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EVALUATION OF THE DFID/WHO PARTNERSHIP: SYNTHESIS REPORT

By Jurrien Toonen
(Royal Tropical Institute – Koninklijk Instituut voor de Tropen, KIT),
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PREFACE

This study was undertaken as part of the programme of evaluation studies commissioned by the Evaluation Department of the Department for International Development (DFID). Evaluation Department is independent of the spending divisions in DFID, and reports to the Management Board through the Director General (Corporate Performance and Knowledge Sharing).

The study evaluates the Department for International Development's partnership with the World Health Organisation. It provides an assessment of both the relevance and appropriateness of the partnership and of the efficiency and effectiveness of DFID's activities under the partnership. The study discusses the concept of partnership creating baselines for future monitoring and evaluation.

The evaluation is expected to be of broad interest because it generates lessons and recommendations for working more effectively in partnership with multilateral organisations more generally in the pursuit of poverty reduction.

The report is structured around the five evaluation criteria of relevance, appropriateness, unity, efficiency, and effectiveness. The study explores these at three levels within DFID and WHO and the team has also consulted other stakeholders. However, the evaluation does not seek to address the performance of either partner, rather it concentrates on the way that each partner perceived performance as part of the evaluation criteria. The report makes a number of recommendations that DFID's International Division will be responsible for considering.

The authors of the report are Jurrien Toonen (Royal Tropical Institute – KIT), Derek Poate (ITAD), Christopher Barnett (ITAD), Maria Paalman (KIT) and Marlene Abrial (KIT). An in-depth desk study, structured interviews and internal consultation fed into this final synthesis report. Phil Compernolle and Catherine Cameron managed the evaluation process for DFID.

M.A. Hammond
Head, Evaluation Department
August 2004

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ABBREVIATIONS

CHAD	Conflict and Humanitarian Affairs Department (DFID)
CFI	Country Focus Initiative
DFID	Department for International Development (UK)
DOH	Department of Health (UK)
EBF	Extra-budgetary funds
FCO	Foreign and Commonwealth Office (UK)
FP	Family Planning
GFATM	Global Funds on AIDS, Tuberculosis and Malaria
HDR	Health Development Report
HRD	Human Resource Development
ISP	Institutional Strategy Paper
IMR	Infant Mortality Rate
LIC	Low Income Country
M&E	Monitoring and Evaluation
MDA	Multilateral Development Agencies
MDGs	Millennium Development Goals
MEFF	Multilateral Effectiveness Framework
MIC	Middle Income Country
MIP	Meeting of Interested Parties (in WHO)
MM	Maternal Mortality
MOPAN	Multilateral Organisations Performance Assessment Network
MOV	Means of Verification
OVI	Objectively Verifiable Indicator
PRSP	Poverty Reduction Strategy Paper
RBB	Results Based Budgeting
RBFs	Regular Budgetary Funds
S&RH	Sexual and Reproductive Health
SWAp	Sector-Wide Approaches
TOR	Terms of Reference
UN	United Nations
WB	World Bank
WHA	World Health Assembly
WHO	World Health Organization
WR	WHO representative (country level)

EXECUTIVE SUMMARY

This report presents the results of the evaluation undertaken by a joint team from KIT and ITAD. Five working papers have been developed: (i) on defining partnerships; (ii) on DFID, WHO and the MDGs (iii) on M&E and results-based management within WHO; (iv) on management of the partnership (including a chapter on DFID's technical support and secondments) and, (v) on the financial aspects of the partnership.

According to the TOR (Appendix 5), the evaluation examines the partnership[1] between WHO and DFID and has two dimensions: firstly as an evaluation of the partnership with WHO, and secondly to provide lessons learnt for future partnerships. One objective of the evaluation is to further operationalise the concept of partnership and to formulate measurable indicators.

The report is structured around five evaluation criteria as identified in the Inception Report:

- **relevance** of the relationship, with special regard to the extent to which DFID's poverty goals are best addressed by support through WHO
- **appropriateness** of the ISP as an instrument to define the relationship and its mode of working
- extent of **unity** within the relationship – mapping the relationship and the trust and values among partnership members
- **efficiency** of joint actions and DFID contributions (management of the relationship, network attributes, resource allocation and communication)
- **effectiveness** of joint actions and DFID contributions (stability, M&E, capacity building)

The study has explored these at three levels: DFID and WHO headquarters and top management interaction; technical programmes; and at country level. The views of other stakeholders have also been solicited. The evaluation does not address the performance of either partner – but the team has considered performance as *perceived* by the other partner as important in the evaluation of criteria such as trust and appropriateness. Views on performance, where included, reflect the opinions of those interviewed not the team. The evaluation methodology was qualitative not quantitative as the sample size was small and the stratification (by level and by stakeholder) further reduced the potential validity of conclusions based on any quantitative data.

Relevance

DFID perceives WHO as the prime institution with an international mandate in the area of health. Its normative work is highly valued as is the technical assistance it can provide at country level. WHO sees DFID as one of its most important donors[2] - and values DFID's strategic role in developing policies, strategies and approaches for the health sector and WHO itself.

[1] In view of the objective to evaluate the partnership, the term relationship is more widely used within the report, so as to distinguish between genuine partnership characteristics and the less specific elements of a working relationship.

[2] The UK contribution to WHO consists of an assessed part, the regular budgetary funds, which is the responsibility of the DOH – and extra-budgetary funds, contributed through DFID. For this report we studied the perception of DFID's role in WHO.

In the December 2003 Annual Report, WHO states its role in attaining the health-related **MDGs**: *providing technical and normative support to countries and development partners, and tracking progress*. DFID, and other like-minded donors, understand WHO's broad mandate and multiple objectives but consider that poverty still needs greater focus in the organisation.

DFID expects WHO to play a role in operationalising poverty reduction strategies in health sector plans at country level. A consistent view expressed in country enquiries is that WHO could have shown stronger inputs to strategies for a poverty focus in health programs. A more pro-active and strategic pro-poor orientation was desired.

Appropriateness

The relationship between DFID and WHO is multi-layered and complex. At global level, DFID defines the relationship through its **Institutional Strategy Paper** (ISP). The DFID-WHO ISP is a formal embodiment of DFID's approach and sets out nine objectives. These deal with support to achieving the MDGs, improving the effectiveness of field programmes, strengthening partnerships with other development actors and increasing the effectiveness of WHO's internal systems.

At DFID headquarters, the ISP is seen as a framework for priority setting. It describes the expected results, but not how DFID aims to work with WHO to stimulate change. The subsequent action plan, (ISP-AP) was intended to define outputs, allocate responsibilities and propose monitoring indicators. But progress in producing it was slow, the text of the action plan shared with WHO after drafting and, although used, it has not been formally adopted. Delays in DFID are attributed to disruption associated with the reorganisation, but in WHO there seemed to be few incentives to finalise the document.

WHO views the ISP as providing common objectives for the partnership and general direction for financial support to WHO. WHO expected the ISP to give clearer guidance on the expenditure of un-earmarked funds. The ISP and the action plan do not define the relationship between DFID and WHO at regional or country level and at this level there was little awareness of the documents.

The ISP does not identify specific measurable indicators of performance. The structure of the ISP- Action Plan (AP) is mainly activity and output–orientated (particularly the May 2003 version). This AP does not yet represent an agreed document, but is considered as an evolving document. As a tool for **monitoring and evaluation** the ISP-AP provides only a narrow basis to assess performance in reaching the ISP objectives. It does not capture important complexities in the partnership. In practice the relationship is monitored informally, through regular contact with staff at the UK Mission in Geneva, and at the Annual Review Meeting. This annual review is a useful forum for policy dialogue and for WHO and DFID to discuss progress and concerns.

Unity

Unity is a criterion developed specifically for this evaluation. The study has mapped the relationship and examined shared values and trust to assess how closely they reflect a partnership.

The **relationship** is particularly complex because of the three levels (management, programme and operational) of partnership and because of the role of the UK Department of Health (DOH) which is the lead department in the relationship with WHO. The complexity of the relationship and number of important actors at various levels in each organization, is illustrated in Figure 1 on page 26.

Relationships between DFID headquarters and WHO Geneva are quite different from those at regional and country level. WHO has a unique governance structure that has led to the development of strong regional offices with a high degree of control over country programmes. According to WHO respondents this complexity is not well understood in DFID. The absence of a regional dimension to the ISP highlights a gap in DFID's conceptualisation of how WHO functions. The relationship is inevitably complex, the implication for managing it is that DFID needs to understand the relevance of the relationship to different stakeholders, and the nature of opportunities to work through stakeholders to pursue objectives. The current strategy fails to distinguish between stakeholders and lacks an agreed implementation plan.

Shared **goals or values** among partners give unity to interpersonal and inter-organisational relationships, and common direction and purpose. DFID's overarching goal of poverty reduction is implemented through an objective-driven management structure linking personal work-plans, country programmes and the Department's Public Service Agreement. Because of its broad mandate and responsibility to respond 190+ member states WHO has less focussed goals.

The overall WHO framework shows similarities to DFID's thinking on health. Whilst the framework suggests compatibility, implementation is less straightforward. Complications arise from the way WHO programmes are developed and implemented at headquarters, regional and country level. Key issues of concern are:

- A significant proportion of WHO work is managed through **"priority" programmes** such as Stop TB. These act as a focal point for staff resources and funding, mostly through extra-budgetary funds. Activities are planned at regional level or in Geneva for country level implementation - often with little consultation with the country WHO office, or other national staff. As a result technical programmes are often prioritised rather than health system development or other issues identified under PRSP processes.
- The definition of **country focus** is also open to interpretation. Some stakeholders see following MOH policies as showing a country-owned approach. Others see a role for WHO in engaging with government to stimulate assessment of pro-poor policy options in the health sector. In this complex environment and given its broad general mandate, in the view of many observers WHO is lacking a coherent approach to poverty.

The level of **trust** between WHO and DFID is considered highly individual-specific and difficult to rate. Process-based trust, which develops through successfully working together is regarded positively by DFID and WHO, so there is a need for implementation activities to promote joint working and shared experience.

Efficiency
In looking at efficiency, the attributes of the relationship as a partnership network are examined: its centralisation, degree of stability and its role in facilitating resources, are key to characterising and managing it.

It is clear from interviews at headquarters and countries that most interaction and coordination is programmed, predictable and centres on specific sector or technical work. There are *no specific resources to maintain the partnership*, and no mechanisms to promote the relationship, as opposed to specific programmes.

Neither DFID's nor WHO's internal reorganisations have had much impact on their working relationships at **country level**. There are no specific partnership mechanisms to coordinate at country level and therefore meetings are issue-based or within regular bilateral or multilateral forums. Communication between DFID headquarters and its country offices about the partnership was considered to be very poor. The majority of WHO representatives contacted had, prior to the evaluation, not received any communication from their regional office or WHO Geneva concerning the DFID ISP.

The **UK Mission** in Geneva performs an important role in communication and liaison between WHO and DFID staff at headquarters. The UK Mission is instrumental in communications with the 7+ Group of like-minded donors. Beyond formal interaction there is little routine sharing of information. DFID (and other donors) find it difficult to obtain up-to-date information such as information on actual spending on programmes supported by WHO. This has however improved during the last years by the introduction of results based management, and WHO is seen as providing better quality information than some other multi-laterals.

Between 1997/98 and 2002/03 the **financing** of development aid by DFID increased in real terms by 43 percent. Multilateral aid represents about 40 percent of total aid, but has increased at a slower rate (+ 30 percent) in real terms over the same period. In the same period, the WHO share evolved more positively, but compared to DFID's bilateral spending on health, the proportional allocation of WHO financing is lower and increased at a slower rate. The study notes that DFID has prioritised bilateral aid rather than funds channelled through WHO to support health activities, and that this tendency has increased over time. WHO is increasingly dependent on extra budgetary funds (EBF).[3] Prior to 1996 contributions to regular budgetary funds were more important than EBF; by 2004/05, the EBF was expected to amount to 68 percent. The channelling of more funds to WHO in pursuit of poverty reduction objectives should depend on the development of more effective and transparent procedures for programme review and performance evaluation by WHO.

[3] Of the total EBF, one quarter is spent on WHO's country programs and three quarters on the nine WHO clusters, of which three take 75 percent: communicable diseases, health technology & pharmaceuticals, and sustainable development & healthy environment. Within the country programs, EBF covers half the expenditures in Africa, South-East Asia

DFID's move to **un-earmarked** EBF contribution is regarded by WHO as a positive mode of financing: it gives flexibility, it allows WHO to fund programs less fashionable in the eyes of donors and stimulates WHO to prioritise. There is no real mechanism in WHO to develop an organisation-wide plan for these funds and WHO's own allocation for 2002 was largely based on past DFID priorities. It is a challenge to DFID to reinforce the move to un-earmarking with support for rigorous programming systems and evaluation of effectiveness.

Effectiveness

At this early stage in the post-ISP relationship, it is not possible to make a definite judgment about change within WHO resulting from the partnership. Observations are limited to perceptions of influence, and the scope to monitor and evaluate change.

Perceptions of **influence** vary considerably according to the viewpoint of the respondent. At WHO headquarters, DFID is credited with being influential in several key areas: the Commission on Macroeconomics and Health; the promotion of a poverty focus to WHO's work; and in technical support to programmes such as HIV/AIDS and the Country Focus Initiative. Many respondents mistakenly consider that British nationals employed by WHO are "agents" of DFID policy objectives, or even working on secondment. Among others there is a negative view of the ISP and its potential influence and they suggest that DFID should confine itself to exerting influence through the WHA. At country level DFID health advisers do not see yet evidence of DFID-promoted change in WHO.

WHO has been implementing **institutional change** including the adoption of a Results Based Budgeting (RBB) approach but reforms are not yet fully bedded-down across the organisation, and there is considerable variance in uptake. The challenge of how to ensure shared planning responsibilities between organisation-wide commitments and locally defined needs has been identified as particularly important. Global priorities were included in procedural guidance for 2002-3, but there is a need for flexibility with regard to regional and country specific health priorities.

With DFID's move to un-earmarked funding, for **monitoring and evaluation** there is increased reliance on WHO's own internal systems such as the Programme Budget. DFID does not yet systematically monitor the effectiveness of other aspects of WHO. It is important to reduce transaction costs and the number of separate reporting systems, but WHO's monitoring of Expected Results does not yet offer a viable alternative way of monitoring performance and may not be fully reporting for several years. The MEFF (multilateral effectiveness) tool, based on a balanced scorecard ('traffic lights') approach, provides valuable additional information for policy dialogue. The system is simple, and focuses on issues of fact concerning the internal organisation of multi-laterals and their "impact" at country level. The MOPAN study on the (perceived) effectiveness of MDAs in the health sector at country level is consistent with the main findings of this partnership evaluation.

Discussion and conclusions
Section 3 of the report reviews the findings of the study through a set of questions derived from the original terms of reference. These examine the notion of partnership and conclude that whilst the relationship exhibits many examples of DFID and WHO working in partnership it is **not a partnership** as such, overall. The high degree of relevance for DFID working with WHO globally is contrasted with a less clear picture at country level, where WHO's commitment to and understanding of a poverty focus is still being developed. The lack of awareness about WHO's mode of working at regional and country levels and the lack of provisions such as partnership funds to foster the relationship in the field are key omissions from the ISP.

DFID's decision not to earmark funds is an expression of trust in advance of demonstrable change within WHO, to enable transparent prioritisation and effective monitoring.

