

Country Office Evaluation: India

Volume 2: Annexes

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The purpose of publishing evaluation reports produced by the WHO Evaluation Office is to fulfil a corporate commitment to transparency through the publication of all completed evaluations. The reports are designed to stimulate a free exchange of ideas among those interested in the topic and to assure those supporting the work of WHO that it rigorously examines its strategies, results and overall effectiveness.

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Annex 1: Terms of Reference

I. Introduction

1. Country Office Evaluations (COE) are part of the Evaluation Office workplan for 2018-2019, approved by the Executive Board in January 2018. The workplan 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 India COE covers the period of the Country Cooperation Strategy (CCS) 2012-2017.

II. Country context

3. India’s economic performance has been strong, but development has been uneven, with the gains of economic progress and access to opportunities differing between population groups and geographic areas. India is already the world’s third largest economy in purchasing parity terms and aspires to become a high-middle income country by 2030. Long-term GDP growth has become more stable, diversified, and resilient. Whilst extreme poverty dropped from 46% to an estimated 13.4% over the two decades before 2015, India is still home to 176 million poor people. The country’s human development indicators - ranging from education outcomes to a low and declining rate of female labour force participation - underscore its substantial development needs.²
4. India’s twelfth National Plan (2012-2017) aimed at an economic growth of 8% and reduction of poverty by 10% and contained specific goals on malnutrition and water safety. Since 2015, the NITI Aayog (National Institution for Transforming India) developed several national strategies with the aim to achieve Sustainable Development Goals,³ including the Three-year Action Agenda (2017-2020). These strategies address health goals directly and through social determinants of health.
5. India is experiencing a rapid health transition, due to changes in the socio-economic context. First, the health priorities are changing from maternal and child mortality towards a growing burden of noncommunicable diseases and some infectious diseases. Second, the Indian health care industry is robust and growing rapidly. Third, catastrophic health care expenditures are a major contributor to poverty. Finally, rising economic growth enables enhanced fiscal capacity.⁴

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

² World Bank India (<http://www.worldbank.org/en/country/india/overview>, accessed 28 November 2018).

³ United Nations Resident Coordinator’s Office, India (2018). Government of India and United Nations Sustainable Development Framework 2018-2022.

⁴ Ministry of Health and Family Welfare, Government of India. National Health Policy 2017.

Table 1: India health statistics⁵

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

6. The Government of India accepts only direct Overseas Development Assistance from restricted donors and under specific conditions, for socially relevant purposes including health. International agencies and partners are expected to provide only state of the art evidence, methodological inspiration and high-level support.⁶ Overall Overseas Development Assistance increased from 1.7 to almost 2.7 billion US\$ from 2012 to 2016.⁷ Whilst a large proportion of foreign funding is allocated for health, foreign aid forms a minimal fraction (less than 1% in 2012)⁸ of health expenditure by Union and state governments. The main development partners for health in India are USAID, Japan, DFID, the European Commission and the UN system and global health partnerships such as GFATM and GAVI.⁹

7. The UN system efforts in India have been guided since 2013 by the UN Development Action Framework (UNDAF) 2013-2017, focusing on MDGs including health-related targets. Health was covered under UNDAF Outcome 4, Equitable Access to Quality Basic Services.¹⁰ The current Government of India-UN Sustainable Development Framework (UNSDF) 2018-2022 aims to support India to reach the SDGs. It groups health, water and sanitation as one of eight priorities, alongside priorities related to social determinants of health, e.g. poverty, education, climate change, disaster resilience and gender equality.¹¹ The UN system has a geographical focus on states with the highest

⁵ Global Health Observatory, WHO (<http://apps.who.int/gho/data/node.cco.ki-IND?lang=en>, accessed 28 November 2018).

⁶ WHO, India (2012). WHO Country Cooperation Strategy India 2012-2017 (<https://apps.who.int/iris/bitstream/handle/10665/161136/B4975.pdf;jsessionid=2A5663A82506C16B5350CEC565FD1A87?sequence=1>).

⁷ OECD data on World Bank (<https://data.worldbank.org/indicator/DT.ODA.ALLD.CD?contextual=default&end=2016&locations=IN&start=2012&view=chart>, accessed 28 November 2018).

⁸ Economic survey of India 2011-12 (<http://indiabudget.nic.in/> accessed 31 March 2012), quoted in CCS 2012-2017.

⁹ WHO, India (2012). WHO Country Cooperation Strategy India 2012-2017 (<https://apps.who.int/iris/bitstream/handle/10665/161136/B4975.pdf;jsessionid=2A5663A82506C16B5350CEC565FD1A87?sequence=1>).

¹⁰ United Nations Resident Coordinator's Office, India (2012). United Nations Development Action Framework 2013-2017.

¹¹ United Nations Resident Coordinator's Office, India (2018). Government of India and United Nations Sustainable Development Framework 2018-2022.

proportion of people living in poverty.¹² Key UN agencies working with WHO in India are the World Bank, UNICEF, UNFPA, UNAIDS and UNDP.¹³

III. WHO activities in India

8. The WHO India Country Office (WCO) is based in New Delhi, with roughly 100 staff. WHO works at national level, but also through 270 field offices of the WHO Public Health Surveillance Project (formerly the National Polio Surveillance Project (NPSP)), with over 1700 NPSP staff. In addition, WHO India employs around 80 TB consultants and 12 state and zonal coordinators for neglected tropical diseases (NTDs).

9. WHO India's partnerships include the Union Ministry of Health and Family Welfare and other entities including the NITI Aayog, non-health ministries, academic institutions and NGOs/civil society organisations.

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

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

11. In 2017, WCO undertook an internal review of the CCS, assessing relevance, efficiency and effectiveness. The main conclusions were that the strategic focus of the CCS became less relevant with the changing national, regional and global priorities, necessitating increasing programming (and expenditure) outside CCS priorities through biennial workplans. Strategic revision could have been addressed through a mid-term review and mid-course correction of the CCS focus areas. This calls for establishing a robust monitoring and evaluation system to oversee the implementation of the CCS. Recommendations for strategic priorities for the next CCS included: 1) emergency and NTDs (including malaria) as they are priorities in the National Health Policy, Regional flagships and the Regional Director's four strategies; 2) further alignment with National Health Policy focus areas: antimicrobial resistance (AMR), mHealth, integration and continuum of care, neonatal mortality and stillbirth, adolescent health, violence against women, health care of the elderly, environmental health, mental health, and viral hepatitis; and 3) improved ownership/engagement of other ministries.¹⁴

12. The draft CCS 2019-2023, developed based on lessons and experience of the earlier CCS, has several strategic priorities, each with focus areas for WHO collaboration:¹⁵

- 1) Accelerate progress on universal health coverage;

¹² For UNSDF: Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Maharashtra, Odisha, Uttar Pradesh & North-East Region; UNDAF also targeted Rajasthan and the North-East, specifically Assam.

¹³ WHO, India (2019). The WHO India Country Cooperation Strategy 2019-2023: a time of transition (draft).

