Country Office Evaluation: Rwanda

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Annex 1: Terms of Reference (18 May 2018)

I. Introduction

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

2. The Rwanda COE is the first Country Office Evaluation undertaken in the WHO African Region by the WHO Evaluation Office. The evaluation will cover the period of the Country Cooperation Strategy (CCS) 2014-2018.

II. Country context

3. Small and landlocked, Rwanda is hilly and fertile with a densely packed population of about 11.9 million people (2016).[2] The second Economic Development and Poverty Reduction Mid-Term Strategy and Rwanda's long-term strategy (Vision 2020)[3] aim to transform the country from a low-income, agriculture-based economy to a knowledge-based, service-oriented economy with middle-income country status by 2020.[2]

4. In 2015, Rwanda was classified by the UNDP[4] in the low human development category with a Human Development Index (HDI) value of 0.498, occupying the 159th position out of 188 countries and territories. The HDI value had increased by 103.9%, from 0.244 to 0.498, between 1990 and 2015 associated to increases in life expectancy at birth (by 31.3 years), mean years of schooling (by 2 years) and expected years of schooling (by 5.1 years). Likewise, Rwanda Gross National Income (GNI) per capita had increased by about 90.9% between 1990 and 2015. Its HDI value is above the average of 0.497 for countries in the low human development group and below the average of 0.523 for countries in Sub-Saharan Africa. When the HDI is discounted for inequality, it falls to 0.339, representing a loss of 31.9% due to inequality. Other Sub-Saharan African countries of similar development category experience similar losses due to inequality. The overall female/male HDI ratio is 0.992, a figure relatively high for Sub-Saharan countries of comparable development level.[4]

5. Poverty declined from 56.7% in 2005/2006 to 44.9% in 2010/2011 with significant poverty reduction experienced particularly in rural areas. The reduction in poverty was supported by a combination of factors including improved agricultural outcomes, increased off-farm job creation; reduction in household sizes as well as public and private transfers.[5]

6. Rwanda has made outstanding socioeconomic progress in recent years with observed significant improvements in health and other key development indicators.[6] The real gross domestic product (GDP) growth averaged 8.2% annually during the last decade, which translated into a GDP per capita growth of 5.1% per year according to data from the Rwandan National Institute of

[1] Evaluation: update and proposed workplan for 2018–2019. EB 142/27
[2] http://www.worldbank.org/en/country/rwanda/overview
[3] http://www.minecofin.gov.rw/fileadmin/templates/documents/NDPR/Vision_2020_.pdf
[4] http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/RWA.pdf (downloaded 5 April 2018).
[5] http://apps.who.int/iris/bitstream/handle/10665/205893/CCS_Rwa_2014_18.pdf?sequence=1
[6] http://apps.who.int/iris/bitstream/handle/10665/136986/ccsbrief_rwa_en.pdf?sequence=1&isAllowed=y

Statistics.[7] Life expectancy at birth has shown a continued steady increase from 43.3 years for males and 53.8 for females in the year 2000 to 60.9 for males and 71.1 for females in 2015.[8]

7. Childhood mortality rates have declined over the past 10 years. Infant mortality has decreased from 86 deaths per 1,000 live births in 2005 to 32 in 2014-2015. During the same period, under-5 mortality has markedly declined from 152 to 50 deaths per 1,000 live births.[9] Maternal mortality also decreased significantly. The 2015 maternal mortality ratio (MMR) for Rwanda is 210 deaths per 100,000 live births, according to the 2014-2015 Rwanda Demographic and Health Survey[9]. In 2014, more than 9 in 10 births occurred in a health facility, primarily in public sector facilities. Women with no education and those living in the poorest households were the most likely to deliver at home. In contrast, only 28% of births in 2005 were delivered in a health facility.[9]

8. More than 9 in 10 (93%) children aged 12-23 months received all basic vaccinations. Children whose mothers have no education are the least likely to be vaccinated (86%), as are children living in the West province (90%) as opposed to those living in Kigali City (96%). The basic vaccination coverage increased from 75% in 2005 to 93% in 2014-2015.[9] Overall, 37% of children aged 6-59 months are anaemic (from 52% in 2005). Anaemia is most common in children living in the poorest households and with mothers lacking education. Nearly 38% of children under five are stunted, or too short for their age (indication of chronic undernutrition). Stunting is more common in West province (45%) as opposed to Kigali City (23%). In addition, 9% of children are underweight, or too thin for their age.[9]

9. Only 7% of women are thin (BMI < 18.5). Comparatively, 21% of women are overweight or obese (BMI ≥ 25.0). Women in urban households are more than twice as likely to be overweight or obese compared to rural women (37% vs. 17%). Overweight and obesity increases with household wealth and education. Since 2005, overweight and obesity has increased from 12% to 21%.[9]

10. The HIV prevalence in Rwanda has remained stable over the last five years at 3% of national prevalence among people aged 15-49 years. Malaria as a major cause of childhood mortality has dropped significantly from the first position in 2005 to the fourth position in 2012.[9]

11. Estimates of the burden of disease in 2012 classified maternal, neonatal and nutritional conditions as the primary cause of disability adjusted life years lost (DALYs), due to a combination of premature mortality and disability. Other infectious diseases were the second cause of DALYs, followed by HIV, TB and malaria.[10]

12. According to the Global Health Observatory, the total expenditure on health per capita in 2014 was US$ 125, representing 7.53% of the GDP.[11] Private expenditure on health represented 61.9% as a percentage of total health expenditure in 2014.[6] Official Development Assistance (ODA) for health to Rwanda had increased significantly during the last decade, although the aid dependency (ODA/GNI ratio) was reduced to 11% in 2015 versus 18.5% in 2000.[12] The total disbursements of development partners in the fiscal year 2015/2016 were US$ 984.9 million which amounted to 66.6% of the total development finance. Health, Education and Social Protection together attracted as much as 44% of the total donor funds in 2015-2016.[12] The health sector appears to be the largest consumer of development finance with disbursements of US$ 228.1 million.[12] ODA Health Disbursements from 2000 to 2010 increased by almost 2000%. In 2010, MDG6

[7] WHO Country Cooperation Strategy 2014-2018 Rwanda.
http://apps.who.int/iris/bitstream/handle/10665/205893/CCS_Rwa_2014_18.pdf?sequence=1
[8] http://apps.who.int/gho/data/?theme=main&vid=61370
[9] Rwanda Demographic and Health Survey 2014-2015. Key findings.
https://www.dhsprogram.com/pubs/pdf/SR229/SR229.pdf
[10] http://www.who.int/gho/countries/rwa.pdf?ua=1
[11] http://www.who.int/countries/rwa/en/
[12] http://www.devpartners.gov.rw/fileadmin/user_upload/ODA_report_201516__2_.pdf

(combat HIV/AIDS, malaria, and other diseases) accounted for 83% of all disbursements, while it was 25% in year 2000.[13]

13. In 2011, the Rwandan Ministry of Health developed the Third Rwandan Health Sector Strategic Plan (HSSP III) as a framework to provide strategic guidance to the health sector for six years, between July 2012 and June 2018. The HSSP III adopted the following priorities for: implementation:

a. Sustain the achievements in the fight for Maternal and Child Health and against infectious diseases—MDGs number 1 (nutrition), 4 (child mortality), 5 (maternal health) and 6 (disease control)—and invest in prevention and control of noncommunicable diseases.
b. Improve accessibility to health services (financial, geographical, community health)
c. Improve quality of health provision (quality assurance, training, medical equipment, supervision)
d. Reinforce institutional strengthening (especially toward district health services, DHUs)
e. Improve quantity and quality of human resources for health (planning, quantity, quality, management).[14]

14. The United Nations is very active as a collaborative partner of the Government of Rwanda and recently the Government of Rwanda, in partnership with the UN Rwanda Country Team has developed the UN Development Assistance Plan (UNDAP) 2013-2018 drawing on lessons from the past cooperation framework (UNDAF), to support the implementation and realization of the strategy for Economic Development and Poverty Reduction Strategy II (EDPRS II 2013-2018) priorities.[7]

15. The United Nations in Rwanda is committed to the vision of Delivering as One.

III. WHO activities in Rwanda

16. The WHO Country Cooperation Strategy 2014-2018 Rwanda outlines the medium-term framework for cooperation with the Government of Rwanda through five strategic priorities that will guide the work of WHO in the country. These are:

a. Support health system strengthening towards health service integration and universal health coverage;
b. Contribute to the reduction of morbidity and mortality from major diseases and thus contribute to the achievement of health-related Millennium Development Goals;
c. Contribute to the reduction of maternal, newborn and child morbidity and mortality;
d. Promote health through addressing social determinants of health, health and environment, nutrition and food safety;
e. Strengthen disaster risk management, epidemic and emergency preparedness and response; and implementation of the International Health Regulations.[15,16]

17. The CCS priorities correspond to the main priorities of the WHO 12th General Programme of Work.[17]

[13] WHO ODA for Health to Rwanda. http://www.who.int/gho/governance_aid_effectiveness/countries/rwa.pdf?ua=1
[14] Rwanda Ministry of Health. Third Health Sector Strategic Plan July 2012-June 2018. Government of Rwanda.
[15] WHO Country Cooperation Strategy 2014-2018 Rwanda http://apps.who.int/iris/bitstream/handle/10665/205893/CCS_Rwa_2014_18.pdf;jsessionid=AA913219BAE3F5A2DF874F36491D30CE?sequence=1
[16] Further details of the Strategic Priorities and Focus areas in Appendix 1.
[17] 12th General Programme of Work. http://apps.who.int/iris/bitstream/handle/10665/112792/GPW_2014-2019_eng.pdf?sequence=1

18. The WHO country office (WCO) in Rwanda describes its main work as delivering on the five strategic priorities by supporting the Ministry of Health and Rwanda Biomedical Centre to coordinate health partners, develop and implement evidence-based policies, strategies and guidelines, set and monitor public health standards, build institutional capacity for public health and monitor the health situation in the country. These are conducted within the framework of WHO reforms and the Transformation Agenda of the WHO Secretariat in the African Region which both aim to transform WHO in the African Region into a more responsive, fit-for-purpose and efficient leader in public health on the continent.[18]

19. Table 1 below identifies briefly the main areas of activities undertaken in the WCO and corresponding levels of investments.[19]

Table 1: WCO Rwanda expenditure in biennia 2014-15 and 2016-17 (pre-country mission data)

		2014-15 US$	2016-17 US$	Total US$	%
CCS priorities					
1	Health system strengthening	532,345	662,305	1,194,651	9.4%
2	Communicable and noncommunicable diseases	1,990,867	926,226	2,917,093	23.0%
3	Reduction of maternal, newborn and child morbidity and mortality	264,035	248,423	512,458	4.0%
4	Social determinants of health, health and environment, nutrition and food safety	1,288,497	1,183,889	2,472,387	19.5%
5	Disaster risk management, epidemic and emergency preparedness and response; International Health Regulations	66,893	120,801	187,694	1.5%
Other activity areas					
	Ageing and health	535	0	535	0.0%
	Poliomyelitis eradication	1,147,834	476,227	1,624,061	12.8%
	Outbreak and crisis response	271,391	394,636	666,028	5.3%
Other expenses					
	Corporate services / enabling functions	989,991	2,111,487	3,101,478	24.5%
	Total	**6,552,390**	**6,123,996**	**12,676,385**	**100.0%**

Source: GSM data, expenditure mapping by evaluation team

20. The WCO Biennial Report 2014 and 2015 concluded that in general the office achieved most of its set targets for the biennium, with a 94% implementation of the 2014/2015 biennial work-plan. This report considered that the office achievements had benefitted from a series of enablers, such as: (i) technical support from the Inter-Country Support Team for East and Southern Africa, the Regional Office for Africa and headquarters; (ii) the provision of pooled funds at the end of the biennium; (iii) the focus on the comparative advantage of the Organization; and (iv) a strong workforce and administration logistics. The report also highlights some challenges to the performance of the WCO, such as: (1) staff shortage, (2) heavy portfolio particularly in areas of health promotion and communication and in maternal and child health; (3) delays in disbursement from the Core Voluntary Contributions Account; and (4) skewed allocation of programme budget, with underfunding of some programmes and low fund absorption capacity of some Ministry of Health programmes. Financial and human resource constraints affected the delivery of the WCO.

[18] World Health Organization Country Office for Rwanda. Brochure. http://www.afro.who.int/sites/default/files/2017-12/WHO_17_Brochure_Website%20final%2011%2012.pdf

[19] Further details of expenditure data in Appendix 2.

The report also considered that the "delivering as One" approach of the UN constituted an important source of joint actions and funding for otherwise less prioritized areas.[20]

21. The WCO undertook a number of efficiency and cost savings measures, including: rationalization of the office space, retirement of old and obsolete equipment; better negotiation of service suppliers (internet, transportation) through the One UN common services platform.[20]

22. WHO plays a leading role in implementing the health response of the UNDAP in partnership with other UN agencies, and it coordinates health sector interventions within UNDAP on behalf of other UN agencies involved in the sector. Within UNDAP, the health sector priorities are reflected in the flagship programme document for 2013-2018 entitled "Strengthening health and population systems with improved governance, analysis and monitoring of results" and developed in partnership with the Ministry of Health. Most of the strategic priorities of the CCS are well aligned with priorities in UNDAP.