Lessons learnt for DFID's partnerships with Multilateral Organisations

DFID is in the process of defining its relationship with a number of MDAs in a series of Institutional Strategy Papers (ISPs). To date, DFID has prepared some twenty-five ISPs, with the primary purpose of providing "a framework for DFID's activities to work with and influence Multilateral Development Agencies across different parts of the office". The lessons learned from this evaluation for DFID partnerships with MDA are as follows.

On defining the concept of partnerships

There are many different definitions of what constitutes a 'partnership'. From a literature review it has been concluded that two qualities are essential to add to the classical evaluation framework: the *unity* between individuals and organisations, and the *direction* (or overarching goals) of the partnership shared among its members.

In this evaluation the following **partnership definition** has been used**:** *Inter-organisational relationships involving activities beyond that which contracts or authority alone would warrant, aimed at achieving shared goals based upon close working relationships.* In establishing a new relationship (or redefining an existing one) it should be decided if this is a desirable and feasible result of the relationship.

Four sets of concepts are key to effective partnership working:

- Trust embodies mutual reliance, dependence and the acceptance of risk.
- Having shared values embodies joint commitment to common goals.
- Clear and understandable communication is often a prerequisite for development of trust and to reinforce actions in support of common goals.
- Network attributes refer to the degree of centralisation or openness of the partnership, its stability in terms of its resources, agenda and the people involved, and the ability of the partnership to facilitate the acquisition and transfer of resources and add to the capacity of partner organisations.

Recommendations

1. DFID and the MDA should agree on the nature of the relationship to be pursued. Specifically:
   - whether a contractual or an administrative relationship is appropriate. A true partnership will give rise to specific dynamics and mutual expectations
   - at what level the relationship will take place – HQ-HQ only, or at country level as well.

The relevance of both partners to each other

The relevance to DFID of working with a MDA hinges on the potential for enhanced contribution to poverty reduction. All MDAs have a commitment to the MDGs, the relevance is in their **comparative advantage** in attaining the MDGs. The degree of relevance differs according to the level at which DFID operates. The relationship could be highly relevant to DFID globally where the MDA fulfils a unique role; but may be less at country level if the MDA is not effective at poverty reduction. The MDA is likely to have a unique position at global level but at country level alternative partners for DFID may exist.

The move towards sector-wide approaches and budget support has changed the nature of DFIDs' relationships with MDAs at country level from a bilateral dialogue to a multi-donor grouping together with the national authorities. This shift is likely to affect modalities for provision of technical assistance. The UN organisations provide an opportunity to substitute the TA formerly provided by projects.

Recommendations

2. Many DFID partnerships have evolved from historic and personal relationships. Relevance to DFID's objectives should be reviewed systematically to enable DFID to target its approach to the relationship (say, through a selection of DFID country offices).

The process of defining a specific partnership with a Multilateral

The relationship between DFID and an MDA has several dimensions – it encompasses more than an institutional strategy. The ISP is a valuable means of expressing common objectives in the relationship between DFID and an MDA, it is a formal embodiment of the shared goals in the partnership. It is entirely appropriate for DFID to have an institutional strategy, especially where DFID contributes a high level of resources through extra-budgetary funding.

MDAs work with many partners; developing an ISP brings significant transaction costs. The development of the ISP has helped DFID to define better its strategy for a working relationship with the MDA, and as a negotiation tool it brings clarity and transparency to the MDA on DFID's strategy. If the IS approach continues to be used, they should be more than a policy statement and include a guiding framework for the partnership. For example, the relation between the ISP and the non-assessed funded programmes supported by DFID should be explained. A better understanding of the relationships between country programmes and headquarters will enable the ISP to address all these levels.

Publication of the ISP is a necessary and desirable contribution to transparency. But publication alone is not sufficient to ensure widespread awareness and understanding. Both DFID and the MDA are likely to gain more from the relationship if the ISP is promoted widely within the organisations.

There is a tension between "partnership" and the asymmetrical relationship that arises because DFID is a major donor. The ISP should address both DFID's expectations and those of the MDA. If not, the ISP will be seen as a statement of DFID policy rather than a basis for joint working.

Any specific bilateral partnership with a MDA has the potential to be seen as undermining the MDA's policy processes and governance structures and its accountability to member states. Stakeholders may see the developing of an ISP as an isolated process that bypasses the influence of the regular governing bodies of the MDA.

Whilst the objectives of an ISP may be shared by other stakeholders, particularly the 7+ Group, and developing countries themselves, negotiation of a joint ISP with a wider group may be difficult to negotiate and potentially unwieldy.

Recommendations

3. At the start of a partnership process, both the MDA and DFID should agree *mutual* expectations.
4. A stakeholder analysis to enable DFID to identify strategies to work with specific groups of stakeholders in pursuit of the ISP objectives should be carried out.
5. The broad lines of DFID's strategy explaining how DFID and the MDA will deal with their relationship at country level needs to be explained in the ISP – at country level this strategy would be adapted to the local context.
6. Efforts need to be made by DFID to ensure that the ISP is properly understood by all member states and is not seen as undermining established governance processes.
7. A communication strategy needs to be developed to promote the concepts of the ISP to other stakeholders. DFID should bring the outcome of the ISP negotiation process to the MDA governing body for recognition and to promote shared objectives by other member states.

Unity and direction

To assess the concept of *partnership*, "unity and direction" are the main criteria. For DFID, poverty reduction is the over-riding objective, and MDAs are committed to this. However, shared commitment to the MDGs does not necessarily mean common understanding of how to **address poverty**. Despite similar thinking to DFID on poverty at a policy level, complications can arise from the way programmes are developed by the MDA. For example, technical programmes to address poverty diseases are not necessarily pro-poor unless arrangements are made to ensure access by the poor. Mainstreaming poverty in technical programs would mean planning how to reach the poor with the services, how to ensure participation on priority setting in the programs, how to target poverty pockets and address inequalities. This is an area where DFID can use the relationship to support the MDA in developing pro-poor policies.

The level of **trust** between staff in DFID and the MDA may be very high, but will depend on shared values and personal relationships. In view of the staff turnover at headquarters and country levels the relationship will benefit from actions to foster working together that help to build trust.

Harmonisation of processes is a practical expression of sharing values. Examples exist of bilateral donors representing each other in meetings – an illustration of taking a risk based on trust.[4]

The extent to which extra budgetary funds are earmarked or un-earmarked affects relationships. DFID's actions to un-earmark funding are a decisive demonstration of trust and a stimulus to improved priority setting by the MDA. But the criteria for un-earmarking are unclear and the change may affect the predictability of funding of pre-existing programmes.

Decisions on un-earmarking of MDA funding should take into account the type of information and the reliability of the MDA's M&E system as this will influence partnership trust. The visibility of DFID funds will be reduced and therefore attribution to DFID contribution to the MDA will be reduced.

Recommendations

8. DFID is well placed to offer technical support to mainstream poverty reduction in the programmes of an MDA.
9. Criteria for un-earmarking of non-assessed funds should be developed, such as the presence of internal mechanisms for priority setting in the MDA, programmes that are key to DFID to be addressed and the reliability of information derived from the M&E system – a 'green' rating for these elements in the MEFF traffic lights.
10. Shared representation on technical issues would be a practical objective for UN harmonisation at country level.
11. As individuals are key to developing partnership and trust, stability of personnel and recruitment of personnel should be a structural issue in the dialogue between DFID and the MDA.
12. Technical support by DFID for programme budgeting, monitoring and evaluation would help MDAs make progress towards ISP goals.
13. DFID should redefine its M&E role, with a greater emphasis on measuring: i) partnership performance; ii) country-level effectiveness and impact; iii) areas not well covered by the MDA's internal performance measurement (such as institutional reform).

[4] DFID's Asia Division has identified the use of so-called silent partnership or delegated cooperation where one donors acts with authority on behalf of one or more other donors as a regional objective (Asia Directorate, *Response to the Challenges to Asia Division from the Management Board*, Working Draft, 19 April 2004, page 21)

Strengthening the performance of the relationship

The reorganisation of DFID's Policy Division had a significant negative effect on implementation of the ISP and the overall relationship with WHO. The role and function of the new policy teams is poorly understood by stakeholders, and in many instances by DFID staff at country level – while there is a lack of internal clarity about who decision makers are.

In order to enable the relationship to achieve it's objectives, arrangements are needed to implement a number of basic features of good partnerships: communications about partnership objectives and ways of working; mechanisms to promote the relationship; resources for capacity building and joint actions; and information sharing. At country level for example, limited support is given to encourage DFID country offices to strengthen the relationship and support institutional reform of WHO.

WHO holds DFID in high regard for the quality of its secondees and technical assistance. DFID's comparative advantage is seen to be derived from its core of technically experienced staff and ability to draw on TA from other UK institutions.

Partnership working is distinct from both market-based relations determined by contract, and relationships in the public sector involving hierarchies based upon authority. It is necessary to look for evidence of *partnership working* in both organisations. A number of methodological issues in M&E of a Multilateral- partnership are to be found in Appendix 4.

Recommendations

14. High priority should be given to continuity of personnel and clarity of responsibility in DFID.
15. Options for supporting and developing the relationship should be considered, including the availability of resources for workshops, training, meetings, etc.
16. The partnership needs to be clearly defined in the ISP, what will be dealt with by which entity at management, program and country level to ensure transparency and facilitate processes.
17. Elements of the evaluation framework of the present study (see Appendix 4) could easily be integrated in MEFF.

1 INTRODUCTION

The KIT/ITAD team was invited to carry out an evaluation of DFID's partnership with WHO within the context of the ISP and the ISP Action Plan, and as a first example of evaluating DFID's partnership with other multilateral organisations.

The approach, the evaluation methodology and framework have been summarised in an Inception Report and presented to, and agreed by, a DFID-WHO Evaluation Panel. This synthesis report is part of the third phase of the evaluation exercise, and has benefited from the comments of the DFID/WHO Evaluation Panel. The inception report and the Synthesis Report have been built on the following reports, produced by the team:

- Defining and evaluating « Partnerships »
- WHO, DFID and the MDGs
- M&E and results-based management within WHO
- DFID's management of the partnership with WHO, including the ISP process, and DFID's technical support to WHO;
- DFID's financial support to WHO.

The third (final) phase will be devoted to the dissemination of the results of the evaluation: presentations in London and in Geneva to an extended Evaluation Panel in the first half of July.

Although the evaluation examines the partnership between WHO and DFID and is not an evaluation of WHO's performance, we recognise that attention for the contribution of WHO to achievement of the MDGs needs to be seen within the context of WHO's total mandate. DFID maintains several partnerships and this evaluation therefore has two dimensions: firstly as a straightforward evaluation of the partnership with WHO as such, and secondly as a case study of what DFID can achieve through partnerships. We understand that one objective of the assignment is to further operationalise the concept of partnership and to provide lessons learnt on evaluating "partnerships" with other MDA.

We aim to assess whether the partnership approach is potentially a relevant, appropriate, efficient and effective way to further DFID's objectives (as laid out in the White Paper) and to achieve the MDGs. DFID realizes that it will not yet be possible to assess the partnership's outcome and impact, but the potential of these should be appreciated. Although an assessment of the performance of the partners was not the objective (for this we refer to MEFF and the MOPAN evaluations) – the performance *as perceived by the partner* is highly relevant for the partnership working. These comments have been taken into account in the report, so comments on this topic do not represent the opinion of the team members but of the interviewees.

An overview of the approach (a summary of the inception report) is to be found in Appendix 1.

About this report
The background, the approach and the methodology of the evaluation are explained in Appendix 1; the findings are discussed in Chapter 2.

First in **Chapter 2** (section 2.1), the **relevance and appropriateness** of the partnership are assessed. This includes examining the comparative advantage of the two partners to each other, both at headquarters and at operational level: why would the organisations work together? What is their added value to the other? Given that poverty eradication is DFID's single most important objective, the role of WHO's activities in the health related aspects of poverty reduction at both levels represents an important issue in the discussion regarding the relevance of the partnership. The ISP states the expectations of the partners in their working together. Questions to be addressed therefore include: "Does the ISP indeed reflect the expectations of the two partners?" and "Does the ISP indeed provide guidance to the working relationship?"

In the second part of Chapter 2 (section 2.2), the **unity** in the partnership is the main subject addressed. First the complexities of the partnership structures involving both organisations are outlined through a description of the architecture of the partnership and by a stakeholder analysis (including a diagram on support and influence). Unity in the partnership demands unity in direction, and therefore shared values and goals. These are assessed in the documents of both parties, and by examining the opinions as expressed by those that should make the partnership work. "Trust" – another key issue in the evaluation framework – is discussed using themes including reliability and predictability.

The next part of Chapter 2 (section 2.3) deals with **Efficiency**. In terms of the partnership evaluation this concerns the network attributes, communication and sourcing of the partnership. The network attributes having changed as a consequence of reforms in both institutions, the effects of these reforms on the relationship will be discussed. Regarding communication, the main issues addressed are frequency and quality – and in particular quality as perceived by those involved in maintaining the partnership. Also important in communication is transparency, the sharing of information, and the centralisation of information.

The relationship is partly characterised by a resource flow from DFID to WHO, and this is an important factor in the way the relationship develops. Although there are many British nationals working for WHO, especially at HQ level, relatively few are funded by DFID; most British TA comes from UK-based knowledge institutes. DFID's financial resources to WHO provide clear indications of the importance of WHO for DFID, but also of what is in WHO that is important for DFID. An interesting issue in this regard, certainly in terms of assessing the partnership, is the recent un-earmarking of a part of DFID's extra-budgetary funding.

In terms of **Effectiveness** (section 2.4), the partnership processes and M&E are important. For the partnership processes, stability is crucial for long-term effectiveness. We also consider the incentives required for both parties to be effective. Finally the scope and utilisation of the results of the M&E system are discussed.

Chapter 3 offers a discussion and conclusions concerning questions that were asked in the approach paper (the Terms of Reference).

2 THE FINDINGS

In this chapter, the findings of the team are presented. As the evaluation addresses the mutual relationship between DFID and WHO and because the methodology is based to a large extent on interviews, the findings often reflect the perception of key players in the two organisations. Thus the opinions in this chapter represent the views of these stakeholders as expressed during the interviews, rather than of the team.

2.1 Relevance and appropriateness

In reviewing the relevance and appropriateness of the partnership the evaluation team was guided by a number of specific questions elaborated in the Approach Paper (TOR). The ISP Review identified a need to establish the significance of the partner's role within the global institutional context specifically in relation to the Millennium Development Goals.

Relevance of WHO as a partner?

- Why WHO? What are the alternatives? What is the link between WHO and the MDGs?
- What value is added through the partnership with DFID? (i.e. the relevance of DFID)
- Are there criteria for working with multilateral organisations?

Appropriateness of DFID – WHO partnership

- What constraints are addressed?
- What are the risks to achieving the intended objectives?

2.1.1 The comparative advantage of both partners

Head Quarter level

For **DFID**, WHO is the key institution with an international mandate on health; as one member of staff said: "If WHO didn't exist yet, we would have to invent a similar organisation". WHO is seen by DFID staff as highly relevant to DFID and in emphasising this reference is made especially to WHO's normative work at headquarter level. WHO produces an enormous number of publications on many types of health problems, disease control, and health systems development. WHO promotes health systems research and the search for innovations in improving health status. Increasingly WHO aims to be a focal point for knowledge and evidence from health-related research. An impressive amount of information is disseminated to member states and shared during conferences and seminars where health professionals meet, exchange and generate knowledge. WHO is the obvious organisation to address surveillance and to coordinate action in relation to world-wide epidemics, with the control of the SARS epidemic as a powerful example of WHO leadership. Through its support to WHO and to its normative and information sharing role DFID feels that it makes a positive contribution to supporting the health sector in many countries.