¹⁴ WHO, India (2016). Internal review of Country Cooperation strategy 2012-2017 (draft).

¹⁵ WHO, India (2019). The WHO India Country Cooperation Strategy 2019-2023: a time of transition (draft).

- 2) Promote health and wellness by addressing determinants of health;
- 3) Better protect the population against health emergencies;
- 4) Enhance India's global leadership in Health.

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

Table 2: Links between CCS India priorities and WHO Programme Budget priorities

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

14. In the period 2012-2017, WHO India spent on average over US\$ 50 million per year on agreed activities. Table 3 identifies briefly the main areas of activities undertaken in the WCO and corresponding levels of investment. The WCO is mainly funded from voluntary contributions, including

funds mobilized locally from donors (Government of India, USAID, US Centers for Disease Control, GAVI, GFATM). Most funds are earmarked for specific programme areas.

Table 3: Estimated expenditure India Country Office 2012-2017 (US\$ 000)¹⁶

Program Area (as per the biennial workplans)	Expenditures (US\$ 000)				allocation
	2012-13	2014-15	2016-17	Total	
1. Communicable Diseases workplan	pm	11 473	15 994	27 466	8%
2. Noncommunicable Diseases workplan Co-morbidity-CD & NCD	2 111	1 374	1 306	2 681 2 111	
3. Promoting Health through the Life-course workplan Mother & Child Health	794	1 022	1 377	2 399 794	
4. Health Systems workplan Pharmaceutical Sector Accreditation-HSD Institutions Stewardship Universal health service coverage	916 243 649 1 048	6 602	3 022	9 623 916 243 649 1 048	3%
5. Preparedness, Surveillance & Response workplan IHR & related commitments	24 818	98	489	587 24 818	7%
6. Corporate Services/Enabling Functions workplan Governance & Management	1 846	2 584	2 193	4 778 1 846	1%
7. Polio workplan Transition-polio, TB & HIV-AIDS	75 890	54 711	55 301	110 012 75 890	32% 22%
8. In-Kind/In-Service (NTD Roadmap)		21 730	27 035	48 765	14%
9. Salary workplan	6 088	8 252	10 406	24 746	7%
	114 402	107 846	117 123	339 371	100%

IV. Objectives and scope of the COE

15. The main purpose of this COE is to identify achievements, challenges and gaps and document best practices and innovations of WHO in India. These include not only the results of the WCO but also contributions from the regional and global levels to the country programme.

16. 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 the results of previous evaluative work to:

- Demonstrate achievements against the objectives formulated in the CCS 2012-2017 (and other relevant strategic instruments) and corresponding expected results developed in the WCO biennial workplans, while pointing out the challenges and opportunities for improvement.
- Support the WCO and partners to operationalize the various priorities of future CCS (and other relevant strategic instruments) based on independent evidence of past successes, challenges and lessons learnt.
- 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.

17. The evaluation will cover all activities undertaken by WHO (WCO, the Regional Office and headquarters) in India, as framed in the CCS 2012-2017 and other strategic documents covering

¹⁶ Source: GSM data on biennial workplans and expenditures

activities not part of the CCS that took place over that period. In addition, it will also include the development process of the CCS 2019-2023.

V. Stakeholders and users of the evaluation

18. Table 4 shows the role and interest of the main evaluation stakeholders and expected users of the evaluation.

Table 4: preliminary stakeholders' analysis

Internal stakeholders	Role and interest in the evaluation
WCO India	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
WHO Regional Office for South-East Asia	As a key contributor to the development of the CCSs 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 India 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 the strategic analysis of CCS content and implementation and is responsible for promoting 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 India	As a donor and recipient of WHO's action, the Government of India has an interest in ensuring that the partnership with WHO and the future programming under the new CCS is the most relevant, effective and efficient. Considering its engagement in international health development, it also has an interest in seeing its best practices independently assessed and disseminated. In addition to the Union and Ministry of Health and Family Welfare, there are a large number of public health partners in-country who all have an interest in the evaluation.
All individuals in India	WHO's action in India should ensure that it benefits all population groups, prioritizes the most vulnerable and does not leave anyone behind. The evaluation will look at the way WHO addresses equity and ensures that all population groups are considered in the various policies and programmes.
UN Country Team	WHO contributes to several outcomes of the UNSDF 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 India's best practices in the health sector.
Donors and partners	In addition to the Government of India, multilateral and bilateral donors 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

19. All COEs address the 3 main Evaluation Questions identified below. The sub-questions are then tailored to the country's specificities and detailed in an evaluation matrix to be developed during the inception phase by the evaluation team, taking into account the timing of this COE and

the available evaluative information. Good practices and lessons learned will be identified across the findings.

EQ1 - Were the strategic choices made in the CCS (and other relevant strategic instruments) the right ones to address India's health needs and coherent with government and partners' priorities? (relevance)

20. This question assesses the strategic choices made by WHO at the CCS design stage and its flexibility to adapt to changes in context. This question will assess both the CCS 2012-2017 and the new CCS 2019-2023 design. When addressing each evaluation sub-question the evaluation team will build on past evaluative information and seek to identify best practices in the design process of the new CCS. The evaluation sub-questions focus on the following elements:

- 1.1 Are the CCSs based on a comprehensive health diagnostic of the entire population and on India's health needs?
- 1.2 Are the CCSs coherent with the National Health Policy, any other relevant national health strategies and the MDG and SDG targets relevant to India?
- 1.3 Are the CCSs coherent with UN Development Action Frameworks? And are the key partners clear about WHO's role in India?
- 1.4 Are the CCSs 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.) between both CCSs but also during the course of the CCS 2012-2017?
- 1.6 Are the CCSs strategically positioned when it comes to:
 - Clear identification of WHO's comparative advantage and clear strategy to maximise it and make a difference?
 - 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?
 - Specificities of the partnership between WHO and the Government of India? And has this positioning evolved between the two CCSs? If so how?

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)

21. To address this question the evaluation team will build on earlier analyses of results per programme area of the CCS 2012-2017 and will focus on best practices and innovations observed for the following:

- 2.1 To what extent were the country biennial work plans (operational during the evaluation period) articulated with the focus areas as defined in the CCS (and other relevant strategic instruments) or as amended during course of implementation?
- 2.2 What were the main results achieved for each outcome, output and deliverable as defined in the country biennial work plans?
- 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 a national ownership of the results and capacities developed?

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

22. In this area the evaluation sub-questions will 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 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

23. 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.

24. 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 India 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 GPW and programme budgets, and iii) identify the main assumptions underlying it.
- Develop and apply an **evaluation matrix**¹⁷ 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** and the **United Nations Evaluation Group (UNEG) norms and standards for evaluations** and **ethical guidelines**.

25. 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.