23. Development activities in the country are coordinated by the Development Partners Coordination Group (DPCG) which is the highest-level coordination body in the country. WHO co-chairs the Country Coordinating Mechanism for the Global Fund to fight AIDS, Tuberculosis and Malaria and is also active in the various DPCG mechanisms in the sector.[7]

IV. Objectives and scope of the COE

24. The main purpose of this COE is to identify achievements, challenges and gaps and document best practices and innovations of WHO in Rwanda. These include results of the WCO but also contributions from the regional and global levels to the country programme.

25. As with all evaluations, this COE meets accountability and learning objectives. It will be publicly available and reported on through the annual Evaluation Report. This evaluation will build on an analysis of existing documents and data of relevance to the purpose of the evaluation, complemented with the perspectives of key stakeholders, to:

a. Demonstrate achievements against the objectives formulated in the CCS (and other relevant strategic instruments) and corresponding expected results developed in the WCO biennial work-plans, while pointing out the challenges and opportunities for improvement.

b. Support the WCO and Partners when developing the next CCS (and other relevant strategic instruments) based on independent evidence of past successes, challenges and lessons learnt.

c. Provide the opportunity to learn from the evaluation results at the various levels of the Organization. All programmes can benefit from knowing about their successes and challenges at global, regional and country levels. These can then usefully inform the development of future country, regional and global support through a systematic approach to organizational learning.

26. The evaluation will cover the period 2014-2018 and all activities undertaken by WHO (WCO, Regional Office for Africa and headquarters) in Rwanda as framed in the CCS 2014-2018 and other strategic documents covering activities not part of the CCS which took place over that period of time. This evaluation will replace the CCS final evaluation due at the end of 2018 and will inform the new CCS starting in 2019.

[20] Rwanda Biennial Report 2014-2015

V. Stakeholders and users of the evaluation

27. Table 2 shows the role and interest of the main evaluation stakeholders and expected users of the evaluation.

Table 2: preliminary stakeholders' analysis

Internal stakeholders	Role and interest in the evaluation
WCO Rwanda	As lead for the development and implementation of the CCS, the WCO is the main stakeholder of the evaluation because it has an interest in enhancing accountability of WHO in-country as well learning from evaluation results for future programming
Regional Office for Africa	As a contributor to the development of the CCS the Regional Office has a direct stake in the evaluation in ensuring that WHO's contribution in-country is relevant, coherent, effective and efficient. The evaluation findings and best practices in Rwanda will be directly useful to inform other WCOs in the Region as well as regional approaches in health.
Headquarters management	The results of the evaluation should be of interest as headquarters management is in charge of coordination of the CCSs and strategic analysis of its content and implementation and is responsible to promote application of best practices in support of regional and country technical cooperation.
Executive Board	The Executive Board has a direct interest in being informed about the added value of WHO's contributions in countries and being kept abreast of best practices as well as challenges through the annual evaluation report.
External Stakeholders	
Government of Rwanda	As a beneficiary of WHO's action it has an interest in the partnership with WHO, both in current and future CCSs, and an interest to see WHO's contribution to health in-country independently assessed.
All individuals in Rwanda	WHO's action in Rwanda has to ensure that it benefits all population groups, prioritize the most vulnerable and does not leave anyone behind The evaluation will look at the way WHO pays attention to equity and ensures that all population groups are paid attention to in the various policies and programmes.
UN Country Team	WHO contributes to several outcomes of the UNDAP alongside other UN agencies. There is therefore an interest for the UN Country Team to be informed about WHO's achievements and be aware of the best practices in the health sector.
Donors and partners	Donors (multilateral and bilateral agencies) and philanthropic foundations have an interest in knowing whether their contributions have been spent effectively and efficiently and if WHO's work contributes to their own strategies and programmes.

VI. Evaluation questions

28. All COEs address the 3 main evaluation questions identified below. The sub-questions are then tailored according to countries specificities and detailed in an evaluation matrix to be developed during the inception phase by the evaluation team. Sub evaluation questions have been tailored taking into account the timing of this COE and the available evaluative information. Good practices and lessons learned will be identified across the findings. The evaluation questions will assess the achievement of the current CCS and will inform the next CCS starting 2019.

EQ1: Were the strategic choices made in the CCS (and other relevant strategic instruments) **addressing Rwanda's health needs and coherent with government and partners priorities? (relevance)**

This question assesses the strategic choices made by WHO at the CCS design stage and its flexibility to adapt to changes in context. The evaluation sub-questions focus on the following elements:

1.1 Are the CCS and other relevant strategic documents based on a comprehensive health diagnostic of the entire population and on Rwanda's health needs?
1.2 Are the CCS and other relevant strategic documents coherent with the Third Rwanda Health Sector Strategic Plan and any other relevant national health strategies, as well as the SDG targets relevant to Rwanda?
1.3 Is the CCS coherent with the UNDAP? Are the key partners clear about WHO's role in Rwanda?
1.4 Is the CCS coherent with the General Programme of Work and aligned with WHO's international commitments?
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 2014-2018?
1.6 Is the CCSs strategically positioned when it comes to:
    i. Clear identification of WHO's comparative advantage and clear strategy to maximise it and make a difference?
    ii. 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?
    iii. Specificities of the partnership between WHO and the Government of Rwanda in the specific context of "delivering as one"?

EQ2: What is the contribution/added value of WHO towards addressing the country's health needs and priorities? (effectiveness /elements of impact/progress towards sustainability)

To address this question the evaluation team will consider the biennial workplans produced during the evaluation period. Specific sub-questions are:

2.1 To what extent were the country biennial workplans (operational during the evaluation period) based on the focus areas as defined in the CCS (and other relevant strategic instruments) (or as amended during the course of implementation)?
2.2 What were the main results achieved for each outcome, output and deliverable for the WCO as defined in the country biennial workplans?
2.3 What has been the added value of regional and headquarters contributions to the achievement of results in-country?
2.4 What has been the contribution of WHO results to long-term changes in health status in-country?
2.5 Is there national ownership of the results and capacities developed?

EQ3: How did WHO achieve the results? (efficiency)

In this area, the evaluation sub-questions will mainly cover the contribution of the core functions, the partnerships and allocation of resources (financial and staffing) to deliver the expected results and for each will seek to identify best practices and innovations.

3.1 For each priority, what were the key core functions most used to achieve the results?
3.2 How did the strategic partnerships contribute to the results achieved?
3.3 How did the funding levels and their timeliness affect the results achieved?
3.4 Was the staffing adequate in view of the objectives to be achieved?
3.5 What were the monitoring mechanisms to inform CCS implementation and progress towards targets?
3.6 To what extent has the CCS been used to inform WHO country workplans, budget allocations and staffing?

VII. Methodology

29. Guided by the WHO Evaluation Practice Handbook, the evaluation will be based on a rigorous and transparent methodology to address the evaluation questions in a way that serves the dual objectives of accountability and learning.

30. During the inception phase the evaluation team will design the methodology which will entail the following:

- Adapt the **theory of change** developed for the evaluation of WHO's presence in countries. The theory of change to frame the COE Rwanda will: i) describe the relationship between the CCS strategic priorities, the focus areas and the activities and budgets as envisaged in the biennial workplans; ii) clarify the linkages with the General Programme of Work and programme budgets, and iii) identify the main assumptions underlying it.
- Develop and apply **an evaluation matrix**[21] geared towards addressing the key evaluation questions taking into account the data availability challenges, the budget and timing constraints.
- Adhere to WHO cross-cutting strategies on **gender, equity and human rights** and include to the extent possible disaggregated data and information.
- Follow the principles set forth in the WHO ***Evaluation Practice Handbook***, the United Nations Evaluation Group (UNEG) **norms and standards for evaluation,** and the **ethical guidelines**.

31. The methodology should demonstrate impartiality and lack of bias by relying on a cross-section of information sources (from various stakeholder groups) and using a mixed methodological approach to ensure triangulation of information through a variety of means.

32. The COE will rely mostly on the following **data collection methods**:

a. Documents review will include analysis of key strategic documents, such as the General Programme of Work, the Programme Budget, the WCO workplan and budget, the CCS (and other relevant strategic instruments), the UNDAP, relevant national policies, strategies and other relevant documentation.

[21] An **Evaluation Matrix** is an organizing tool to help plan for the conduct of an evaluation. It is prepared by the evaluation team during the inception phase of the evaluation, and is then used throughout the data collection, analysis and report writing phases. The Evaluation Matrix forms the main analytical framework for the evaluation. It reflects the key evaluation questions and sub-questions to be answered and helps the team consider the most appropriate and feasible method to collect data for answering each question. It guides analysis and ensures that all data collected is analysed, triangulated and used to answer the evaluation questions, and make conclusions and recommendations.

b. Stakeholder interviews. Interviews will be conducted with external and internal stakeholders at global, regional and country levels of the Organization. External stakeholders for this evaluation are: ministry of health officials and officials of other relevant governmental institutions; healthcare professional associations and other relevant professional bodies; relevant research institutes, agencies and academia; health care provider institutions; UN agencies, other relevant multilateral organizations; donor agencies; other relevant partners; NGOs and civil society.

c. Mission in-country. Following the document reviews and some stakeholders' interviews, the country visit will be the opportunity for the evaluation team to develop an in-depth understanding of the perspectives of the various stakeholders around the evaluation questions and collect additional secondary data, in particular from external stakeholders.

33. **Stakeholders consultation**. In addition to acting as key informants during the evaluation process, both internal and external stakeholders will be consulted at the drafting stages of the terms of reference, inception note and evaluation report and will have the opportunity to provide comments.

34. **Limitations**. No major primary quantitative data collection is envisaged to inform this evaluation. The evaluation team will mainly use data (after having assessed their reliability) collected by WHO and partners during the timeframe evaluated.

VIII. Phases and deliverables

35. The evaluation is structured around 5 phases summarized in table 3 below.

Table 3: summary tentative timeline – key evaluation milestones

Main phases	Timeline	Tasks and deliverables
1. Preparation	April 2018	Draft and final TOR Evaluation team contracted
2. Inception	April 2018	Desk review of existing literature, headquarters and Regional Office briefings Draft and final inception note
3. Data collection and analysis	May 2018	Key interviews with headquarters and Regional Office staff Country visit Aide memoire of key findings (PPT)
4. Reporting	June 2018	Draft and final evaluation report
5. Management response and dissemination	July 2018	Management response to the evaluation recommendations Dissemination of evaluation results

36. **Preparation**. These TOR are prepared following the WHO Evaluation Practice Handbook. The final version of the TOR will take into consideration results of consultations with key internal and external stakeholders.

⇨ **1st deliverable: Final TOR**

37. The **inception phase** will start with a first review of key documents and briefings with headquarters, Regional Office and WCO key stakeholders. During the inception phase the evaluation team will assess the various logical/results frameworks and their underlying Theory of Change. The inception note will close this phase. Its draft will be shared with key internal stakeholders (at the

three levels of the Organization) for their feedback. The inception note will be prepared following the Evaluation Office template and will focus on methodological and planning elements. Taking into account the various logical/results frameworks and the evaluation questions, it will present a detailed evaluation framework and the evaluation matrix. Data collection tools and approaches will be clearly identified in the evaluation matrix.

- ⇨ **2nd deliverable: Inception note**

38. **Data collection and analysis**. This phase will include additional document review, key stakeholders interviews at headquarters and regional levels and a country visit. The in-country mission will start with a briefing to the WCO and key partners and will end with a debriefing with the same group.

- ⇨ **3rd Deliverable: Aide memoire of key findings** to be prepared at the end of the country visit to be used to support the debriefing with the stakeholders**.**

39. **Reporting.** This phase is dedicated to the in-depth analysis of the results of the data and documents analysis and of the data collected through the field work. The results of this analysis will be presented in the evaluation report. The draft evaluation report will be shared with key internal and external stakeholders for comments.

- ⇨ **4th deliverable: Evaluation Report** will be prepared according to the WHO Evaluation Practice Handbook; it will provide an assessment of the results according to the evaluation questions identified above. It will include conclusions based on the evidence generated in the findings and draw actionable recommendations.

40. To be noted: Submission of revised versions of any of the deliverables by the evaluation team will be accompanied by feedback on each comment provided. This feedback will succinctly summarize if and how comments were addressed and if they were not it will justify why.

41. **Management response and dissemination of results**. The management response will be prepared by the WCO and posted on the internet once finalized, alongside the evaluation report. Dissemination of evaluation results and contribution to organizational learning will be ensured at all levels of the organization as appropriate.

IX. Evaluation team

42. The evaluation team will be led by the Director-General's Representative for Evaluation and Organizational Learning, and will include 2 colleagues from the WHO Evaluation Office and 2 senior consultants. Together they bring the relevant expertise in evaluation, health and WHO's governance mechanisms.

