Evaluation of the Three-Year Programme to Improve the Performance of the World Health Organization (TYP)

1 October – 30 November 2007

Health Action in Crises

Claude de Ville de Goyet
Emmanuel Eben-Moussi
Ann Canavan
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The Evaluators realize the extra burden that their visit placed on the humanitarian staff in the countries. In particular, they express their gratitude for the logistical support provided by country and sub country offices, often at the cost of their own mobility.

Most important and enlightening were the interviews and meeting with actors directly serving the affected population. These dedicated humanitarian experts from WHO, other UN agencies or non-governmental organizations and the local health authorities generously shared their time with our team, as they did so many times in the preceding months with bilateral, international or other missions. We hope that this experience has been as enriching for them as it was for us.

Many of the conclusions and recommendations represent the views of the seasoned professionals in the field who had reflected on the strengths and weakness of the humanitarian system but, too often, are not in position to share their opinions with the decision makers.

Finally, the evaluators thank the members of the Contact Group and Dr. Ala Alwan, Assistant Director General in charge of HAC, for this opportunity to observe WHO in action during crises.
Evaluation of the Three-Year Programme to Improve the Performance of the World Health Organization (TYP)
Executive Summary

- The relatively modest funding contribution of the TYP was magnified by the political impetus given by the Humanitarian Reform.

- The TYP initiated a change visible at all levels of WHO organizational and cultural approach to humanitarian action. Considering the low pre-TYP baseline in some countries and regions, much remains to be done. Most appreciated were the coordination and information roles of WHO. Occasionally overzealous “gap filling” directly by WHO was criticized by some partner non-governmental organizations in the Health Cluster.

- WHO’s increased presence and impact on site were noted. However, performance was hampered by the rigid enforcement of inefficient and antiquated rules and regulations. Human resources management was particularly below standards, leading to poor retention of valuable staff. WHO financial system will need adjustment to provide managerial information on a more transparent and meaningful manner.

- Strengthening of the regional offices and improved coordination and horizontal/vertical communications within the Organization was a significant achievement. Coordination between the two WHO clusters with a primary role in crisis (HAC and HSE) left much to desire.

- WHO is at a critical juncture. To maintain its contribution to humanitarian health action in crises, WHO will require sustained core investment by donors. These contributions should go predominantly to retain experts at country/regional level, with commensurate proportion allocated for building the institutional capacity of the ministries of health.

Background

In September 2004, a Three-Year Programme (TYP) to improve the performance of the World Health Organization was launched with the support of four humanitarian donors. The Canadian International Development Agency, the United Kingdom Department for International Development, the European Commission Humanitarian Office and the Swedish International Development Agency contributed approximately US$ 30 million in order to:

- Enhance WHO’s ability to respond well and quickly to emergencies;
- Improve WHO’s collaboration with other UN agencies and key partners;
- Streamline administrative procedures for emergency operations;
- Increase transparency and information flow between all levels of the Organization and intensify structured exchange of information and lesson-learning;
• Mobilize adequate resources (staff, equipment and funds) for immediate and effective response;
• Streamline “emergency issues” into the work of WHO’s key technical programmes;
• Provide concrete and predictable support to countries for preparedness, response and recovery.

A three-member evaluation team was tasked to assess changes in the following areas and determine the TYP contribution to those changes:

• WHO’s performance in countries and the contributions of the TYP to those changes;
• WHO’s global set-up to work in the emergency and humanitarian context in a predictable manner and to respond well and quickly to emergencies and the contribution of the TYP to those changes;
• WHO’s ability to respond to the key requirements of the Humanitarian Reform and in particular to collaborate with other UN agencies and key humanitarian partners;
• WHO’s effectiveness in standard setting and developing guidelines for overall improved emergency health care response;
• The overall management of the TYP by WHO and funding partners.

Methodology

This evaluation presented a special challenge because of its broad thematic and geographic scope, a tight calendar without the usual break for draft review and not least the uniquely decentralized structure of WHO.

As a first step, the team reviewed extensive documentation including a comprehensive 2002 evaluation of HAC by Margaret Whahlström, a pre-TYP evaluation, the TYP official proposal, annual reports, joint reviews on WHO’s response to disasters, the TYP mid-term evaluation, numerous reports on the Humanitarian Reform, country-specific reports, guidelines published by or in preparation in HAC, and the financial analysis. At country level, job descriptions of field coordinators and key staff and curriculum of incumbents were randomly reviewed.

The team visited the Democratic Republic of the Congo, Sudan, Pakistan and the occupied Palestinian territory1; two regional offices (AFRO and EMRO) and headquarters. Interviews were conducted with three other regional offices (AMRO, EURO and SEARO).

A special effort was made to interview confidentially a broad range of actors outside WHO including health authorities, UN agencies, donor agencies (especially those supporting the TYP), non-governmental organizations2 and affiliates of the Red Cross System. Early contact was sought with agencies or Health Cluster actors likely to be straightforward in sharing their views on WHO’s strengths and weaknesses. The identified matters of concern were raised in subsequent interviews to corroborate the information received (triangulation of the information).

Undoubtedly, valuable interlocutors may have been missed or overlooked especially at headquarters level.

After each field visit, a report was prepared, discussed with WHO staff and then shared with all persons interviewed for factual comments. Final country reports have been circulated to

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1 The latter has not received funding from the TYP.
2 The number of non-governmental organizations working in the occupied Palestinian territory was not as high as in other areas.
all WHO country offices visited; they can be made available to readers of this evaluation on request.

**Changes in WHO’s Performance at Country Level**

In the four countries visited, WHO’s partners were almost unanimous in reporting positive changes in WHO’s performance. The message was clear that WHO is progressively becoming an indispensable actor in the humanitarian field. However, despite the improvements that have taken place in the last two years, there remains ample room for improvement.

- **Clarity of mandate and strategy.**
  - Out of the four key functions identified by WHO, two (coordination and assessment of needs) were particularly well understood and implemented. The role of WHO as Cluster Lead was particularly praised in the aftermath of the earthquake in Pakistan. Those two functions are perceived by all actors as the comparative advantage of WHO. Assessment of needs is highly appreciated but analysis of the data collected is weak (the “so what” question).
  - The other two functions – gap filling (including “provider of last resort”) and capacity building – left more room for improvement. Filling gaps is understood by many WHO Representatives as an opportunity to raise funds for WHO’s under-funded priorities, whether humanitarian or developmental. The boundary between humanitarian response in crisis and development is thus blurred in many instances, giving rise to an over-extension of post-crisis humanitarian activities. For instance, donors in the Democratic Republic of the Congo objected to low-fatality seasonal outbreaks and polio eradication activities being presented as humanitarian priorities.
  - HAC prioritized building up the capacity of ministries of health in acute and chronic crises, but the extent to which this was done varied according to the Ministries of Health in all four countries visited. In the Democratic Republic of the Congo the Ministry of Health was generally satisfied with the support received from WHO. The Pakistani Ministry of Health, however, was concerned with a lack of support for preparedness and risk reduction while in the occupied Palestinian territory, the operationally highly successful essential drugs project managed by WHO was perceived as not transferring skills to counterparts.

- **There was a high level of political commitment of senior management in WHO and the ministries of health.** At global level, WHO is perceived by external counterparts as taking the newfound role of the Health Cluster lead seriously. At country level, the recommendations from joint evaluations or reviews, when within the authority of the Country Office, were being addressed. An encouraging sign was the proactive and constructive reaction of the WHO Representatives and HAC staff to the country reports submitted by the evaluators. Accountability and transparency have increased but much remains to be done in this regard.

- **Specialized presence and reach of WHO (including HAC) presence into the “deep field” is the most noticeable progress and is directly attributable to TYP funding.** The competence and dedication of the field staff met by the evaluators were in general good, although not apparent in the curriculum (lack of experience in some cases). The few who participated in global or regional training clearly benefited. On-the-job training through
supervisory visits was insufficient. WHO’s most critical failure is in the retention of good international and national staff. In all countries visited, poor contractual conditions were not conducive to the predictable and reliable delivery of mandates and services. Lack of logistic support, guidance and administrative personnel reduced the capacity of HAC staff and impeded proper focus on WHO’s primary role. In most contexts, a disproportionate amount of effort was dedicated to operational projects (such as emergency kits or referral healthcare support) for which other agencies have a comparative advantage.

- WHO’s role vis-à-vis its partners was strengthened, while collaboration with UN agencies and non-governmental organizations has increased. The TYP contributed to WHO’s readiness to assume the functions of Cluster coordination. Being Cluster Lead has started to change the nature of the WHO Representatives’ relationship with non-governmental organizations, while the introduction of a more interactive collaboration also had a positive impact on the ministries of health receptiveness and reactivity. Some shortcomings were reported: for instance, coordination meetings are regarded as not sufficiently action-oriented but more of an information-sharing forum.

- WHO offered technical support and guidance to the cluster members. Its technical expertise was appreciated especially in the field of epidemiological surveillance and control. Health agencies were unanimous in their positive feedback on use of WHO’s guidelines, protocols and tools when available locally. Unfortunately, availability of TYP-produced global material was quite limited in the visited countries.

- This privileged position as Cluster Lead was used to increase the funding available to meet health needs. Funding, though, was not channelled to the health partners but primarily to WHO at the detriment, perhaps, of other actors who expressed their concern to the evaluators. WHO has a tendency to venture unnecessarily into operational areas where it has no comparative advantage such as distribution of emergency kits, refurbishing of health centres and local training. Contrarily to UNICEF and UNHCR, WHO has no organizational will and concomitant administrative mechanisms to transfer promptly CERF funds to non-governmental organizations.

Five recommendations are directed at Country Offices

- At country level, WHO should streamline its currently all-inclusive definition of humanitarian action. Not all life-saving activities caused by chronic poverty or minor crises qualify for extraordinary measures and funding. Determining WHO’s operational priorities should not be driven by the availability of humanitarian funding.