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

- Document review will include analysis of key strategic documents, such as the general programmes of work, the programme budgets, the WCO workplan and budget, the CCS (and other relevant strategic instruments), UNDAF and UNSDF, relevant national policies, strategies and other relevant documentation.
- 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 & Family Welfare officials and officials of other relevant governmental institutions; healthcare professional associations and other relevant professional bodies; relevant research institutes, agencies and

¹⁷An **Evaluation Matrix** is an organizing tool to help plan for the conduct of an evaluation. 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.

academia; health care provider institutions; nongovernmental organizations and civil society; UN agencies and other relevant multilateral organizations; donor agencies; and other relevant partners.

- **Mission in-country.** Following the document review and some stakeholder 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. Depending on the need, the mission might include field visits.

27. **Stakeholder 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.

28. **Limitation.** 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

29. The evaluation is structured around 5 phases summarized in Table 5 below.

Table 5: summary tentative timeline – key evaluation milestones

Main phases	Timeline	Deliverables
1. Preparation	December 2018	Terms of Reference and evaluation team contracted
2. Inception	January 2019	Inception note
3. Data collection and analysis	February 2019	Aide memoire of key findings
4. Reporting	March 2019	Evaluation report
5. Management response and dissemination	April 2018	Management Response Evaluation report online

30. **Preparation.** These Terms of Reference are prepared following the WHO Evaluation Practice Handbook. The final version of the Terms of Reference takes into consideration results of consultations with key internal and external stakeholders.

⇒ Final Terms of Reference

31. The **inception phase** will start with a first review of key documents and briefings with headquarters, Regional Office and WCO staff. 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 (headquarters, Regional Office and WCO levels) for their feedback.

⇒ Inception note.

It will be prepared following the Evaluation Office template and will focus on methodological and planning elements. It will present, taking into account the various logical/results frameworks and evaluation questions, a detailed evaluation framework and the evaluation matrix. Data collection tools and approaches will be clearly identified in the evaluation matrix.

32. **Data collection and analysis.** This phase will include additional document review, key stakeholder interviews at headquarters and Regional Office levels and a country visit. The mission will start a briefing to the WCO and key partners and end with a debriefing with the same group.

- ⇒ **Aide memoire of key findings** to be prepared at the end of the country visit and used to support the debriefing with the stakeholders.

33. **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.

- ⇒ **Evaluation Report** will be prepared in accordance with 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.

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.

34. **Management response** and dissemination of results. The management response will be prepared by the WCO and posted on the website of the Evaluation Office 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 management

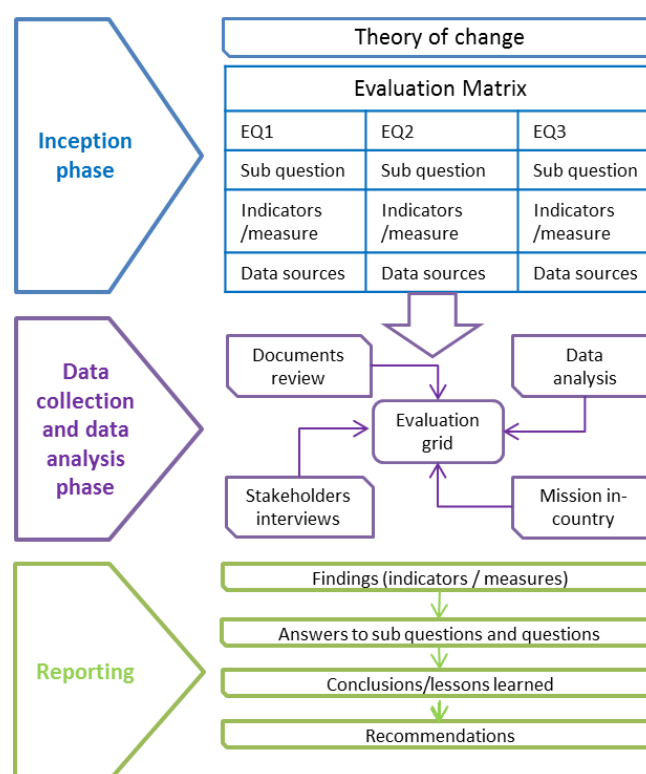
35. The COE will be commissioned and managed by the WHO Evaluation Office. The Evaluation Office will establish an evaluation team formed by independent external evaluation consultants and Evaluation Office staff. The evaluation team will report to the Director-General's Representative for Evaluation and Organizational Learning in his capacity as Evaluation Commissioner. A WHO Senior Evaluation Officer will act as the Evaluation Manager, representing to the Evaluation Commissioner in the management and day-to-day operations of the evaluation.

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 January and April 2019 by a core team from the WHO Evaluation Office supported by two external consultants.

Figure 1: Methodological approach



Inception phase

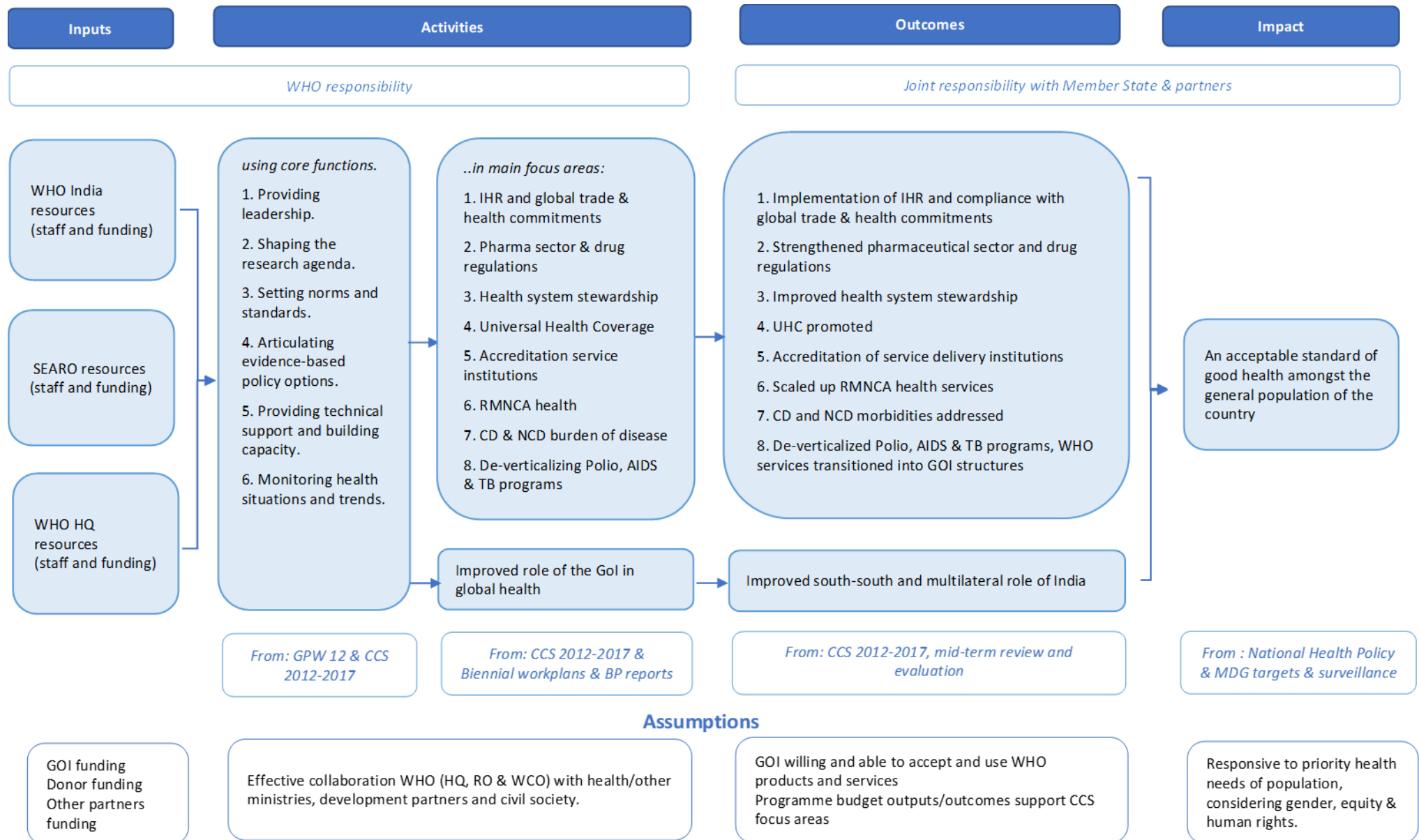
a. Theory of change underlying WHO's contribution in India