Appendix 1

Strategic agenda for Government of Rwanda and WHO cooperation (WHO CCS 2014-2018)[22]

d. **Strategic Priority 1**. Support health system strengthening towards health service integration and universal health coverage;

   i. ***Main focus area 1.1:*** Support the Ministry of Health to strengthen capacity for health system governance and stewardship
   ii. ***Main focus area 1.2:*** Support the Ministry of Health to improve service delivery
   iii. ***Main focus area 1.3:*** Strengthen country capacity to develop strategies and mechanisms to improve production and management of human resources for health
   iv. ***Main focus area 1.4:*** Strengthen country capacity to develop and implement a health financing system which ensures that quality essential health services are accessible to the whole population in an equitable, efficient, and sustainable manner
   v. ***Main focus area 1.5:*** Promote improved access to health products and health-care technologies based on primary health care
   vi. ***Main focus area 1.6:*** Promote health system information and evidence sharing, monitoring of trends, data generation and analysis of health priorities, eHealth, health research and knowledge management

e. **Strategic Priority 2.** Contribute to the reduction of morbidity and mortality from major diseases and thus contribute to the achievement of health-related Millennium Development Goals;

   vii. ***Main focus area 2.1***: Support the health sector to prevent and control HIV and AIDS, malaria, tuberculosis, neglected tropical diseases and other communicable diseases
   viii. ***Main focus area 2.2***: Support prevention and control of noncommunicable diseases

f. **Strategic Priority 3**. Contribute to the reduction of maternal, newborn and child morbidity and mortality;

   ix. ***Main focus area 3.1:*** Support Ministry of Health to improve access to sexual and reproductive health information and quality services with focus on the life cycle approach
   x. ***Main focus area 3.2***: Strengthen national capacity to improve maternal and child health interventions including access to skilled attendance at deliveries and to scale up high impact child survival interventions
   xi. ***Main focus area 3.3***: Strengthen immunization systems including preventable disease surveillance and cold chain management, and support the introduction of new vaccines
   xii. ***Main focus area 3.4:*** Strengthen surveillance, prevention and management of malnutrition in mothers, infants and young children

[22] Rwanda WHO Country Cooperation Strategy 2014-2018

g. ***Strategic Priority 4***. Promote health through addressing social determinants of health, health and environment, nutrition and food safety;

   xiii. Main focus area 4.1: Promote health and the social determinants of health
   xiv. ***Main focus area 4.2:*** Promote a safer and healthier environment, improved nutrition and food safety

h. **Strategic priority 5**. Strengthen disaster risk management, epidemic and emergency preparedness and response; and, implementation of the International Health Regulations

   xv. Main focus area 5.1: Support the Ministry of Health to strengthen the capacity for implementation of the Integrated Disease Surveillance and Response through IHRs and One Health strategy frameworks
   xvi. Main focus area 5.2: Support Ministry of Health and MIDIMAR to develop and implement preparedness and response measures for disaster risk management, prevention and control epidemics, and other emergencies

Appendix 2

COE Rwanda: Expenditure mapping

The WHO Country Cooperation Strategy 2014-2018 Rwanda identified five strategic priorities to guide the work of WHO in the country. These priorities corresponded with programme areas of the WHO 12th General Programme of Work. The table below shows a mapping of the CCS priorities with the WHO 12th GPW categories and programme areas.

1	Support health system strengthening towards health service integration and universal health coverage
2	Contribute to the reduction of morbidity and mortality from major communicable and non-communicable diseases towards consolidation of health-related MDG gains and achievements of post 2015 development goals
3	Contribute to the reduction of maternal, newborn and child morbidity and mortality
4	Promote health through addressing social determinants of health, health and environment, nutrition and food safety
5	Strengthen disaster risk management, epidemic and emergency preparedness and response; and implementation of the International Health Regulations

Alignment of CCS priorities and main focus areas with the WHO 12th GPW categories, 2014-2019	CCS strategic priorities				
	1	2	3	4	5
Category 1: Communicable diseases					
HIV / AIDS		●			
Tuberculosis		●			
Malaria		●			
Neglected tropical diseases		●			
Vaccine-preventable diseases		●			
Category 2: Noncommunicable diseases					
Non-communicable diseases		●			
Mental health and substance abuse		●			
Violence and injuries		●			
Disabilities and rehabilitation		●			
Nutrition			●		
Category 3: Promoting health through the life-course					
Reproductive, maternal, new-born, child and adolescent health			●		
Ageing and health					
Gender, equity and human rights mainstreaming					
Social determinants of health				●	
Health and the environment				●	
Category 4: Health systems					
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	●				
Category 5: Preparedness, surveillance and response					
Alert and response capacities					●
Epidemic- and pandemic-prone diseases					●
Emergency risk and crisis management					●
Food safety				●	
Poliomyelitis eradication					
Outbreak and crisis response					●
Category 6: Corporate services/enabling functions					
Leadership and governance					
Transparency, accountability and risk management					
Strategic planning, resource coordination and reporting					
Management and administration					
Strategic communications					

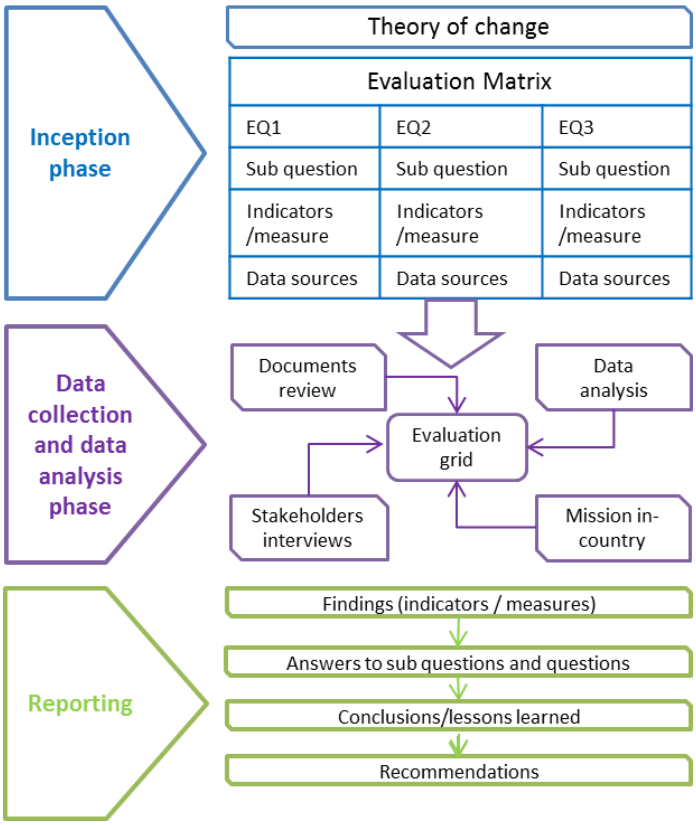
Source: WHO Country Cooperation Strategy 2014-2018 Rwanda (pages 38-47), mapping by evaluation team and validated by WHO country office Rwanda

Annex 2: Evaluation methodology and evaluation matrix

This Annex summarizes the approach adopted in this COE and the main methods and tools employed. It draws on the inception note.

Guided by the *WHO Evaluation Practice Handbook*, the overall methodological approach adopted by the evaluation team is summarized in Figure 1. This shows the sequencing and interrelationship of activities under each of the three main phases of the evaluation process. Concretely, the evaluation was conducted between April and July 2018 by a core team of five members.

Figure 1: Methodological approach



Inception phase

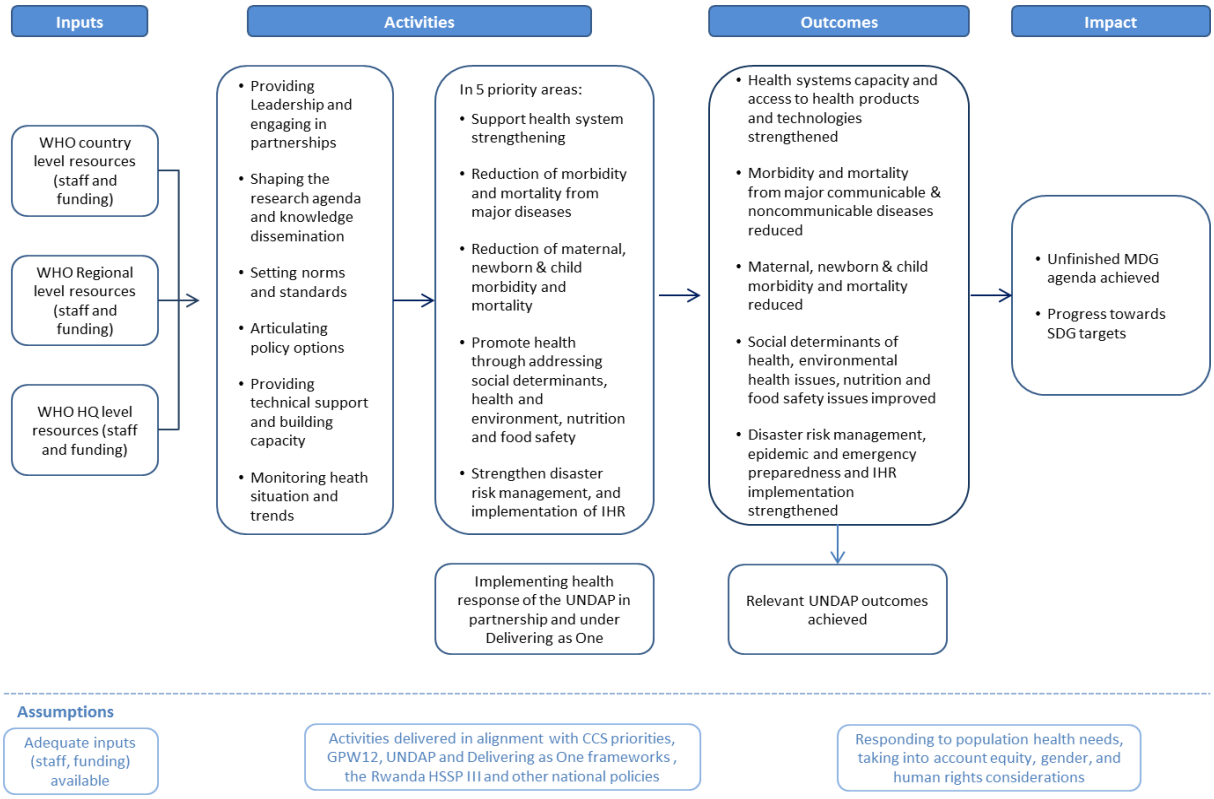
a. Theory of change underlying WHO's contribution in Rwanda

In the absence of an explicit logic model or theory of change (TOC) to frame the contributions of WHO in Rwanda over the evaluation period, the evaluation team reconstructed a TOC that clarifies WHO's contribution to the national health objectives and goals in terms of health outcomes and potentially the health impact of its collaborative programmes with the Government of Rwanda, as defined in the CCS and the biennial work plans.

The TOC aims to encompass contributions from all levels of the Organization and all strategic contribution areas of WHO in the country. The TOC is aligned with that validated by WHO in the context of the evaluation of WHO's presence in countries[23] and in the evaluation of the WHO Country Office in Thailand[24] and was validated by the WR and WCO team during the field mission.

[23] WHO (2015). Evaluation of WHO's Presence in Countries. Geneva: WHO Evaluation Office

Figure 2: Theory of Change (TOC) – WHO contribution in Rwanda 2014-2017 [25]



b. Evaluation matrix

Using the TOC, the evaluation team developed an evaluation matrix which defines specific indicators/measures for assessing each sub-question and indicates what data collection method and data sources will be used to inform each of these. The evaluation matrix is available at the end of this Annex.

c. Inception note

The inception note was prepared following the Evaluation Office template and focused on methodological and planning elements of the evaluation. It presented, taking into account the various logical/results frameworks and the evaluation questions, a detailed evaluation framework and the evaluation matrix. Data collection tools and approaches were clearly identified in the evaluation matrix. It was shared with the WCO prior to the mission for their comments.

Data collection phase

The evaluation team used a pragmatic mixed-methods approach in addressing the evaluation questions. The evaluation matrix details for each sub-question the main data collection methods. To this end, different instruments have been employed and evidence from different sources triangulated.

a. Documents review

The evaluation matrix identified key documents that were reviewed prior to the mission. Relevant information has been extracted to address the corresponding sub-questions. A preliminary review of documents available had shown limitations in terms of data availability as some of the sub-questions

(http://www.who.int/about/evaluation/prepublication-country-presence-evaluation.pdf?ua=1).

[24] WHO (2017). Country Office Evaluation, Thailand. Geneva: WHO Evaluation Office (http://www.who.int/about/evaluation/thailand_country_office_evaluation_report.pdf?ua=1).