- HAC and the WHO Representatives should continue their efforts to mobilize funding locally. However, they should avoid competing with other Health Cluster partners by limiting WHO’s operational involvement to activities that cannot be done by other partners or for which it has a definite comparative advantage (last resort). In other words, WHO should mobilize resources for public health and not uniquely for WHO as institution.

- HAC should improve the analysis and interpretation of the data collected in the needs assessment to identify gaps for action and to provide partners and donors with clear guidance for their decision making.

- The WHO Representatives and HAC should provide increased WHO’s support to capacity building in the ministries of health by mainstreaming this component, when appropriate, in all humanitarian proposals submitted to donors.

3 OCHA and others welcome WHO’s focus on the management of strategic stockpiles for the benefits of all partners rather than on the micromanagement of distributions.
• The WHO Representatives and HAC should give the highest priority to the adequate provision of technical, administrative and logistic support to the HAC experts at local level.

In the International Humanitarian Arena (Headquarters and Regional Level)

Changes in WHO’s global set-up to respond well and quickly to emergencies

• Clarity of mandate and strategy at the global and regional levels is quite variable. All regions interviewed except AFRO (WPRO was not interviewed) have a clear but distinct concept of what needs to be done, how to do it and how to collaborate with other actors within or outside WHO. The four key functions were guiding their actions, although not all regions have adopted a pragmatic and reasonable approach on their role as provider of last resort. The perceptions and opinions on all pending issues also demonstrated strong political commitment.

• Among the four key functions, developing the national capacity of the ministries of health is the most generally overlooked according to national counterparts. The focus on risk reduction is particularly timely considering the upcoming global public awareness campaign on Safe Hospitals to be launched by the International Strategy for Disaster Reduction (ISDR).

• At the global level, the evaluators can only praise the Director General for her commitment to humanitarian action. The upgrading of HAC from the level of a department to that of a cluster is the most visible and concrete evidence. The interest and understanding shown during the debriefing and the concern evidenced for the maintenance of WHO’s performance by covering the gaps anticipated upon the termination of the TYP funding are encouraging. The dedication of the Assistant Director General in charge of HAC and his commitment for capacity building of ministries of health has marked the TYP.

• Managerial structures and staffing were adequate in EMRO, SEARO, AMRO and EURO. All HAC advisers have direct access to senior management and are respected. In AFRO, the reporting channel is removed from the decision-making level. Although Evaluators were not able to assess the appropriateness of AFRO inter-country staff, they have some reservations following the review of their work plan (few visits mainly for conducting workshops) and the decision to post them in the sub regional offices. Harare is obviously not the most convenient hub for sub regional travelling and does not synchronize with key counterpart agencies sub-offices (e.g. WFP, UNICEF).

• At the country level, administrative procedures, including the Standard Operating Procedures remain the most critical issue. Procurement and personnel management is heavily centralized, inefficient and slow. The Standard Operating Procedures are presented as the panacea but remain elusive. They have not yet been adopted by any of the countries visited, but reports from Uganda suggest that the WHO Representative has activated some of the revised Procedures for administrative and financial regulations.

• At the regional level, many of the serious and unacceptable problems in human resources management result from the rigid application of rules and procedures combined with an aversion to any financial risk. Morale and working conditions in EMRO, EURO, SEARO and PAHO are however better than at the global level where loss of experienced staff and the change in upper management have affected the performance. Evaluators noted
that further progress in information-sharing, reduction of duplication and collaboration among the main units in HAC needs to be pursued.

Five recommendations are directed at the Regional Offices and headquarters

- Regional Directors should formally activate the Standard Operating Procedures in all ongoing crises in their region. In particular, they should decentralize the international procurement of supplies and the recruitment of consultants to WHO Offices in countries with large chronic humanitarian crises (R 7). The WHO Director General should give necessary instructions for the immediate application of the Standard Operating Procedures for all humanitarian projects, including the necessary adjustments that may be required in the Global Management System. (R 15) Regional Offices should offer fixed-term contracts to a pre-established percentage of the national and international professionals presently employed on a temporary basis. International experts offered fixed-term contract should be regional and available for extended assignment in any country of the region to adjust to the changing needs and funding. The pre-established percentage should be established based on a conservative estimate of the humanitarian funding anticipated in the coming biennium (R 9). Regional Offices should include capacity building in preparedness and mitigation as a standard activity in all relevant humanitarian projects. A fixed percentage of 10% is suggested (R 10).

- HAC should intensify its effort to implement its risk reduction and preparedness strategy in support to the ministries of health in particular through the Safe Hospitals awareness campaign launched by the ISDR. (R 14)

Changes in WHO’s ability to respond to the key requirements of the Humanitarian Reform (HR)

- The interaction between the Humanitarian Reform and the TYP has been symbiotic. It is doubtful that the progress made possible by the TYP would have taken place without the political impetus created by the Humanitarian Reform initiative.

- The Humanitarian Reform mandate and strategy are similar to those of the TYP. WHO has capitalized on this similarity.

- The political commitment of WHO’s senior management (regional and headquarters levels) to the Humanitarian Reform is outstanding. WHO could not relinquish its customary leadership in the health sector when and where it is most needed such as in crisis situations. The possibility that someone else might lead the Cluster/sector galvanized WHO into action.

- Interventions to reinforce collaboration vary according to culture and personalities. Formal contacts and memoranda of understanding are now common. In EMRO and AMRO, the outreach to other organizations is proactive: memoranda, joint projects, consultations, etc. At the global level, HAC organized meetings with all actors while responsibilities for the development of guidelines on all topics was delegated across a broad range of UN agencies and non-governmental organizations (not always the most appropriate approach). This may lead to a costly dispersion of efforts.
One recommendation is directed at WHO headquarters

- HAC Global Cluster coordination should focus on a more limited number of initiatives (guidelines and others) keeping in mind that the real challenge and investment are not compiling technical documents but ensuring their use in current practice. (R 13)

WHO’s effectiveness in standard setting and developing guidelines

- Improvement of HAC’s relations with other WHO technical departments varies: it is good in countries visited (HAC is the main player) and in most of the regional offices, while the assessment is more nuanced at the global level. In Geneva, various initiatives launched by HAC jointly with other departments were apparently appreciated by partners. However, collaboration between the main two emergency responders (HAC and the cluster for Communicable Diseases, now called Health Security and Environment), while smooth at the most senior level, remains sensitive at the more operational level. Both clusters would gain from a clarification of their respective roles and from a joint formulation of the follow up proposal to the TYP.

- Funding is the predominant means employed to stimulate buy-in by technical departments. A true delegation of financial management to the other technical department is not common however as HAC feels compelled to maintain initiative and final control due to its accountability to donors for project results. Ownership by technical departments may require that HAC assume this risk.

- WHO guidelines are more technical in nature than existing standards such as the SPHERE; the focus should always be on the quality and coverage of services provided rather than on the volume of services rendered. However, minimum standards for recovery are lacking. Indeed, once these generous “minimum” SPHERE standards are promoted in an acute emergency, it becomes difficult and sensitive for the Government, WHO or other agencies to adopt inferior recovery standards even if these are more compatible with the overall living conditions among the unaffected population and more adapted to the realistic expectations of recovery assistance. WHO, as well as the humanitarian community, lacks an exit (or transition) strategy.

- It is premature to assess the impact of the TYP-funded guidelines. As noted earlier, lack of dissemination is an obvious shortcoming. A sustained investment is required to ensure dissemination and adoption of tools and guidelines developed at the global level, but to date this activity is not budgeted. Regional Offices are also developing guidelines and manuals. This should not been seen as a duplication but as an asset since adaptation to every environment is required.

Three recommendations are directed to WHO headquarters

- HAC should continue to mobilize humanitarian resources but should devolve full authority (allotment) for the implementation to the respective technical clusters and units while retaining the responsibility for reporting to donors (R11).

- Roles and responsibilities between HAC and HSE should be better defined, stressing the coordination and resource mobilization responsibility of HAC and the thematic specialization of HSE. (R 12)

- WHO should give full authority to the new Assistant Director General in charge of HAC to reassign functions and change posts and incumbents in order to minimize duplications
and competition within HAC and achieve efficient communication and cooperation between departments or persons. (R 19)

**Overall management of the TYP by WHO and funding partners**

- In general, the actions and goals of the TYP and of the Humanitarian Reform have been coherent. General limitations are caused by the lack of shared understanding of what humanitarian activities cover at field level. The management structures and in particular the Global Steering Committee respond to the need for involving funding partners in the process. However, the decentralized nature of WHO and its cumbersome management system complicate their involvement in the actual decision making process.

- Transparency of operations and reporting could improve. The present administrative and financial systems do not facilitate sharing of managerial information on how funds are used or leveraged, on the rationale used for their allocation to regions or on the differences between TYP funding and other sources. In headquarters, a more pro-active attitude towards greater sharing of non-scientific information would benefit WHO. Reports tend to present a listing of activities and achievements without substantive analysis of problems encountered and impact. The complexity of WHO financial management – there are 78 allotments for the TYP alone – and the sporadic availability of CERF, CAP or other funding for similar activities further complicates assessing the leverage of TYP funds. Basic budgetary figures and consolidated trends, delineating resource allocation of TYP funds were not readily available to the evaluators.

- Post-disaster field reviews, like any timely lesson learned exercise, were very useful as feedback to the staff. They also provided donors with a measure of the TYP impact on the actual response. However, they cannot address the underlying weaknesses and tend to be technical in their approach. The real issues are systemic as noted by the Mid-Term Evaluation.