The evaluation adopted the CCS as a primary criterion for the evaluation. However, in the absence of an explicit logic model or theory of change to frame the contributions of WHO in India over the evaluation period, during the inception phase the evaluation team proposed a theory of change (see Figure 2). This theory of change describes the relationship between the CCS strategic priorities, the focus areas and the activities and budgets as envisaged in the biennial workplans; clarifies the linkages with the GPW and programme budgets; and identifies the main assumptions underlying it.

The theory of change aims to encompass contributions from all levels of the Organization and all strategic contribution areas of WHO in the country. It is aligned with that validated by WHO in the context of the evaluation of WHO's presence in countries¹⁸ and previous COEs.

¹⁸ WHO (2015). Evaluation of WHO's Presence in Countries. Geneva: WHO Evaluation Office (<http://www.who.int/about/evaluation/prepublication-country-presence-evaluation.pdf?ua=1>).

Figure 2: Theory of Change (TOC) – WHO contribution in India 2012-2017



b. Evaluation matrix

Using the theory of change, 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 were 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.

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

b. Stakeholder interviews

These were the main form of primary data collection. The evaluation team conducted a large number of interviews (list available in Annex 5) with WHO colleagues at the three levels of the Organization as well as with all main partners 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 February 2019 and was the opportunity for the evaluation to complement the information gathered through 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. The mission also included visits to regional sub-offices in Bangalore and Lucknow.

d. Data analysis

The evaluation team triangulated all information collected and compiled information in an evaluation grid structured by evaluation question, sub-question and indicators. Evaluation findings were then drawn only after a thorough cross-checking and triangulation of all information related to each evaluation question. This ensured that answers to evaluation questions 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.

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.

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 will be 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 encountered a few other relevant issues:

- The lack of a theory of change to identify and assess the value chain of WHO work and in particular of the WCO in India represents an important challenge. This constraint was mitigated by proposing a theory of change, including assumptions, to be tested during the evaluation.
- Another constraint is the absence of performance indicators for CCS focus areas, means of verification and targets (including baseline values). Whilst WHO programme budgets contain global output and outcome indicators, targets are not specified for India. This constraint was mitigated by stakeholder interviews, analysis of secondary data and triangulation of available evidence to assess progress towards CCS priorities and focus areas.

Considering the limitations identified above, the evaluation team could only assess progress for each of the main outcome groups identified in the theory of change 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 info
EQ1 - Were the strategic choices made in the CCS 2012-2017 (and other relevant strategic instruments) the right ones to address India's health needs and coherent with government and partners priorities? [This question will assess both the CCS 2012-2017 and the new CCS 2019-2023 design] (relevance)		
1.1 Are the CCSs based on a comprehensive health diagnostic of the entire population and on India's health needs?	<ul style="list-style-type: none"> - Availability in both CCSs of a comprehensive health diagnostic inclusive of gender-related issues and covering all populations (minorities, migrants) living in India - Changes in health issues/challenges between the two CCSs 	Documents review <ul style="list-style-type: none"> - CCS 2012-2017, draft CCS 2019-2023 and other strategic documents - Needs assessment for both CCSs - WHO Global Health Observatory data - WB indicators for India, other health stats
1.2 Are the CCSs coherent with the National Health Policy, any other relevant national health strategies and the MDG and SDG targets relevant to India?	<ul style="list-style-type: none"> - Level of alignment of health priorities identified in the CCSs, and other relevant strategic documents, with <ul style="list-style-type: none"> o India National Health Policy o MDG/SDG targets in India 	Documents review <ul style="list-style-type: none"> - WHO CCS 2012-2017, draft CCS 2019-2023 and other WCO strategic documents - India National Health Policy 2000 and 2017 updates - MDG/SDG indicators
1.3 Are the CCSs coherent with the UN Development Action Framework 2013-2017/UN Sustainable Development Framework? Are the key partners clear about WHO's role in India?	<ul style="list-style-type: none"> - Level of alignment of the CCSs with the UNDAF/UNSDF - WHO work in UN focus states vs national? - Level of clarity among GoI, UN and other partners about the role of WHO in India 	Document review <ul style="list-style-type: none"> - CCS 2012-2017 & draft 2019-2023 - UNDAF 2008-2012, 2013-2017 & UNSDF KII: <ul style="list-style-type: none"> - WCO - UN Res Cord, UNDP, UNICEF, UNFPA, UNAIDS, WFP, FAO - MoHFW - USAID, DFID, key bilateral donors
1.4 Are the CCSs coherent with the General Programme of Work and aligned with WHO's international commitments? Do the CCSs support good governance, gender equality and the empowerment of women?	<ul style="list-style-type: none"> - Level of coherence between the CCS and GPW 11, 12 & 13, MDG & SDG - Availability of explicit reference in the CCS to good governance, gender equality and empowerment of women 	Documents review <ul style="list-style-type: none"> - CCS 2012-2017 and draft 2019-2023 - 11th, 12th & 13th GPW, - MDG & SDG health related targets KII <ul style="list-style-type: none"> - WCO
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.) between both CCSs but also during the course of the CCS 2012-2017?	<ul style="list-style-type: none"> - Changes of orientation in the implementation of the CCS 2012-2017 and rationale for these changes, e.g. move from Polio to Public Health - Differences between both CCSs based on: 	Document review <ul style="list-style-type: none"> - CCS 2012-2017 and draft 2019-2023, CCS evaluation - WCO biennial workplans, biennial reports KII <ul style="list-style-type: none"> - WCO - RO