[25] The main framing document of the theory of change is the CCS 2014-2018.

do not easily lend themselves to quantitative assessment. This reinforced the case for combining careful review of different data sources.

b. Stakeholder interviews

These have been the main form of primary data collection. The evaluation team conducted a large number of interviews (list available in Annex 5) with WHO colleagues as well as with national and international partners and institutions in-country. Care was taken to ensure that the interviewees felt comfortable to express their opinions. The evaluation used a combination of individual and group interviews across the different activities. In practice, individual interviews were usually the most useful in providing detailed information and opinions. Group interviews, on the other hand, provided helpful insights into retrospectively understanding the processes of decision-making (which have often not been systematically recorded) as well as the implementation processes (where participants identified what elements fed into decisions, and how the implementation process took place over time). By default, all interviews have been treated as confidential by the evaluation team.

c. Country mission

Planned after the document review, the country mission took place in May 2018 and provided the opportunity to complement the information gathered with stakeholder interviews. The mission started with a briefing with the WCO. An in-country feedback session was organized at the end of the mission with the WCO.

d. Data analysis

The evaluation team triangulated all information collected by compiling it in an evaluation grid structured by evaluation question (EQ), sub-question and indicator. Evaluation findings were then drawn only after a thorough cross-checking and triangulation of all information related to each EQ. This ensured that answers to EQs were based on solid and cross-checked evidence. The evaluation team identified a certain number of challenges to address some of the evaluation questions, which are described below in the section on limitations.

Reporting

On the basis of the cross-checked evaluation findings, the team formulated answers to the evaluation questions. These answers informed the drafting of the conclusions. These included, to the extent possible, lessons learned and best practices identified in the course of the evaluation to further strengthen the current CCS.

Finally, the evaluation team provided practical, operational recommendations for future adjustments and actions. Each recommendation is based on the answers to evaluation questions and overall conclusions, which in turn are linked to evaluation findings per evaluation question and ultimately to the data collected.

Gender, equity and human rights

The evaluation ensured that gender, equity and human rights issues were addressed to the extent possible and through several means. A number of sub-questions within the evaluation matrix are gender sensitive with appropriate related indicators. The document review paid specific attention to how these issues were addressed at planning, implementation, monitoring and evaluation stages of WHO contributions. Finally, these dimensions have been reflected in the interviews.

Limitations of the evaluation

The evaluation had to deal with a number of challenges:

- Though there are linkages between the CCS and other WHO corporate planning and reporting tools, these are not clear enough to identify outputs and outcomes specific to the CCS within the WCO workplans.

- In the absence of a clear theory of change or of a logical or results framework, the corporate outcomes and outputs defined in the programme budget are not systematically translated at country level with corresponding benchmarks and quantified targets.
- Considering that WHO's expected contribution to national programmes prioritized in the CCS is not systematically identified at the planning stage, it was challenging to establish the extent to which activities undertaken contribute to the achievement of objectives defined in national programmes, plans or strategies.
- No major primary quantitative data collection was undertaken to inform this evaluation. The evaluation team mainly used existing data collected by WHO and partners during the timeframe evaluated.

Considering the limitations identified above, the evaluation team could only assess progress for each of the main outcome groups identified in the TOC but was not able to measure them against planned targets as they were not identified in a measurable manner.

Evaluation matrix

Evaluation sub-questions	Indicator / measure	Main source of information							
EQ 1 - Were the strategic choices made in the CCS (and other relevant strategic instruments) **addressing Rwanda's health needs and coherent with government and partners priorities? (relevance)**		**Doc. review**	**Key informant interviews**						
			WCO staff	**RO / HQ staff**	**MOH**	**Nat. ins-titutions**	**Donors**	**NGOs / partners**	**UN agencies**
1.1 Are the CCS and other relevant strategic documents based on a comprehensive health diagnostic of the entire population and on Rwanda's health needs?	- Availability in the CCS of a comprehensive health diagnostic inclusive of gender related issues and covering all population (minorities, migrants) living in Rwanda and based on evidence-based data available such as data from the Global health observatory or other reliable and valid sources (such as the Demographic Health survey or others)								
1.2 Are the CCS and other relevant strategic documents coherent with the Third Rwanda Health Sector Strategic Plan or any other relevant national health strategies, as well as the SDGs targets relevant to Rwanda?	- Level of alignment of health priorities identified in the CCS, and other relevant strategic documents, with - Priorities of the Third Rwanda Health Sector Strategic Plan - MDG targets in Rwanda - SDG targets in Rwanda								
1.3 Is the CCS coherent with the UNDAP? And are the key partners clear about WHO's role in Rwanda?	- Level of alignment of the CCS with the UNDAP and the Delivery as One framework - Level of clarity among partners about the role of WHO in Rwanda								
1.4 Is the CCSs coherent with the General Programme of Work and aligned with WHO's international commitments?	- Level of coherence between the CCS and GPW, MDG, SDG								
1.4.1 And does the CCS support good governance, gender equality and the empowerment of women?	- Availability of explicit reference in the CCS to - good governance, - gender equality and empowerment of women								
1.5 Has WHO learned from experience and changed its approach in view of evolving contexts (needs, priorities, new international SDG agenda, polio transition etc.) during the course of the CCS 2014-2018?	- Changes or orientation in the implementation of the CCS 2014-2018 and rationale for these changes - Consider changes with regards to the SDG agenda								
1.6 Is the CCS strategically positioned when it comes to:	- Indications 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 - Explicit strategy to value the comparative advantages identified								

Evaluation sub-questions	Indicator / measure	Main source of information							
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 priorities and most important health needs in the country as identified in the health diagnostic (see 1.1) - 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 Rwanda in the specific context of "delivering as one"?	- Indication of partnerships elements in the CCS - indication of evolution in the CCS - Reasons for change in partners - Reasons for evolution within continuing partners								
EQ 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)		**Doc. review**	**Key informant interviews**						
			WCO staff	**RO / HQ staff**	**MOH**	**Nat. ins-titutions**	**Donors**	**NGOs / partners**	**UN agencies**
2.1 To what extent were the country biennial work plans (operational during the evaluation period) based on the focus areas as defined in the CCS (and other relevant strategic instruments) (or as amended during course of implementation)?	- Availability of explicit linkages between the work plans and the focus areas described in the CCS 2014-2018 - Weight (and trend) of activities in work plans not included in the CCS and rationale for their inclusion in the work plans								
2.2 What were the main results achieved for each outcome, output and deliverable for the WCO as defined in the country biennial work plans?	- Level of achievement for each CCS priority and other key activities within and outside the CCS - 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 and/or RO contributions to CCS development and to the design of other strategic documents - Indication of HQ and/or RO contributions to specific activities in Rwanda - Indication of participation of Rwanda partners to regional or global initiatives /capacity development opportunities directly linked to CCS 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 Rwanda?	- 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								

Evaluation sub-questions	Indicator / measure	Main source of information							
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								
EQ 3 - How did WHO achieve the results? (efficiency)		**Doc. review**	**Key informant interviews**						
			WCO staff	**RO / HQ staff**	**MOH**	**Nat. ins-titutions**	**Donors**	**NGOs / partners**	**UN agencies**
3.1 For each priority, what were the key core functions 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, 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 and other activities - Timing of funding over the CCS 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 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 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 has the CCS been used to inform WHO country work plans, budget allocations and staffing?	- Availability of explicit linkages between CCS and work plans, budget allocations and staffing - Weight of the CCS versus other activities undertaken by WCO								

Annex 3: WHO's main planning instruments and associated challenges

This Annex presents briefly the main planning instruments WHO has developed to frame its action at the various levels of the Organization and the main implications for the Rwanda country office evaluation.

Figure 1: Timeframes of key planning instruments at the different levels of the Organization

The WHO high-level strategic planning document is the **General Programme of Work (GPW)**. It sets out priorities and provides an overall direction for a given period. The current 12th GPW[26] encompasses six years (2014-2019),[27] and defines six categories as high-level domains for technical cooperation and normative work (e.g. communicable diseases, health systems). These categories are divided into individual programme areas (e.g. malaria, nutrition) and provide a programmatic and budget structure for the work of WHO. Through a results chain, the GPW furthermore explains how WHO's work will be organized over the specific timeframe and how the work of the Organization will contribute to the achievement of a set of intended outcomes and impacts.[28] Hence, the GPW is the high-level strategic vision for the work of the entire Organization.

At country level, the main strategic planning document to guide WHO's work is the **Country Cooperation Strategy (CCS)**.[29] It is a medium-term strategic vision for technical cooperation in and with a given Member State, responding to the country's specific needs and the national targets under the Sustainable Development Goals. The time frame of the CCS is flexible to be aligned with national and United Nations planning cycles and to accommodate changing circumstances (e.g. emergencies, humanitarian crises or post-conflict situations).

The priorities and expected results in the GPW find their operational expression for a particular biennium in WHO's **Programme budget (PB)**, which puts in concrete terms how intended outcomes and impacts shall be achieved. The PB is structured by category and programme area, each one with a set of outcomes, which are a joint responsibility of Member States and the Secretariat, and

[26] WHO (2014). Twelfth General Programme of Work 2014-2019. Not merely the absence of disease. Geneva: World Health Organization (http://apps.who.int/iris/bitstream/handle/10665/112792/GPW_2014-2019_eng.pdf?sequence=1).
[27] It will be superseded by the 13th GPW (2019-2023) in 2019.
[28] WHO (2014). Twelfth General Programme of Work 2014-2019. Not merely the absence of disease. Geneva: World Health Organization (http://apps.who.int/iris/bitstream/handle/10665/112792/GPW_2014-2019_eng.pdf?sequence=1).
[29] WHO (2016). WHO Country Cooperation Strategy. Guide 2016. Geneva: World Health Organization (http://www.who.int/country-cooperation/publications/ccs-formulation-guide-2016/en/).

outputs defining what the Secretariat will be accountable for delivering during the respective biennium.[30]

The PB then serves as the biennial instrument for the development of **workplans**. Each workplan consists of a set of products and services, with associated activities and related costs but these are not related to the CCS in any explicit way. In WHO's internal planning system, all products, services and associated activities are considered as tasks.[31] Each task is explicitly linked to one output in the programme budget at corporate level, which means the task should support its expected achievement. The workplans ultimately break down the desired results of WHO's strategic planning into sets of corresponding tasks. Workplans are developed and implemented by budget centres, which are generally organizational units (for example, the WHO country office is one such budget centre).

Some challenges

As discussed, planning at WHO is based on various instruments, which are connected through linkages at different organizational levels. WHO's planning framework seeks to ideally establish an explicit interaction between the strategic plans at country (CCS) and corporate level (GPW/PB). Concretely, CCS priorities and focus areas should provide the strategic basis for the country-level input into the PB bottom-up planning process and thus ideally into the identification of corporate priorities and budget allocations. On the other hand, the GPW/PB priorities in turn should inform new CCS agendas if they are outdated and about to be renewed.[32] However, the concrete processes of the mutual interaction between the CCS and the PB are not consistent. All workplans and their respective tasks must relate to outputs in the PB, regardless of the organizational level at which they are being developed and implemented. This implies that the PB is directly influencing activities at country level (insofar as they must at least be linked to it). However, the extent to which the worldwide heterogeneous CCS agendas inform the biennial PB planning process varies and the process is not always harmonized.

Figure 1 visualizes the various planning cycles and timeframes of WHO for the period of the Rwanda Country Office Evaluation. As can be seen from this Figure, the main planning instruments have different timeframes. This can cause programmatic divergences between the different levels insofar as perennial planning instruments, once drafted and adopted, cannot take into account upcoming strategic shifts being introduced on another level.

The Rwanda CCS was established in 2014 with the expectation to last until 2018. However, due to evolving circumstances, including progress in achieving the MDGs, the CCS was revised in 2016, leading to a CCS framework with slightly modified focus areas.