- Unearmarked predictable funding is “the” issue for strengthening WHO’s humanitarian role. WHO is an indispensable partner for coordination in the health sector but it does not have a buffer of flexible funding compared to other UN partners. It has a budget that is micro-allocated by either its Member States or its donors. Sources of potential core funding include:
  - The Regular Budget (i.e. the assessed contributions) as approved by Member States – HAC share remains unduly low, in spite of a significant increase for the 2008/09 biennium.
  - The income from Programme Support Cost and the Project Monitoring and Reporting fee levied by WHO on the approximately US$ 150 million of humanitarian funds mobilized annually – this income is only partially used to support HAC (for instance bridging gap).
  - TYP-like funding – this funding should be reserved for maintaining or boosting the presence of WHO when crisis-earmarked funds are not available (delayed in sudden disasters or not forthcoming in forgotten crisis).
  - Emergency Funds – Regional Offices are increasingly the first responders. Two regions established regional emergency funds for increased flexibility.

- A gap in TYP funding could have a catastrophic impact. While the cultural changes initiated in WHO may endure, temporarily at least, the loss of field presence (staff with contracts ending on 31 December) would result in a regression of the whole impetus of
field coordination, partnerships and capacity building initiatives to the pre-TYP level. The evaluators offered some suggestions to WHO for the formulation of the next proposal as this document was not made available at the time of writing this report.

- The predictability of TYP funding was limited to DFID contribution. Disbursements were irregular. The benefits of this predictability and flexibility were not evident at regional or country level. Headquarters did not make a firm multi-year commitment to regional offices resulting in uncertainty and short term funding of posts by a risk adverse administration. The tied conditionality of annual contributions to a detailed annual work plan added a major source of uncertainty for regional administrators, denying them flexibility for long-term planning. There is a practical difference between requiring the submission of an annual report and work plan and determining the funds available next year subject to approval of annual plans by headquarters (or donors alike).

Four recommendations are directed to WHO/headquarters and three to donors

- Regional offices that did not do so should include the post of HAC Regional Adviser under their Regular Budget. (R 6)
- Regional offices should explore the convenience of setting up a regional Emergency Fund on the model of those established in AMRO and more recently in SEARO. (R 8)
- WHO should consider submitting to the Executive Board approval a significant increase of HAC budget for the biennium 2010-2011 as well as the establishment of an Emergency Fund at the global level. (R 16)
- HAC should finalize without delay a five-year proposal for securing flexible and predictable funding unearmarked to specific activities or work plans. Priority should be given to sustaining WHO’s field and regional humanitarian presence in countries most vulnerable to disasters by increasing the proportion of fixed-term contracts. (R 17)
- WHO should convene a Pledging Conference with donors to seek long-term follow-up funding to the TYP. (R 18) Donors should allocate immediate bridge-funding for one year to allow the retention of the most critical humanitarian staff. (R 20)
- Donors should consider a favourable and generous response to a five-year proposal to further strengthen WHO’s overall humanitarian capacity provided:
  - WHO has effectively implemented the Standard Operating Procedures;
  - The proposal is the result of a joint consultation between HAC and HSE;
  - The provision and retention of expertise at field level is a priority. (R 21)
- Donors should provide this follow-up funding unearmarked or lightly earmarked. Annual instalments for the institutional strengthening of WHO should not be linked to detailed work plans negating WHO the necessary flexibility and predictability. (R 22)
Evaluation of the Three-Year Programme to Improve the Performance of the World Health Organization (TYP)
Main Report

1 Introduction

“WHO’s goal is to help all stakeholders working with crisis-prone and affected communities to have the greatest possible impact on human survival through ‘efficient and effective action that reduces avoidable loss of life, burden of disease and disability in emergencies and post-crisis transitions’.

Three Year Programme; To improve the performance of WHO Health Action in Crises, April 2004.

1.1 Historical Developments in the WHO Health Action in Crises

In 2002, WHO’s management recognized the gaps in response capacity and the vital need to strengthen emergency preparedness and response efforts. Several evaluations\(^4\) were undertaken by WHO which collectively highlighted gaps in management and operations. While there was a broad internal consensus that WHO should take on a stronger lead in humanitarian crises and increase its capacity to facilitate assessments, information sharing and technical guidance for health partners, stable funding was a limiting factor.

An August 2003 recommended the development of a Three-Year Programme (TYP). In 2005, a consultative process involving over 300 stakeholders globally defined four core functions for WHO’s work in countries affected by crises. This framework was endorsed by the 2005 World Health Assembly resolution WHA58.1.

**WHO Core Functions**

2. Support Member States and stakeholders in coordinating action for health.
3. Ensure that critical gaps in health response are rapidly identified and filled.
4. Support restoration and revitalization of essential public health functions and build capacity of national health systems for crisis preparedness and response.”

WHO’s strategic planning at the global and regional levels, which also received input from country management, resulted in the Medium-Term Strategy (2008-2013), where the expected results of humanitarian action for health are mapped out by the Strategic Objective Five. At both the global and country levels, strategic frameworks acknowledge the importance of dedicated resources to enhance the emergency preparedness and response programme.

\(^4\) Both internal and external evaluations were undertaken between 2002 and 2005 to include both acute and chronic emergency crises.
1.2 **Health Cluster – the Way Forward**

The cluster approach has so far been activated, to varying degrees, in eight chronic humanitarian crises and six sudden-onset emergencies.

*Global Health Cluster Framework for Development of a Strategic Plan, (September 2007)*

The Humanitarian Reform process that developed the Cluster approach and designated WHO as Cluster Lead was conducted independently of the TYP process. Being the country Health Cluster Lead implies for the WHO Representatives high level responsibilities and accountability, ranging from coordination to monitoring of the impact of interventions using agreed benchmarks. It also includes emergency preparedness as well as ensuring links to early recovery.

The role of the Global Health Cluster is to facilitate the development of a shared approach to a more effective humanitarian health response. In its first year, the Health Cluster focused on five major strategic areas of operation: (i) coordination and management guidance and tools, (ii) management systems, (iii) surge capacity, (iv) capacity building of national stakeholders and (v) building partnerships.

The Global Health Cluster is not an operational entity as such; it serves as a management and advisory group, governed by a steering group made up of UN, non-governmental and Red Cross partners.5

1.3 **Monitoring and Evaluation of HAC**

Over the three-year duration of the TYP, a series of joint review missions were conducted by WHO and donors6 in the form of “real time assessments” of the response capacity in selected countries. The assessments captured a cross section of crises situations, from natural disaster response (Pakistan, Mozambique) to response capacity in complex emergency environments (Democratic Republic of the Congo, Darfur/Sudan).

The reports presented significant findings on the strengths and weaknesses of WHO’s response and proposed recommendations addressing the gaps identified.

In addition to the joint reviews, a mid-term evaluation conducted in September 2006 addressed the progress made against the objectives outlined in the original TYP proposal to donors. The Mid-Term Evaluation report was treated as an internal document, thus the findings were not disseminated widely and had limited uptake in the field.

Key milestones were captured and documented largely in the joint reviews undertaken by donors in collaboration with HAC. The process of donor engagement made a significant contribution to the development of the TYP and contributed to an interactive style of programme management.

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5 Two full time staff within HAC form a quasi technical secretariat who provide the support and administrative functions to the Health Cluster.

6 Joint Reviews (WHO HAC/Donors) were conducted in, DRC, Sudan, Chad, Ethiopia, N-Uganda, Tajikistan, Liberia, Pakistan and CAR from 2005 – 2006
2 Methodology

The scope of this evaluation as presented in the terms of reference is very broad. The overall humanitarian capacity of WHO is being assessed from political commitment at the global level to the delivery of technical cooperation and allocation of TYP funding at the local level.

The calendar of the evaluation posed also a difficult challenge to the team. If the total number of working days assigned for this task is in line with usual practice, the absence of any break in the process complicated an orderly and timely draft review process by the sponsoring agencies.

As a first step, the team tracked and reviewed the extensive documentation made available to them, 7 such as the TYP official proposal and reports (including the joint reviews of WHO’s response to disasters occurring during the TYP period, the mid-term evaluation and the annual reports), the country specific reports, the guidelines published by or in preparation in HAC and the financial analysis. At country level, post description and curriculum of incumbents were often reviewed.

The team visited the Democratic Republic of the Congo, Sudan, Pakistan and the occupied Palestinian territory, two regional offices (AFRO and EMRO) and WHO headquarters. All visits included travel to remote provinces or communities. Interviews were conducted with three other regional offices (AMRO, EURO and SEARO). The short time available and the limited number of countries visited were compensated by the breadth of contacts. Extrapolations based on four countries may not always be accurate in spite of additional consultations and the evaluators’ experiences.

WHO’s four core functions under the TYP are not directed to affected populations but to health partners serving them. Those partners are best placed to judge the effectiveness of WHO. A special effort was therefore made to interview confidentially a broad range of actors outside WHO including health authorities, UN agencies, donor agencies (especially those supporting the TYP), non-governmental organizations 8 and Red Cross affiliates. 9 The list of contacts is attached in annex.

Table 1 and figure 1 show the distribution of people contacted according to the type of institution.

Particular attention was given to establishing early contact with agencies or Health Cluster actors likely to be straightforward in sharing their views on WHO’s strengths and weaknesses. The identified matters of concern were raised in subsequent interviews to corroborate the information received (triangulation of the information). Interviews were open-ended and adapted to the interlocutors’ field of expertise, length of familiarity with WHO performance and seniority.

7 The evaluators are appreciative that all their documentation requests were met. The problem was rather the difficulty for the Team to become aware of the many activities, documents, guidelines and publications produced by HAC in Geneva.

8 The number of non-governmental organizations working in the occupied Palestinian territory was not as high as in other countries.