In response to demand from member states, and reinforced by the change in the DGs office, WHO has increased the primacy given to "priority (or so-called "*vertical*" programmes) and to emergencies. Some see this as an example of WHO leadership, while others fear for the consequences of the wide range of demands made on the organisation.

For **WHO**, DFID is not just one of its most important external financing agencies, it also provides strong strategic inputs to the development of policies, strategies and approaches for the health sector *and* to the organisation itself. This input is given during the regular WHO meetings (WHA and MIP) and during bilateral meetings to discuss the specific DFID financial contributions and the realisation of the expected results in WHO. Other major donors also provide important inputs, but specific to the relationship between DFID and WHO is that the expected results of the bilateral relationship in the ISP have been defined and agreed on. In addition, an aspect that is highly valued by WHO is access to technical expertise available in the UK. For instance, DFID facilitates cooperation with public health schools in the UK. This is one successful aspect of the cooperation at the level of Headquarters that WHO would like to see expanded to facilitate access to technical expertise at country level.

DFID's positive, critical attitude within the organisation is appreciated. WHO sees DFID as a useful partner/donor as it pushes for improvements and has people on the ground that are in a position to give good feedback on the performance of WHO.

Country Level

From the **DFID perspective**, the added value of WHO is in providing **technical assistance** to Ministry of Health programmes. As the only multilateral organisation with a primary mandate to work in the health sector and because of its internationally accepted normative role, WHO is considered to be important and is highly appreciated by DFID and other partners at country level. WHO has a commitment to evidence-based action and policy, which is seen as important. WHO is seen as an important and credible party at country level. WHO staff and the WR have influence with the national ministries and health authorities. WHO is still in a position to provide expertise and extra hands. In addition, WHO is seen as having credibility and international experience that enhance the success of programmes.

In the current policy context (SWAp, Budget Support) bilateral donors increasingly engage in the policy debate and withdraw technical assistance from programmes and projects. DFID sees a role for WHO in providing technical advice to governments. WHO's leadership on technical issues and normative work in disease control programmes are widely recognised at country level. This is less so in relation to policy and strategy development or in relation to health system development and institutional development. The support WHO gives to systems and institutional development varies widely from country to country and for this reason WHO is not the natural party for DFID in all countries. When it comes to issues like sector reform DFID often considers the World Bank and the EU the most relevant partners. WHO tends to be less interested in reform and to avoid taking positions on politically sensitive issues.

For WHO, DFID remains an important potential source of funding for activities, although requests are less frequently awarded than in the past and WHO realises that funding will increasingly go through the national ministries. WHO staff at country level acknowledge that DFID is strong on strategic issues, vision and leadership, and refer to their expertise. Several people mentioned that DFID's input into issues related to the Global Fund and other Global Initiatives were particularly important at country level. WHO staff see a continued need for this and would welcome increased input from DFID on policy and strategy questions.

WHO is concerned about the future of Budget Support when DFID and other donors cease to provide technical assistance. There will be a continued need for support after technical assistants have been withdrawn from projects and programmes to strengthen capacity in Ministries of Health and to maintain progress. WHO sees a possible future role for itself in this area and sees it as an extension of its natural role. It has country offices, well-established networks and institutional support. It is independent and has access to a great wealth of technical skills.

In times of SWAp and Budget Support the relationship between both partners **at country level** has undergone important changes. Major decisions are, in general, no longer taken during bilateral meetings of two external partners in a country. Instead they are increasingly taken together with the Ministry and with other donors. The outcome of future tasks and the role of WHO in technical assistance, in relation to a future contraction of technical expertise in bilateral donor offices like DFID, will therefore depend on the (perceived) quality of WHO's services. Essential for the MOH in this is national leadership in establishing the priorities for technical assistance.

WHO Technical Assistance to Ministries is not always perceived as meeting satisfactory standards. To some extent quality problems would seem to be the result of the policy of recruiting promising young national health professionals to positions in the country office. They are often judged as lacking the seniority and experience to provide technical assistance to senior health staff in the relevant ministries. During a round table discussion, a number of Dutch experts with experience of WHO at country level gave another possible explanation for the perceived quality problems. They suggested that the pyramid and hierarchical nature (between the different levels of WHO and within the country office) leads to bureaucracy, and is a reason why professionals at country level may not dare to take risks, or hesitate to be creative or push too hard. Another reason mentioned was that WHO staff-recruitment practices at regional and country level are not rigorous enough and appointments are too often made on "political grounds". These views were shared by a number of the DFID health advisors interviewed.

There is, of course, a great variety between country offices; it was frequently mentioned that much depends on the WR. Changes in WHO Representatives appear to have a great impact on the success of the relationship, which – as in most partnerships – is determined to a great extent by the personalities involved. DFID staff reported that with regard to technical matters they chose to work with NGOs rather than with WHO in specific cases where the WR was seen as less interested or less effective.

The **MOPAN-study** (Dec 2003) was launched by like-minded donors in response to an increased focus on the performance of multilateral organisations at country level. The study focuses on health and compares the performance of WHO, WB, Unicef and three regional development banks. According to MOPAN, WHO is seen as technically competent. Developmental changes at country level, such as SWAp and Budget Support has brought about new challenges for multilaterals and the way in which they function. Indeed the assessment concludes that WHO is in line with national strategies, and has become more responsive to government requests. Also, more than other multi-laterals, WHO has increased its efforts of coordination in the last three years. WHO could however play a more active role in coordination between MOH and other partners in health – as it does

not always manage to achieve the role of leading normative agency with respect to health policies. WHO disburses its funds more through government budgets than other multilaterals, but still this is low, and it does not respond to national procurement procedures. WHO translates fewer of its documents in local languages (less than PAHO or Unicef) and pro-active information sharing may be improved. WHO contributes to capacity building, but rather at central than at sub-national level in countries – as it fosters less participation of primary stakeholders than other agencies (like Unicef). Finally, the assessment concluded that the WHO's behaviour is largely attributable to *personal factors* rather than institutional ones, and like all multi-laterals, it is very hierarchical.

2.1.2 Roles of WHO and DFID in Poverty reduction and achieving the MDGs

Since the 1997 DFID White Paper, elimination of world poverty through support for the international sustainable development targets has become the single most important and overall goal of DFID's endeavours. This means that for DFID poverty reduction represents the single most important issue in terms of relevance in WHO. One of the key intended outcomes as stipulated in the ISP is that WHO embrace the MDGs and mainstream poverty across the organisation. DFID has constructed an elaborate objective-driven management structure linking personal workplans, country programmes and the Department's Public Service Agreement. (see Balogun and De 2002: 18-19).

This implies that WHO would formulate objectives that focus on poverty and the Millennium Development Goals, supported by M&E and reporting that is coherent with this focus. The intention is that the WHO reform programme should reflect this pro-poor focus and that WHO would engage in pro-poor approaches at country level.[5]

The WHO framework shows similarities to DFID's thinking on poverty and health. Emphasis is placed on the scaling-up of financial resources; on giving priority to the private sector providing services to the poor and the role of stewardship in the public sector; on mobilising resources for pro-poor health; on the development of equitable financing systems and of systems that measure health system performance; and on the promotion and study of global public goods.

However whereas poverty elimination is an overarching objective for DFID, this is not the case for WHO. Comparable UN agencies have poverty more prominently on their agendas. WHO has a much broader view on health, and addresses wider health issues than are highlighted in the MDGs. Many of these are important for the health status of the poor, for example a focus on factors to improve a healthy environment and health system development – as well as an important role in combating epidemics.

Head Quarter level

In 2003 WHO produced under the auspices of the OECD/DAC a strategy paper (**"poverty and health"**) in collaboration with different UK-based knowledge institutes. This paper outlines the strategic framework necessary to achieve poverty reduction through a pro-poor health approach. The framework prioritises five strategies, and outlines what partner countries and development agencies should do to promote a pro-poor health approach – *it did not specifically address the role of WHO in poverty reduction*.

[5] DFID (2002) *Working in Partnership with the World Health Organisation*

Before December 2003 **Annual Report** WHO had not presented its vision of the organisation's role in supporting countries and development partners in their efforts to achieve the health-related MDGs. However, it does not give *exclusive* priority to work related to meeting the MDGs. WHO has a broad health mandate and does not exclude work on topics or in countries that lack a clear link to the MDGs. WHO usually takes a broad view of health issues because of its mandate to respond to the expectations and needs of all member states.

The strategy paper distinguishes *three pillars* or components to WHO's work which form the "poverty focus*"* (see Appendix 2): Allocating a pro-poor focus to the normative and technical work; tracking progress and measuring achievement; and strengthening technical collaboration through individual Country Co-operation Strategies. In addition it mentions the importance of specific strategies and activities: working in partnerships and WHO organised a High Level Forum on health-related MDGs to review progress over the whole range of health-related MDGs.

The Evaluation reviewed evidence of poverty mainstreaming at the Headquarters level. One such example is the Emergency Humanitarian Action (which has become a department under the Director General and has been renamed **Health Action in Crisis** (HAC). This move reflects the increased priority given to poverty reduction by WHO, a clearer understanding of the role of emergencies in creating and deepening poverty, and the fact that poverty-related public health problems are concentrated in emergency sites. DFID supported this new department from the start, CHAD being a key donor in the capacity building programme (CBP) and its evaluation (£1.5m).

DFID (and other "like-minded" donors) are still of the view that poverty **needs focus** in the organisation. A comment made by several people is that poverty focus is needed in the approaches of disease control programs. It is not enough to address malaria as a poverty disease, it is important to know how a malaria control programme can reach poverty pockets. WHO has a potentially crucial role to play here, as in its normative role it establishes standards and guidelines that set international standards. If WHO Guidelines include a clear poverty focus this is likely to have an impact on country programmes. Some programmes and Departments (like RHR) are working to integrate poverty in their approaches, but this seems not yet to be happening across the organisation.

Other aspects of mainstreaming poverty in disease control programmes mentioned include health systems development and human resource development. Support for this kind of cross-sectoral working is needed to address the other important dimensions of poverty (including security, dignity, and accountability of, and participation in, national and local governments). According to the respondents, these aspects seem to receive less attention in WHO because of new prioritisation of technical "vertical" programmes and the continuing focus on health services.

In the supply of services, WHO relies to a large extent on its good relationships with the different Ministries of Health and does not invest significantly in other potential partners such as the private sector, NGOs and civil society.

Operational Level

While Headquarters can provide leadership and an environment that prioritises poverty reduction through pro-poor health services, the implementation largely has to take place at the operational level. At country level it is necessary to ensure that increased attention is given to poverty diseases and, above all, that health interventions reach the poor. DFID looks to WHO for guidance on operationalising poverty reduction strategies in the health sector at country level.

Specific pro-poor health programmes need to be developed, including appropriate and equitable allocation criteria, specific channelling mechanisms and implementing agencies. Without overarching programmes, Ministries are faced with a Herculean task in understanding and coordinating the various mechanisms, programmes and instruments. WHO is involved, to a greater or lesser extent, in all initiatives at global level and is expected to play an important role in translating these **global initiatives** and implementing them at country level.

WHO has participated in establishing most of the country poverty reduction strategy programmes that show a strong pro-poor agenda. With regard to the *PRSP and Global Funds* WHO has provided an important input in developing the *technical aspects* of the disease control chapters of the plans. It is however broadly felt that WHO could have shown a more pro-active attitude and strategic pro-poor orientation. For instance, in defining the poverty aspects of the different disease-specific programmes and in developing ideas about how best to address these. Support and technical assistance in developing pro-poor approaches and poverty disaggregated data is an expressed need at country level by Ministries of Health. WHO is not seen as "leading" or "proactive" in this providing this kind of support. This can be partly explained by the fact that this is a complex and cross-sectoral area and not one in which WHO is traditionally strong. One WHO staff member explained that "the technical parts are easier to address".

For programmes like PRSP and the Global Fund (GFATM) to have an effect on poverty reduction, it is important that they should address several "**cross-cutting issues**", such as development of health systems and human resources, resource allocation, geographical/ social-cultural and financial accessibility. Priority programs have received more attention in the PRSP and GFATM than these topics – the MOH received this kind of support more from bilateral organisations, such as DFID.

The **monitoring and evaluation** of progress in attaining the MDGs provides another example of WHO's relative slowness to integrate the MDGs and the poverty agenda. This is a highly complex task, and developing a data system disaggregated for poverty is challenging. Only in the 2003 Annual Report does WHO say that it will give methodological support to countries in tracking progress of the health-related indicators. While WHO has made a start on this in some countries, in a country like Ghana WHO is not seen as promoting such an approach but rather reacting to demand. WHO staff suggest that slow progress in this area is partly due to a lack of resources and perhaps this is an area in which DFID could have been, or could be, more active in their support WHO.

There are positive exceptions to be mentioned of country offices taking up a **more pro-active** pro-poor agenda. WHO has taken a more active role and has shown leadership in

advocating increased spending on health. The Report of the Commission on Macroeconomics and Health and follow-up at country level were strong in advocating investment in the health of the poor. It fostered a multi-sectoral approach at country level. WHO organised an important number of meetings and advisory missions to prepare plans for investing in health. A number of WRs claim that WHO has a strong advocacy role in promoting a poverty focus, organizing workshops on poverty and health, promoting interventions that aim to target the poor.

The **MOPAN evaluation** revealed that WHO had taken an active part in policy discussions in the context of the PRSP, mainly through advocating health issues. WHO contributed to analytical work (although less than the World Bank), especially through international experts. On the other hand, the study concludes that WHO did little to review its strategies in the light of national PRSPs.

2.1.3 The ISP as a tool for defining the partnership

The 1997 White Paper set out where DFID was going, pulling together its range of activities and setting out longer-term priorities. It was planned to develop a series of cascading institutional strategies with more detail (how DFID works with others), focussed to more longer-term engagement with institutions. The ISP lays out the specific objectives as to how DFID intends to work with WHO, and how DFID wants to support the institutional changes in WHO. It is however widely acknowledged, both within DFID and WHO, that the ISP embodies only part of the relationship. Staff of both organisations identify at least three aspects to the relationship:

- The **ISP** itself as an overarching framework
- Cooperation in the context of **technical programmes**, such as Roll-Back Malaria (RBM) or Health Action in Crisis (HAC)
- Cooperation at **country level**

The ISP sets out what DFID expects from its partners; it provides a framework for DFID's own priorities as the basis for engagement with the MDA, rather than a jointly agreed document which defines the specific nature of the partnership between the two partners. Key intended outcomes for DFID are:

- Strengthened **country focus**, with appropriate assistance from partners
- Human and financial **resources aligned** with strategic programming
- MDGs embraced by and **poverty mainstreamed** across the organisation

The development process of the ISP

The ISP does not outline one UK partnership with WHO: Instead the ISP represents merely DFID's approach from the UK-side. It is the Department of Health (DoH) that represents the UK in the WHA, although the DoH did not participate actively in the development of the ISP - as the DoH does not write ISPs. Hence the document does not represent UK priorities but rather the DFID developmental priorities in WHO, with approval from DoH.