Evaluation sub-questions	Indicator/measure	Main source of info
	<ul style="list-style-type: none">○ Changes in health needs○ Changes in GoI priorities○ Changes in WHO regional/global priorities?	
1.6 Are the CCSs strategically positioned when it comes to:	- Indication of best practice in terms of strategic positioning	Documents review <ul style="list-style-type: none">- CCS 2012-2017 & draft 2019-2023, and relevant WCO documents- UNDAF/UNSDF- National health planning strategic documents- Country Coordination Mechanism documents- Agreements for collaboration with bilateral donors. KII <ul style="list-style-type: none">- WCO- MoHFW, national health institutions- UN agencies- Main donors to WHO India- Civil society- Implementing partners/collaborating centres
1.6.1 Clear identification of WHO’s comparative advantage and clear strategy to maximise it and make a difference?	<ul style="list-style-type: none">- Explicit elements of WHO’s comparative advantage identified in the CCSs- Explicit strategy to value the comparative advantages identified	
1.6.2 Capacity of WHO to position health priorities (based on needs analysis) in the national agenda and in those of the national partners in the health sector?	<ul style="list-style-type: none">- 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 India? Has this positioning evolved between the two CCSs? If so, how?	<ul style="list-style-type: none">- Indication of partnership elements in both CCSs- indication of evolution between both CCSs- Reasons for change in partners- Reasons for evolution within continuing partners	
EQ2 -What is the contribution/added value of WHO towards addressing the country’s health needs and priorities in the CCS 2012-2017 period? (effectiveness /elements of impact/progress towards sustainability)		
2.1 To what extent were the country biennial work plans (operational during the evaluation period) articulated with the focus areas as defined in the CCS (and other relevant strategic instruments) or as amended during course of implementation?	<ul style="list-style-type: none">- Availability of explicit linkages between the workplans and the focus areas described in the CCS 2012-2017- Weight (and trend) of activities in workplans not included in the CCS and rationale for their inclusion in the workplans	Documents review: <ul style="list-style-type: none">- Biennial workplans 2012-2013, 2014-2015 & 2016-2017- Biennial report 2012-2013, 2014-2015 & 2016-2017- Program Budget reviews 2012-2013, 2014-2015 & 2016-2017- CCS mid-term review and final evaluation KII <ul style="list-style-type: none">- WCO management and programme leads
2.2 What were the main results achieved for each outcome, output and deliverable for the WCO as defined in the country biennial workplans?	<ul style="list-style-type: none">- Level of achievement for each CCS priority and other key activities within and outside the CCS- Identification of key results and best practices of added value of WHO contributions	Documents review: <ul style="list-style-type: none">- Biennial workplans 2012-2013, 2014-2015 & 2016-2017- Biennial report 2012-2013, 2014-2015 & 2016-2017- Biennial Program Budget reviews- CCS mid-term review and final evaluation- Relevant documents demonstrating results KII <ul style="list-style-type: none">- WCO management and programme leads- Main partners technical programs

Evaluation sub-questions	Indicator/measure	Main source of info
2.3 What has been the added value of regional and headquarters contributions to the achievement of results in-country?	<ul style="list-style-type: none"> - 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 India - Indication of participation of India partners to regional or global initiatives/capacity development opportunities directly linked to CCS priorities - Identified best practices 	Document review <ul style="list-style-type: none"> - CCS 2012-2017 Mid-term review and final Evaluation - Biennial Program Budget reviews KII <ul style="list-style-type: none"> - WCO, RO, HQ - MoHFW, National health institutions - UN agencies - Main donors to WHO India - Civil society and implementing partners
2.4 What has been the contribution of WHO results to long-term changes in health status in-country?	<ul style="list-style-type: none"> - Indication of long-term WHO engagement in selected areas or work - Perception of stakeholders on WHO's role to changes in these areas - Identified best practices 	KII <ul style="list-style-type: none"> - WCO, RO and HQ - MoHFW, national health institutions, - UN agencies - Donors to WHO India - Civil society and implementing partners
2.5 Is there national ownership of the results and capacities developed?	<ul style="list-style-type: none"> - 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 best practices 	Document reviews <ul style="list-style-type: none"> - CCS mid-term review and final evaluation KII <ul style="list-style-type: none"> - WCO - MoHFW, national health institutions, - UN agencies - Donors to WHO India - Civil society and implementing partners
EQ3 – How did WHO achieve the results? (efficiency)		
3.1 For each CCS 2012-2017 priority, what were the key core functions ¹⁹ most used to achieve the results?	<ul style="list-style-type: none"> - Reference to core functions supporting achievement of results in CCS mid-term review and final evaluation - Linkages between activities in programme budgets and core functions - Perception of stakeholders about WHO functions most used - Identified best practices 	Document reviews <ul style="list-style-type: none"> - CCS mid-term review and final evaluation KII <ul style="list-style-type: none"> - WCO - MoHFW, national health institutions, - UN agencies - Donors to WHO India - Civil society and implementing partners
3.2 How did the strategic partnerships contribute to the results achieved?	<ul style="list-style-type: none"> - Reference to the strategic partnerships identified in the CCS, in the mid-term review and final evaluation - Indication of their contributions to the results 	Document reviews <ul style="list-style-type: none"> - CCS mid-term review and final evaluation KII <ul style="list-style-type: none"> - WCO

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

Evaluation sub-questions	Indicator/measure	Main source of info
	<ul style="list-style-type: none"> - Perception of strategic partners about the contribution of the partnerships to the achievements - Identified best practices 	<ul style="list-style-type: none"> - MoHFW, national health institutions, - UN agencies - Donors to WHO India - Civil society and implementing partners
3.3 How did the funding levels and their timeliness affect the results achieved?	<ul style="list-style-type: none"> - Level of funding compared with budget planned for CCS and other activities - Level of funding from Gol and other donors - Timing of funding over the CCS period - Main funding mechanisms used - Perception of stakeholders on level of funding, timeliness and relationship with WCO performance - Identified best practices 	Document review <ul style="list-style-type: none"> - Funding data KII <ul style="list-style-type: none"> - WCO, RO, HQ - MoHFW, national health institutions, - UN agencies - Donors to WHO India - Civil society and implementing partners
3.4 Was the staffing adequate in view of the objectives to be achieved?	<ul style="list-style-type: none"> - Level and number of staff available for CCS implementation and other activities - Perception of stakeholders on staffing situation and relationship with WCO performance - Identified best practices 	Document review <ul style="list-style-type: none"> - Staffing data KII <ul style="list-style-type: none"> - WCO, RO, HQ - MoHFW, national health institutions, - UN agencies - Donors to WHO India - Civil society and implementing partners
3.5 What were the monitoring mechanisms to inform CCS implementation and progress towards targets?	<ul style="list-style-type: none"> - Availability of monitoring mechanisms - Availability and usefulness of monitoring reports on progress towards targets - Identified best practices 	Document review <ul style="list-style-type: none"> - Monitoring reports KII <ul style="list-style-type: none"> - WCO, RO, HQ - Main national partners
3.6 To what extent has the CCS been used to inform WHO country workplans, budget allocations and staffing?	<ul style="list-style-type: none"> - Availability of explicit linkages between CCS and work plans, budget allocations and staffing - Weight of the CCS versus other activities undertaken by WCO 	Document review <ul style="list-style-type: none"> - Biennial workplans, budgets KII <ul style="list-style-type: none"> - WCO, RO, HQ

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 India COE.