9 The mid-term evaluation focused overwhelmingly on WHO staff.
Sixty consecutive days were allocated for completing this evaluation including the last two weeks for report writing, which took place on WHO premises. This arrangement is not particularly suitable and does not provide the interval necessary to ensure the review of the draft by the five agencies of the Steering Committee.10

The Evaluators are reporting on products or activities that they directly reviewed, observed or discussed with third parties (users). Many more achievements are listed in HAC annual reports.

In each country visited, a technical report was drafted by the team, discussed with WHO staff, amended to reflect their validated concern, then circulated to all persons interviewed for further comments and finalized. The country reports were intended for educational debriefing locally and are not intended to be part of the present report.

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<th>Table 1 distribution of contacts per institution</th>
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<td>Global/Regional</td>
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3 Coordination: The Prime Function of HAC

“Trust building is at the heart of the whole process, HAC needs to build up trust and credibility with its partners. With such a diverse array of partner agencies and some resistant to collaboration, this is a very challenging job”.

UN Agency respondent

Effectiveness of Coordination Improved

- Partners noted considerable improvements at country level;
- Coordination among regions and between Regional Offices and headquarters was strengthened;
- Challenges remain in communication/coordination at the global level;
- Despite efforts, further progress is needed in the field of coordination with non-governmental organizations/civil society and, within WHO, between HAC and HSE.

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10 A very incomplete and rough draft was shared with the Assistant Director General in charge of HAC for his briefing prior to a meeting with the WHO Director General. Following its circulation to the senior HAC staff, clarifications were provided and additional documentation was reviewed while suggested additional key informant interviews were made by the team simultaneously with the team internal discussion and redaction process.
3.1 WHO and the Humanitarian Reform

“What has changed most notably is the “attitude of leaders in WHO”, to a more positive and engaged leadership, in relation to humanitarian response efforts and WHO commitment.”

Jan Egeland (former Emergency Relief Coordinator)

The Humanitarian reform developed by the Inter-Agency Standing Committee (IASC) in 2005 attends to three major pillars that constitute the most important components of all humanitarian operations: (i) finance, (ii) leadership and (iii) the cluster concept. The reform process is focused primarily on streamlining the response capacity and associated funding while ensuring strong leadership through the Humanitarian Coordinators at country level.

All agency representatives interviewed acknowledged WHO’s positive contribution to the global humanitarian reform initiatives. Initially doubts were raised that WHO, as a health policy-oriented and technical agency, could step up its operational capacity to the level required from the Health Cluster lead. Two years later, as a result of up scaling of WHO global and field capacity in health cluster coordination, it is evident that the roles are mutually enhancing. The need to adjust both management and operational modalities was recognized within WHO and fundamental changes are in progress.

At the regional and global levels, WHO undoubtedly increased its profile significantly in the humanitarian response arena. In three of the countries visited, WHO Representatives participate actively in the UN CERF and CAP planning and application processes. At the global level, this is mirrored by an active engagement in the UNOCHA and IASC fora, the locus for strategic decision-making on financing and the UN reform. Again, WHO was acknowledged as contributing actively to the meetings and advocating for resource allocations to health as a priority cluster.

Some of the issues raised by partner agencies during the evaluation include:

- WHO needs to further strengthen its alignment with other UN agencies’ priorities and needs to recognize the important contributions of other key health-related agencies.
- Agencies request WHO to acknowledge the strength of diversity and to create opportunities for health counterparts to assume leadership including co-chairing the Health Cluster.
- WHO’s contribution on technical guidance is widely acknowledged among partner UN agencies and international non-governmental organizations; agencies identified the need for WHO to endorse non-WHO guidelines, such as the International Committee of the Red Cross Guidelines for Mobile Clinic Services (2007) and the Médecins Sans Frontières Guidelines for Mental Health (2006).

3.2 WHO Coordination of Response at Country Level

There is consensus among health partners that WHO is making rapid progress in the health sector coordination. The response to the October 2005 earthquake in Pakistan, where the UN
cluster approach was initially piloted, proved to be a major success for both WHO and the UN. While setting a remarkable precedent, the subsequent response to the July 2007 floods in Pakistan highlighted the unique challenges that each crisis presents. WHO was faced with a very different set of demands that were not anticipated and that required the formulation of a new approach to coordination in absence of support from the provincial authorities.

“We want to coordinate with WHO and not be coordinated by….”

(non-governmental organization representative)

Partnerships are by definition democratic and inclusive; the Health Cluster is no exception. While agencies felt that health sector coordination has evolved, there is still room for improvement. There are mixed results regarding the quality of dialogue and analysis during coordination meetings. Agencies in both chronic and acute crises response contexts expect coordination meetings to provide more discussion on planning and decision-making than on information giving. Collaborating agencies within the health sector felt that it is important to distinguish between WHO as a health sector/cluster lead and WHO as an agency; the need for this differentiation is reflected in several seminal documents on cluster development globally. As the UN Resident Coordinator in Pakistan and the WHO Director General expressed on separate occasions, there is a need for a firewall between both functions.

Examples given included:

i. Boundaries are commonly blurred while WHO plans and reports against achievements, as opposed to recognizing the collective contributions of all participating agencies;

ii. The chair of the health sector meeting is compromised by “wearing two hats”, a challenge to priority setting and resource allocation choices;

iii. The issue of WHO “sitting too close to the ministry of health” becomes a concern when the government are “seen as part of the problem and not part of the solution”.

Where the cluster approach has been implemented, HAC would normally be expected to appoint a Health Cluster Field Coordinator with appropriate support to carry out the role of cluster coordination. WHO Representatives and HAC tend to have distinct views regarding reporting lines of the health cluster coordinator: some favour his/her reporting to the WHO Representatives while others support reporting to the Humanitarian Coordinator11 and therefore UNOCHA. In practice, the majority of the critical decision-making rests with WHO Representatives and the regional management. The present ambiguity is likely to prevail unless formal instructions are issued to WHO Representatives.

The success of the inter-cluster coordination varied across the countries visited. It has visibly led to more interaction but not necessarily to productive collaboration. The joint efforts of the Health and Water/Sanitation Clusters met with notable success in some countries where both the WHO and UNICEF coordinators are motivated to collaborate. The level of collaboration extended to conducting joint assessments, sharing of resources and co-writing of lessons learned in the Pakistan floods response. Successful collaboration at district level was reported in Pakistan (Muzaffarabad) and Sudan (Darfur) with WHO providing full-scale water quality testing for UNICEF-supported water points for internally displaced people.

11 A dual reporting system: administrative and technical is now formally included in the draft revised WHO manual and will become official policy.
Criteria for success in health coordination include the ability to mobilize and maintain experienced staff at the central and district hubs. Excessive turnover of effective coordinators has proved to be detrimental to the continuity and maturation of coordination. This was critical in three of the four countries visited.

3.3 WHO Coordination at Global level

“WHO is taking the role of health cluster seriously.”

(UNOCHA representative)

The development of the Global Health Cluster is distinct from the WHO capacity building exercise funded by the TYP. The Global Health Cluster activities are governed by 32 agencies gathered in four working groups overseen by an Executive Board. While HAC supports the work with a two-person secretariat, the Health Cluster has both decision-making and operational autonomy, separately from WHO, according to the HAC Officer in charge of the Global Cluster Unit.

Donors committed US$ 4 million (non-TYP) to the first phase of the Global Health Cluster activities with a no-cost extension for the continuation of product development and training to end-2008. Additional funding may be required and is likely to be included in the TYP follow-up proposal.

Over the past 18 months, HAC facilitated a series of global meetings and teleconferences focusing on the development of an ambitious Global Cluster work plan. Some members having expressed concern that the plan is too broad in scope to be achievable, the need to distil out priority initiatives is being considered. Committee members assume a highly participatory role, which may, in the longer-term, prove to be a challenge for those who are in charge of multiple mandates.

Guidance and tools under development include

- Gap analysis framework draft with proposed field testing in 2008;
- Initial rapid assessment for health, nutrition and water/sanitation was field tested in three countries and currently in the second stage of field testing in AFRO countries;
- The Health Cluster Field Coordinator roster and associated training for selected members is planned;
- A stakeholder database to map key health services is being developed;
- A pocketbook is in progress which will serve as a compilation of all the key tools, guidelines and essential reference information for health crises response.

The 2008 Health Cluster work plan includes proposals for training country level staff in the use of the above guidelines and tools. Capacity building of national stakeholders on how to build local level capacity for project cycle management in acute crises contexts is also planned.

The Evaluators acknowledge that it is premature to gauge the impact of the Global Health Cluster initiatives on the WHO’s health response to crises. The complexity and amount of details observed in the guidelines presented during the November 2007), lead some participants and the Evaluators to question the applicability in sudden-impact disasters. Pilot testing under normal conditions and application under disaster context are different.
Global Health Cluster members need to be aware that the scale of resources and level of effort should be directly commensurate with the potential impact at beneficiary level. Ultimately, all tools and guidelines need to be tailored to field-level requirements, to involve regional and country representatives in the formative stages of piloting and to be systematically introduced at country level.

Resources seem dispersed on a broad range of guidelines and tool development. A significant budget and sustained commitment to promote them at field level to ensure their practical value is imperative to the success of this initiative.

A word of caution may be in order: investing too much on coordination, for the sake of coordination can be wasteful. To reiterate the sentiments expressed during the October 2007 Inter-Agency Cluster Evaluation, “by focusing on improving coordination, and the considerable work it entails, humanitarian actors would be distracted from their real purpose, which is to enhance humanitarian response to save more lives and relieve more suffering.”

3.4 Coordination among Headquarters, Regional Offices and Countries

A major asset of the TYP has been the intense consultation (and therefore coordination) process between all levels of the Organization for its formulation and implementation. The much closer collaboration among regions and between Regional Offices and headquarters can be attributed to the TYP process as well as to the leadership in HAC. The progress in the last two years has been particularly dramatic.