The wide range of stakeholders identified in the architecture of the relationship (see 2.2.1) highlights an important weakness in the current ISP. DFID needs to capitalise on this

diversity, especially by understanding the range of stakeholders and their roles, level of support for ISP objectives and scope to influence WHO. For instance, the absence of a regional dimension to the ISP highlights a gap in DFID's conceptualisation of how WHO functions. The ISP arrangements do not include any special provision for working with the regional health organisations.

In principle, the first draft of the ISP was written by DFID staff only, but for the second draft there was much more (and wider) consultation with WHO. When compared with the ISP process, the ISP Action Plan represents much more a DFID Action Plan and it involved only a few people at HQ level in WHO (and outside).

It was always intended that the five-year commitment of the ISP would be worked out in a more specific work plan, the ISP Action Plan (ISP-AP). This work plan was perceived as a critical element of monitoring the partnership and progress made towards the ISP objectives – it has been developed but not yet an agreed upon document. DFID sees as a "living" document or an "evolving document" which is trying to take into account recent changes within WHO.

Perception and interpretation of the ISP

Headquarter level

In **DFID**-HQ, the ISP is regarded as a framework for prioritisation of funding and more selectivity – as a result, decisions should be less ad hoc. While it explains the expected results, the processes by which DFID intends to work with WHO to stimulate change, and what kind of programs will be supported, are not clear.

Also in **WHO**, many people perceive the ISP document as a set of common objectives for the relationship between DFID and WHO, providing general direction for financial support to WHO. In fact WHO expected that the ISP would give clear direction as to how the basket of (un-earmarked) funds should be invested according to DFID and this is not the case.

In WHO the ISP is understood as an arrangement between managers at the top-level of both organisations. In the process of drawing up the ISP and the ISP-AP, most of the WHO Departments were not asked for their views, no meetings were held, and they were not asked to give clearance of drafts. For that reason the ISP has little ownership at this level.

In the Director General's office the appropriateness of having an ISP with DFID is not questioned. At lower levels in the organisation the appropriateness of having separate arrangements with each donor is less obvious. At this level the opinion is often voiced that there is a MIP that allows for discussion of progress and results and the World Health Assembly, which is charged with priority setting and where "influencing" could take place – and *"that should be enough".* This was confirmed by representatives of other member states, certainly the non-aligned members, but also in the like-minded group. According to these respondents, donors should not act outside the governing bodies – although they recognise that the governing bodies have to improve their performance.

Some find the ISP very one-sided (it says what DFID wants WHO to do); time-consuming for its consultative nature (it took two years to formulate); and as so labour intensive that it had already become outdated. Others stated that the ISP should become *even more*

comprehensive:"DFID doesn't only buy products in WHO, it should also buy into processes and problem solving".

An ISP for the partnership between the "7+ like-minded group" and WHO does not seem to be realistic for political reasons. A joint action between the members of this group is very sensitive in the group of 77 non-aligned members. Also, the objectives of the 7+ group are little more than to consult and keep each other well informed: a joint 7+ ISP would create a relationship that appeared more like a formal alliance, existing outside the usual governing structures.

Operational Level

The ISP and its action plan were not used to define the relationship between DFID and WHO at country level. The ISP is considered rather as guidance for the relationship between the two organizations at global level; at country level they do not claim a specific relationship. Both DFID and WHO acknowledge that it would be a good idea to define the relationship and the mutual expectations better at country level, too: to improve definitions of the roles of WHO and of DFID in policy and strategy development, and in translating the global initiatives to country level. But it is to be preferred to do this exercise within the UN family, and within the SWAp-context.

The scope of M&E arrangements to monitor progress under the ISP

The ISP, although stating the key objectives of the partnership, does not identify specific measurable indicators.[6] The structure of the ISP-AP is mainly activity and output -orientated, but particularly so in the May 2003 version.

Many of the 'outputs' presented in the ISP-AP cannot be solely **attributed** to the activities of DFID or WHO. This presents a fundamental question as to what it is that needs to be monitored? Attribution to any one donor is problematic and inconsistent with the overall approach; i.e. if it is the realisation of the ISP objectives that is to be monitored, then many (if not most) of these could have occurred due to the support of other players. This could lead to the conclusion that the monitoring of the partnership should focus more on what the ISP and the partnership brings to the relationship rather than the realisation of these objectives. Such an emphasis could cover aspects such as the partnerships contribution to better governance or the provision of a more structured (and institutional) approach to the relationship.

Apart from these more fundamental issues, the ISP-AP (May 2003 version) also contains a number of weaknesses to its **technical design** – as perceived from a more orthodox M&E perspective. Firstly, very few of the indicators (OVIs) have a timeframe for their achievement. Secondly, the output-level indicators are often non-specific, and not easily measurable. For example "*Outcome focus in programme budgets at all levels from 2004-2005*" does specify what 'outcome focus' means in this context. Thirdly the activities are very broad, and cover a wide organisational scope. They are also defined very generally, using terms such as 'support', 'share' and 'contribute'. The ISP-AP sets out responsibilities against each activity, but many of the actors are only broadly specified. Greater precision is needed about individual roles and responsibilities, and the mechanisms by which these feed into personal and country work plans. A key aspect of this is the role and resources available to the UK Representative in Geneva, who has responsibility for monitoring the ISP.

[6] A point also noted by the NAO (2002: 30) report on Performance Management.

More fundamentally and as a monitoring tool, the ISP-AP is weak in two main areas. Firstly, it does not adequately capture the complexity of interpersonal relationships – like at the country level between DFID advisors and WHO representatives. Secondly, the ISP-AP monitors activities and outputs in a fairly rigid manner. Partnerships, and influencing activities, develop and may follow a myriad of ways in order to achieve the desired outcomes. It may therefore be more appropriate to move beyond a structured 'planned versus actual' approach, to one that is more process-orientated; At a time when DFID is moving away from earmarked funding (and a project approach that tends to distort priorities), a focus on the outcomes of the partnership and a more reflexive two-way approach to monitoring the processes may indeed be a more appropriate way forward.

The latest version of the ISP-AP attempts to reconcile its indicators of performance with the RBM information from WHO's internal performance indicators. DFID recognises the rapid pace of recent change in WHO's management systems and the quality of information - a direct consequence of the work towards results based management.

Summary

For DFID, the comparative advantage of WHO at HQ level is beyond any doubt, certainly in regard of its normative role. This image in DFID is less positive for WHO at country level: DFID (and others) would like to see WHO more proactive in policy and strategy development for the health sector.

DFID's comparative advantage for WHO is not limited to its funding: its support to strategic thinking within the organisation and its critical role in assessing WHO's performance are just as important. In most countries DFID and WHO are "just two" of many partners in a SWAp context – there is no case for a specific bilateral relationship. As the perceived performance varies between different WHO offices, DFID's support to WHO programmes at country level varies too.

WHO foresees a gap in the supply of technical assistance as a consequence of bilateral donors (like DFID) embarking on SWAp and/or budget support; WHO thinks it could take over this role.

The relevance of WHO is assessed in the context of poverty eradication and attaining the MDG. At HQ level, WHO is actually starting to bring a poverty focus into its normative work, and it gave more importance to Health Action in Crisis which may be regarded as pro-poor. Criticisms are expressed on WHO at country level for not being sufficiently pro-active in strategic planning of pro-poor services but focussing on technical aspects of disease control (e.g. in PRSP) – with the exemption of the "macroeconomics and health" initiative.

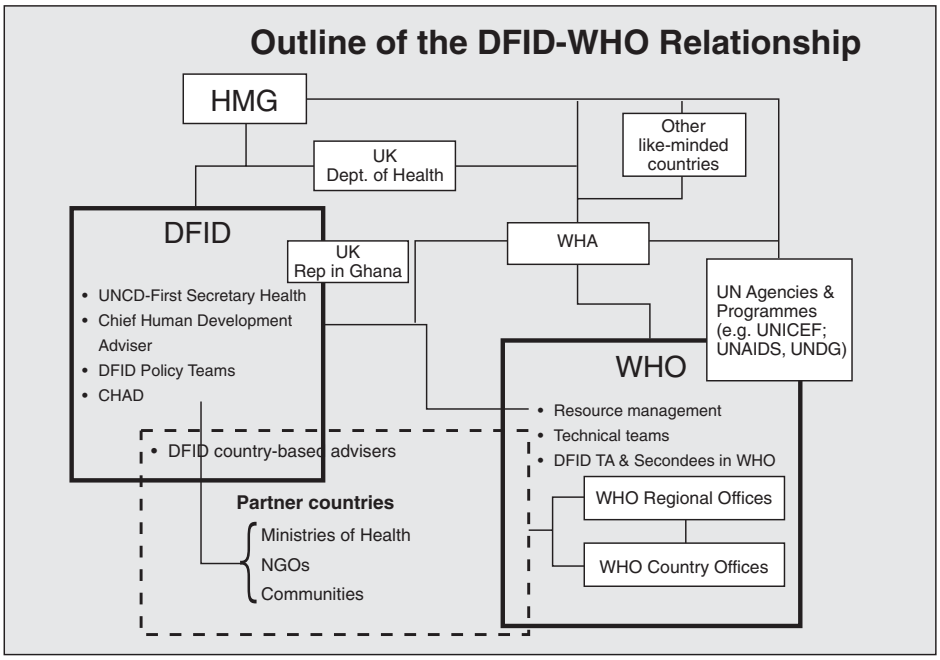
The ISP only addresses a part of the partnership working. In DFID it is seen as a strategic framework for future support to WHO, while in WHO it is viewed as an HQ to HQ matter, with DFID expressing in a transparent way what it expects from WHO. Many challenge the appropriateness of having an ISP as being an isolated action of one of many member states who all have existing channels to express their interests (WHA, MIP and others). The ISP has made little impression at country level, where most declare that there is no need for such an arrangement.

2.2 Unity of the partnership

2.2.1 Partnership structures

It is widely acknowledged, both within DFID and WHO, that the ISP embodies only part of the relationship. Firstly, DFID's relationship with WHO exists within a tri-partite relationship within HMG with the UK's Department of Health (DOH) and Foreign and Commonwealth Office (FCO), The Department of Health (DH) is the lead department for the UK's relationship with WHO, representing Her Majesty's Government (HMG) position at the WHA and providing the annual assessed contribution.[7] The Foreign and Commonwealth Office (FCO) provides a coordinating function with the express aim of ensure joint-working between departments of HMG, as well as consistency in the UK position to all United Nations agencies. Then there is a more loose relationship the like-minded donors (the so-called 7+ group) and health-related multilateral organisations such as UNICEF and the World Bank. Figure 1 illustrates the relationship:

Figure 1 Complexity of the DFID-WHO relationship



A variety of interactions take place between DFID and WHO staff between different levels within each organisation and across various locations internationally. At the headquarters level, the 2003 reorganisation of DFID's Policy Division led to the replacement of sectorally-based departments (such as the Health and Population Department) with a series of thematic-based Policy Teams. This created a situation where UNCD now leads on the overall relationship, financial aspects, policy and performance. The Chief Human Development Advisor retains responsibility for professional development in health (as well as education), and by implication this has a bearing on the relationship with WHO. The

[7] The UK position is also represented at the WHO Regional level, not only within EURO but PAHO and Western Pacific.

role is still evolving but appears to be primarily dealing with technical programmes, policy and performance. DFID's Policy Teams and CHAD tend to liase directly, and somewhat independently, with WHO's technical programmes (such as Reproductive Health, Roll Back Malaria, Health Action in Crisis, etc). There are however recent instances of collaboration between Policy Teams and UNCD.

What is less evident is that all these interactions occur within the overarching framework of the UK Department of Health as lead department for the UK, through the WHA and Executive Board. This has gained a practical dimension with the appointment in 2003 of the First Secretary (Health), UK Mission in Geneva – a post that includes the relationship with WHO. The incumbent is a former DFID staff member, now working on behalf of both DH and DFID, through the FCO.

Relations between DFID headquarters and WHO Geneva are quite distinct from relations at regional and country levels. WHO has a unique governance structure that has led to the development of strong regional offices that have a high degree of control over country programmes. At country level, the architecture is defined by the nature of involvement of both parties in national health programmes. Thus in both Ghana and Zambia the relationship is largely determined by the sector-wide approach to development assistance. DFID and WHO meet in, and work together through, a joined donor group under national leadership. In countries without sector-wide approaches a wide range of *ad hoc* working arrangements exist.

In considering the relationship it is important to consider why is it that separate bilateral processes are necessary in addition to the WHA, MIP and monthly DG-office information meetings. Would it be more desirable for the relationship to find other ways to make existing processes work better?

Stakeholder analysis

The complexity of the relationship is probably unavoidable. But the implication for managing it is that DFID needs to understand the relevance of the relationship to different stakeholders, and the nature of opportunities to work through those stakeholders in pursuit of objectives.

Figure 2 presents a stakeholder relationship characterising the level of support for DFID's objectives and the level of influence over WHO policy and practice. Levels of support and influence are relative and do not imply any absolute judgements. The arrows in Figure 2 signify the need to develop strategies that move different groups of stakeholders towards positions of greater support for DFID's objectives and to have a greater effect on WHO.

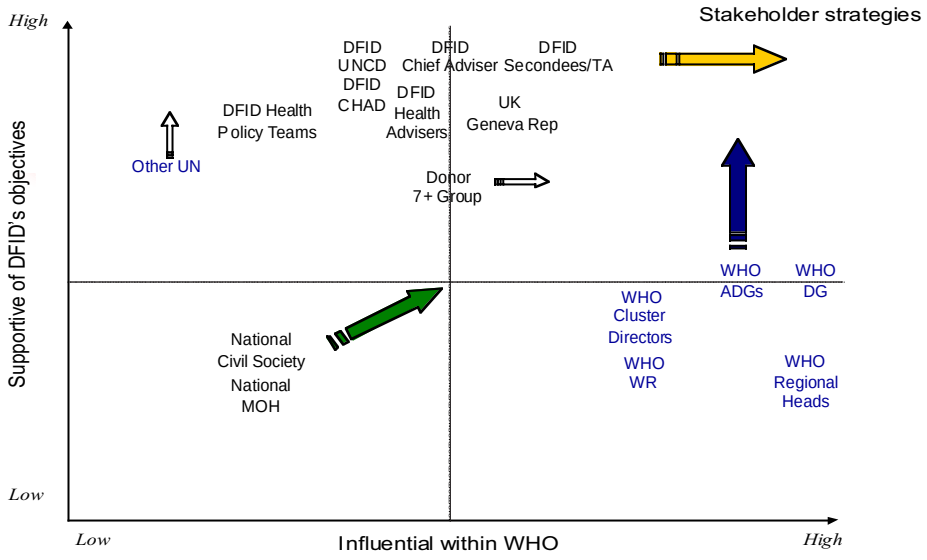


Figure 2: Diagram of stakeholder support and influence

A stakeholder analysis seems to be important in defining the relationship between DFID and WHO. Criteria for such an analysis could be the supportiveness to the relationship's objectives, the influence over WHO. Appendix 3 sets out how the analysis can be used to develop strategies for DFID.

2.2.2 Values and goals

This sharing of goals or values among partners provides both a unity to their interpersonal and inter-organisational relationship, plus a sense of common direction and purpose. In reality each party will have their own values and resource requirements that, within appropriate limits, they will be able to pursue. In order to allow this tension between individual and collective values to co-exist it is important that partners develop and display an appropriate level of interpersonal trust (see 6.2.3) – which in itself becomes an instrumental value in the relationship.