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

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
CCS	CCS 2012-2017						Extension	CCS 2019-2023		
BWP/PB	BWP 2012-2013		BWP 2014-2015		BWP 2016-2017		BWP 2018-2019		BWP 2020-2021	
GPW	11 th GPW 2006-2015									
			12 th GPW 2014-2019							
								13 th GPW 2019-2023		

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 CCS 2012-2017 was informed by the 11th GPW but fell essentially within the timeframe of the 12th GPW,²⁰ which encompassed six years (2014-2019),²¹ and defined six categories as high-level domains for technical cooperation and normative work (e.g. communicable diseases, health systems). These categories were divided into individual programme areas (e.g. malaria, nutrition) and provided a programmatic and budget structure for the work of WHO. Through a results chain, the GPW furthermore explained how WHO's work would be organized over the specific timeframe and how the work of the Organization would contribute to the achievement of a set of intended outcomes and impacts.²² The 13th GPW (2019-2023)²³ represents a shift from categories and programme areas and is structured around three interconnected strategic priorities to ensure healthy lives and well-being for all at all ages: achieving universal health coverage, addressing health emergencies and promoting healthier populations. Under this structure, WHO's work will be organized around nine health outcomes and three leadership and enabling outcomes. 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)**.²⁴ 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 currently 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

²⁰ 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).

²¹ Superseded by the 13th GPW (2019-2023) in 2019.

²² 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).

²³ WHO (2018). Thirteenth General Programme of Work 2019-2023 (http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_4-en.pdf?ua=1).

²⁴ 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.²⁵

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.²⁶ 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.²⁷ 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 India COE. 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.

A common problem at country level, including for the India 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.

Hence, there is often no documented traceability of 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

²⁵ 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).

²⁶ WHO (2015). Programme Management. Glossary of Terms. Unpublished internal document. Geneva: World Health Organization.

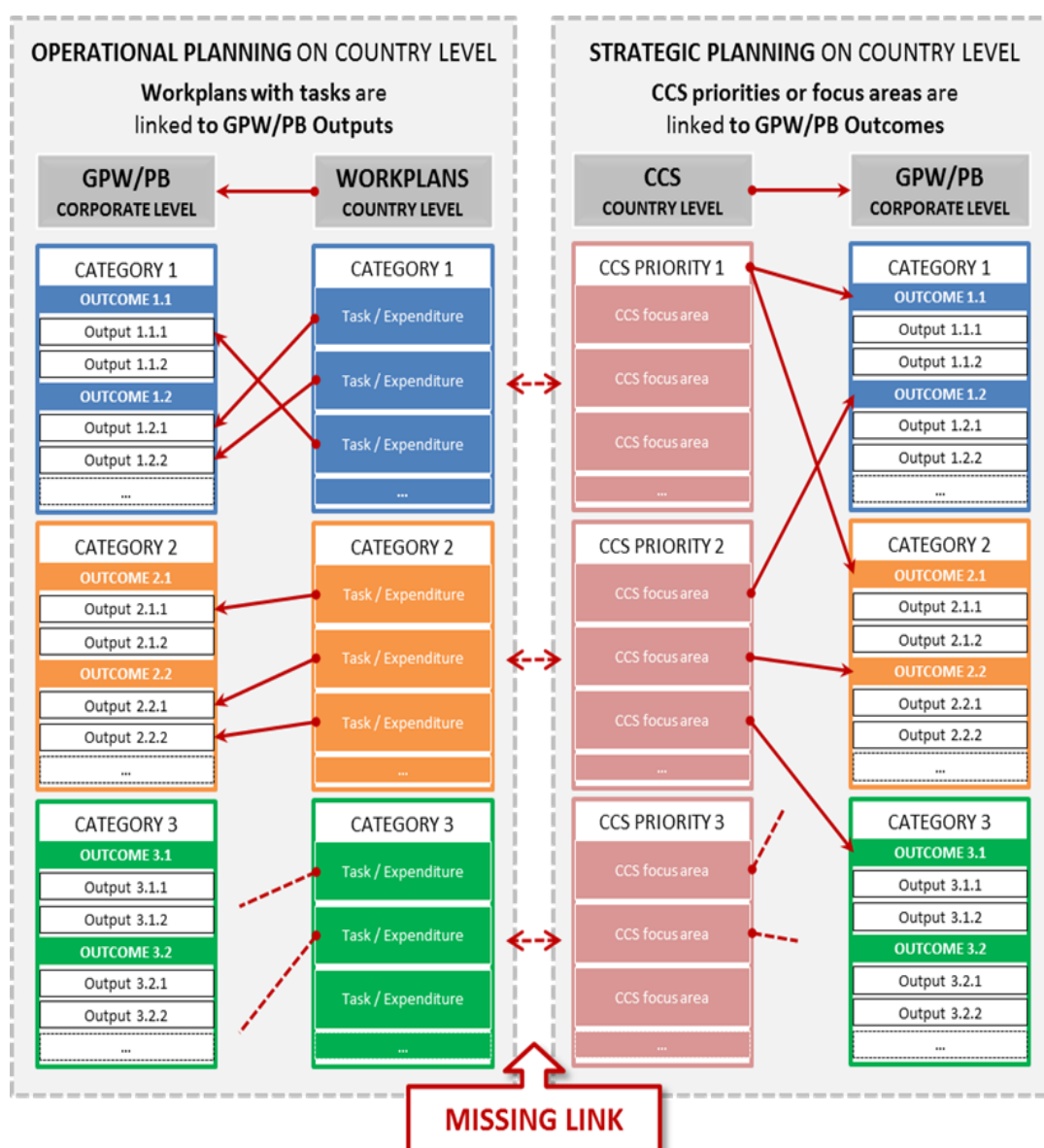
²⁷ WHO (2016). WHO Country Cooperation Strategy. Guide 2016. Geneva: World Health Organization (<http://www.who.int/country-cooperation/publications/ccs-formulation-guide-2016/en/>).

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, it is intended that the impact and outcome-focused approach of the 13th GPW will provide a better base for priority setting and programming at country level, and align more clearly with country planning and delivery of the work needed through the development of country support plans involving the three levels of the Organization.