Since 2001, WHO has held regular induction briefings for regional and country level staff working in emergency preparedness and response; these briefings were instrumental in promoting and enhancing a common understanding of WHO’s role in humanitarian action. With the advent of the TYP in 2004, the TYP Global Steering Committee began disseminating information updates to all priority crisis countries through the HAC web site and the annual reports. This process culminated in annual review meetings at regional and global levels. The first global HAC review workshop, held in Geneva in September 2007 with 40 participants from 23 countries, undertook a full review of policy and management issues related to WHO’s health action in crises. A position statement was developed, delineating the role of WHO’s health action in sudden onset or chronic crisis contexts.12

While endeavouring to strengthen further the operational response, clear lines of responsibility need to be demarcated across the global, regional and country levels within HAC. The division of labour and the designation of respective roles and responsibilities are occasionally duplicated within HAC at headquarters (see section 9) and between global and regional levels.13 With the rapid expansion and ongoing turnover of WHO staff working for health action in crises, efforts to maintain strategic information flows are critical. Recent workshops, seminars and meetings of HAC or WHO senior management have in part addressed the need for regular information updates while also serving to clarify roles and responsibilities. Continued efforts are required to address the growing complexity of the work and related responsibilities.

13 One example is the development of independent rosters at global, regional and even country level.
3.5 Coordination of HAC with Other WHO Departments and Clusters at Headquarters Level

WHO HAC internal coordination and communication with other departments and clusters has resulted in the development of a number of recent initiatives. While recognizing the wide scope of work within the mandate of HAC as a coordination cluster, its strategic role is concerned with engaging other WHO departments and clusters in a streamlined response to identified health needs.

While the Evaluators encountered time constraints to meet with all WHO collaborating staff, a selection of interviews with key departments and clusters provided an illustration of the quality of collaborative efforts that are currently in progress.

The following are some of the key joint developments since 2004

- **IASC Guidelines on Mental Health and Psychosocial Support** – HAC actively participated through the IASC working group and in cooperation with Mental Health (NMH).
- Tri-Cluster collaboration for the development of the Initial Rapid Assessment Tool with the Nutrition and Water/Sanitation Clusters.
- Operational co-working with Water Sanitation and Health (WSH) for the provision of water and sanitation to field hospitals and the enforcement of WASH minimum standards for health facilities.
- Close working relations with Health and Nutrition (HND) have led to ongoing joint work initiatives including the development of a recent proposal for funding of health and nutrition activities. The TYP funded a position of nutritionist within HND until end 2006.
- HAC and Health Systems held meetings on the mobilization of funds from the Global Alliance for Vaccines and Immunization Health Systems Strengthening (GAVI HSS) for health system strengthening in the Democratic Republic of the Congo.
- The HIV/AIDS department proposed a collaboration on risk mapping for HIV in fragile states, which could be an entry point for the integration of HIV activities into primary health care service delivery.

The opportunities for future cross-technical collaboration within WHO is subject to the identification of appropriate working modalities. Success cannot be contingent upon interpersonal relations but should rely on the development of a range of institutional mechanisms for collaboration. The Health Cluster offers a forum for strategic planning, technical guidance and monitoring.

While, several colleagues expressed that joint missions were not the panacea, one department suggested that HAC could initiate the development of inter-departmental memoranda of understanding and/or country-based contracts with agreed timelines and priorities to facilitate future co-working.

One of the remaining challenge lies with the collaboration with the WHO Communicable Diseases Cluster (CDS/HSE) (See section 9).

3.6 Conclusions

Interviewees unanimously agreed that the scaling up of field presence, the induction briefings to all key staff and the development of WHO’s surge capacity initiated by the TYP made it
a major catalyst in developing WHO’s state of readiness to assume the Health Cluster lead. Sustained investment will be required to maintain the momentum and deliver tools, guidance and management support. At country level, perceived “unfair competition from WHO” for resources remains a matter of concern from partner non-governmental organizations in the Cluster.

Widely fluctuating resources created rapid changes in the size of HAC in the last three years (up and down). Combined with the absence of inter-unit communication and accountability, it contributed to the duplication of activities. HAC in headquarters is increasingly capitalizing on technical contributions from other departments. Although, it is a departure from the past, it requires further effort especially at global level.

The experiences and outcomes of inter-cluster coordination are variable and seem to depend largely on the efforts of individual coordinators rather than a standard institutional response. The turnover of Health Cluster coordinators is seen as disruptive for the stability and success of the coordination efforts.

## 4 Information: A Strong Asset of WHO

In all the countries visited, the interlocutors expressed increased satisfaction with the improvement of WHO’s capacity for needs assessments. This progress can be attributed to the TYP-funded Country Focal Points and their teams at both provincial and local levels.

- WHO’s assessment of needs improved in all countries visited;
- Disease surveillance is the most praised and visible contribution;
- The TYP made possible a large array of services and publications at headquarters;
- Harmonization and pro-active dissemination are required.

### 4.1 Information Management at Global Level

The production of information in HAC covers a complex set of products and initiatives. They are classified in four main groups greatly expanded in the last three years.\(^{14}\)

Funding from the TYP Year 3 (US$ 285 000) was allocated to the preparatory developments of the Health and Nutrition Tracking System. An Inter agency Steering Committee has been established and a Project Manager appointed, while initial engagements with other partners are under way. This initiative is in the early stages and it is premature to make any evaluative judgement regarding the likely outcomes. However, improving the reliability of health indicators is clearly a function of WHO and of HAC in particular.

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\(^{14}\) The four lines of products are:

1. General information based on weekly summaries on emergencies, monthly and annual reports and other contributions as requested;
2. Crisis operations with front page of the HAC web site, weekly Highlights, daily crisis reports, financial CERF status, etc.;
3. Operational information on the status of medical stockpiles and availability of the related supplies on the international market; logistic services availability in the UN system (ref partnership with WFP);
4. Risk monitoring, based on HACALERT Database (updated daily, summarized weekly) and the Red-Orange-Yellow ROY list (updated quarterly) as an essential risk mapping database.
The Health Library for Disaster (HELID) available on a CD ROM is well-known and widely available in the field. The WHO website development and updates were appreciated by regional and country public health users who expressed satisfaction with the coverage and quality of reports. Evaluating further the technical effectiveness and impact of HAC sophisticated information products would deserve a separate study.

4.2 Information Management at Country Level

In almost all the countries visited, health information was collected and disseminated on a regular basis through weekly or monthly publications. During the acute emergencies in Pakistan, situation reports were issued daily. Also, technical guidelines and tools for monitoring performance were disseminated for partners’ use (e.g. in Pakistan). Coordination meetings were another means of providing and sharing information gathered by WHO and other health actors, ensuring a strong information-sharing culture within the Cluster Approach. Other services included sharing data on ongoing trainings, evaluation exercises or the coverage of health services (in camps for internally displaced people whether in periurban or rural areas) as well as the mapping of health facilities (operational or not) in affected areas.

Information was not limited to crises and post-crisis assessment. Substantial information was compiled on the vulnerability to disaster in EMRO and other regions. By means of a questionnaire on the status of preparedness in the health sector, a survey was carried out first at the regional level (AMRO, EMRO, SEARO) and then at the global level. The TYP contributed also to the risk mapping of EMRO countries, the design of a EURO survey protocol later funded by the European Union and many other preparedness initiatives in headquarters or at the regional level. SEARO’s initiative in establishing a matrix and a 12-indicator benchmarks of progress for its Member States is also worth noting.

Weaknesses were related to the perceived usefulness of the assessment provided:

- the lack of routine reliable management information or substantive baseline data for comparative analysis was reported for Sudan’s Darfur region.
- A small minority interviewed in the occupied Palestinian territory remarked that data did not always reflect the "true picture" as they saw it. This is unavoidable and due to political and physical constraints in terms of accessibility.
- Specialized partners reported occasional gaps in information (e.g. mother and child health indicators, drug shortages, mental health status of affected populations, downscaling of primary health care, human resources required to manage renewed and expanded health facilities).
- Partners reported some shortcomings on geographical coverage, availability of human resources and infrastructure status in the Democratic Republic of the Congo and Sudan. Again these gaps are common in chronic complex emergencies where access is limited by insecurity.
- The most important and frequently mentioned gap concerns the presentation of information: too much data and too little analysis or interpretation, in terms of action or recommended decisions for non-technical donors or managers.

These weaknesses should be interpreted in light of the complex and unending demand for information in crisis situations. Altogether, WHO has done a highly commendable work in meeting most, if not all, of those needs.
4.3 Epidemiological Surveillance

An important and sometimes overwhelming component of this assessment of the needs and diagnosis of the situation is the surveillance of communicable and epidemic-prone diseases. This activity (e.g. the Diseases Early Warning Surveillance or DEWS in Pakistan) is regarded by most as the essence of WHO information role during both sudden and chronic crises. The asset of an expanded TYP-funded field presence of HAC and of field-level cooperation with the WHO experts responsible for communicable diseases surveillance and response explain the predominant role of HAC in this activity.

In some countries (the Democratic Republic of the Congo among others), HAC took over the responsibility for the countrywide routine epidemiological surveillance, publishing a national Weekly Epidemiological Bulletin. These routine activities, more focused on development than humanitarian issues, may represent the bulk of HAC’s activities at country level and it is unclear how much the particular focus on surveillance may have distracted HAC from other topics. Sustainability is questionable once humanitarian emergencies (and funding) will be over.

WHO’s Information on major outbreaks of international concern is seen by many as the greatest achievement of HAC as was the case in the Ebola outbreak in the Democratic Republic of the Congo.

