

Implementation of the Framework of engagement with non-State actors (FENSA)

Respondents: Regional offices, Country offices and Headquarter clusters assessing its implications

Introduction:

1. The 138th Executive requested the Secretariat to provide a balanced and objective report of the implications of the implementation of the Framework of engagement with non-State actors (FENSA) well in advance of the resumed session of the Open-ended intergovernmental meeting of 25-27 April 2016.

2. To this end, all WHO Regional Offices and Clusters in Headquarters and a selection of Country Offices are invited to provide their inputs through this questionnaire. In addition a more detailed matrix of analysis will be sent for comments to FENSA focal points in regions and clusters.

3. In order to assure that we can present a balanced and objective report to Member States, the External Auditor has kindly agreed to validate and comment this questionnaire, the more detailed analysis matrix and write the final report.

4. The adoption and implementation of FENSA will modify the way WHO manages its engagement with non-State actors (NGO's, private sector entities, philanthropic foundations and academic institutions). The main changes concern the following points

- a. FENSA is covering all engagements within with all non-State actors, while the current policies covered engagement with private sector entities and NGOs in official relations only
- b. Transparency will be increased through the Register of non-State actors (including information on objectives, governance and funding of non-State actors and description of engagements)
- c. FENSA calls for a consistent implementation at all 3 levels of the Organization and all regions and hosted partnerships through an electronic workflow, due diligence by central unit for, a guide for staff, clear decision making
- d. FENSA will increase accountability towards Members States by strengthened oversight of the Executive Board
- e. The Director General will report annually on engagement with non-State actors

5. Some of the proposals made during the negotiation process have not been included in the text and are no longer under consideration. They should therefore also be excluded from the analysis of implications of FENSA implementation. Such issues include in particular:

- a. FENSA applies only to engagement with non-State actors as institutions and not to engagements with individual experts.
- b. There will not be a defined ceiling for contributions received from non-State actors

- c. Due diligence and risk assessment is a process conducted by the Secretariat with no direct involvement of Member States
 - d. Free services provided by non-State actors are an in-kind contribution, but not covered by the not yet agreed provisions on secondments.
6. Several current policies are confirmed by the draft Framework and often made more explicit:
- a. WHO does not engage with the tobacco and arms industries
 - b. Official relations (while currently all entities are called NGO's, non-State actors in official relations will in the future be distinguished in NGOs, International Business Associations and Philanthropic foundations)
 - c. Several specific paragraphs on private sector engagement (such as clinical trials) are transposed from the current guidelines into the private sector policy.
 - d. The CPSC (Committee on Private Sector Cooperation) will be replaced by an engagement coordination group ECG
7. For information here are the elements which would likely be covered in the report on implications of implementation of FENSA:
- a. Changes to the work of WHO governing bodies
 - b. Costs of implementation
 - i. Direct financial costs of implementation
 - ii. Direct human resource costs
 - iii. Indirect human resource costs
 - iv. Startup costs
 - GEM build up to provide the IT tool for the Register of non-State actors
 - Training costs
 - Additional burden of filling the register with first time entries
 - c. Potential efficiency savings through implementation of FENSA
 - i. Information gathering
 - ii. Clarity on actors, process and earlier decisions
 - d. Added value of FENSA
 - i. Stronger protection from undue influences
 - ii. Coherence in engagement across WHO and across different engagements
 - iii. Clarity on engagement

- iv. Transparency
- v. Better information, documentation, intelligence and lessons learnt on non-State actors and engagements
- vi. Clear process of senior management decision making
- e. Risks of FENSA
 - i. Potentially cumbersome process
 - ii. High number of engagement
 - iii. Lack of flexibility
 - iv. Potential bottle-neck in due diligence and risk assessment process
 - f. Changes to the engagement opportunities and risks
 - i. Policy changes in engagement
 - ii. Incentive changes for engagement

QUESTIONS:

8. Estimation of the volume of engagements. Questions in paragraphs 9 and 10 try to estimate the volume of engagements which should in the future be handled through the process defined by FENSA. The External Auditors will compile your input from country, regional and headquarter level into an overall estimation. Please note that this refers to formalized engagement as defined in the paragraphs 15-21 of the draft FENSA and not to informal interactions. Formal engagements include amongst others: a meeting with official invitations, agenda, list of participants, etc; any interaction involving a signature of a agreement or MoU to receive resources, work as implementing partner, allow the use of advocacy material, enter into technical collaboration, etc. Preparation for such engagement or informal contacts by phone, e-mail or informal discussion are considered as engagements.
9. Please provide a rough estimate of the **numbers of non-State actors** you engaged with in 2015 by type of engagement in the following table for your region (excluding country level), cluster or country office respectively