Coherence of the partnership with DFID and WHO corporate objectives

There is **unity** in both organisations on main goals in the relationship such as the programmes financed by EBF (earmarked or not), the poverty focus (see 1.2.2), the country focus, improved performance against agreed objectives, and improved UK coordination *vis à vis* WHO. This unity is found at institutional level – as it has been laid down in contractual relationships – but also at the individual level (as confirmed during the interviews). Differences appear in operationalising these goals, which is partly due institutional constraints (WHO's mandate, reorienting DFID policies, etc.) and partly to different priorities – and for that reason to different values.

Both organisations change over time their priorities, and for that reason "**direction**". DFID is heading progressively from project- via program- to budget support – which implies important consequences for it relationship with WHO. WHO, in turn, is perceived to change direction after the changes brought by the new DG that are understood by many as a renewed focus on priority programmes.

As part of a more general process of UN reforms, WHO has been undergoing a series of major institutional changes. The aim is to promote a more coherent and accountable approach, and a greater **outcome-focus** to the mechanisms of priority setting, planning, budgeting and management. WHO has been introducing these changes over a number years since 1998. 2002-3, results-based budgeting (RBB) had been introduced organisation-wide. A key feature of the reforms is the use of the budget as an instrument for advancing reform (WHO 2003c: 2). The framework demonstrates a close compatibility But observers in the field are still sceptical about the pace and prospects for reform (see effectiveness).

Programming at **country level** is guided by WHO Regional Offices. In Zambia, for example, the current biennial budget is made up of one third regular budgetary funds and two thirds extra budgetary. The implication is that in the main, only the smaller budget of RBF has flexibility to be organised to meet country needs, whereas the EBF is largely tied to regional- or headquarters-led technical programmes.

A significant proportion of WHO work is managed through **priority programmes** such as Stop TB. These act as a focal point for staff resources and funding, mostly through extra-budgetary means. Activities are programmed at the regional level or in Geneva for country level implementation - often with minimal prior consultation with the country WHO office, or other national or UN staff. As a result they bring a *de facto* prioritisation to technical programmes rather than health system development or other issues identified under the PRSP, which may give rise to different approaches between DFID and WHO.

An example of country level working and prioritisation: Ghana and Zambia

WHO and DFID work together in support of the sector programme. They support the same national health plan and recognise the national leadership in it. The focus of both is poverty oriented and rights based. Their priority is investing in local capacities. But whereas WHO holds the MOH accountable at *activity* level, DFID does this based on the *results* – and the same is true for financial accountability. **For DFID**, a sector-wide approach is coherent with its global policy, and the country office can respond to the demand of the local health authorities. The largest part of DFID financing enters into the pooled funds for the sector, most of it un-earmarked, to be decided upon under national leadership. Also, DFID sits at the negotiation table where the decision making on the policies and strategies takes place. **In contrast, WHO** cannot contribute to the pooled funds. Although all WHO-supported activities are integrated in the national plan of work, it holds control over the activities and monies funded by it. It needs to consult the regional office levels and Geneva for approval. In many instances the means by which WHO country programmes are planned are not transparent and there appears to be little opportunity for other UN agencies or donors to interact over issues of prioritisation.

2.2.3 Trust

The approach to partnerships is based upon the premise that people are the fabric of partnerships, and the glue that holds them together is interpersonal trust (Partnerships Paper pages 6-7). In the development of a partnership two types of interpersonal trust may be key to its success: *values-based* trust (Fukuyama 1995: importance of shared

values) and *process-based* trust (Sydow 1998). The latter is achieved through successive, successful interactions over time. This development constitutes the social capital of the partnership. Personal relationships grounded upon trust between partner individuals are the key to unlocking organisational resources.

Reliability and predictability

A wide range of people interviewed within DFID and among the 7+ group of donors attested to having a high level of interpersonal trust with staff in WHO. This tended to be based on personal experience and familiarity. The importance of trust in the relationship is seen clearly in the survey of DFID country-based health advisers, all of whom considered trust as highly important. Respect was also mentioned as important as was the ability to form effective relationships.

The level of trust with WHO is considered highly individual-specific and difficult to rate although most DFID respondents (at country level) rated it as a mid level of trust. Conflicts were reported, the most notable being a big conflict regarding WHO's policy on Polio, where '*heated arguments'* took place. Other conflicts related to '*mis-matched expectations'* and '*bureaucracy within WHO*. Most conflicts are resolved through dialogue and through time: '*The system grinds on...*'. Open dialogue and a keenness to maintain good relations help resolve conflict.

At country level both DFID and WHO find partners that are trustworthy, but most respondents rated the WHO people they deal with as fairly unreliable in meeting their obligations in the relationship. They attributed this to their counterparts being unaware of the relationship or their obligations and therefore unable to meet them. Once agreements on joint activities are established both parties tend to comply and are reliable in their commitments. In cases where WHO is not always predictable, this is often because they have to respond to regulations at the regional level.

This is an element of *value-based* trust, but, given the diversity of opinion about pro-poor orientation, values may not necessarily be closely shared. Clearly, *process-based* trust is regarded positively by DFID and WHO, so there is a need for implementation to actively promote joint working.

A consistent message from all donors is that there is a good level of interpersonal trust in the working relationships with WHO. But trust is more than just about having confidence in each other. It also concerns the willingness of individuals to take risks and be innovative. This is a key element of the added value of a partnership. Several examples were put forward in Zambia where WHO staff in the recent past had declined opportunities to take a lead on aspects such as coordinating TA provision under the sector plan. Indeed, a common observation was that WHO staff play a passive role in many committees and meetings. An interesting contrast can be found that in order to reduce the pressure of meetings to coordinate sector work, DFID and other bilateral donors are willing to share attendance and represent each other's views. Such sharing of responsibility does not extend to WHO, neither by the bilateral donors nor by other UN agencies.

Summary
The relationship between DFID and WHO is complex, involving a wide diversity of people in different locations and organisational settings. DFID needs to capitalise on this diversity, especially by understanding the range of stakeholders and their roles and scope to influence WHO.

The extent to which the relationship shares goals is uncertain. DFID has a clear focus on poverty elimination and is organised and managed against that goal. Poverty is just one among many concerns for WHO. DFID can and does structure all work at country level in pursuit of poverty reduction. Country health advisers have the flexibility and delegated authority to do so. They use their relationship with governments to promote pro-poor health policies.

WHO's interpretation of country focus is more responsive to national policy. It is less inclined to challenge governments and provide critical support on policy. WHO's programmes are more top-down, driven by regional offices and Geneva. Its national workplans are not transparent and open to be contested by other health sector stakeholders.

Trust is important in the relationship, but DFID staff report it to be highly individual-specific. There is scope to build trust by working together, but the contrasting ways of working at country level do not always create the right opportunities. The study found only a few examples of trust enabling innovation among the partners.

2.3 Efficiency of DFID's contribution

2.3.1 Network attributes

The fourth aspect of *partnership working* concerns the attributes of the partnership as a network: its centralisation, degree of stability and its role in facilitating resources, are key to both characterising and diagnosing it. The degree of centralisation within a partnership is an important element of its characterisation, as is the ability of the partnership to respond quickly to events and issues as they arise.

It is clear from interviews at headquarters and countries that the majority of interaction and coordination is programmed, predictable and centres on specific sector or technical work. There are no examples of resources linked to the partnership, no elements of capacity building and no mechanisms to promote the relationship, as opposed to specific programmes.

The influence of the different institutional reforms

The re-organisation of DFID's Policy Division (PD) has left people in DFID's country offices very confused about the roles of specific teams. So much so that some claim that a "*vacuum has been left since 'Health & Population' was disbanded*" and that PD is no longer the primary link to the WHO. The understanding of the role of UNCD and of the Chief Human Development Adviser vis ˆ vis WHO was not yet clear for most respondents, although the situation was better with regards to the policy teams.

Neither DFID's nor WHO's internal reorganisations seemed to have much impact on working relationships at country offices except with regard to gaining information from headquarters. There are no specific partnership mechanisms to coordinate with WHO at country level as meetings are within regular bilateral or multilateral forums, unaffected by both the ISP and reorganisations.

2.3.2 Communication

Communication between DFID headquarters and the country offices about the relationship was considered to be very poor and often completely lacking. There was a general feeling of confusion about which department to contact. Most reported a total absence of communication with DFID HQ regarding the relationship since the reorganisation of PD. Among DFID staff, there was a feeling that the relationship would benefit if there were better communication, internally and externally and particularly, the communication between HQs and country offices of both DFID and WHO.

Communication has been weakest around the time of the DFID reorganisation, as well as the lack of any subsequent expression of new priorities. Some programmes like Roll Back Malaria, and Macro Economics and Health, feel uninformed as to why past financial support has not been renewed in the general move to non-earmarked funding. Staff responsible for technical programmes are not always aware of (or consulted over) the allocation and prioritisation of DFID funding.

Reported quality of communication between DFID and WHO **in-country** was considered rather varied, depending on individuals again, but few DFID respondents appreciated this as good – especially more meetings concerning the strategy would be appreciated. The majority of WHO representatives contacted during this study had little information on the relationship outside their own at country level. Most rely on the established and effective channels for communication around the sector programme and regular meetings are held between the WR and DFID health advisor in addition to meetings in the SWAp context.

Transparency and sharing of information

In the DFID-WHO relationship, the UK Mission in Geneva performs an important role in day-to-day communications, such as liasing between WHO and DFID staff at headquarters (particularly UNCD). The UK Mission is also instrumental in communications with the 7+ Group of like-minded donors. Technical dialogue (between Policy Teams and UK-based technical institutes like the London School of Hygiene & Tropical Medicine on the one hand, and WHO's technical programmes) is also regarded by WHO as an important (if not the most important and appreciated) part of the communication between the organisations. The general consensus sees DFID as a particularly 'enlightened' donor with good professional staff - something which also helps give DFID access to policy dialogue.

Beyond formal interaction there is little in the way of routine sharing of information. Both at country level and between headquarters, DFID (and other donors) find it difficult to obtain up-to-date information about actual spending on programmes supported by WHO. This is particularly so for programmes of capacity-building support to health sector staff at country level.

Centralisation of the relationship

The evidence about the extent of centralisation of the relationship is somewhat paradoxical. The relationship is strongly oriented towards the relationship between headquarters and deals primarily with policy, strategy and management. The **governmental bodies** of WHO (like the WHA and MIP) represent the formal network attributes for the relationship, plus the DG's office provide monthly briefings to all members, while the programs in WHO inform regularly on their activities. Additional to these contacts, DFID sees it as important to hold bilateral discussions based on specific reporting for DFID. This is explained by the fact that the scope of the discussions in the governing bodies is too broad for policy discussions, and that the information provided does not yet meet expectations. Other donor countries (like the Nordics) put progressively less emphasis on this bilateral approach.

At country level, the relationship lacks the focus of the ISP, but is driven more by a coalition of views in support of national health sector programme. Country staff within DFID, and less so within WHO, have a high degree of flexibility in how they relate to each other. In these respects the relationship is both centralised and dispersed. For DFID, the strong link between headquarters and the field contains the basis to harmonise policy and practise.

For WHO, the link between headquarters and country presence is through the **regional level**. DFID however has no working unit at the regions, and the DFID-WHO relationship is least well formed in this regard. Yet within WHO, regions hold considerable influence both as a channel of communication between Geneva and country offices, and as a source of authority and finance for country programmes. This missing level appears to be a key

gap in the relationship, that in effect contributes to a degree of communication breakdown between headquarters and the field.

2.3.3 Technical Support and secondments

For DFID, secondments provide an opportunity for increased knowledge of, and improved links with, organisations like WHO. For WHO, secondments provide a means for plugging skills gaps and a better understanding of government functions and specifically the operations of DFID. For both organisations it may provide a reinforcement of partnership objectives. There is however only one DFID secondees at WHO headquarters in Geneva directly linked to the ISP objectives (the Country Focus Initiative). Another DFID-funded TA post is related to the intended direction set out by the ISP (HIV/AIDS, and especially the "3 by 5" initiative). The placement of the secondment and TA provides an indication of DFID's priorities within WHO, while their status within the organisation places them clearly within the policy-making environment. The secondment for the Country Focus Initiative (CFI) shows DFID's interest in pursuing successes in the WHO's reform agenda. Influencing and changing the organisation is therefore a key part of the secondment.

Still, the number of DFID supported posts- is not large within WHO, despite perceptions to the contrary – there are only two in an organisation of 1524 WHO staff - other *British* secondees come from other organisations than DFID.

It is clear from the interviews that the technical input from the UK is highly appreciated in WHO, and it is important to consider the best way to provide this kind of support in the future. Currently DFID supports key areas of technical assistance provided by **UK-based institutes** like the London and Liverpool schools of public health. Their input to the normative work for technical programmes and for policy development programmes is highly regarded. DFID enables a measure of flexibility to these institutes in the way they offer support, as funding is not limited to sharply defined projects - thereby allowing greater participation other ways, such as in pro-active meetings.

DFID supports the CFI strongly. It should perhaps not only focus on the headquarters aspects of the partnership, but be more coherent in its support to the country level too. Actually, this level receives much less support than the WR would like. The support is often limited to bilateral policy and strategy discussions between the WR and the DFID country Health Advisor. DFID's move towards support for the **sector-wide approach** within the context of a multi-donor support, means an important change in its relationship with WHO – and consequently the WHO's comparative advantage from a DFID perspective: As DFID funding is progressively integrated in the pooled funding for the MOH in most countries, the organisation will have less of a need to finance interventions through intermediates such as WHO. A consequence of this may be that WHO (and others) will disappear more and more from the "financial loop", and that support for WHO will concentrate on the "technical loop". But here also, within the context of SWAp, DFID shows a preference to invest in local capacities.

This brings in an interesting issue for the (near) future. As DFID progresses towards multi-donor Budget Support, this will probably mean that TA provided by the donors will reduce in the aftermath of the withdrawal from the project approach. In many countries, the MOH

give clear signals that there is still a need for TA to remains significant. In such a scenario, DFID (and other like-minded donors) could move towards commissioning the **TA-function to the UN family**, and for the health sector this would most naturally fall *under WHO*. This could be underpinned by, for example, un-earmarked DFID funding for TA, WHO housing a "TA-basket" of different donors. Alternative solutions for DFID could be *outside WHO*, long-term contracts for institutional support with knowledge institutes or leaving it to the different MOH to seek TA *ˆla carte.*

2.3.4 Mobilisation of resources

Overall financing of the WHO-interventions on extra budgetary funds (including DFID)
The financial resources of WHO are determined by the overall contributions of the member states and other donors. The contributions are characterised by an increased dependency on extra budgetary funds (EBF), as the member states have decided not to increase the regularly budget contributions (RBF) of the UN family. Before 1996 the member's contributions for RBF were more important than for the EBF – this changed to an increase of the EBF in the WHO budget: 68% in 2004/05 and has resulted in a high dependency on EBF. According to the WHO programme budget for 2000/01, for example, the total budget for WHO was US$ 2,176 million – of which EBF represented US $ 1,356 million.

Where are WHO-funds spent? Of the EBF 41% are spend at head quarters and 59% are allocated to the regions (from which less than half goes to country programmes). Of the regional funding 37% was for Africa, 11% for Europe & Eastern Mediterranean and 11% for the rest of the member states.