4.4 Information and Advocacy

WHO’s specific function for advocacy benefited from the valuable information collected and interpreted to highlight priority needs. Indeed, the backing of evidence and information permitted WHO to effectively advocate for the right to health of crisis-affected populations (e.g. access to referral medical care for patients in Gaza or in Sudan). Information was also used to present the case for attention to and increased resources for the health status of populations, to promote specific courses of action and, in general, to contribute towards minimum access to health care.

4.5 Conclusions

The TYP significantly improved the quantity and quality of the health information provided by WHO. The information content and timing was widely appreciated. However, gaps remain and the impact of the information could be enhanced by a more target- and action-oriented analysis.

In most of the countries, needs assessment focused extensively on the surveillance of epidemic-prone diseases, generally WHO’s most praised achievement. This highlights the importance of close cooperation between HAC and the coordinating WHO departments and clusters (with or without extensive field presence).

5 WHO as “Provider of Last Resort” to Fill Gaps?

The agencies designated as Cluster leaders are the “last resort providers” to fill in identified gaps in their domain.

15 In the Democratic Republic of the Congo, HAC has 12 Focal Points serving as epidemiologists while HSE has only one expert responsible for surveillance. A balance that may be questioned as Kinshasa and North Kivu Provinces had one each.
In countries facing disasters or complex humanitarian crises, needs always exceed resources. This is particularly true when the international community and WHO use the SPHERE standards to define the level of needs as the “minimum standards” recommended by the SPHERE generally exceed those enjoyed by the affected population or the host communities in ordinary conditions.

The last resort provision is the subject of broad and conflicting interpretations. “Saving lives” is invoked often to obtain funding; however, humanitarian emergency response is not the only means to save lives!

Many interviewees noted that WHO implemented a variety of field activities for which, they rightly believed, WHO had no special comparative advantage.

5.1 Provision of Supplies and Essential Drugs

Over the years, WHO’s donation of emergency kits has become the central feature in some crises. There seems to be an inverse correlation between the donation of emergency kits and the focus on information.

In the Democratic Republic of the Congo, there was a consensus among interviewees that this gap was over-attended by WHO. Interlocutors, among them UNOCHA, suggested that WHO should focus on the procurement and management of strategic stockpiles and leave the distribution to health facilities to non-governmental organizations. The distribution of emergency kits has become a major operational (and public relation) activity for WHO with little monitoring of their actual use.

In the West Bank and Gaza, ECHO and the World Bank placed their confidence in WHO’s operational responsibility and management capacity for the delivery of more than US$ 13 million worth of supplies. In this case, WHO found itself as the best placed actor (if not the only one as the World Bank project was not successful). This project, which will carry on in 2008, includes a significant component of monitoring and quality control of drug use. However, it suffered from the inefficiencies of WHO’s centralized procurement system.

5.2 Access to Secondary or Tertiary Health Care

In general, WHO was identified particularly with technical guidance and support to primary health care. There were however some cases where its foray in secondary and tertiary medical care was filling important gaps.

In Darfur, WHO used funding from ECHO to upgrade secondary health facilities and to provide staff incentives in exchange for free access for patients referred by humanitarian actors. This project not only benefited the internally displaced populations but was also appreciated by the referring non-governmental organizations.

In the occupied Palestinian territory, where tertiary level referral of patients is subject to security clearance, WHO focused its attention on the compilation and dissemination of information (collected from all sources) on the instances where access was denied.
5.3 Other gaps

Three other areas were mentioned:

1. Mental health issues during the transition period following sudden-onset disasters (earthquake, floods and tsunami) or in a chronic complex emergency environment is a cross cutting issue acknowledged by WHO. However, WHO’s role as last resort provider is variable. In the occupied Palestinian territory, a strong mental health programme was established (as was the case following the tsunami). In other countries, WHO has placed far less emphasis on a direct operational contribution.

2. Nutrition issues, often mentioned, are the responsibilities of UNICEF. WHO’s focus is more on technical protocols and guidelines, and on improving and promoting nutritional surveillance.\textsuperscript{16}

3. Disease surveillance with cross-border implications and political or security constraints – a particular example would be the March 2006 suspected outbreak of Avian Influenza in Gaza, which caused much concern in neighbouring countries and throughout the Middle East. It is definitely an area where WHO has more than a comparative advantage!

5.4 Conclusions

A key function of WHO in crisis is to ensure that critical gaps in the health response are identified. Determining which of these gaps WHO should fill is another matter. The Evaluators observed a variety of interpretations in the visited countries ranging from developmental priorities being promoted as humanitarian gaps to a money-driven opportunistic approach based on donor priorities.

Being the last provider, a Cluster Leader role, has the potential for mission creep. HAC should formulate guidelines and provide support to WHO Representatives to ensure a more consistent and conservative approach and encourage focus on coordination and information, two functions that no other institutions can provide. It should be kept in mind that WHO is primarily a technical agency.

6 Institutional Capacity Building of the Ministry of Health: An Afterthought?

“Building capacity of health systems for preparedness and response” is the fourth WHO key function in a crisis. It is a component that should be progressively integrated into HAC programs at country level, once the most acute emergency is over.

- WHO appropriately promoted the ministries of health involvement in the coordination of the Cluster/sector;
- WHO and donors often underestimate the need for funding for ministry of health capacity building;
- Ministries of health are requesting increased WHO technical support for their disaster risk reduction and preparedness programmes.

\textsuperscript{16} In the occupied Palestinian territory.
6.1 At Country Level

In all countries visited by the Evaluators, the interviews conducted with ministry of health representatives and WHO experts suggested that this function is not well attended by the Country Office. The authorities often expressed convincingly their needs for increased WHO technical cooperation in building their own response management capacity.

**Pakistan**

Did WHO include building capacity of its Ministry of Health counterpart within its response soon enough after the initial impact of the earthquake? At the time of this evaluation, interviewees offered a more positive reply than in previous evaluation in March 2006.\(^{17}\) In recovery, WHO did strengthen the Earthquake Reconstruction and Rehabilitation Authority (ERRA) by recruiting and seconding a national expert to join the small unit in charge of health reconstruction. A wise and well appreciated investment!

In the flood response, WHO included much earlier a stronger component of working closely with and strengthening of the provincial health authorities. However, the provision of international assistance in areas that are historically bereft of much needed health resources may contribute to a delay in the strengthening of ministries of health for a prompt takeover.

Regarding multi-hazard preparedness and risk reduction, the Secretary of Health and his staff pleaded for increased WHO support for the emerging preparedness programme. However, WHO’s advocacy for the creation an appropriate unit, which should be staffed as of January 2008, was not mentioned. It is unclear whether WHO has the necessary funding to second a professional staff member to this new unit as is requested and required.

**The occupied Palestinian territory\(^{18}\)**

The concern focused on the overall strengthening of the new Ministry of Health. In particular, WHO’s management of the procurement of supplies and drugs was seen as vertical. According to the highest authorities in the Ministry of Health, WHO was not contributing to the development of the Ministry’s capacity (from issuing tenders to monitoring the use of medicines at health centre level). It is a very strong argument in favour of WHO decentralizing the international procurement of emergency and recovery supplies from Headquarters to country offices during large-scale and prolonged crises. On the positive side, a senior HAC-funded adviser was posted in Ministry’s headquarters in Nablus. It is the first step towards having WHO staff sharing their time between the WHO Office in Jerusalem and the Ministry of Health facilities in Nablus and Ramallah.

**Sudan**

Although WHO invested in capacity building, it was more visible at the state level than at federal level.

Achievements in capacity building included:

- Support to planning and implementation for the delivery of emergency health services to internally displaced communities and of primary health care outreach and for the provision of referral medical services;

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\(^{17}\) The same District Health officer interviewed in both visits was much more positive in this evaluation.

\(^{18}\) No TYP funding was allocated.
• Support to health sector in the Darfur region through planning and co-chairing of meetings with the State ministries of health;

• Support to the three Darfur State ministries of health in developing annual plans for 2008.

6.2 Risk Reduction at Regional or Global Level

Regional level

Four out of the six WHO regions (EMRO, EURO, SEARO and WPRO) benefited most from the TYP funding while contributing to global valuable initiatives to support national capacity building. Each region agreed to assume a lead role as follows:

• Benchmarks for monitoring of progress (SEARO);
• Hazard mapping (EMRO);
• Mass casualty management (WPRO);
• Methodology for national preparedness field surveys (EURO).

AFRO is expected to integrate risk-reduction and emergency preparedness into the primary health care approach while AMRO, where national capacity building is the main priority, will continue to provide technical support to the UN ISDR global public awareness campaign on Safe hospitals for 2008-2009.

All regional offices, reportedly, have agreed to dedicate 1% of the regional budget to emergency preparedness and risk reduction in order to achieve the priority activities in the next biennium.

Global level

The TYP was an important resource for promoting preparedness and risk reduction. For instance, it helped contribute to both the global survey and the design of the forthcoming two-year global awareness campaign for Safe Hospitals jointly with the UN ISDR.

HAC is closely involved in the health sector institutional capacity development through activities such as coordination and management, establishing evidence and knowledge base, information-sharing, technical human capacity, strengthening of country health systems and community resilience. Among the many publications focusing on capacity building reported by HAC, the following are particularly worth mentioning:

• *Risk reduction and emergency preparedness six-year strategy for the health sector.* Based on the recommendations of a global consultation held by WHO in February 2006, it focuses on community capacity building;

• *Mass casualty management systems, strategies and guidelines for building health sector capacity;*


• *Guidelines on non-communicable disease management in emergency and humanitarian settings.*

• *Guidelines on mental health and psychosocial support in emergency settings,* published early 2007 by the IASC Task Force of the same name and to which HAC contributed.
TYP funds were also used by HAC in headquarters to support the initial institutional capacity building of other core WHO departments, such as the department for Nutrition. A proposal has already been developed to serve as a prototype for the departments for Health Security and Environment, Family and Community Health and Mental Health; it will be included as part of a package for funding in the next phase of the TYP.