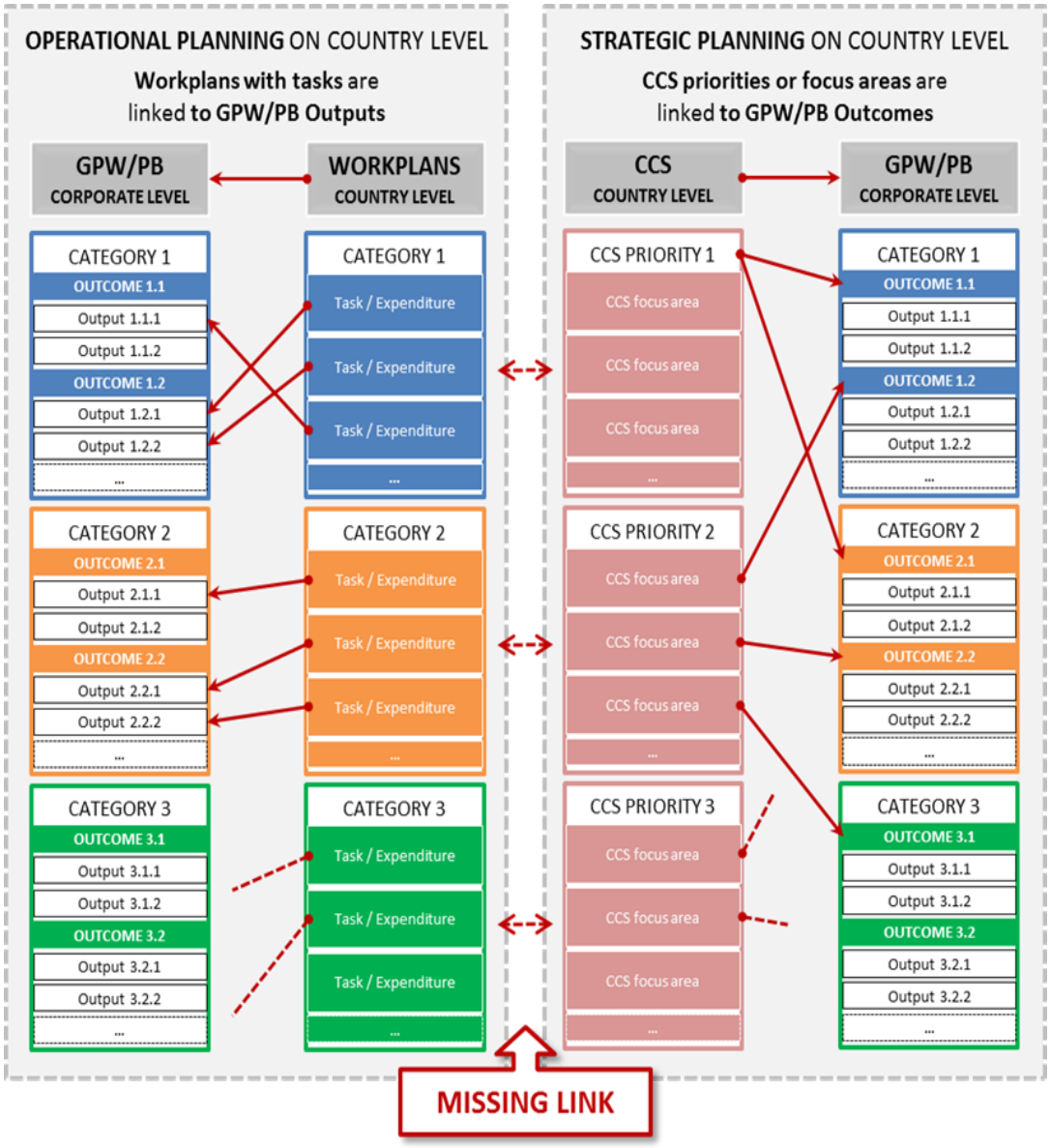
A common problem at country level, including for the Rwanda WCO, is the lack of a consistently clear link between workplans drafted at country level and the strategic priorities established in the CCS. WHO's organization-wide planning system is designed in such a way that all workplans and their respective tasks relate to outputs in the PB (see left side in Figure 2). The programmatic structure in this process are the categories that represent the high-level domains for WHO's work (e.g. communicable diseases). These categories may be, but are often not, congruent with CCS priorities. Instead, each CCS is supposed to explicitly specify how its various focus areas are connected to one or more outcomes in the GPW, thus providing another link between the country and corporate level (see right side in Figure 2). However, this does not allow drawing conclusions regarding the link between workplans and the agenda of a specific CCS.

[30] WHO (2014). Twelfth General Programme of Work 2014-2019. Not merely the absence of disease. Geneva: World Health Organization (http://apps.who.int/iris/bitstream/handle/10665/112792/GPW_2014-2019_eng.pdf?sequence=1).
[31] WHO (2015). Programme Management. Glossary of Terms. Unpublished internal document. Geneva: World Health Organization.
[32] WHO (2016). WHO Country Cooperation Strategy. Guide 2016. Geneva: World Health Organization (http://www.who.int/country-cooperation/publications/ccs-formulation-guide-2016/en/).

Hence, there is often no documented traceability how individual tasks in the workplans at country level are supposed to support CCS priorities or their focus areas. In such instances, there is no systematic way to assign financial figures to CCS priorities. Furthermore, most country level biennial workplans also include other critical country level activities beyond the focus areas identified in the CCS.

Finally, whilst annual and biennial reporting of results takes place through the mid-term review and the PB performance assessment reports to the governing bodies, there is, in general, no systematic monitoring and reporting against results at country level. Indeed, the tasks included in the workplans are not framed together against a specific objective or expected outcome in the CCS expressing the expected contribution of WHO in-country over a period of time in a specific area of engagement. Nor are there any indicators associated with these except for expenditures and self-reporting under the form of a narrative. However, the introduction of Key Performance Indicators as part of the Transformation Agenda of the WHO Regional Office for Africa, is an attempt to better monitor delivery at country level.

Figure 2: Relation between strategic and operational planning on country level



Annex 4: Evaluation observations per strategic priority of CCS 2014-2018

This Annex summarizes systematically specific observations for the five CCS strategic priorities. These observations are mapped against the relevant sub-evaluation questions defined in the evaluation matrix in Annex 2 (column 1).

STRATEGIC PRIORITY 1: Support health system strengthening towards health service integration and universal health coverage		
Main focus areas for WHO cooperation (as set out in updated CCS brief):	a) **National health policies, strategies and plans:** Strengthening the capacity to develop, implement and review a comprehensive national health policy, strategies and plans with adequate mainstreaming of the SDGs principles and targets, especially the Goal 3 and other SDGs with direct or indirect impact on health; Update and implementation of the Health Financing Strategic Plan in line with the Universal Health Coverage (UHC) principles, including CBHI management systems strengthening; HRTT & NHA reporting; and UHC monitoring. b) **Access to medicines and health technologies and strengthening regulatory capacity:** Establishment of an autonomous medical products regulatory authority; Development of strategies to improve access to medical products and technologies and to promote their rational use; Support to the monitoring of antimicrobials consumption; Identification of research priorities and promotion of research related to health products and technologies; Support to the adoption of WHO technical guidelines, norms and standards relating to quality assurance and safety of health products and technologies ; Capacity building for the implementation of accreditation process of heath related institutions and services. c) Support to the improvement of quantity and quality of **human resources for health**. d) **Health systems, information and evidence:** Strengthening of the national health information system capacity toward a good monitoring of health situation and trends taking into account national, regional and global priorities; Development of the country profile and statistical factsheet, Rollout of the National Health Observatory; Strengthening of the regulation of medical records; Capacity building to review and implement the e-Health strategic plan and the National Research Agenda. Support strengthening of Civil Registration and Vital Statistics (CRVS) system as a tool to track progress of the SDG targets.	
Included in previous CCS?	Yes, as **strategic priority IV. Enhancing health system performance,** with focus areas: - Health system policies and offer of services - Financing health and social protection - Production and management of human resources - Capacity building in the integrated management of the Health Information System (HIS) - Strengthening of the policy on access to medical technologies and products (WHO Country Cooperation Strategy Rwanda 2009-2013, p.31-32)	
Evaluation sub-questions	**Indicator / measure**	**Key observations** (document & interview synthesis)
1.1 Priority based on population health needs	- Availability in CCS of a health diagnostic from which the priority can be derived	- CCS contains an analysis of national health challenges (p.13-27), from which the priority is derived; broad data basis, with figures mainly from national Economic Development and Poverty Reduction Strategy (EDPRS), the National Institute of Statistics of Rwanda (NHIS) and the national Health Management Information System (HMIS) - Updated CCS brief incorporates strategic adjustments based on further developments in government priorities and SDGs
1.2 Priority's coherence with national health strategies and MDG/SDGs targets	Alignment of priority with: - Health Sector Strategic Plan - MDG/SDG targets	- CCS provides general mapping with overall priorities of third Health Sector Strategic Plan (p.47) - Coherence with HSSP III component 2: Health Support Systems - Coherence with MDG 8.E (access to affordable essential drugs) - Incorporates mainstreaming of SDGs principles and targets
1.3 Priority's coherence with the UNDAP	- Level of alignment with UNDAP and Delivery as One framework	- CCS provides mapping with UNDAP outcomes and outputs (p.48) - Coherence with UNDAP result area 1 (outcome 2) and result area 3 (outcome 3.2)
1.4 Priority's coherence with the General Programme of Work	- Level of coherence between the priority and the GPW	- CCS provides a (incomplete) validation with the 12th GPW (p.48) - Generally, priorities are in line with GPW programme areas - Coherence with programme areas 4.1 to 4.4
1.5 WHO adaptation capacity to evolving context during the course of the CCS 2014-2018	- Changes in implementation of the priority in the CCS 2014-2018 and rationale for these changes	- Strategic priorities were adjusted during the course of the CCS 2014-2018, mainly to reflect further developments in government priorities and SDGs - Activities on health policies, strategies and plans were adapted to incorporate mainstreaming of SDGs principles and targets

1.6.1 Identification of WHO's comparative advantage and strategy to maximise it	- Elements of WHO's comparative advantage identified for priority	- CCS underlines that consideration was given to WHO's comparative advantages and core functions when outlining the strategic priorities (p.10, 50); core functions most used for this priority are listed under sub-question 3.1
1.6.2 Capacity of WHO to position the priority (based on needs analysis) in the national agenda	- Linkages between priority and most important health needs - Indication of role played to enforce priority's consideration in national agenda	- WCO contributed to the development and objectives of the Health Sector Strategic Plans (HSSP III/HSSP IV); it also fostered the integration of SDGs in the process - Otherwise, the government was found to be very determined and assertive regarding the national agenda
1.6.3 Specificities of partnership between WHO and the Government of Rwanda in the context of "delivering as one"	- Indication of partnerships elements in the priority - Reasons for change in partners - Reasons for evolution within continuing partners	- In accordance with the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, the Government of Rwanda has structured the division of labour between development partners through Sector Working Groups, where government and development partners meet to discuss sector planning and prioritization according to strategic plans and programs - In addition to the MoH and WHO, the health sector working group also includes the Belgian Development Agency (Enabel), the Swiss Agency for Development and Cooperation (SDC) and the United States Agency for International Development (USAID) - WCO contributed to the harmonization of the country support for the UNDAP implementation through active participation in the One UN forums
2.1 Inclusion of priority's focus areas in country work plans	- Availability of explicit linkages between work plans and focus areas in the CCS 2014-2018	- Activities for this priority are listed under programme areas 4.1 to 4.4 in the budget centre workplans for biennia 2014-15, 2016-17 and 2018-19
2.2 Main results achieved	- Achievements for CCS priority - Key results and best practices	- Support to coordinate the health sector working group - Support to conduct mid-term review of HSSP III - Support to development of the National Health Sector Policy (HSSP IV) as well as for several other plans and policies - Support to health systems institutional strengthening (such as by the National Health Observatory; the National Drug Regulatory body, Social Security Board, the Civil Registration and Vital Statistics Systems) - Strengthening of Community-Based Health Insurance (CBHI) management systems - Support to introduce the medical certification of causes of deaths (MCCOD) in all public health facilities to strengthen the civil registration and vital statistics (CRVS) system - Guidance to integrate health indicators in the Economic Development and Poverty Reduction Strategy (EDPRS) monitoring system in line with UHC principles
2.3 Added value of regional and headquarters contributions	- Indication of HQ and/or RO contributions to specific activities in Rwanda	Support from the Regional Office for Africa: - To conduct the mid-term review of the HSSP III - To support the development of HSSP IV - To establish the National Health Observatory Activities implemented by the Regional Office for Africa: - Organization of First Africa Health Forum
2.4 Contribution of WHO results to long-term changes in health status in Rwanda	- Indication of long term WHO engagement in focus areas - Perception of stakeholders on WHO's role to change areas	- Improved coordination of the health sector - Reformed health financing systems and improved equity in financial risk protection - Improved availability of reliable health information
2.5 National ownership of results and capacities developed	- National capacities developed - Indication of changed practices or continued activities among partners following WHO support and activities	- Establishment of the Rwanda Food and Drug Authority - Establishment of National Health Observatory, supported by WCO and now exclusively managed by MoH - Integration of procedures in national health facilities (MCCOD) - Contributions to the development of national policies and plans
3.1 Key core functions most used to achieve results	- Stakeholder's perception and reference to core functions supporting achievements	WCO self-assessment of core functions most used: - Leadership and partnerships - Articulating ethical and evidence-based policy options - Technical support and institutional capacity building - Monitoring the health situation Perception of government stakeholders (across all priorities): - Policy advice & dialogue, technical assistance, capacity building - WHO respected among partners as technical and advisory body - Setting norms & standards, provide guidelines Perception of partners (across all priorities): - Leadership in health, convener, policy advice and support - Technical assistance and financial support - Capacity building, support research, advocacy

3.2 Contribution of strategic partnerships to results achieved	- Reference to the strategic partnerships and indication of their contributions to the results	- Partnerships with UN agencies and health development partners facilitated domestication of SDGs in national policy documents - Health sector involves many stakeholders and interest groups; need for WHO to be present and consider new ways of working, e.g. outside MOH and with non-traditional partners
3.3 Funding levels	- Level and timeliness of funding and perception of stakeholders	- Lack of predictability of funding and high dependency on voluntary contribution hinder implementation of WCO activities - Inequity in funding of the work plan: skewed allocation of programme funding results in better funded areas (such as immunization and nutrition) and poorly funded areas (such as non-communicable diseases and public health) - Unpredictability of levels and timeliness of funding hampers planning and cooperation with partners; differing alignment of budget cycles between WHO and MoH/government creates further difficulties
3.4 Adequacy of staffing	- Staff available for the implementation of activities and perception of stakeholders	- Overall, staffing is perceived as insufficient (both internally and in the perception of external stakeholders) and staff need to handle wide portfolios; partners occasionally praised in-depth technical expertise, while in some cases need for further training was expressed (regarding technical knowledge, programme management and reporting skills) - For this priority: Lack of staff capacity for data analysis and health information management; need for stronger M&E capacities and skills
3.5 Monitoring mechanisms to inform CCS implementation and progress towards targets	- Availability of monitoring mechanisms and reports on progress towards targets	- Mid and end-term review of WCO biennial plans; annual reporting of UNDAP activities; WCO involved in semi-annual monitoring of MoH workplans - CCS priorities aligned with Health Sector Strategic Plan. HSSP 4 integrates SDGs and policy briefs have been drafted for its implementation; National Health Observatory is in charge to monitor SDGs indicators (with technical assistance from WCO) - Good availability of data in-country as all hospitals are using DHIS 2 (District Health Information System 2). However, there is need to address data quality and access.