Cluster: HQ Department of Emergency Risk Management (OHE Cluster)

	Participation	Resources	Evidence	Advocacy	Technical collaboration
NGOs	25 (Global Health Cluster); 24 Country Clusters with a number of NGO members ranging from 10 to 200 members	75 (NGOs we transfer funds from donor contributions)	6 Standby partners	-	3 Standby partners

	(awaiting for details on number from countries)*, 5 stand-by partners				
Private sector entities	-	-	-	-	-
Philanthropic foundations	4 (standby partners)	2 (entities from which we received funds in 2015)	-	-	-
Academic institutions	3 (Global health Cluster) 3 (standby partners)	-	-	-	-

- *Countries with a Health Cluster in place under the umbrella of the HQ Global Health Cluster: Afghanistan, Central African Republic, Chad, Colombia, Democratic Republic of the Congo, Guinea, Iraq, Liberia, Mali, Myanmar, Niger, occupied Palestinian territory, Western Pacific, Pakistan, Philippines, Somalia, South Sudan, Sudan, Turkey, Ukraine, Yemen.

10. Please provide a rough estimate of the numbers of **engagements** in 2015 by type of engagement in the following table. For engagements covering more than one type count them only once for the most relevant type.

	Participation	Resources	Evidence	Advocacy	Technical collaboration
NGOs	25 meetings at HQ level (Global Health Cluster); 64 (24 country health clusters), 5 (standby partners)	Many clusters have a NGO co-lead	-	-	16 (Global Health Cluster and country Health Clusters)
Private sector entities	-	-	-	-	-
Philanthropic foundations	4 (standby partners)	-	-	-	-
Academic institutions	25 meetings at HQ level (Global Health Cluster), unknown number for 24 country health clusters)**; 3 (standby	-	-	-	-

	partners)				
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** Waiting for information of the nature of the partners at country health clusters.

Comments on the methodology used and its difficulties of this estimation,

Methodology for the calculation of engagements under the Global Health Cluster arrangement. The Cluster Approach as multi-agency coordination mechanism, adopted by the Inter-Agency Standing Committee (IASC) in 2005 to address humanitarian gaps and to increase the effectiveness of humanitarian response by building partnerships that result in timely, predictable and accountable assistance. The calculation of engagements at HQ level is based on the number of meetings (noting that those meetings are part of a yearly workplan of the Global Health Cluster therefore even if the topics are different, they may be counted as one engagement). Under the umbrella of the Global Health Cluster, currently, there are health clusters active in 24 countries affected by humanitarian health emergencies (list provided above). Within each country health cluster, partners (the majority of whom are operational /technical I/NGOs) attend meetings to share information, participate in joint needs assessment and planning, contribute to delivery of services defined in the plan and assist with monitoring and evaluating the response. In some settings NGOs provide staff to co-lead the cluster at the national or sub-national level in collaboration with WHO.

The estimation of engagements at country level for health cluster participation is difficult because the number of stakeholders and engagements varies depending on whether there is a crisis or the type of crisis. The methodology used is 50% of the country health clusters meet 1 time per week, the other 50% 1 time per month.

Methodology for the calculation of engagements with NSA standby partners. These are NGOs or academic institutions that sign an agreement with WHO to deploy experts in emergencies. We have counted 1 engagement per agreement signed organization. Several engagements occur after but based on the agreement.

Methodology for the calculation of NSAs under resources: 1 engagement per preparation of the agreements for the transfer/receipt of funds per organization.

11. Please estimate the number of non-State actors you engage with in emergency situations (as described in the Emergency Response Framework) and describe the type of these engagements

This is very difficult to estimate, when acute emergencies occur, such as the Philippines Haiyan Typhoon, the Nepal earthquake, or the Ebola outbreak in West Africa, hundreds of NGOs participate in country health cluster meetings and some of them become implementation partners (receive resources). After the earthquake in Haiti in 2010, over 300 NGOs participated in health cluster meetings. So in average we could say that for acute onset emergencies there will be 150 NSA partners. The engagements may occur as early as 24 hours after the event.

12. Please describe the main opportunities you see for the work of your region / cluster / country office through the adoption and implementation of FENSA

Through this process, WHO will have a better overview of its partners (especially NGOs at country level), and more clarity on the rules of partnership engagement.

13. Please describe the main risks you see for the work of your region / cluster/ country office through the adoption and implementation of FENSA. This question does not refer to the risks of individual engagements as defined in FENSA but rather to the overall risks and challenges of implementing FENSA as a new policy.