However, some of these recent valuable initiatives have not yet been given sufficient visibility and circulation so that it is difficult to evaluate their impact. In particular, the guidelines developed by HAC would gain from a more proactive distribution and promotion. Most recent and outstanding technical documents are often not available to HAC or partners’ staff in disaster-affected areas. Materials distributed to other agencies or to WHO Country Offices often do not reach the field users.

### 6.3 Cross Cutting Issues

There are several cross cutting issues of general interest:

- The role of the ministries of health in the Cluster. WHO encourages ministries of health to assume or share chairmanship of the Health Cluster. The attempt, if well-timed, is appropriate but its application depends on the ministry’s capacity, its understanding of humanitarian assistance and on political acceptability from the international community. The Cluster leadership is assigned to WHO but in the case of natural disasters, the ultimate authority and responsibility for coordination should be with the ministry of health, WHO’s traditional counterpart. Success in reaching a balance in safeguarding the needs of all the health partners has been mixed in some instances (Democratic Republic of the Congo).

- National versus international staff. An effective capacity building strategy is to delegate a WHO national staff to strengthen the ministry of health. However, country offices do not always appreciate that a national staff member without international experience will have difficulties coordinating a Cluster with a large number of seasoned expatriates. In the early stage of a large operation or in sensitive political contexts, international staff should be favoured.

- It was surprising to note the relative absence of scenario-building in WHO country offices or in ministries of health. The only contingency planning exercise reported was conducted in Goma where the UN Team has projected the most likely scenarios for 2008 (not particularly optimist). Another initiative supported by the TYP is an attempt to project scenarios in case of an unilateral declaration of independence by Kosovo. This process should be more systematic and involve counterparts.

### 6.4 Conclusions

According to most of health officials interviewed, WHO and the TYP should pay greater attention to capacity building.

Clearly, in the initial phase of an acute emergency, it is not and should not be a main concern. However, it should rapidly evolve into a priority. It is not always the case. Scarcity of specific funding due to the lack of visibility of this topic compared to emergency response is probably a major factor.

Overall, WHO should be praised for encouraging the ministries of health to play a major role in coordinating the assistance and chairing the Cluster. WHO should not however renounce its responsibility and leadership.
7 From Response to Recovery: An Ongoing Debate

7.1 Global and Local Views on Relief to Recovery

“Recovery programmes, whether it is from conflict to peace or from disaster to reconstruction, pose great challenges to national stakeholders, international partners and donors”

Extract from WHO HAC Concept paper on Early Recovery, (September 2007).

HAC is decisively addressing the need for a strategy for recovery and development in transition countries.
Emergency response and sustainable recovery (development) may require distinct skills and approaches.

Significant results have been achieved in emergency response operations during the past three years, while less attention was given to early recovery. It is important to note however that the recovery department of HAC was established in 2006 and is still nascent.

The views on recovery and its timing were very distinct according to the interlocutors:

- Governments tend to favour a very early recovery process;
- WHO Representatives advocate building in the recovery process from the outset of the emergency;
- Humanitarian experts in the countries visited actually prolonged the emergency style of operations as long as funding was channelled through HAC.

At the international level, there is an increasing trend towards considering recovery (early or not) as an integral part of development.

Several initiatives are under way to remediate the lack of clear definition and policy on recovery:

- A global consultation process in planned for December 2007, with a wide range of stakeholders. It will address the issue of early recovery and build a consensus on a strategy to follow during transition situations.
- A manual on Health Systems in Crisis is nearing completion, incorporating the experience gained in contemporary crises, such as Afghanistan, Sudan, Liberia, Iraq, the Democratic Republic of the Congo and Somalia. A first course is being launched in Tunisia for 60 participants (November 2007).
- A Sudan Recovery Framework is in progress.\(^1\)

Despite the catastrophic impact on the populations, crises can also turn adversity into opportunity, by accelerating the flow of resources to underserved populations and attracting attention to the chronic lack of services in remote rural areas. For instance, the Pakistan Earthquake Reconstruction and Rehabilitation Authority (ERRA) launched a “Build back

\(^1\) It is anticipating on the post-conflict scenarios and focusing on the proposed health priorities that will be addressed subject to signing of the peace agreement. In Geneva, WHO has written a preliminary guidance document, “Scaling up public health interventions in Darfur”. Priorities were identified through a consultative process with all stakeholders with a costing of the framework to determine the budgetary requirements for phased delivery of the recovery plan.
better” initiative in the earthquake-affected areas, some the poorest and most overlooked by national and international agencies.

During chronic emergencies where agencies deliver humanitarian support to affected populations, such as in Darfur, the success of this type of interventions is more difficult to measure given the complex configuration of government and non-government investment. WHO has supported capacity building for health service delivery in Darfur and advocacy for increased access to referral health services in the occupied Palestinian territory in conjunction with emergency response plans.

7.2 HAC Exit Strategy and Relief to Development Transition

At country level, concerns were raised about activities undertaken by HAC that should technically come under the auspices of those WHO departments which have a more normative function. In Pakistan for instance, about 140 HAC-funded staff are implementing development activities two years after the earthquake. This has major implications for a smooth exit strategy from humanitarian interventions to transitional programmes. The Disease Early Warning System in Pakistan, currently funded and managed by HAC, is another example. Given the short-term nature of humanitarian funding, such technical interventions are best relocated under the corresponding technical department. The question here is whether these initiatives are fund-driven or whether WHO is first defining the strategic priority and then identifying the funding source to fulfil the need.

The issue of the various skills required to implement recovery and transition programmes is also of concern. If emergency response operations require skills different to those required for transitional operations, then this places inordinate demands on humanitarian personnel to fulfil roles that they may not be qualified to deliver. The move from relief to recovery and onwards to development should also be an opportunity for national staff to replace the high numbers of international staff recruited during the emergency phase.

SPHERE provides minimum standards for relief operations subscribed by most international humanitarian agencies. However, comparable targets for post-emergency situations are not available. HAC need to pay more attention to the selection of realistic targets for early recovery interventions. These standards are most likely to be less ambitious but more realistic than the SPHERE standards. It is paradoxical that the more expensive the delivery of a service, the higher the international community is setting its “minimum” level.

7.3 Conclusions

The issue of who decides when or how early recovery mechanisms will be implemented depends on the government’s capacity and relations with international partners. It should not be dictated only by the availability of “humanitarian funding”. A consultation convened by HAC and scheduled for December 2007 may respond to the overdue need for a strategy in WHO (and the rest of the system).

Transitional programmes whether relief to recovery or recovery to development, raise some key concerns regarding the humanitarian versus longer-term skill sets required to plan and manage the recovery and development phase of a programme. HAC assumes that humanitarian personnel who are already in post can manage the transitions. Is this assumption founded on evidence or on convenience? A clear exit strategy is required.
8 Support Services: The Weakness of WHO

The September 2006 mid-term TYP evaluation validated the opinions of many that WHO’s procedures and administrative practices remain a major handicap for WHO response in crisis:

- “There is still a common concern amongst HAC field staff and stakeholders that WHO is conducting “business as usual” in terms of systems and procedures”.20
- “In addition to a lack of streamlined systems and procedures for timely internal resource flow, there is also a marked lack of decentralization in terms of roles and responsibilities at national and sub-office levels”.21

8.1 Human Resources Management

“The existing human resources and contract system does not provide a basis for building a sustainable group of professionals.”

From Margareta Whahlström’s review of HAC, 2002

Weak management of field humanitarian staff results in poor morale and damaging turnover. The predictable three-year funding for WHO has not resulted into better contractual or work conditions of experts or a higher retention rate.

Previous reviews and evaluations have documented the deficiencies in WHO’s human resources practices with respect to delays in recruitment, turnover of staff and poor benefits package. All staff interviewed identified these as unresolved issues and this in spite of the availability of the TYP “predictable” funding.

8.1.1 Selection and Recruitment of Personnel

The Evaluators found that the quality of the staff selected by HAC has improved, especially at the international level. UN and non-governmental interlocutors generally have praised the dedication and experience of most HAC staff. The lack of relevant experience in disasters was still occasionally a matter of concern, especially for the local staff who often has limited management exposure to humanitarian activities.

The recruitment of emergency consultants remains extraordinarily slow especially in AFRO. Table 2 shows the source of delays.

Table 2 Delays for deployment of international emergency consultants in AFRO

<table>
<thead>
<tr>
<th>Steps after verifying availability</th>
<th>Average duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Examination and Clearance</td>
<td>14 days</td>
</tr>
<tr>
<td>Regional Director’s Approval</td>
<td>9 days</td>
</tr>
<tr>
<td>Processing and signature of contract</td>
<td>27 days</td>
</tr>
<tr>
<td>Visa and travel</td>
<td>10 – 15 days</td>
</tr>
</tbody>
</table>

20 Paragraph 3.4.5 page 8
21 Paragraph 3.4.7 page 8
It is unclear why WHO has not come to the conclusion that executing most steps in parallel rather in sequence will shorten the process. There is no contractual commitment until a contract is offered to the consultant. The only risk is that some administrative work may be done in vain if clearance is not obtained.

If international recruitment cannot be decentralized at country level, the Regional Director should delegate his approval authority to HAC or the supervisor in the Regional Office.

Field staff did not receive adequate technical support from the Country office, the Regional Office or from headquarters. In many instances, technical supervisors rarely visited their field level and when doing so had not on-site thematic discussion to improve their skills and reach a shared view on the issues at hand. There was no tutoring.

Logistic support was also lacking (particularly in the Democratic Republic of the Congo) where individual transportation and other facilities were not provided to the staff. Similarly, administrative staff was rarely provided despite the time needed to micromanage millions of dollars in humanitarian projects (CERF or others). Few are trained for this task which is distracting them from the core functions of coordination and information.