On what are WHO funds spent? Of all WHO extra-budgetary resources 25% were allocated to WHO's country programs and the remainder to the nine WHO clusters.

Table 1: WHO budget on EBF sources by WHO-programs

Thematic field	Proportion of EBF	from which to the regions
communicable diseases	41%	70%
Health Technology & pharmaceutical	19%	50%
sustainable development & healthy environment	15%	10%
other 6 areas	25%	

The EBF cover substantially all (80-90%) of the three clusters named above and half of the country programmes in Africa, South-East Asia and Eastern Mediterranean, and more than 80% of expenditures in Europe. Almost two-thirds of the current non-staff operational costs are covered by extra budgetary resources. It is clear from the above that WHO is highly dependant on the voluntary extra donor contributions (EBF) for its activities both content-wise and for the different levels of the organisation. EBF are mostly earmarked, which provides the donor with the opportunity to express its priorities in WHO and to influence WHO's agenda. However, they are fairly predictable and stable, even showing an increase for each year.

Relative importance of WHO in DFID funding

Between 1997/98 and 2002/03 the financing of development aid by DFID increased in real terms by 43%[8]to US$ 5.2 billion planned for 2003/04. The trends over time of DFID's annual financial **support to the health sector** are shown in the table below (representing fiscal years):

Table 2 DFID Gross Public Expenditures for the health sector (current £ 000)

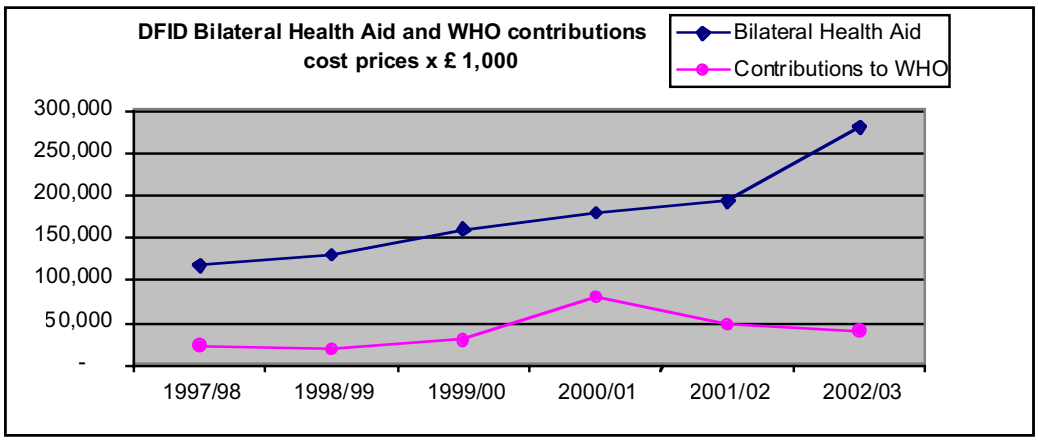
	Y1997/98	Y1998/99	Y1999/00	Y2000/01	Y2001/02	Y2002/03
DFID bilateral aid Health and population (1)	116,754	133,485	167,804	184,038	203,556	297,750
DFID - WHO (2)	12,099	8,091	20,300	75,110	41,348	34,156
total (1+2)	128,853	141,576	188,104	259,148	244,904	331,906
Share (WHO/ DFID-bilateral + WHO)	**9.4%**	**5.7%**	**10.8%**	**29.0%**	**16.9%**	**10.3%**
total UN agencies DFID (3)	114,976	106,277	151,638	219,247	213,501	165,368
Share WHO (2) as a proportion of UN (3)	**10.5%**	**7.6%**	**13.4%**	**34.3%**	**19.4%**	**20.7%**

Source : Statistics on International Development/ DFID/ 2002 and 2003

From 1997/98 to 2002/03, DFID financing for **WHO** increased from £12 million to £34 million. It should be noted that *WHO also received funding from other UK departments* and if this is included, the amount increased from £22.8 million in 97/98 to £46.0 million in 2002/03. Therefore, not only did the funding from DFID increased, but the proportion of DFID's contribution to the total UK funding for WHO also increased.

The WHO share in DFID funding evolved more positively than the contributions to the total of the UN-system. Contributions to WHO more than doubled and seen as a proportion of DFID funding to *UN agencies* it went from 10.5% to almost 20.7% in 2002/03. Because of a temporary increase to support the Polio eradication programme, there was even a peak of 35% in 2000/01. So, through the years DFID seems to have prioritised WHO in comparison to others in the UN system. However, compared to DFID's bilateral spending *on health*, the weight of WHO financing is relatively lower and increased at a lower pace, see the figure below:

Figure 3 DFID contributions to health through bilateral support, compared to WHO



[8] Source : financial statistics of expenditures/DFID in SIDs 2002 and 2003/DFID, department reports

So although DFID financing to WHO has substantially increased DFID has given even more priority to increasing bilateral aid as a means of channelling its support to health activities.

The adequacy of DFID sourcing WHO to achieve the partnership goals

For a partnership to function, it is essential that it be adequately resourced. In this case there was a positive budget execution rate (132% on average) for the period 1988/89 to 2000/01. This was partly due to an underestimation in the planning of the extra budgetary funds, but also by preparedness in DFID to provide extra funding when needed, as in the case of humanitarian emergencies, and also when new initiatives or plans were presented by WHO. In this sense DFID proved to be a reliable and flexible partner.

The **un-earmarking** of a part of the EBF may also be regarded as another example of trust: DFID providing WHO with the flexibility to set its own priorities. This way, DFID has addressed some of the constraints of WHOs dependency on EBF that were mentioned above. In 2002 DFID proposed to provide WHO with £12.4 million un-earmarked EBF. For WHO this type of contribution represents an important share of the DFID contributions (about 30%). For WHO, this is generally regarded as a very positive mode of financing: not only does it give more "freedom of manoeuvre", it allows funding to be apportioned to topics seen as important but less fashionable to donors.
DFID hopes that, in the future, the un-earmarking will lead to a reduction in transaction costs. For the moment this is not yet the case because all types of transaction costs have remained in place.

Another explanation is that un-earmarking is consistent with policy trends such as SWAp and Budget Support. However, the case of WHO is different from sector-wide country support: it is an institute with a mandate given by the different member states, to carry out a number of delegated tasks by those members. Seen from that perspective, it has been argued that the member states (via the Assembly) and not the Organization itself should set priorities within the un-earmarked funds. This vision has been expressed by other ("non-aligned") WHO-members.

An important effect is that some programs (like Roll Back Malaria, Macroeconomics and Health, Reproductive health, e.g.) do not receive the EBF anymore, and will depend on priority setting in WHO. Only, the system for organisation-wide priority setting in WHO is not performing well, and the total of the un-earmarked funds is much less than the total of EBF those programs received before. To them this meant that DFID funding appeared not to be predictable.

Summary
DFID's institutional reform has not had a visible effect on the relationship with WHO. But within DFID the changing arrangements have brought confusion and uncertainty.

Communication with WHO at country level is mostly structured around health sector programme issues. There are instances of additional bilateral meetings, but these are in the minority. There are no resources with which to develop the relationship with WHO, nor resources for partnership-related activities at country level.

UK staff in WHO are over-represented, but DFID makes little use of providing secondments to WHO. It provides technical support through the regular meetings and at program level through UK-based institutes. But this is mostly focussed at HQ level, and at country level this kind of support is provided directly to the national health programs.

The increase of DFID funding for WHO was higher if compared to other members of the UN-family, but (much) lower if compared to support to the health sector through the bilateral channel. As it had been decided between different UN member states that RBF for UN organisations should not increase anymore, the increase in WHO funding was in EBF – which means a prioritisation of certain health programs. Of all EBF in WHO, 40% has been used at HQ level.

Of DFID's EBF, 77% went to disease control and only 9% to pro-poor health – a completely different picture from the spending of bilateral funds for health. This seems to represent what DFID's interests in WHO are – the more because future commitments seem to prioritise "3 by 5" for example.

DFID funding has been stable and increasingly provided support to different programs, with DFID often being one of the first donors to support new innovative programs in WHO.

An interesting change in DFID's management arrangements is in un-earmarking a part of the EBF. This gives more flexibility to WHOs planning, possibility to fund also less fashionable programs and it seems to mean DFID trusting WHO to take responsibility and ownership. It may reduce transaction costs, but this is not very probable in the current situation. It may also result in less attention for DFID's priorities, but so far WHO has prepared a program for these funds that seems to be largely based on DFID's expectations.

2.4 Effectiveness

2.4.1 Partnership processes

With so little evidence of awareness of the partnership or of *partnership working* at country level, there is little to conclude about effectiveness.

Stability

The stability of a partnership is crucial for its long-term effectiveness. A partnership with constantly changing resources, agenda and personnel may have difficulty achieving much other than secure itself a degree of stability. The relationship between both institutions is perceived by both partners to be stable – but challenged by the change in leadership (in WHO) and the reorganisation in DFID, although key actors at senior levels are well known to each other. DFID's decision to commit more funds without earmarking is an additional factor in bringing more stability at HQ level, though staff in programmes that no longer have earmarked contributions view it otherwise.

DFID **funding** in the case of RBF has been regular by definition. Also, the EBF have been disbursed without interruption, and with important increases. Even if the annual contributions (key in stability) arrive late in the financial year (in July for 1999 and 2000, in December for 2001 to 2003) this does not seem to imply a particular problem for WHO.

Although the un-earmarked EBF are perceived as a very positive change within the higher levels of WHO, those programs that do not receive earmarked EBF anymore are of course less happy with the new arrangements and for them the EBF have turned out to be less predictable than they thought. The un-earmarking had not been well explained to them and the explanation was not timely. DFID sees this as a question of internal priority setting.

The effect of the un-earmarking was that WHO programs formerly earmarked by DFID including the tracer programs for the evaluation (Macroeconomics and health, reproductive health and roll back malaria no longer received the usual DFID funding. Instead these programmes relied on the WHO's own priority setting process. As the sum of the previous year's funding for the three tracer programmes was considerably higher than the £12.4 million un-earmarked EBF, this necessarily resulted in a significant drop of DFID funding to these programs.

The situation is less clear-cut at **country level**, where rotation of postings brings periodic change. Two aspects contribute to instability here. One is that so much of the relationship is founded on interpersonal factors, any change leads to disruption until a new bond is forged. The second reflects the high degree of personal style that a WR or DFID Health Adviser brings to their job. Expectations of WHO being more pro-active, taking more leadership in strategic issues, and providing more technical support are highly dependent on the personal disposition of the WR. That said, most of DFID respondents considered the relationship good.

Unity and direction

The way in which **DFID financed WHO** may provide a perspective on "unity and direction".

Firstly, there is still no budget attached to the ISP necessary to develop a partnership working.

Secondly, the ISP was intended to guide resource allocation. The relatively short period of existence does not permit yet to conclude if the strategy indeed induced changes, but there are some tendencies that may be traced. We appreciated the unity in DFIDs bilateral spending on health if compared its EBF financing of WHO programs. Table 4 below shows a comparison of the annual expenditures of DFID from 1998/99 to 2002/03 in the framework of bilateral health aid with the general expenses made for programmes financed through WHO in the same period:

Table 4: DFID expenditures in Health through bilateral and through WHO

Areas	Share in DFID Bilateral Health Aid (1)	Share in DFID/WHO commitments (2)
Communicable Disease Control	18 %	77 %
Pro-Poor Health	23 %	9 %
Reproductive Health	14 %	2 %
Multisect. Response HIV/AIDS	17 %	8 %
Health Policy	28 %	4 %
Total	100 %	100%

Notes: (1) from data in SID 2003; and (2) from data in PRISM

The characteristics of the two types of DFID channelling of its funding are quite different; it seems that the added value for DFID in its partnership with WHO is focused on control of communicable diseases (and here especially on Polio and the Malaria control), while for the other fields there is a preference for the bilateral channels. From this data one could conclude that that there is not a clear unity in direction and that priorities are different but this is not necessarily the case. It could also be argued that earmarking of WHO programs has been used selectively to complement DFID's bilateral aid for the health sector.

An essential element in providing direction is the health dimension in poverty eradication. Specific attention should therefore be drawn to the label "**Pro-Poor Health**". There is a difference in the label "pro-poor" as defined for the White Paper and that applied to the relationship between DFID and WHO. The latter definition represents a fairly arbitrary designation, where programmes can be categorised as pro-poor interventions *if* they target poverty pockets in countries. The financial data give us no insights into whether programmes reach the poor and are not disaggregated for poverty so we have to rely on the DFID-WHO definition of pro-poor health. In that case the following may be concluded:

From the table 4 above we can see that only 9% of DFID funding *through WHO* was to support pro-poor health, while this was 23% for the *bilateral* channel. The bilateral funding of pro-poor health has tripled in 5 years in real terms (to £60 million per year in 2002/03). One explanation would be that DFID relied more on its bilateral channels for pro-poor health rather than delegating this task to WHO. This may change in the future. From 2002

onwards HIV/AIDS represents 61% and Pro Poor 32% in terms of *planned* DFID commitments (not real expenditures) for WHO.

It should also be noted that the part of the EBF that was recently un-earmarked is *arbitrarily* labelled as "pro-poor" – not all activities that are financed this way may be regarded as pro-poor.

The situation in Zambia illustrates the challenges facing the DFID-WHO relationship at country level. Widely expressed views from stakeholders are: that WHO puts disproportionate effort into **priority programmes** such as Stop TB; that the agenda for these are set at global and regional level; and that insufficient emphasis is given to health system and economics issues to inform policy and public expenditure. There is also a perceived lack of contact with the private and non-governmental sectors. Such capacity building that is done is conducted on a bilateral basis with the ministry or department of health and not subjected to informed debate by a wide pool of stakeholders. Several examples were given to support these criticisms:

- A large-scale polio eradication campaign was planned top-down from region or Geneva without calculating the budget implications. A shortfall in finance had to be met from sector basket funds although basket donors had not been consulted prior to the programme.
- Government in Zambia has recently decided to adopt a brand-name artemesinine based combination therapy for malaria treatment in 28 of 72 districts. This has been promoted by WHO, which led negotiations with the manufacturer. The costs dose are considerably higher than similar treatments that are available with serious complications for the total budget available per capita at district level. The programme is being funded by a grant from the Global Fund for AIDS, TB and Malaria (GFATM) under which WHO is the procuring partner.
- The proposed 3 by 5 AIDS programme implies a tenfold increase in the number of AIDS sufferers receiving ART. Both the logistics and budget implications of coping with this expansion do not appear to be getting serious analysis. As one donor pointed out, by not tackling the problem of prioritisation the effect will be prioritisation by first-come, first-served basis, which is morally contestable and contrary to the national poverty strategy.

On the other hand, DFID policy at country level is more geared towards coherence with national mid-term investment plans.

The perception of influencing

Perceptions of influencing vary considerably according to the viewpoint of the respondent. At WHO **headquarters**, DFID is credited with being influential in several key areas: the Commission on Macroeconomics and Health; the promotion of a country focus and a poverty focus to WHO's work; and in technical support to programmes such as HIV/AIDS and the Country Focus Initiative. Many respondents mistakenly consider that British nationals employed by WHO are agents of DFID policy objectives, or even working on secondment. There is a less positive view of the ISP as a mean of influencing: the ISP is seen as essentially an internal UK matter and that DFID should confine it's influencing to actions through the World Health Assembly.