FENSA bears the risk of limiting and slowing down partner engagement which in emergency

setting is a huge risk for WHO. The strength of the WHO's partnerships with NSAs (mainly NGOs) in emergencies is based on its cooperation with a wide range of partners who provide the requisite technical skills and operational capacity needed to rapidly response to complex and diverse health needs. Based on current understanding, the requirements of FENSA, the number of partners may decline (due to the current requirement for disclosure of information) and the health impact suffer, if some current and potential new partners are deemed non-compliant.

For acute onset emergencies the main risk is to stop engagement with key NSA (mainly NGOs) because due diligence process takes weeks. This would be unacceptable for WHO as the lead agency for coordinator on health interventions in emergencies.

Other risks include:

Some NSA might appreciate the collaboration with WHO as part of the coordination mechanism, but for variety of reasons might not want to be or be perceived as being in "official relations" with WHO. This could be because of the organizations values and orientation, for example some organizations stress their independence from the government in order to ensure services to all parts of the population (including minorities or opposition), whereas WHO might have close relations with the Ministry of Health or other government agencies.

Further NSA might have concerns disclosing their financial resources. While in general it is welcomed to require a high level of transparency of partners, and they should be disclosing their assets in order to avoid them not being in accordance with WHO's standards. In practice some organizations in particular in conflict or complex emergencies might feel that disclosing this sort of information could expose them to harm and/or discrimination. They might prefer working with other organizations, which do not have the same requirements as WHO.

In particular if the process of allowing partners to attend coordination meetings is limited or slowed down in settings of sudden onset (i.e. earthquake) or acute need (i.e. refugee surge in a protracted crisis), the work to facilitate access to health might significantly loose impact because not all relevant partners will be admitted to the cluster in time. In consequence, the service delivered to those in most urgent need will receive less or less coordinated support. In addition to reducing WHO's impact as Cluster Lead agency, it would have a significant competitive disadvantage in comparison to other agencies which have more flexible, operationally oriented procedures.

In the emergency sector there has been a significant shift towards working with more local partners. This is due to different factors, which include but are not limited to: 1) more contexts are difficult to access or unsafe for international staff therefore local partner organisations take over service delivery in these areas; 2) more funding goes directly to local NGOs rather than being channelled through international bodies because it is seen as strengthening local capacity which are more sustainable long term and 3) better value for money.

The danger in particular is to exclude smaller local NGOs which are not known internationally to contribute to the health response because they are not admitted through FENSA.

This might lead to losing the support from partners as they do not see that WHO implements the recommendations of the various bodies working on the Emergency Reform which stress the need for WHO's increased openness to partners and stronger coordination with partners at the field level. Ebola has demonstrated in the most painful way the need to improve the cooperation and coordination with partners. In the current Emergency Reform, effective engagement with partners is seen as a crucial pillar of WHO's future success. It requires the organisation to further open up to partners, acknowledging partners capacity and facilitating a joint response to emergency health needs. As a single agency, WHO which does not usually provide direct health services itself, and does not have capacity to respond to the ever growing needs alone. Its strength should be the coordination of the response including NSA.

Partners in the response might further doubt that WHO is the best choice as Cluster Lead

Agency in the context of a wider UN humanitarian response, and doubt its true commitment to lead the health segment of the humanitarian response. WHO might lose the leadership to other organisations who are more agile and operational and open to partnerships. In consequence, alternative structures of coordination to WHO might be used or newly established, allowing for a quicker response to emergencies making the health cluster irrelevant.

14. Please describe the specific resources (staff and activity costs) currently working on engagement with non-State actors within your region / cluster/ country office.

One Technical Officer (P3) for Global Health Cluster engagement

- 2 Technical officers for Standby partner engagement

- 2 Technical offices for resource disbursement/receipt

Awaiting information from countries and regions on country health clusters

15. Please describe the specific incremental resources (staff and activity costs) that you would expect to be necessary to implement FENSA :

One off resources/costs:

- The process of negotiating, registering and gathering the information required for the due diligence process for what could be up to 1,000 NSAs will require at least 1 person per country cluster (24), plus a dedicate team in HQ to brief/train countries and facilitate the process. It may take several months or years depending on the capacity put in place.

Recurring or On-going resources/costs:

Similar to above with additional resources (especially at country level) for acute emergencies.

The non-monetary costs has been outlined above: FENSA might lead to a reduction of number of active partners as well as a loss of impact and importance of the health cluster as well as WHO as the cluster lead agency.