Figure 2: Relation between strategic and operational planning on country level (12th GPW)



Annex 4: Programmatic achievement in the CCS 2012-2017 priority areas

Priority 1: Improved role of GOI in global health
<p>Objective 1.1: Ensuring the implementation of IHR and similar commitments</p> <ul style="list-style-type: none"> • IHR certified as per self-assessment in 2016 (no joint external evaluation) • Avian/pandemic influenza Inter-Ministerial Task Force and Joint Monitoring Group on various acute public health events • National Crisis Management Plan • Training on competencies for surveillance and response measures at point of entry • Joint monitoring mission of Integrated Disease Surveillance Project • Technical support and funding cause of death surveillance • National Consultation and Plan on Risk Communication • A network of district and state (referral) laboratories for Influenza surveillance in the country • World Health Day 2015 on Food Safety • National and State Action Plans for AMR developed, and support for WHONET training and guidelines • Development of Epidemic Intelligence Officers to investigate and respond to disease outbreaks • WHO's field team (NPSP) support during disease outbreaks and natural disasters, in the area of disease surveillance • Support for yellow fever vaccine procurement
<p>Objective 1.2: Strengthening the pharmaceutical sector, including drug regulatory capacity and trade & health</p> <ul style="list-style-type: none"> • Assessment of National Regulatory Authority for vaccines • Institutional Development Plan for National Regulatory Authority • Pharmacovigilance systems set up in HIV AIDS and Tuberculosis programmes including Bedaquiline monitoring • Pentavalent safety study undertaken in two states • Demonstration Project selected from Translational Health Science and Technology Institute • Support for Ministry of AYUSH (traditional medicine) in regulating traditional medicines
<p>Objective 1.3: Improving stewardship of entire Indian health system</p> <ul style="list-style-type: none"> • Technical assistance to national government on 15-year health sector vision • Support for National Health Policy 2017 & Three Year Action Agenda 2017-2018 to 2019-2020 • Support for SDGs Implementation Plan and a Monitoring Framework for India²⁸ • Participation in various national committees (Taskforce on Primary Health Care, National Health Accounts Steering Committee, Governance Committee for the National Health Protection Scheme, etc.) • Support to improve health information in the country including support to MoHFW, Ministry of Statistics and Programme Information and NITI Aayog • Support on health system strengthening to state governments ((blood transfusion, service delivery and health financing, injection safety, etc.) • Support for development of electronic disease surveillance system, (Integrated Health Information Platform) • Support for establishment and quality improvements of diagnostic laboratories testing communicable diseases and AMR • Support for nationwide study for validation most reliable software for verbal autopsy

²⁸ UNDAF 2013-2017. WHO major achievements (draft internal review).

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

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

- Technical support for the development of many of the new policies, strategic plans, action plans, guidelines and standard protocols that have been adopted to meet the Government's new health goals²⁹
- Chair of UNCT task team on UHC and designated technical partner to MoHFW
- Support for health financing reform
- High-level policy dialogue with MoHFW and NITI Aayog resulting in Ayushman Bharat (2018)
- Evaluation of free medicines scheme in Rajasthan and free diagnostic scheme in Madhya Pradesh and Andhra Pradesh
- Modelling study of National WASH campaign (*Swachh Bharat*)

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

- Support for implementing Clinical Establishments Act 2010, including assessment (rules for private health services)
- Assistance to MOHFW related to RSBY and designing the upcoming National Health Protection Scheme
- Advocacy and assistance for improving quality of care in the country

Priority 3: Helping to confront the new epidemiological reality

Objective 3.1: scaling up RMNCAH services

- Technical support for quality of facility-based maternal and newborn services, delaying Early Pregnancy in Adolescents, Prevention of Pneumonia and Diarrhoea, new born care, early child development, gender-based violence management
- Generating evidence on midwifery
- Support for training for Midwifery cadres and Skilled-birth Attendance, adolescent health
- Review and support for Integrated Management of Newborn and Childhood Illnesses
- Technical support for Birth-defects and Still Births Surveillance, Maternal and Child Death Reviews, and national population surveys
- Research on anaemia in pregnancy management
- Validation of Maternal and Neonatal Tetanus Elimination
- Advocacy on WHO Global Plan of Action on Violence against Women
- Consultation on updated UNSG Global Strategy for women's Children's and Adolescents' health

²⁹ WHO/India (2019). The WHO India Country Cooperation Strategy 2019-2023: a time of transition.

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

Objective 3.2: addressing increased combinations of communicable and noncommunicable diseases

Communicable diseases

- Support for Tuberculosis control in the form of 1) evidence generation on management innovations; 2) advocacy and support for national strategy development; 3) technical support for revision of guidelines; 4) support for surveillance; and 5) Joint program monitoring missions
- WHO field level TB consultants supporting innovations, surveillance support and monitoring trainings
- Support for HIV/AIDS control in the form of 1) technical and normative support for quality treatment services, including co-infection; 2) operational research on prevention models including PMTCT and PrEP; 3) technical support for service monitoring and HIV surveillance; 4) blood transfusion safety guidelines; 5) Joint review and revision of the national HIV strategy and programme
- Support for hepatitis control through consensus statements, technical workshops, costing studies and technical support to state programs
- Strategic planning support for National Strategic Plan for Malaria Elimination
- Technical support for revision of dengue case management guidelines national integrated vector management guidelines

Neglected tropical diseases and vaccine preventable diseases

- National level advocacy for elimination of NTDs and support for accelerated strategic plans for elimination of kala azar, lymphatic filariasis and leprosy
- Eight State and seven zonal NTD coordinators in high-burden locations for hands-on support for planning and independent monitoring of campaigns, case finding and treatment, supervision of surveys, and advocacy to local authorities
- NPSP operational support for vaccination campaigns against measles and rubella in five States and roll out of new vaccines in routine immunization programme
- Revision of National Guidelines for adverse events following immunization based on WHO guidelines

Noncommunicable diseases

- Support (with UNDP) for multi-ministry platform and CSO forum on NCDs, and strategic planning support for National Multisectoral Action Plan formulation
- Technical assistance to states strengthening NCD service delivery, including palliative care, NCD co-morbidities, adolescent health, and m-Health for prevention and control of NCDs
- Capacity building National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke
- Support for tobacco control program through evidence creation, capacity building of NTCP, care providers and program managers at state and district level; and operational guidelines
- Evidence generation to support policy advocacy, including NCD risk factor survey, economic burden of alcohol, health impact assessment of several ministries, malnutrition and obesity among children, mental health, air pollution and open defaecation/sanitation³⁰
- 25 WHO medical officers in 25 districts in five states support India Hypertension Management Initiative, with management protocols, health worker training and monitoring

³⁰ Jointly with UNICEF

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

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

- Polio operations transferred to MoHFW, including Investigation of AFP cases
- Quality assurance maintained at NPSP, including training, micro-planning, supervision
- Polio funding transferred to MoHFW, direct government funding for laboratory costs
- Funding mobilized from donors (GAVI, BMGF) and GoI to contract WHO for transition activities
- NPSP widened its scope include routine immunization and multiple other public health initiatives (measles/rubella campaigns, spraying campaigns for Kala Azar, etc.)
- NPSP staff reorganized, workload reorganized (Polio from 100% to 50%) trained for new roles, transfers to states with low RI coverage
- NPSP field volunteers (1500) outsourced to third party or directly managed by the MoHFW
- NPSP transition plan developed (2019)
- All routine and non-technical TB activities transitioned to RNTCP