STRATEGIC PRIORITY 2: Contribute to the reduction of morbidity and mortality from major communicable and non-communicable diseases towards consolidation of health-related MDG gains and achievement of post 2015 development goals		
Main focus areas for WHO cooperation (as set out in updated CCS brief):	a) Development of new strategic plans and guidelines for both **HIV and hepatitis** for 2019-2024; capacity building for HIV and hepatitis responses, including monitoring. b) Development of a new **TB** strategic plan 2019-2024 and revision and update of TB guidelines and capacity building in TB response, including monitoring. c) Development of a **malaria** strategic plan 2019-2024; and update of strategic information for monitoring of malaria response along with capacity building for case management. d) Implementation of **NTD** strategic plan; reduction of the morbidity caused by endemic soil-transmitted helminthiasis and schistosomiasis through NTD mapping and deworming campaigns to meet WHO targets for NTD control and elimination by 2020. **Non-communicable diseases**: Development of an intersectoral and decentralized policy and strategy including prevention and management of NCDs; Capacity building of health care providers for prevention and management of NCDs; and development of a national protocol for NCDs.	
Included in previous CCS?	Yes, as **strategic priority II. Control of communicable and non-communicable diseases**, with focus areas: - Integrated Disease Management and Response (IDMR) - Combating HIV/AIDS, malaria and tuberculosis - Control of Neglected Tropical Diseases (NTDs): - Prevention, care and treatment of noncommunicable diseases - Management of health consequences of emergencies and disasters (WHO Country Cooperation Strategy Rwanda 2009-2013, p.27-29)	
Evaluation sub-questions	**Indicator / measure**	**Key observations** (document & interview synthesis)
1.1 Priority based on population health needs	- Availability in CCS of a health diagnostic from which the priority can be derived	- CCS contains an analysis of national health challenges (p.13 27), from which the priority is derived; broad data basis, with figures mainly from national Economic Development and Poverty Reduction Strategy (EDPRS), the National Institute of Statistics of Rwanda (NHIS) and the national Health Management Information System (HMIS) - Updated CCS brief incorporates strategic adjustments based on

		further developments in government priorities and SDGs
1.2 Priority's coherence with national health strategies and MDG/SDGs targets	Alignment of priority with: - Health Sector Strategic Plan - MDG/SDG targets	- CCS provides general mapping with overall priorities of third Health Sector Strategic Plan (p.47) - Coherence with HSSP III component 1: Programs (Disease Prevention and Control) - Coherence with MDG 6 (Combat HIV/AIDS, malaria and other diseases)
1.3 Priority's coherence with the UNDAP	- Level of alignment with UNDAP and Delivery as One framework	- CCS provides mapping with UNDAP outcomes and outputs (p.48) - Coherence with UNDAP result area 3 (outcome 3.2)
1.4 Priority's coherence with the General Programme of Work	- Level of coherence between the priority and the GPW	- CCS provides a (incomplete) validation with the 12th GPW (p.48) - Generally, priorities are in line with GPW programme areas - Coherence with programme areas 1.1 to 1.5 and 2.1 to 2.4
1.5 WHO adaptation capacity to evolving context during the course of the CCS 2014-2018	- Changes in implementation of the priority in the CCS 2014-2018 and rationale for these changes	- Strategic priorities were adjusted during the course of the CCS 2014-2018, mainly to reflect further developments in government priorities and SDGs - Main focus areas in this priority remained unchanged, while activities were adjusted to reflect recent developments (such as the elaboration of new strategic plans)
1.6.1 Identification of WHO's comparative advantage and strategy to maximise it	- Elements of WHO's comparative advantage identified for priority	- CCS underlines that consideration was given to WHO's comparative advantages and core functions when outlining the strategic priorities (p.10, 50); core functions most used for this priority are listed under sub-question 3.1
1.6.2 Capacity of WHO to position the priority (based on needs analysis) in the national agenda	- Linkages between priority and most important health needs - Indication of role played to enforce priority's consideration in national agenda	- WCO contributed to the development and objectives of the Health Sector Strategic Plans (HSSP III/HSSP IV); it also fostered the integration of SDGs in the process - Otherwise, the government was found to be very determined and assertive regarding the national agenda
1.6.3 Specificities of partnership between WHO and the Government of Rwanda in the context of "delivering as one"	- Indication of partnerships elements in the priority - Reasons for change in partners - Reasons for evolution within continuing partners	- In accordance with the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, the Government of Rwanda has structured the division of labour between development partners through Sector Working Groups, where government and development partners meet to discuss sector planning and prioritization according to strategic plans and programs - In addition to the MoH and WHO, the health sector working group also includes the Belgian Development Agency (Enabel), the Swiss Agency for Development and Cooperation (SDC) and the United States Agency for International Development (USAID) - WCO contributed to the harmonization of the country support for the UNDAP implementation through active participation in the One UN forums
2.1 Inclusion of priority's focus areas in country work plans	- Availability of explicit linkages between work plans and focus areas in the CCS 2014-2018	- Activities for this priority are listed under programme areas 1.1 to 1.5 and 2.1 to 2.4 in the budget centre workplans for biennia 2014-15, 2016-17 and 2018-19
2.2 Main results achieved	- Achievements for CCS priority - Key results and best practices	- Support to develop national strategies, operational plans and adaption of guidelines for major communicable diseases and non-communicable programme (HIV, TB, Malaria, Hepatitis, NTDs, NCDs) - Carrying out of risk assessments for communicable diseases and NTDs (for yellow fever, Trypanosomiasis, meningitis) - Capacity building on disease management and surveillance - Support to mass drug administration activities against soil transmitted diseases and schistosomiasis - Support to implementation of STEPS survey to determine the prevalence and risk factors of some NCDs
2.3 Added value of regional and headquarters contributions	- Indication of HQ and/or RO contributions to specific activities in Rwanda	Support from Headquarters and the Regional Office for Africa: - To conduct the mid-term reviews and revision of the national HIV, TB and malaria strategic plans Support from the Regional Office for Africa: - To conduct yellow fever and meningitis risk assessments - To establish yellow fever surveillance system
2.4 Contribution of WHO results to long-term changes in health status in Rwanda	- Indication of long term WHO engagement in focus areas - Perception of stakeholders on WHO's role to change areas	- Attainment of health-related MDG 6 (Combat HIV/AIDS, malaria and other diseases) by reducing HIV and TB prevalence rate
2.5 National ownership of results and capacities developed	- National capacities developed - Indication of changed practices or continued activities among partners following WHO support and activities	- PLHIV peer support for adherence is incorporated in national protocols after WHO supported research on pilot project - Capacity development for MoH staff (in disease management and surveillance) - Contributions to the development of national strategies,

		guidelines and plans
3.1 Key core functions most used to achieve results	- Stakeholder's perception and reference to core functions supporting achievements	WCO self-assessment of core functions most used: - Setting norms and standards - Technical support and institutional capacity building - Articulating ethical and evidence-based policy options Perception of government stakeholders (across all priorities): - Policy advice & dialogue, technical assistance, capacity building - WHO respected among partners as technical and advisory body - Setting norms & standards, provide guidelines Perception of partners (across all priorities): - Leadership in health, convener, policy advice and support - Technical assistance and financial support - Capacity building, support research, advocacy
3.2 Contribution of strategic partnerships to results achieved	- Reference to the strategic partnerships and indication of their contributions to the results	- Partnerships with local NGOs increased capacity to engage at the community level (for instance partnership with RRP+, the Rwanda Network of People living with HIS/AIDS) - Indications that the WCO struggled to engage with non-health partners on NCD issues
3.3 Funding levels	- Level and timeliness of funding and perception of stakeholders	- Lack of predictability of funding and high dependency on voluntary contribution hinder implementation of WCO activities - Inequity in funding of the work plan: skewed allocation of programme funding results in better funded areas (such as immunization and nutrition) and poorly funded areas (such as non-communicable diseases and public health) - Unpredictability of levels and timeliness of funding hampers planning and cooperation with partners; differing alignment of budget cycles between WHO and MoH/government creates further difficulties
3.4 Adequacy of staffing	- Staff available for the implementation of activities and perception of stakeholders	- Overall, staffing is perceived as insufficient (both internally and in the perception of external stakeholders) and staff need to handle wide portfolios; partners occasionally praised in-depth technical expertise, while in some cases need for further training was expressed (regarding technical knowledge, programme management and reporting skills) - For this priority: Lack of staff capacity for NCDs, in particular for mental health
3.5 Monitoring mechanisms to inform CCS implementation and progress towards targets	- Availability of monitoring mechanisms and reports on progress towards targets	- Mid and end-term review of WCO biennial plans; annual reporting of UNDAP activities; WCO involved in semi-annual monitoring of MoH workplans - CCS priorities aligned with Health Sector Strategic Plan. HSSP 4 integrates SDGs and policy briefs have been drafted for its implementation; National Health Observatory is in charge to monitor SDGs indicators (with technical assistance from WCO) - Good availability of data in-country as all hospitals are using DHIS 2 (District Health Information System 2). However, there is need to address data quality and access. - Lack of data in particular on NCDs, mortality and morbidity

STRATEGIC PRIORITY 3: Contribute to the reduction of maternal newborn and child morbidity and mortality	
Main focus areas for WHO cooperation (as set out in updated CCS brief):	a) **Maternal, child and adolescent Health**: Review and update of policy and strategies, norms and standards, tools and guidelines to improve the quality of maternal, newborn, child and sexual reproductive health (SRH) including adolescent-friendly SRH services ; Conduct of research, monitoring and evaluation for maternal, child health and SRH; Capacity building for health care providers for quality essential and emergency maternal and newborn care including ECD and PMTCT; Improvement of management of key child health interventions; and strengthening of maternal newborn and child deaths surveillance and response. b) **Vaccine preventable diseases**: Contribution to the reduction of the under-five mortality rate through the use of community health workers to enhance immunization services; Strengthening of immunization systems including preventable disease surveillance and cold chain management; and support to the introduction of new vaccines**.** c) **Nutrition**: Revision of the national protocol on prevention and management of malnutrition; improvement of nutrition surveillance data analysis and results dissemination; Capacity building for prevention and management of malnutrition in children under five and conduct of operational research to strengthen nutrition interventions.
Included in previous CCS?	Yes, as **strategic priority I. Reduction of maternal and child mortality**, with focus areas: - Implementation of the road map for accelerating the reduction of maternal and neonatal mortality

