core functions[155] most used to achieve the results?	- Reference to core functions supporting achievement of results in biennial reports and other WCO, RO and HQ documents - Linkages between activities in programme budgets and core functions - Perception of stakeholders about WHO functions most used - Identified best practices
3.2 How did the strategic partnerships contribute to the results achieved?	- Reference to the strategic partnerships identified in the CCS/BCA, and to others as identified by the WCO, including the UNCT - Indication of their contributions to the results - Perception of strategic partners about the contribution of the partnerships to the achievements
3.3 How did the funding levels and their timeliness affect the results achieved?	- Level of funding compared with budget planned for CCS/BCA and other activities - Timing of funding over the CCS/BCA period - Main funding mechanisms used - Perception of stakeholders on level of funding, timeliness and relationship with WCO performance
3.4 Was the staffing adequate in view of the objectives to be achieved?	- Level and number of staff available for CCS/BCA implementation and other activities - Perception of stakeholders on staffing situation and relationship with WCO performance
3.5 What were the monitoring mechanisms to inform CCS/BCA implementation and progress towards targets?	- Availability of monitoring mechanisms - Availability and usefulness of monitoring reports on progress towards targets - Identified best practices
3.6 To what extent have the CCS/BCA been used to inform WHO country work plans, budget allocations and staffing?	- Availability of explicit linkages between CCS/BCA and work plans, budget allocations and staffing - Weight of the CCS/BCA versus other activities undertaken by WCO

[155] **Core functions**: 1) Providing leadership and engaging in partnerships; 2) Shaping the research agenda, and simulating the generation transition & dissemination of knowledge; 3) Setting norms & standards and promoting implementation; 4) Articulating evidence-based policy options; 5) Providing technical support & building capacity; 6) Monitoring health situations & trends