The focus of DFID's influence **at country level** is primarily national policy rather than WHO. In general, DFID health advisers do not think that DFID has been effective at promoting change in WHO, however there are two interesting examples. The first example is of DFID and WHO cooperating on the dissemination of the findings of the commission on Macroeconomics and Health and on a number of studies related to demand side financing. DFID and WHO undertook together technical missions and cooperate in an informal technical group on the issue. WHO is considered to have influenced DFID in increasing their commitment to this area. A second example is of the close working relationship between DFID and WHO in the area of water and sanitation in Bangladesh. This is seen as mostly a consequence of the four advisers from both organisations all sharing their office in the Department of Public Health Engineering in the Ministry of Local Government. There are many informal and formal contacts, both at policy and technical levels. The relationship is not governed by the organisations having a contractual relationship, but by cooperation at the technical level.

Trust

In financing, DFID has prioritised WHO within the UN-family which can be seen as an indication of DFID's trust in WHO – on the other hand for health it has prioritised bilateral funding over funding WHO. At the level of headquarters the un-earmarking is generally welcomed and regarded as a signal of trust, above all because it gives WHO more flexibility in planning and strengthening the organization. At program levels in the organization this opinion is not always shared and here a preference is often given to continue with earmarking DFID's funds for a variety of reasons including:

- the closer relationship with DFID
- earmarking provides more possibilities for accountability
- DFID's critical role is seen as positive for the organization
- Donors are often not explicit enough on their expectations.

Representatives of the 7+ group of **like-minded donors** are less convinced of the readiness of WHO for un-earmarked funds. In particular, their argument is supported by the following opinions:

- the quality of reporting seems to differ enormously between departments
- priorities in WHO can easily change
- the process of prioritisation is not especially transparent, with no explicit criteria
- there is a need for accountability of the member states to their governments
- it is not certain that the poor (including those in non-poor countries) will benefit more

Some major donors, most notably the UK, Sweden, Norway and the Netherlands have indicated their willingness to provide un-earmarked funding. The Dutch approach for example, is to provide comprehensive support to one package by not defining partnership objectives but broad priorities like 'poverty', 'sexual and reproductive health' and 'health systems development'. After a period of completely untying the Dutch-WHO program, the Dutch approach has once again become more tightly controlled. This has been as a consequence of what the Dutch see as a lack of attention with their priorities within WHO, although it is also because it is perceived that WHO has had some difficulties in handling untied EBF – something which was confirmed in DFID.

2.4.2 Monitoring and evaluation

The effect of M&E on policy, strategy and management decision-making

The implementation of the reform agenda, and specifically the use of Results Based Budgeting (RBB), presents enormous challenges for the various reforms in WHO. In the Implementation of the Programme Budget 2000-2001 (WHO 2002a), some regions set out clear agendas for briefing, training and supporting staff, while others barely mention RBB. The Africa Region, for example, adopted the RBM approach in a participatory way, although it experienced staff capacity problems with understanding and applying the concept of expected results (WHO 2002a: 51-53). Other regions, such as the Pan American Region, experienced some resistance outside the Office of Analysis and Strategic Planning – with managers feeling it is a bureaucratic process with little effect on decision-making and resource allocation (WHO 2002a: 70-72). Others still, like the South-East Asia Region, make no mention of RBM except in some limited reference to M&E (WHO 2002a: 87-89). The question remains how far this outcome-focused approach really extends beyond the expertise and agenda of the department responsible in WHO for implementation.

While specific global priorities were included in the procedural guidance for 2002-3, there remains a need for flexibility with regard to regional and country specific health priorities – as well as the monitoring of this 'flexibility' (WHO 2001a: 16-17). This is the issue identified in the country visits, where top-down programmes have the effect of overshadowing country-driven plans. During the Retreat on Results Based Budgeting, the challenge of how to ensure shared planning responsibilities between organisation-wide commitments and locally defined needs was seen as particularly important. This has implications for ensuring consistency between strategic and operational plans, where the timeframe means that operational plans (of activities, products and services) for regions and countries are often developed prior (or simultaneous) to the development of programme budgets – which contain the organisation-wide expected results (WHO 2003c: 6).

The scope of M&E arrangements to monitor progress

In practice, monitoring of the relationship is mainly achieved informally, through the regular contact of staff at the UK Mission in Geneva, and also at the Annual Review. The Annual Review is a useful forum for policy dialogue as well as providing a mechanism for WHO to cite progress and DFID to raise concerns. It is mostly about WHO effectiveness, rather than the relationship per se, and perhaps less objective and evidence-based (i.e. without a more formalised monitoring report feeding into it).

To assess the effectiveness, the challenge facing DFID is how to balance information needs among four competing dimensions:

i) The effectiveness with which support to WHO is organised by DFID

ii) The performance of the *DFID-WHO relationship*, both at headquarters and country levels

iii) The *internal performance* of WHO, like the institutional reform

iv) Overall impact of WHO, especially at *country level*, as one of many multilateral UN agencies.

Recently, DFID is in discussion with WHO on using the results of the reporting system of the MEFF (**multilateral effectiveness**). The MEFF is an evidence-based approach that draws primarily on multilaterals' own information sources. The system addresses the issues (ii) to (iv) mentioned above, but not the effectiveness of DFID's financing of multi-laterals (like WHO). The MEFF methodology assesses the effectiveness of multilateral organisational systems by means of a checklist of questions on 24 criteria and an adapted balanced scorecard ('traffic lights') approach, focussing on issues of fact. The system is simple and aims at policy dialogue.

Within MEFF, and with the move to un-earmarked funding, there is an increased reliance on WHO's own internal systems (the Programme Budget, etc). While it is important to reduce transaction costs, WHO's monitoring of Expected Results will probably not be fully reporting for a number of years. At the present time it does not yet offer a viable approach to monitoring performance. The internal system of WHO is based on aggregated expected results – which represents both a strength (for its simplicity) and a weakness because of the aggregation of multiple-country programs. It does not provide information on its policy against its mandate, nor the quality of WHO's programme or the results at country level – this will have to come from the MEFF-exercise which will interview different stakeholders. The MOPAN-system will provide information from country level – but on WHO's performance as it is perceived.

Summary
The relationship is considered to be a stable one, and not disrupted either by DFID's internal reorganisation or WHO's new ED. Predictability is questionable. One the one hand DFID's move to de-earmark a major part of its funds should increase predictability as WHO has a medium-term funding commitment to work within. But by transferring responsibility for the allocation of funds to WHO, managers of technical programmes that used to be funded face uncertainty about future resources. Other donors are also critical of this shift, arguing that WHO lacks the means to monitor and report expenditure in sufficient detail.

Moves by WHO to introduce results-based budgeting are positive but have been fairly slow. In particular, the structure of the budget and the quality of indicators are such that the system will not be able to provide the information needed to track performance towards the type of change envisaged by the ISP.

3 DISCUSSION AND CONCLUSIONS

This section sets out a number of important conclusions from the evaluation. Indeed many of these conclusions establish further questions and challenges for both DFID and WHO, and should provide the basis for future discussions.

Defining the relationship
A partnership is a working arrangement that goes beyond a contract or MOU. The trust and practical arrangements enable the partners to be innovative and take risks in support of common goals. Monitoring of such an arrangement needs to focus on the ways in which trust is developed and fostered, the ways in which the partners coalesce behind jointly shared objectives and the achievement of declared and unintended objectives. Monitoring and evaluation should be undertaken jointly following the concepts set out in the partnerships working paper.

The relationship between DFID and WHO is more complex than other relationships between DFID and multilateral agencies, on two counts. Firstly, because DFID is not the lead body for the relationship between HMG and WHO; secondly because WHO has a more complex governance structure than other UN agencies, with a high degree of independence and authority vested in the regional health organisations. DFID has recognised the former but not taken the latter sufficiently into account in the ISP and ISP action plan.

The appropriateness of the ISP
In WHO most representatives at the programme level think that the existing governing structures (WHA, MIP, etc) should be sufficient for DFID to express its expectations (and even 'influence') the organisation and its outcomes. Indeed many in the group of 77 non-aligned member states, and to a lesser extent in the 7+ like-minded members, do not see it as appropriate to develop isolated partnership structures.

There is a tension between WHO with its broad mandate (and broad scope of demand from the member states) on the one hand, and DFID wanting to see value for money and seeking to attain its objectives through WHO. Despite this, the objectives that DFID pursues (poverty reduction and improvement of WHO-performance and a country focus) are shared by all member states of the UN.

Relevance of the partnership
Relevance is actually quite complicated to determine. If the goal for DFID is achievement of the MDGs at individual or collective country level, there is a plausible case to be made that DFID, working in collaboration with other like-minded donors and in support of national health strategies and poverty reduction strategies, does not need to work through WHO. Indeed this has an important bearing on the ISP Objective Two and DFID's support of the Country Focus Initiative. But although the case for <u>not</u> working through WHO is probably quite strong in some countries, in fact there are good reasons for continuing with WHO:

- Achievement of the MDGs requires substantial resources in support of tackling communicable diseases such as HIV/AIDS, malaria and TB. WHO brings considerable technical and programming skills (the global public goods argument) in these areas, for which there is no substitute.

- The combination of normative skills and neutrality of the UN should be a powerful force for health reforms. A better understanding of poverty would enable health systems to be planned to foster pro-poor mechanisms. But in many countries, WHO falls short of its potential to play the role desired by bilateral donors, of support for health systems development, economics and health policy.

This evaluation is an evaluation of DFID in the partnership, not WHO. But perceptions among DFID staff suggest that WHO does not fulfil these roles adequately at country level. The added value to DFID is therefore much diminished here. In its relation with WHO, DFID should make strategic choices – if the perception in DFID is that actually the added value of WHO lays at headquarter level, it may concentrate on this *or* take measures to reinforce the country level. In the latter case DFID may decide to reinforce WHO at country level in policy and strategy development for poverty reduction in matters as mentioned above.

This issue becomes progressively more important because in the actual overall strategy from project approach via programme and sector-wide approach towards Budget Support, technical people are progressively less involved in DFID support (and of other bilateral donors) to the health sector. Many are looking at the UN family to fill the TA gap that probably will be the consequence of BS. This may be an important aspect in DFID's strategic choice in supporting WHO. WHO may represent an important element in solving this problem, as a substitute for the TA that was formerly provided within the context of bilateral programmes. But WHO's technical capacities would need to be strengthened by bilateral donors, such as DFID. Otherwise, alternative solutions need to be found.

The added value to WHO of working with DFID is significant and it is unlikely WHO would wish to see the relationship eroded. Key areas are the financial support provided by DFID and intellectual contribution to technical and policy debate. All are valued.

Partnership working

In terms of the definitions set out in the partnerships paper the overall relationship is not a partnership. But there are many examples of *partnership working*, mainly in the technical programmes and to a lesser extent at country level. Frequent uncritical use of the term partnerships devalues the concept.

Managing the partnership

At present there is little or no management of the relationship. The single biggest weakness is communication, more so within WHO than DFID, although the reorganisation disrupted communication there as well. Practical ways to improve management include the following:

- Drop the term partnership and use *relationship* – it is less exclusive and carries lower risk of alienating other stakeholders
- Invest in a communication strategy to inform staff at all levels in HQ, regions and the field about how DFID is planning to work with WHO, towards mutually-agreed ends.
- Develop the ideas about stakeholder analysis presented within this report for DFID to draft a strategy for communication and influencing.
- Make funds available to enable staff at country level to foster the relationship and joint working.

- Invest time and resources in a joint review and evaluation capability in support of WHO's fledgling evaluation reforms. Invite other donors to join the review process.

DFID's institutional reforms
DFID's internal reorganisation has raised problems, leading to a loss of coherence about health policy and the relationship with WHO. The shift to UNCD is not generally regarded as a problem *per se*, but the changes in the roles of decision-makers (such as the former post of Chief Health Advisor) have undermined efficient working within DFID. Furthermore, the coordination between technical support and financial commitments (during both the reforms of Policy Division and the un-earmarking of funds) has created significant uncertainty for some technical programmes within WHO (e.g. Roll-Back Malaria; Macro Economics and Health). It appears that the major issue was poor communication of the change rather than the change itself.

The use of earmarked funds
After years of EBF, DFID has recently made a commitment to the un-earmarking of funds in support of WHO. Unsurprisingly senior management has largely welcomed this move as it provides WHO with a certain flexibility, while some technical programmes (e.g. Roll-Back Malaria; Reproductive Health; Macro Economics and Health; Health Action in Crisis) are less supportive. The latter is not surprising because the total of the un-earmarked funds represents much less then the total of EBF those programs received before – for them the predictability of DFID funding (key in "trust") turned out not to be guaranteed – also, the introduction of the un-earmarking was not communicated to them on forehand.

The appropriateness of un-earmarking will depend on several factors. Firstly, there is an apparent lack of a systematic, transparent process for the prioritisation of funds, so for un-earmarked funds too. For DFID too, it raises issues, such as how to support innovative or high-priority areas of work – which in the past have been widely appreciated and an important contribution of DFID support in the partnership (e.g. the EHA Capacity Building Programme). Changing towards un-earmarking would mean for DFID to have confidence in WHO reporting system, the performance of WHO governing bodies (WHA and MIP) for priority setting, its direction (poverty focus), evidence of results of WHO country initiative and attempts to come to "One WHO", and of course an efficient use of funds in WHO. This is considered very ambitious for many representatives in DFID and other WHO partners. Indeed a recent example within DFID has shown a reversion to earmarked funding, where support for WHO's essential drugs policy is to be directly funded by UNCD, the Access to Medicines Policy Team and the International Trade Department. This may be entirely justified, but it is not clear on what basis earmarked funding are deemed appropriate.

There is also a significant amount of DFID funding that is disbursed through Country Offices to WHO or WHO supported programmes. It is not apparent that these are in any way coordinated or coherent within the overall relationship with WHO.

Resources for the partnership
The relationship needs access to resources to develop "unity and direction", and foster "trust". Relatively small funds available to a variety of actors, such as policy division teams and country-based health advisors would enable collaborative actions with WHO in support of the ISP goals. At country level for example, DFID funding (and staff) is mostly concerned

with projects, programmes and increasingly sector-wide approaches and budget support. Little attention is paid to facilitating the relationship with WHO, and enabling WHO to be more effective in its role.

Monitoring the partnership

Neither the unimplemented arrangement under the ISP-Action Plan, nor current work in support of RBB by WHO provide the level of detail necessary to track the relationship. The underlying problem is that, at the time of developing the ISP, neither the stakeholders nor the activities were specified at a sufficient level of detail to form the basis of a monitorable plan. This is something that needs to be given greater thought at the time of developing the ISP, and indeed may be true for many of the ISPs; In a recent evaluation of the DFID-UNDP ISP for example, the evaluation team had first to design indicators before the evaluation could take place.

Indeed, within WHO, the process for the transparent and systematic allocation (and prioritisation) of un-earmarked funds is generally weak. Furthermore, there are still circumstances where DFID uses (and continues to use) earmarked funding. It is not clear under what circumstances these are appropriate or indeed desirable.

Current arrangements for monitoring and reporting are insufficiently developed for adequate tracking of these resources. Furthermore, DFID has inadequately redefined its monitoring role in response to this transition – placing the burden of responsibility solely on WHO's internal systems.

Appendix 1: Approach and methodology

The evaluators have proposed a definition of **partnership** that will determine the framework of the evaluation, and to translate this definition into operational indicators.