	- Implementation of the reproductive health policy - Implementation of child survival interventions (WHO Country Cooperation Strategy Rwanda 2009-2013, p.26-27)	
Evaluation sub-questions	**Indicator / measure**	**Key observations** (document & interview synthesis)
1.1 Priority based on population health needs	- Availability in CCS of a health diagnostic from which the priority can be derived	- CCS contains an analysis of national health challenges (p.13-27), from which the priority is derived; broad data basis, with figures mainly from national Economic Development and Poverty Reduction Strategy (EDPRS), the National Institute of Statistics of Rwanda (NHIS) and the national Health Management Information System (HMIS) - Updated CCS brief incorporates strategic adjustments based on further developments in government priorities and SDGs
1.2 Priority's coherence with national health strategies and MDG/SDGs targets	Alignment of priority with: - Health Sector Strategic Plan - MDG/SDG targets	- CCS provides general mapping with overall priorities of third Health Sector Strategic Plan (p.47) - Coherence with HSSP III component 1: Programs (Maternal and Child Health) - Coherence with MDG 4 (Reduce child mortality) and MDG 5 (Improve maternal health)
1.3 Priority's coherence with the UNDAP	- Level of alignment with UNDAP and Delivery as One framework	- CCS provides mapping with UNDAP outcomes and outputs (p.48) - Coherence with UNDAP result area 3 (outcome 3.1)
1.4 Priority's coherence with the General Programme of Work	- Level of coherence between the priority and the GPW	- CCS provides a (incomplete) validation with the 12th GPW (p.48) - Generally, priorities are in line with GPW programme areas - Coherence with programme areas 2.5 and 3.1
1.5 WHO adaptation capacity to evolving context during the course of the CCS 2014-2018	- Changes in implementation of the priority in the CCS 2014-2018 and rationale for these changes	- Strategic priorities were adjusted during the course of the CCS 2014-2018, mainly to reflect further developments in government priorities and SDGs - When MDGs on maternal and child mortality were met, the focus shifted to neonatal mortality and early childhood development as a mid-term correction to remain relevant - Activities on nutrition under this priority have been highlighted in the updated CCS brief to reflect its increasing importance as a government priority (in particular the reduction of stunting)
1.6.1 Identification of WHO's comparative advantage and strategy to maximise it	- Elements of WHO's comparative advantage identified for priority	- CCS underlines that consideration was given to WHO's comparative advantages and core functions when outlining the strategic priorities (p.10, 50); core functions most used for this priority are listed under sub-question 3.1
1.6.2 Capacity of WHO to position the priority (based on needs analysis) in the national agenda	- Linkages between priority and most important health needs - Indication of role played to enforce priority's consideration in national agenda	- WCO contributed to the development and objectives of the Health Sector Strategic Plans (HSSP III/HSSP IV); it also fostered the integration of SDGs in the process - Otherwise, the government was found to be very determined and assertive regarding the national agenda
1.6.3 Specificities of partnership between WHO and the Government of Rwanda in the context of "delivering as one"	- Indication of partnerships elements in the priority - Reasons for change in partners - Reasons for evolution within continuing partners	- In accordance with the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, the Government of Rwanda has structured the division of labour between development partners through Sector Working Groups, where government and development partners meet to discuss sector planning and prioritization according to strategic plans and programs - In addition to the MoH and WHO, the health sector working group also includes the Belgian Development Agency (Enabel), the Swiss Agency for Development and Cooperation (SDC) and the United States Agency for International Development (USAID) - WCO contributed to the harmonization of the country support for the UNDAP implementation through active participation in the One UN forums
2.1 Inclusion of priority's focus areas in country work plans	- Availability of explicit linkages between work plans and focus areas in the CCS 2014-2018	- Activities for this priority are listed under programme areas 2.5 and 3.1 in the budget centre workplans for biennia 2014-15, 2016-17 and 2018-19
2.2 Main results achieved	- Achievements for CCS priority - Key results and best practices	- Support to development of national strategies, operational plans and adaption of guidelines for the programme area of maternal, new born and child morbidity and mortality - Support to capacity building, development and dissemination of training materials; integration of programme materials in IMCI computerized training tool; train the trainers programmes - Adaptation of medical eligibility criteria (MEC) wheel for family planning and its dissemination - Support to introduction of new vaccines, vaccine surveillance and programme evaluations

2.3 Added value of regional and headquarters contributions	- Indication of HQ and/or RO contributions to specific activities in Rwanda	Support from the Regional Office for Africa: - To adapt the medical eligibility criteria (MEC) wheel to the local context, conduct cascade training for health workers and to produce and distribute the wheel to health centres and hospitals - To conduct integrated management of childhood illnesses (IMCI) survey to improve quality of care Support from Headquarters and the Regional Office for Africa: - To introduce new vaccines such as measles/rubella, inactivated polio vaccine, rotavirus vaccine and human papilloma vaccine into the routine immunization system of the country
2.4 Contribution of WHO results to long-term changes in health status	- Indication of long term WHO engagement in focus areas - Perception of stakeholders on WHO's role to change areas	- Attainment of health-related MDG 4 (Reduce child mortality) and MDG 5 (Improve maternal health) - Routine immunization coverage of over 95% - Interruption of wild polio virus circulation since 1993 and elimination of neonatal tetanus in 2004
2.5 National ownership of results and capacities developed	- National capacities developed - Indication of changed practices or continued activities among partners following WHO support and activities	- Capacity development for health workers (IMCI) and health care providers (implementation of Reaching Every Child strategy) - Use of medical eligibility criteria (MEC) wheel for family planning - Contributions to the development of national strategies, guidelines and plans
3.1 Key core functions most used to achieve results	- Stakeholder's perception and reference to core functions supporting achievements	WCO self-assessment of core functions most used: - Setting norms and standards - Technical support and institutional capacity building - Articulating ethical and evidence-based policy options Perception of government stakeholders (across all priorities): - Policy advice & dialogue, technical assistance, capacity building - WHO respected among partners as technical and advisory body - Setting norms & standards, provide guidelines Perception of partners (across all priorities): - Leadership in health, convener, policy advice and support - Technical assistance and financial support - Capacity building, support research, advocacy
3.2 Contribution of strategic partnerships to results achieved	- Reference to the strategic partnerships and indication of their contributions to the results	- ONE UN as a platform facilitates dealing with cross-sectoral issues, nutrition has become a key priority under a joint strategy - Government and partners commend the division of labour between WHO, UNICEF (technical assistance, policy advice) and UNFPA (service delivery & supply chain) in the MCCH area
3.3 Funding levels	- Level and timeliness of funding and perception of stakeholders	- Lack of predictability of funding and high dependency on voluntary contribution hinder implementation of WCO activities - Inequity in funding of the work plan: skewed allocation of programme funding results in better funded areas (such as immunization and nutrition) and poorly funded areas (such as non-communicable diseases and public health) - Unpredictability of levels and timeliness of funding hampers planning and cooperation with partners; differing alignment of budget cycles between WHO and MoH/government creates further difficulties
3.4 Adequacy of staffing	- Staff available for the implementation of activities and perception of stakeholders	- Overall, staffing is perceived as insufficient (both internally and in the perception of external stakeholders) and staff need to handle wide portfolios; partners occasionally praised in-depth technical expertise, while in some cases need for further training was expressed (regarding technical knowledge, programme management and reporting skills) - For this priority: Lack of staff capacity for MCCH
3.5 Monitoring mechanisms to inform CCS implementation and progress towards targets	- Availability of monitoring mechanisms and reports on progress towards targets	- Mid and end-term review of WCO biennial plans; annual reporting of UNDAP activities; WCO involved in semi-annual monitoring of MoH workplans - CCS priorities aligned with Health Sector Strategic Plan. HSSP 4 integrates SDGs and policy briefs have been drafted for its implementation; National Health Observatory is in charge to monitor SDGs indicators (with technical assistance from WCO) - Good availability of data in-country as all hospitals are using DHIS 2 (District Health Information System 2). However, there is need to address data quality and access.

STRATEGIC PRIORITY 4: Promote health by addressing social determinants of health, health and the environment, nutrition and food safety		
Main focus areas for WHO cooperation (as set out in updated CCS brief):	a) **Health promotion and the social determinants of health** through support to the implementation, monitoring and evaluation of health promotion activities at decentralized level; and promotion of healthy lifestyles addressing NCD risk factors, targeting school ages and other vulnerable groups. b) **Promotion of a safer and healthier environment and improved food safety** through improved water, sanitation and hygiene services; multisectoral interventions and collaboration addressing the environmental determinants to human health and ecosystem integrity; and strengthening of national and decentralized systems for food safety inspection and risk analysis.	
Included in previous CCS?	Yes, as **strategic priority III. Health promotion, food safety and nutrition, health and the environment**, with focus areas: - Promotion of healthy lifestyles - Promotion of the management of the health of communities - Promotion of an enabling physical health environment - Food safety and nutrition (WHO Country Cooperation Strategy Rwanda 2009-2013, p.30-31)	
Evaluation sub-questions	**Indicator / measure**	**Key observations** (document & interview synthesis)
1.1 Priority based on population health needs	- Availability in CCS of a health diagnostic from which the priority can be derived	- CCS contains an analysis of national health challenges (p.13-27), from which the priority is derived; broad data basis, with figures mainly from national Economic Development and Poverty Reduction Strategy (EDPRS), the National Institute of Statistics of Rwanda (NHIS) and the national Health Management Information System (HMIS) - Updated CCS brief incorporates strategic adjustments based on further developments in government priorities and SDGs
1.2 Priority's coherence with national health strategies and MDG/SDGs targets	Alignment of priority with: - Health Sector Strategic Plan - MDG/SDG targets	- CCS provides general mapping with overall priorities of third Health Sector Strategic Plan (p.47) - Coherence with HSSP III component 1: Programs (Health Promotion and Environmental Health) - Coherence with MDG 7 (Ensure environmental sustainability)
1.3 Priority's coherence with the UNDAP	- Level of alignment with UNDAP and Delivery as One framework	- CCS provides mapping with UNDAP outcomes and outputs (p.48) - Coherence with UNDAP result area 1 (outcome 3) and result area 3 (outcomes 3.1 and 3.3)
1.4 Priority's coherence with the General Programme of Work	- Level of coherence between the priority and the GPW	- CCS provides a (incomplete) validation with the 12th GPW (p.48) - Generally, priorities are in line with GPW programme areas - Coherence with programme areas 3.4, 3.5 and 4.4
1.5 WHO adaptation capacity to evolving context during the course of the CCS 2014-2018	- Changes in implementation of the priority in the CCS 2014-2018 and rationale for these changes	- Strategic priorities were adjusted during the course of the CCS 2014-2018, mainly to reflect further developments in government priorities and SDGs - In the CCS, nutrition was originally listed as part of this priority, but has been shifted to priority 3 in the updated CCS brief to align with government's priority to address malnutrition in children (in particular to reduce stunting)
1.6.1 Identification of WHO's comparative advantage and strategy to maximise it	- Elements of WHO's comparative advantage identified for priority	- CCS underlines that consideration was given to WHO's comparative advantages and core functions when outlining the strategic priorities (p.10, 50); core functions most used for this priority are listed under sub-question 3.1
1.6.2 Capacity of WHO to position the priority (based on needs analysis) in the national agenda	- Linkages between priority and most important health needs - Indication of role played to enforce priority's consideration in national agenda	- WCO contributed to the development and objectives of the Health Sector Strategic Plans (HSSP III/HSSP IV); it also fostered the integration of SDGs in the process - Otherwise, the government was found to be very determined and assertive regarding the national agenda
1.6.3 Specificities of partnership between WHO and the Government of Rwanda in the context of "delivering as one"	- Indication of partnerships elements in the priority - Reasons for change in partners - Reasons for evolution within continuing partners	- In accordance with the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, the Government of Rwanda has structured the division of labour between development partners through Sector Working Groups, where government and development partners meet to discuss sector planning and prioritization according to strategic plans and programs - In addition to the MoH and WHO, the health sector working group also includes the Belgian Development Agency (Enabel), the Swiss Agency for Development and Cooperation (SDC) and the United States Agency for International Development (USAID) - WCO contributed to the harmonization of the country support for the UNDAP implementation through active participation in

		the One UN forums
2.1 Inclusion of priority's focus areas in country work plans	- Availability of explicit linkages between work plans and focus areas in the CCS 2014-2018	- Activities for this priority are listed under programme areas 3.4, 3.5 and 4.4 in the budget centre workplans for biennia 2014-15, 2016-17 and 2018-19
2.2 Main results achieved	- Achievements for CCS priority - Key results and best practices	- Support to development of national strategies, operational plans and adaption of guidelines (in nutrition, food safety, health promotion, health care waste management, water and sanitation, school health) - Supported development of national food standards - Capacity building to health providers and school teachers (nutrition) and development of training manuals - Capacity building of public, private and civil society organizations on tobacco control law enforcement and other NCDs risk factors - Support to research (social determinants and intersectoral actions, and malnutrition)
2.3 Added value of regional and headquarters contributions	- Indication of HQ and/or RO contributions to specific activities in Rwanda	Support from the Regional Office for Africa: - For capacity building measures on tobacco control law enforcement and other NCDs risk factors
2.4 Contribution of WHO results to long-term changes in health status in Rwanda	- Indication of long term WHO engagement in focus areas - Perception of stakeholders on WHO's role to change areas	[no major indications]
2.5 National ownership of results and capacities developed	- National capacities developed - Indication of changed practices or continued activities among partners following WHO support and activities	- Capacity development for health providers and school teachers (nutrition) and for public, private and civil society organizations (tobacco control law enforcement and other NCDs risk factors) - Contributions to the development of national strategies, guidelines and plans
3.1 Key core functions most used to achieve results	- Stakeholder's perception and reference to core functions supporting achievements	WCO self-assessment of core functions most used: - Shaping the research agenda - Technical support and institutional capacity building Perception of government stakeholders (across all priorities): - Policy advice & dialogue, technical assistance, capacity building - WHO respected among partners as technical and advisory body - Setting norms & standards, provide guidelines Perception of partners (across all priorities): - Leadership in health, convener, policy advice and support - Technical assistance and financial support - Capacity building, support research, advocacy
3.2 Contribution of strategic partnerships to results achieved	- Reference to the strategic partnerships and indication of their contributions to the results	[no major indications]
3.3 Funding levels	- Level and timeliness of funding and perception of stakeholders	- Lack of predictability of funding and high dependency on voluntary contribution hinder implementation of WCO activities - Inequity in funding of the work plan: skewed allocation of programme funding results in better funded areas (such as immunization and nutrition) and poorly funded areas (such as non-communicable diseases and public health) - Unpredictability of levels and timeliness of funding hampers planning and cooperation with partners; differing alignment of budget cycles between WHO and MoH/government creates further difficulties
3.4 Adequacy of staffing	- Staff available for the implementation of activities and perception of stakeholders	- Overall, staffing is perceived as insufficient (both internally and in the perception of external stakeholders) and staff need to handle wide portfolios; partners occasionally praised in-depth technical expertise, while in some cases need for further training was expressed (regarding technical knowledge, programme management and reporting skills) - For this priority: Lack of staff capacity for nutrition (planning foresees an international staff to join soon)
3.5 Monitoring mechanisms to inform CCS implementation and progress towards targets	- Availability of monitoring mechanisms and reports on progress towards targets	- Mid and end-term review of WCO biennial plans; annual reporting of UNDAP activities; WCO involved in semi-annual monitoring of MoH workplans - CCS priorities aligned with Health Sector Strategic Plan. HSSP 4 integrates SDGs and policy briefs have been drafted for its implementation; National Health Observatory is in charge to monitor SDGs indicators (with technical assistance from WCO) - Good availability of data in-country as all hospitals are using DHIS 2 (District Health Information System 2). However, there is need to address data quality and access.