Annex 5: List of people interviewed

WHO Country Office

Bekedam, Henk	WHO Representative
De Graeve, Hilde	Team Leader, Health Systems
Francis, Paul	National Professional Officer, Planning
Gupta, Madhur	National Professional Officer, Pharmaceuticals
Harvey, Pauline	Team Leader, NPSP
Murthy, Pavana	National Professional Officer, Health Security and Emergency, Infectious Hazard Management, Surveillance and Response
Mwinga, Kasonde	Team Leader, RMNCAH
Payden	Deputy Head of WHO Country Office
Seguy, Nicole	Team Leader, Communicable Diseases
Tullu, Fikru	Team Leader, Noncommunicable Diseases
Vanderlanh Smith, Michele	Administrative Officer

WHO regional sub-offices, India

Bajpai, Madhup (and team)	Regional Team Leader, Uttar Pradesh NPSP
Satapathy, Asish Kumar (and team)	Regional Team Leader, South India, NPSP

WHO Regional Office for South-East Asia

Allen, David	Director, Administration and Finance
Chauhan, Sharat	Partnerships, Interagency Collaboration and Resource Mobilization
Maza, Rony	Coordinator, Programme Planning, Monitoring and Evaluation
Namgyal, Pem	Director, Programme Management
Singh, Poonam Khetrpal	Regional Director

WHO headquarters

Floyd, Katherine	Coordinator, M&E, Global TB Programme
Glaziou, Philippe	Epidemiologist, Global TB Programme
Krishnamurthy, Ramesh	Senior Adviser, Information, Evidence and Research
Swaminathan, Soumya	Chief Scientist
Kanchar, Avinash	Medical Officer, TB/HIV and Community Engagement, Global TB Programme
Verma, Harish	Medical Officer, Clinical Trials and Research, Polio Eradication
Zaffran, Michel	Director, Polio Eradication

National partners and institutions

Agarwal, Lav	Joint Secretary, International Health, MoHFW
Aggarwal, Mahesh Kumar	Deputy Commissioner, Universal Immunization Programme, MoHFW
Akhtar, Jawaid	Principal Secretary, Department of Health & Family Welfare Services, Govt of Karnataka
Baswal, Dinesh	Deputy Commissioner, MRH and Midwifery, MoHFW
Benara, S.K.	National Institute of Medical Statistics, Indian Council of Medical Research
Bhargava, Balram	Secretary, Department of Health Research, MoHFW & Director General, Indian Council of Medical Research
Bhushan, Indu	CEO, National Health Agency, MoHFW
Chaturvedi, Arun	State Immunization Officer, Directorate of Family Welfare, Uttar Pradesh
Damle, Abhay	Joint Secretary, Ministry of Road Transport & Highways
Dass, J.K.	Director, National Institute of Health and Family Welfare
Dhingra, Neeraj	Additional Director, NVBDCP (Malaria)
Dhuria, Meera	Deputy Director, Division of Epidemiology, NCDC
Gupta, R.S.	Deputy Director General, National AIDS Control Organization, MoHFW
Gupta, Sanjay	Dean, National Institute of Health And Family Welfare
Gupta, Sunil	Additional Director, HAG & HOD, Division of Microbiology, NCDC
Iyer, Parameswaran	Secretary, Ministry of Drinking Water and Sanitation
Jain, Sudhir Kumar	Additional Director & HOD, Division of Epidemiology, NCDC
Jain, Tanu	Assistant Director General, Directorate General of Health Services, MoHFW
Jhalani, Manoj	Additional Secretary and Mission Director, National Health Mission, MoHFW
Halder, Pradeep	Deputy Commissioner, Immunization, MoHFW
Kabra, Sandhya	Additional Director, NCDC & National Viral Hepatitis Control Programme
Khera, Ajay	Deputy Commissioner & In charge, Child & Adolescent Health, MoHFW
Kumar, Sanjeeva	Additional Secretary, MoHFW
Kumar, Rajeev	Director, MoHFW (Noncommunicable diseases)
Manaktala, Anil	Deputy Director General (Policy), Directorate General of Health Services, MoHFW
Mathew, Binoy	Senior Programme Officer, Communications, Voluntary Health Association of India
Mishra, C.K.	Secretary, Ministry of Environment, Forest & Climate Change
Mukhopadhyay, Bhavna	Chief Executive, Voluntary Health Association of India
Paul, Vinod K.	Member, National Institution for Transforming India, Government of India
Prakash, Ved	General Manager, Procurement, National Health Mission, Uttar Pradesh

Raikwar, Madhu	Director, Central Bureau of Health Intelligence
Rao, Vishnu Vardhana	Director, National Institute of Medical Statistics (Indian Council of Medical Research)
Reddy, Srinath	President, Public Health Foundation of India & Institute of Public Health
Roy, Nupur	Additional Director, NVBDCP (NTDs)
Sarin, Sundeep	Adviser, Department of Biotechnology, Ministry of Science & Technology
Singh, Ritesh Kumar	Joint Secretary, Ministry of Environment, Forest and Climate Change
Singh, Sujeet K.	Director, National Centre for Disease Control, Directorate General for Health Services, MoHFW
Tandon, Rajiv	Director (Technical), PATH India State Immunization Officer, Department of Health & Family Welfare, Karnataka

International partners and institutions

Agha, Ahmad Abbas	Senior Project Officer, Health Systems Strengthening, United Nations Development Programme, Lucknow
Bharadwaj, Praful	Health Officer, UNICEF, Lucknow
Batra, Radhika Kaul	Chief of Staff, UN Resident Coordinator's Office
Camara, Bilali	UNAIDS Country Director
Chowdhury, Dipa Nag	Deputy Director, India, MacArthur Foundation
Foyouzat, Foroogh	Deputy Representative, Programmes, United Nations Children's Fund
Gupta, Gagan	Chief of Health, United Nations Children's Fund
Gupta, Sachin	Advisor, Maternal and Child Health, Health Office, United States Agency for International Development
Hari, Suresh	Rotary, Bangalore
Holtz, Timothy (and team)	Country Director, Division of Global HIV and Tuberculosis, US Centers for Disease Control and Prevention
Khan, Shariqua Yunus	Head of Unit, Nutrition, United Nations World Food Programme
Khandait, Devendra (and team)	Deputy Director, India Country Office, Bill & Melinda Gates Foundation
Mohammed, Suresh K.	Senior Health Specialist, The World Bank, New Delhi
Ratna, Parul	Coordinator, Consortium of PCI, ADRA & CRS, Lucknow
Rasheed, Nadia	Deputy Country Director, United Nations Development Programme
Saxena, Ajay Kumar	Rotary, Lucknow
Sidhwa, Xerses	Director, Health Office, United States Agency for International Development
Thacker, Deep	State Team Leader, Rotavirus Vaccine Introduction Project, Lucknow

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