The approach

The inception phase led to an approach that can be characterised as follows.

Firstly, we identified five key thematic areas for analysis:

- the relevance of the relationship, with special regard to the extent to which DFID's poverty goals are best addressed by support through WHO
- the appropriateness of the ISP as an instrument to define the partnership and its mode of operation
- the extent of unity within the partnership – the trust and values among partnership members – and mapping of the relationship
- the efficiency of joint actions and DFID contributions (management of the partnership, network attributes, resource allocation and communication)
- the effectiveness of joint actions and DFID contributions (stability, M&E, capacity building)

These thematic areas will be explored at a number of levels:

- DFID and WHO headquarters and top management interaction
- as manifest through technical programmes
- at country level

The technical programmes clearly transcend both headquarters and country levels, but provide a distinct perspective on the relationship.

We have taken the view that an effective partnership brings added value over and above a contractual relationship. Given the multiple aspects of the DFID-WHO relationship, this hypothesis needs to be tested. We will do this by asking questions of all stakeholders to explore the nature of the relationship, yielding evidence as to whether there is a working partnership.

In taking this approach we are bringing three extra dimensions to the terms of reference:

- focussing on the unity (trust and values) of a partnership, in addition to the evaluation criteria of relevance, effectiveness and efficiency
- exploring this complex relationship at three distinct levels
- using a methodology that unpicks partnership working through a variety of relationships – institutional as well as interpersonal.

Methodology and overview of the assignment

An Action Plan for the KIT/ ITAD evaluation was approved by DFID in consultation with WHO. The assignment to be structured in four phases, summarised as follows:

During the **Preparatory Phase**, the scope of the evaluation, the expected results and the planning of the assignment were discussed in London with DFID and DOH and in Geneva with WHO.

In the **First Phase,** based on the documents provided, the international literature and the experience of the consultants, three background papers were written on:

- Defining and evaluating « Partnerships »
- WHO, DFID and the MDGs
- M&E and results-based management within WHO

Each of these documents has provided elements for evaluating the partnership; an analytical framework (attached) and an outline for the evaluation tools was developed.

During the **Second Phase,** the partnership (***not*** the performance of WHO or particular programmes) was evaluated based on the approach and the tools developed in the inception report.

The methodology followed three stages:

- An analysis of the aims, objectives, structure and outcomes of the partnership to identify its key operating parameters; this information is used to calibrate a questionnaire for the second stage.
- Interviews with individual members of the partnership, using a semi-structured questionnaire, either in person (in London, Geneva and during the country studies) or by email and telephone.
- Mapping of the architecture of the partnership based on the analysis and interviews, leading to an overall assessment of the effectiveness of the partnership.

The interviews focussed not only on the objectives formulated in the ISP and ISP-Action Plan, but also on three "**tracer programmes**" in WHO. These programmes were selected on the basis of criteria including their importance related to (i) the WHO strategies and mandate; (ii) presumed impact on the MDGs; (iii) DFID input (high or low); and (iv) the recommendations of representatives in DFID and WHO. Two technical and one policy programmes were selected[9]:

- Roll Back Malaria
- Sexual & Reproductive health
- Macroeconomics and Health

The fact that some programmes (for instance Roll Back Malaria) have already been evaluated extensively meant that there was a considerable amount of information on these programmes at the disposal of the evaluation team.

[9] DFID and WHO's cooperation in the field of emergency response will be covered through the selection of Zambia (drought response) as country case study, see below.

To appreciate the partnership as comprehensively as possible the perspective at headquarter level and at **country level** was appreciated: a "multi-level approach" was chosen, to assess the coherence of priorities, policies and strategies that were agreed upon by headquarters between the levels. To this purpose three country visits and telephone inquiries were carried out. The countries were selected on the following criteria: (i) geographical focus of DFID: two countries in Africa and one in Asia; (ii) the perceived nature of the partnership to study the determinants of a good partnership; (iii) WHO involvement in emergency situations; (iv) the extent of DFID's channelling its support through WHO, and (v) the recommendations made by different interviewees.

The information needed was gathered through desk studies and interviews with key stakeholders:

- At headquarters level: interviews at WHO and DFID.
- With other WHO member states**:** DGIS (the Dutch equivalent of DFID) was visited for interviews on their partnership with WHO. A seminar was held with Dutch public health professionals to discuss their experiences of working with WHO. The perspectives on the DFID/WHO partnership of the "supporting countries" (the 7+ like-minded countries) and of two "non-aligned" member states (Senegal and Bangladesh) were studied, too.
- At country level by three country visits (Bangladesh, Ghana and Zambia); here the WR and other WHO staff, health advisors of DFID and senior representatives of the MOH and of other key donors were interviewed.
- At country level through telephone enquiries to WHO and DFID representatives in a selection of countries: **WHO** country offices in Nigeria, Tanzania, Ethiopia, Uganda, Mozambique, Thailand, China, India, Nepal and Vietnam; and senior **DFID** Health Advisors from country offices in India, China, Thailand, Malawi, Kenya, Uganda, Southern Africa, Nigeria and Bolivia – some of them also had significant experience working in other country offices (Nepal, Vietnam, Burma, Nicaragua, South Africa, Bangladesh, and Zambia).

The results were presented in country visit reports and in two working papers. The focus in these two papers is on:

- DFID's management of the partnership with WHO, including the ISP process, and DFID's technical support and secondments to WHO;
- DFID's financial support to WHO.

The results of these results were in turn analysed and summarised for this draft synthesis report.

During the **Final Phase,** this draft synthesis report will be presented to the Reference Panel to which the primary stakeholders in DFID and WHO will be invited. After adaptation to comments, the final report will be presented to other interested parties at a seminar at DFID, London and WHO, Geneva. Moreover, the report will be sent to those directly interested, and will be placed on agreed websites after an announcement to (secondary and tertiary) stakeholders.

APPENDIX 2: WHO'S ROLE IN POVERTY REDUCTION

Before December 2003 **Annual Report** WHO had not presented its vision of the organisation's role in supporting countries and development partners in their efforts to achieve the health-related MDGs. The strategy paper distinguishes *three pillars* or components to WHO's work which form the "poverty focus":

- Allocating a pro-poor focus to the *normative and technical work:* increasing attention will be paid to the areas of child and maternal health, but also to health systems and environmental health.
- *Tracking progress and measuring achievements:* identifying indicators associated with each health-related MDG and target, and developing coherent reporting procedures (the *Health Metrics Network)*. WHO will report on 17 health-related MDG indicators. WHO also aims to build capacity in countries to collect, analyse and act on the information collected.
- *Strengthening technical collaboration* through individual Country Co-operation Strategies.

In addition it mentions the importance of specific strategies and activities:

- *Working in partnerships*: collaboration with the *Millennium Project* conducting research on the strategies needed to achieve the MDGs. Ten task forces will work on the operational priorities, the organisational means of implementation and the financing necessary to reach the MDGs. WHO will contribute to the preparation of national MDG reports and will work with national authorities to act on their recommendations.
- WHO organised a *High Level Forum on health-related MDGs* between senior officials from donor agencies and national governments to review progress over the whole range of health-related MDGs.

Appendix 3: Example stakeholder strategy development for DFID's relationship with WHO

Stakeholder	Supportiveness of ISP objectives	Influence over WHO	Illustrations of potential DFID strategy
National civil society; National healthcare interest groups; National MOH	Low to median	Low to median	Increase awareness about health policy issues and WHO performance
WHO Representatives; WHO Regional Heads	Low to median	High	Share lessons and experience to promote ISP objectives
DFID Health Policy Teams; DFID Health Advisers	High	Low to median	Develop common influencing policies and skills
Donor 7+ Group	Median to high	Median	Develop common positions on health sector approaches and multilateral performance
Other UN Agencies	Median to high	Low	Promote multilateral performance measurement at country level

Appendix 4: Evaluation framework for partnerships with MDA

Methodological issues in M&E of a Multilateral- partnership

It is necessary to look for evidence of *partnership working* in both organisations. Partnership working is distinct from both market-based relations determined by contract, and relationships in the public sector involving hierarchies based upon authority.

The **multilevel approach** used in this evaluation proved to be very useful in the DFID-WHO evaluation to assess the "partnership working". Important differences of perspectives were seen at management level, program level and country level. Certainly the perspectives at country level have been very important indeed – here one may appreciate the effects of the partnership arrangements on the indirect beneficiaries.

The idea of choosing tracer programs also worked out well because the number of technical programmes in a MDA is too vast to encompass – but it is important to know the perspectives at programme level. The multi-level approach should primarily be based on the architecture of the relationships and the stakeholder analysis in the ISP. For this approach, identifying a number of tracer-programs is essential to focus the discussions and to ensure that the same issues are discussed at each level.

An evaluation of a partnership should not be confused with an evaluation of the performance of one of the partners. Of course the ***perceived performance*** of the other partner is of utmost importance for trust, the flexibility in planning and monitoring of the activities, in the importance of frequency of communication and the strength of the network attributes – and for that reason for the partnership working.

Sending the evaluation framework of the inception report beforehand helped to focus the discussions and make a complex process more efficient. Interviewing key-persons at country level by telephone is time-consuming and it was more productive to visit a number of countries. The outcome of the telephone inquiries did not add significant new dimensions to the findings.

The table overleaf sets out an evaluation framework for partnerships with MDA, and includes evaluation criteria, issues involved and puts forward some candidate indicators.

Recommendations

1. The additional evaluation criterion of unity developed for this evaluation is relevant only where a true partnership exists. For contractual and administrative relationships, evaluation can be based on the conventional criteria of relevance, impact, effectiveness, efficiency etc.
2. The methodology of a partnership evaluation should be qualitative rather than quantitative, use a multi-level approach, include country visits and focus on perceived performance of partners

The framework used for this evaluation should be built into the action plans for ISPs, to help focus on the overriding issues that determine the relationship, and on DFID's priorities in the particular MDA. These action plans, including the partnership issues, could be jointly monitored on a regular basis. The results should provide the basis for a dialogue between both partners, and help to track progress in attaining the objectives.

Evaluation Criteria	Issue	Possible indicators
Relevance	The extent to which the relationship will increase the ability of partners to achieve their goals	Ability to demonstrate how the partnership can improve DFID's results chain or development logic towards poverty reduction
		Extent to which DFID staff seek professional support and advice from the partner organisation
Unity	Extent to which partners share common goals, objectives, values and expected results	Level of support by DFID staff at a range of grade levels and across organisational units for stated partnership objectives
	Level of trust between partners	Assessment of trust in the partnership by DFID staff
		Examples of trust in practice such as one partner representing the other in meetings
Effectiveness	The relationship increases the added value of expenditure by DFID on poverty reduction	Improving performance of operations where DFID works with the partner (value for money)
	Arrangements for monitoring and evaluation	Adoption of common reporting and monitoring procedures
		Participation in joint evaluations
	Outcomes	Achievement of expected benefits
Efficiency	(Effective network attributes) Arrangements to manage the relationship and foster trust	Transparency in sharing information
		Success of programmes to foster joint working and development of relationships
	Availability of resources for the relationship	Predictable budget and human resources available where required
	Capacity building among partner staff	Success of capacity building observed through improved performance in identified areas of need
	Communication among partners	Exchanges of information and other communications perceived by partner staff to be appropriate

Appendix 5: Terms of Reference for the EVALUATION OF WHO – DFID PARTNERSHIP

Introduction

1. Within the context of Evaluation Department's work on partnerships with multilateral organisations, the evaluation of the partnership between the World Health Organisation (WHO) and DFID will be the first case study.

2. The evaluation will assess the relevance and appropriateness of the partnership and the efficiency and effectiveness of DFID's partnership activities. It is expected that the evaluative work will help specify the concept of "partnership" in DFID and capture its content and implications in more measurable ways. By doing so now, the study will create a baseline for future monitoring and evaluating of the partnership. Furthermore, the evaluation is expected to generate lessons about working effectively in partnership with multilateral organisations, such as the WHO, in the pursuit of poverty reduction.

Background

3. WHO is the directing and co-ordinating authority on international health work, with as its overall purpose the '*the attainment by all people of the highest possible level of health*'. DFID's main interest is in the WHO as a key development partner for achieving DFID's White Paper objectives and the Millennium Development Goals (MDGs), especially those related to health and poverty.

4. WHO is an improving organisation and is currently engaged in a process of widespread reform. DFID is committed to supporting this reform process and has worked together with the WHO to produce a set of partnership objectives, closely linked to WHO's corporate objectives. The objectives and the strategy to achieve the objectives are stated in the ISP *"Working in partnership with the World Health Organization"*, which was published in August 2002 and is planned to run until 2006.

5. It is important to note that the WHO – DFID partnership is placed within the broader context of the cooperation between the UK Government and the WHO, (whereby Department of Health provides the overall lead); the cooperation between like-minded donors in the WHO (the so-called 7+ Group[10]); and the UK as one of the now 192 Member States represented in the World Health Assembly (WHA).

Outputs of evaluation

6. The first part of the evaluation will lead to an Inception Report on the partnership, its organisation and background, and the relevance and appropriateness of the partnership, as the basis for the further evaluation (by Mid November).

[10] Denmark, Finland, Ireland, the Netherlands, Norway, Sweden, and UK

7. It is suggested that as a background to this report, three separate working papers will be produced on:
   - Defining "partnership" in this particular context;
   - WHO and the MDGs, to establish the significance of the partners' role within the global institutional environment;
   - WHO's monitoring and evaluation efforts and results-based management system and its potential usefulness to assess the outcome of the partnership and WHO's reform process.

8. The second part of the evaluation, focusing on the effectiveness and efficiency of DFID's partnership with WHO, should produce three main sub-reports:
   - Sub-report on DFID's management of the WHO partnership, which includes a more in-depth evaluation of the ISP process;
   - Sub-report on efficiency and effectiveness of technical support to the WHO, with a specific focus on the use of secondments;
   - Sub-report on financial support to the WHO.

9. The final synthesis report should include lessons learned and recommendations for the partnership with WHO in particular and multilaterals in general. The synthesis report should also include recommendations for future evaluation work in the field of partnerships with multilateral organisations.

Time frame

Time	**Milestones**
August - September	Set-up of Evaluation team Consultation UK / Geneva
September	**Work plan for evaluation**
October	Relationship map, defining “partnership Report on WHO - MDGs **Report on WHO M&E, RBM**
November	**Inception Report**
March	Report on ISP Report on Secondments Report on Financial support
March	**Presentation/Consultation draft synthesis report**
April/May	**Dissemination Final synthesis report WHO-DFID partnership**

DEPARTMENT FOR INTERNATIONAL DEVELOPMENT

The Department for International Development (DFID) is the UK Government department responsible for promoting sustainable development and reducing poverty. The central focus of the Government's policy, based on the 1997 and 2000 White Papers on International Development, is a commitment to the internationally agreed Millennium Development Goals, to be achieved by 2015. These seek to:

- Eradicate extreme poverty and hunger
- Achieve universal primary education
- Promote gender equality and empower women
- Reduce child mortality
- Improve maternal health
- Combat HIV/AIDS, malaria and other diseases
- Ensure environmental sustainability
- Develop a global partnership for development

DFID's assistance is concentrated in the poorest countries of sub-Saharan Africa and Asia, but also contributes to poverty reduction and sustainable development in middle-income countries, including those in Latin America and Eastern Europe.

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DFID has headquarters in London and East Kilbride, offices in many developing countries, and staff based in British embassies and high commissions around the world.

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