STRATEGIC PRIORITY 5: Strengthen disaster risk management and epidemic emergency preparedness and response; and implementation of the International Health Regulations		
Main focus areas for WHO cooperation (as set out in updated CCS brief):	a) **Preparedness surveillance and response to outbreaks and crisis:** Development of capacity for disaster risk management (DRM) in health sector; Ensuring the availability of relevant policies, strategies and capacities for DRM in the health sector; Strengthening of the use of evidence for early warning, preparedness and response to emergencies and disasters. b) **Epidemic infectious diseases:** Strengthening capacity to prevent and control epidemic diseases and other public health emergencies through the implementation of an effective and efficient national epidemiological surveillance system.	
Included in previous CCS?	Not included as a separate priority. Instead, **strategic priority II. Control of communicable and non-communicable diseases**, included the focus areas: - Integrated Disease Management and Response (IDMR) - Management of health consequences of emergencies and disasters (WHO Country Cooperation Strategy Rwanda 2009-2013, p.27-29)	
Evaluation sub-questions	**Indicator / measure**	**Key observations** (document & interview synthesis)
1.1 Priority based on population health needs	- Availability in CCS of a health diagnostic from which the priority can be derived	- CCS contains an analysis of national health challenges (p.13-27), from which the priority is derived; broad data basis, with figures mainly from national Economic Development and Poverty Reduction Strategy (EDPRS), the National Institute of Statistics of Rwanda (NHIS) and the national Health Management Information System (HMIS) - Updated CCS brief incorporates strategic adjustments based on further developments in government priorities and SDGs
1.2 Priority's coherence with national health strategies and MDG/SDGs targets	Alignment of priority with: - Health Sector Strategic Plan - MDG/SDG targets	- CCS provides general mapping with overall priorities of third Health Sector Strategic Plan (p.47) - Coherence with HSSP III component 1: Programs (Integrated Disease Surveillance and Response)
1.3 Priority's coherence with the UNDAP	- Level of alignment with UNDAP and Delivery as One framework	- CCS provides mapping with UNDAP outcomes and outputs (p.48) - Coherence with UNDAP result area 3 (outcome 3b.1)
1.4 Priority's coherence with the General Programme of Work	- Level of coherence between the priority and the GPW	- CCS provides a (incomplete) validation with the 12th GPW (p.48) - Generally, priorities are in line with GPW programme areas - Coherence with programme areas 5.1 to 5.3 and 5.6
1.5 WHO adaptation capacity to evolving context during the course of the CCS 2014-2018	- Changes in implementation of the priority in the CCS 2014-2018 and rationale for these changes	- Strategic priorities were adjusted during the course of the CCS 2014-2018, mainly to reflect further developments in government priorities and SDGs - No major changes in this priority
1.6.1 Identification of WHO's comparative advantage and strategy to maximise it	- Elements of WHO's comparative advantage identified for priority	- CCS underlines that consideration was given to WHO's comparative advantages and core functions when outlining the strategic priorities (p.10, 50); core functions most used for this priority are listed under sub-question 3.1
1.6.2 Capacity of WHO to position the priority (based on needs analysis) in the national agenda	- Linkages between priority and most important health needs - Indication of role played to enforce priority's consideration in national agenda	- WCO contributed to the development and objectives of the Health Sector Strategic Plans (HSSP III/HSSP IV); it also fostered the integration of SDGs in the process - Otherwise, the government was found to be very determined and assertive regarding the national agenda
1.6.3 Specificities of partnership between WHO and the Government of Rwanda in the context of "delivering as one"	- Indication of partnerships elements in the priority - Reasons for change in partners - Reasons for evolution within continuing partners	- In accordance with the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, the Government of Rwanda has structured the division of labour between development partners through Sector Working Groups, where government and development partners meet to discuss sector planning and prioritization according to strategic plans and programs - In addition to the MoH and WHO, the health sector working group also includes the Belgian Development Agency (Enabel), the Swiss Agency for Development and Cooperation (SDC) and the United States Agency for International Development (USAID) - WCO contributed to the harmonization of the country support for the UNDAP implementation through active participation in the One UN forums
2.1 Inclusion of priority's focus areas in country work plans	- Availability of explicit linkages between work plans and focus areas in the CCS 2014-2018	- Activities for this priority are listed under programme areas 5.1 to 5.3 and 5.6 in the budget centre workplans for biennia 2014-15, 2016-17 and 2018-19
2.2 Main results achieved	- Achievements for CCS priority - Key results and best practices	- Support to development of national strategies, operational plans and adaption of guidelines (One health, integrated disease

		surveillance and response system, refugee response plan) - Support to outbreak response and to response to refugee humanitarian crisis; recruitment of a public health officer in charge of implementing IDSR (Integrated Disease Surveillance and Response) and HMIS (Health Management Information System) activities in refugee camp for prevention and control of epidemics - Support to strengthen outbreak disease preparedness - Assessment of IHR capacity
2.3 Added value of regional and headquarters contributions	- Indication of HQ and/or RO contributions to specific activities in Rwanda	Support from the Regional Office for Africa: - To conduct vulnerability risk assessment - To assess core capacities of the IHR
2.4 Contribution of WHO results to long-term changes in health status in Rwanda	- Indication of long term WHO engagement in focus areas - Perception of stakeholders on WHO's role to change areas	[no major indications]
2.5 National ownership of results and capacities developed	- National capacities developed - Indication of changed practices or continued activities among partners following WHO support and activities	- Contributions to the development of national strategies, guidelines and plans integrated disease surveillance and response system - Capacity development for health workers (electronic Integrated Disease Surveillance & Response)
3.1 Key core functions most used to achieve results	- Stakeholder's perception and reference to core functions supporting achievements	WCO self-assessment of core functions most used: - Technical support and institutional capacity building Perception of government stakeholders (across all priorities): - Policy advice & dialogue, technical assistance, capacity building - WHO respected among partners as technical and advisory body - Setting norms & standards, provide guidelines Perception of partners (across all priorities): - Leadership in health, convener, policy advice and support - Technical assistance and financial support - Capacity building, support research, advocacy
3.2 Contribution of strategic partnerships to results achieved	- Reference to the strategic partnerships and indication of their contributions to the results	- Partnerships with other UN agencies and health development partners facilitated mobilization of resources to implement key activities. UNCT regularly conducts joint resource mobilization for disaster response
3.3 Funding levels	- Level and timeliness of funding and perception of stakeholders	- Lack of predictability of funding and high dependency on voluntary contribution hinder implementation of WCO activities - Inequity in funding of the work plan: skewed allocation of programme funding results in better funded areas (such as immunization and nutrition) and poorly funded areas (such as non-communicable diseases and public health) - Unpredictability of levels and timeliness of funding hampers planning and cooperation with partners; differing alignment of budget cycles between WHO and MoH/government creates further difficulties
3.4 Adequacy of staffing	- Staff available for the implementation of activities and perception of stakeholders	- Overall, staffing is perceived as insufficient (both internally and in the perception of external stakeholders) and staff need to handle wide portfolios; partners occasionally praised in-depth technical expertise, while in some cases need for further training was expressed (regarding technical knowledge, programme management and reporting skills)
3.5 Monitoring mechanisms to inform CCS implementation and progress towards targets	- Availability of monitoring mechanisms and reports on progress towards targets	- Mid and end-term review of WCO biennial plans; annual reporting of UNDAP activities; WCO involved in semi-annual monitoring of MoH workplans - CCS priorities aligned with Health Sector Strategic Plan. HSSP 4 integrates SDGs and policy briefs have been drafted for its implementation; National Health Observatory is in charge to monitor SDGs indicators (with technical assistance from WCO) - Good availability of data in-country as all hospitals are using DHIS 2 (District Health Information System 2). However, there is need to address data quality and access.

Annex 5: List of people interviewed

WHO Country Office	
Bataringaya, Juliet Evelyn	Technical Officer, Health System Strengthening
Gasherebuka, Jean Bosco	National Professional Officer, Health Information Promotion
Habimana, Innocent	National Professional Officer, Protection of the Human Environment
Kalisa, Ina	Consultant, Community based health insurance
Mujawamariya, Marie	National Professional Officer, Family Health Planning
Nyandwi, Alphonse	National Professional Officer, ICT Focal Point
Olushayo, Olu	WHO Representative
Rugambwa, Celse	National Professional Officer, Extended Program of Immunization
Rusanganwa, André	National Professional Officer, Disease Prevention and Control
Tran Ngoc, Candide	National Professional Officer, African Health Observatory
Tuyisenge, Stella Matutina	National Professional Officer, Essential Drugs and Medicines

WHO Regional Office for Africa	
Dovlo, Delanyo Yao Tsidi	Director, Health Systems and Services Unit
Fall, Ibrahima-Soce	Regional Emergency Director, WHO Health Emergencies Programme
Kasolo, Francis Chisaka	Coordinator, Country and Inter-country Support
Zawaira, Felicitas	Director, Family and Reproductive Health Unit

National partners and institutions	
Condo, Jeanine	RBC, Director General
Gafarasi, Isidore	Agricultural Board of Rwanda, Director of Veterinary Services
Gashumba, Diane	Minister of Health
Ingabire, Veneranda	MIDIMAR, Single Project Implementation Unit Coordinator
Kamukunzi, Mechtilde	MOH, Health System Analysis Specialist
Karera, Patrick	MINECOFIN, Planning Unit
Kayumba, Malick	RBC, Head of Rwanda Health Communication Centre
Mazarati, Jean Baptist	RBC, Head of Department of Biomedical Services
Mbituyumuremyi, Aimable	RBC, Malaria and Other Parasitic Diseases Division
Mucumbitsi, Alexis	National Early Childhood Development Program
Mugenzi, Pacifique	Rwanda Military Hospital, Oncologist
Mukamunana, Alphonsine	MOH, Environmental Health Specialist
Muvunyi, Zuberi	MOH, Director General of Clinical and Public Health Services
Ndayisaba, Gilles Francois	RBC, Non Communicable Diseases Division
Nteziyaremye, Fidel	MININFRA, Water & Sanitation Coordinator
Nyamusore, José	RBC, Epidemic Surveillance and Response (ESR) Division

Nyemazi, Jean Pierre	MOH, Permanent Secretary
Sayinzoga, Felix	RBC, Maternal, Child and Community Health Division
Sibomana, Hassan	RBC, Vaccine preventable diseases unit
Turate, Innocent	RBC, Head of Institute of HIV/AIDS, Disease Prevention and Control
Uwaliraye, Parfait	MOH, Director General Planning, Health Financing and Information System

International partners and institutions

Alemu, Daniel	UNFPA Deputy Representative
Baba Fall, Ahmed	UNHCR Representative
Banamwana, Robert	UNFPA M&E and SRH Policy Advisor
Borg Aigt, Jan	Enabel, Public Health Budget Support Expert
Godwin, Lisa	USAID, Health Office Director
Dongier, Pierre	MSH, Team leader of governance, policy and planning
Joseph, Jesse	USAID, Health Office Deputy Director
Karagire, Itete	Country Coordinating Mechanism for the Global Fund, Permanent Secretary
Kayiarangwa, Eugenie	CDC, Associate Director
Maly, Ted	UNICEF Representative
Muhinda, Otto	FAO Assistant Representative
Muthu, Maharajan	UNICEF Consultant HIV/AIDS
Ndiaye, Fode	UNDP Resident Representative / UN Resident Coordinator
Otoo, George	UNDP Coordination Specialist
Rwanyilijira, Elizabeth	USAID, Health systems strengthening
Semafara, Sage	Rwanda Network for People Living with HIV, Executive Secretary
Shimomura, Masae	WFP Head of Program
Siddiqui, Abdur Rahim	WFP Deputy Country Director
Tesfaye, Anteneh	UNHCR Administrator
Twahirwa, Théoneste	SDC, Health Advisor
Woldesmayat, Betro	UNAIDS Country Director

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