### 8.1.2 Retention of Personnel

While recruitment is a major challenge for HAC, retention is equally critical. In all countries visited by the Evaluators, but particularly in the Democratic Republic of the Congo, there were consistent reports of staff leaving for the better salaries and conditions provided by other UN agencies. More disturbing, was AFRO staff accepting 75% salary cuts to work for non-governmental organizations in the same province. The issue is not merely one of contractual conditions but of working conditions for Professional staff. Delegation of authority and mutual trust are absent. According to direct observations, interviews and second-hand reports, some of the most experienced staff in the visited countries or in headquarters have left HAC during the TYP period.

Short-term contracts for both national and international staff are a major cause of complaint. The majority of staff interviewed during the Evaluators’ visit were on three- to six-month contracts with no security whatsoever concerning their future. It is unacceptable considering that a predictable funding was requested for this very purpose. Cases of staff being extended in the last minute for two months then taking a one month-break stretching day by day to three months are not uncommon. They reflect a very low level of administrative competency, sensitivity and concern for the mission of WHO.

Now that this source of stable TYP funding is terminating, this investment in human resources and significant institutional memory is likely to be lost. The Evaluators were not briefed on significant and convincing efforts at local and regional level to bridge the unavoidable short gap between the TYP and its follow up. Is WHO commitment to the four core functions due to expire on 31 December midnight?

### 8.1.3 Supervision of Personnel

The TYP proposal endorses the need to adopt Results Based Management, including performance management for HAC staff. Performance appraisals are conducted routinely for fixed-term staff, but the practice has not been introduced for temporary staff who, in some cases, may be employed irregularly for several years. Outside headquarters, HAC’s line management and support systems are left largely at the discretion of the WHO Representatives and of the Regional Office management. Few staff interviewed report having received performance
appraisals\textsuperscript{22} while low staff morale due to the prevailing uncertainty of employment tenure is considered to be a normal feature in the life of HAC programme.

\textbf{8.1.4 Surge Capacity}

One of the core functions of HAC focuses on the provision of an effective emergency response and surge capacity. The experience and competence of surge staff continues to be variable.

HAC in headquarters has recently established a roster for the deployment of personnel with appropriate technical skills and experience. The roster is managed at headquarters through a process of (i) identification of candidates and verification of credentials, (ii) classification of profiles according to skill sets and (iii) selection of most qualified candidates. The selected candidates are registered on a database and CVs are shared with regional offices and on the SharePoint network. To date, 77 candidates have been selected out of approximately 100 who were trained for pre-deployment while a total of 300 freelance roster members are registered on the database.

Other units in HAC which maintained their own list of experts and consultants are now encouraged to pool their information into this central roster.

Similarly, Regional and Country Offices are planning rosters. The roster approach is viewed as the panacea to meet the surge demands in acute emergencies. Previous experiences in WHO and other agencies highlighted the limitations of this approach, unless significant human resources are invested in its maintenance. There is a risk of over marketing this tool.

\textbf{8.1.5 Professional Development and Training}

The TYP was originally designed to support performance enhancement including management and leadership functions. Overall, it was noted that most agencies perceive technical training as one of the major roles of WHO within the health sector. Likewise, governments expect from WHO all specialized training for both technical and management staff. These expectations are increasingly met by WHO.

Since 2004, several training activities have been designed and delivered by HAC including:

- Public Health Pre-Deployment Training – So far three courses have been conducted and over 100 personnel trained.
- Management of Health Information in Crises – A series of country-based training activities for WHO and external staff involved in emergencies.
- Analysing disrupted health systems in Countries in Crisis – A training activity focused on post-emergency and post-conflict scenarios and the recovery and revitalization of the health system.

Overall, participants gave positive feedback on the quality of the global trainings, with high regard for the course content and calibre of the trainers. Areas to be addressed relate to (i) the small number of participants who benefit from global trainings, (ii) the lack of follow up support to participants and (iii) limited opportunities for self-directed learning once in the field. Distance learning modules are being developed by HAC and should come online in the near future.

At country level, concerns were expressed by non-governmental organizations and collaborating UN agencies regarding the quality of the on-site training provided. Concerns included: (i) the selection of trainees may be biased towards the immediate catchment areas while neglecting

\textsuperscript{22} Some are even working and being remunerated without having a contract!
peripheral facilities, (ii) the quality of training could be further improved with more experiential training, (iii) follow up is rarely conducted and only with limited supervision and (iv) training is centralized, usually in the capital towns which excludes the opportunity for health workers from remote areas to attend.

8.1.6 Conclusions
High levels of satisfaction were reported from former participants and agencies who seconded staff to the WHO global level trainings; this applies to both training content and calibre of the trainers.

While global trainings are mostly praised, the quality of in-country technical training is met with mixed reviews. Local training is far from meeting the high expectations of both government and non-government counterparts. However, is it WHO’s role to provide all specialized and generic training?

Weak support systems and concomitant low staff morale is endemic within HAC programmes at all levels. The notable absence of performance management tools and appropriate line management support systems for temporary staff at least exacerbates the uncertain and unstable work conditions. The result is a permanent haemorrhage of country or global staff with long vacancy periods.

The importance of solid management and leadership has been articulated in the Global Cluster evaluation report and several other recent review documents. Efforts to identify and mobilize high calibre field level coordinators are encouraging.

Gaps remain at national and sub-national level where field coordinators are expected to perform multiple roles and responsibilities while having limited recourse to appropriate skill building. Alignment with leadership training scheduled by UNOCHA and other Cluster partners is also critical to harness existing training resources, while fostering wider collaboration across the Cluster network.

8.2 Procurement and Logistics

8.2.1 Procurement
Procurement continues to be one of the major constraints to operational efficiency at field level. All four countries visited reported challenges to the optimal procurement and delivery of supplies with reports of extended waiting time of up to nine months for international procurement requests from WHO Contracting and Procurement Services either at regional or headquarters level. This delay is significantly higher than those of non-governmental organizations. Centralization of procurement has left the field staff with little means to accelerate the procedure and ensure that special requirements or local constraints are taken in consideration (for instance, transit through Israel of medicines bought for the occupied Palestinian territory requires compliance with Ministry of Health specifications).

Some progress was noted in Sudan where efforts to accelerate procurement of supplies has been achieved through daily intranet updates between the Country and Regional Offices to track potential bottlenecks and how to resolve them. In countries where WHO has adopted the Logistic Support System (LSS), users appreciated this tool and the training provided by WHO to national and counterpart government staff.

With the adoption of the revised Standard Operating Procedures for disasters, public health emergencies and complex emergencies, procurement constraints currently encountered should
be resolved, but up to now there are not been clear arrangements for emergency status linked to the WHO Global Support Management (GSM) system.

### 8.2.2 Logistic Support

The delays noted at country level are not limited to the international procurement process through the WHO Contracting and Procurement Services. Two examples among many were noted in the field visits:

- In the Democratic Republic of the Congo, partners and UN agencies complained about significant delays in obtaining vaccines for the initial response to the meningitis epidemic in Bunia.  
- In Pakistan, transport of drugs and supplies was hampered in two provinces during the 2007 flood response.

The entire logistic chain is the object of attention from HAC.

Substantial progress has been made in the last two years with the signing, in November 2006, of a Memorandum of Understanding between WHO and WFP, aiming to improve health logistics support during emergency response operations. WFP is the reference point and source of common logistic services for the UN (UN Joint Logistic Centre).

A Common Logistics Platform has been set up since last year, to provide direct access to five hubs (Brindisi, Dubai, Accra, Panama City and soon Subang) for the storage at no cost of health-related supplies and equipment. This logistic decentralization and pre-positioning will facilitate rapid deployment and increase the reactivity of the Organization. The benefit of this common platform was already felt in the recent Ebola outbreak in the Democratic Republic of the Congo (shipment of vehicles) and to Cyclone Sidr in Bangladesh.

A training component with WHO and WFP logisticians and facilitators is also included:

- Logistics response team training, second session, October 2007;
- Public Health Pre-Deployment Training (see above).

The HAC Logistics Unit, in coordination with the WHO Contract and Procurement Service, will also inform the suppliers (advance warning) when orders have been received later than the nine-month window for routine delivery. This is often the case for supplies purchased under CERF and Flash Appeals funding.

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23 The problem was at country level. In February 2007, the shipment of the vaccines from Kinshasa to Adi (Ituri) was delayed by more than eight days, jeopardizing the vaccines’ efficacy (temperature indicator in the red and a temperature of 25°C on arrival). Delays were caused by mere bureaucratic inefficiency within WHO. This situation was subsequently remedied by the WHO Representative: vaccines for a second campaign in April were received from Geneva in eight days, in comparison with almost two weeks in February.

24 The fist batch of adapted emergency kits reached the districts on Day 6 while other stocks took up to four weeks from procurement to time of arrival. The lack of temporary warehousing and logisticians to manage the supply chain was noted by the Government. WHO's own capacity to respond to gaps was later augmented with logisticians and water engineers mobilized from the earthquake-affected provinces.

25 These arrangements have been confirmed by the WFP Director, Geneva.
**8.3 Funding and Financial Management**

| WHO was highly successful in mobilizing humanitarian resources, especially at country level. |
| WHO predictable core funding remains precarious compared to other agencies. |
| Predictability of TYP funding did not permit Fixed-Term Staff recruitment. |

The Regular Budget is tightly controlled by the WHO governing bodies, largely allocated to the traditional development priorities. The total contribution from the WHO Regular Budget to the 2006/07 biennium was US$ 9,899,000, or 2.5% of the total available resources amounting to US$ 354 million as of November 200726 (See table 4 for comparison with other WHO departments).

Discretionary funds, such as the DG and RD development funds, the Programme Support Cost (fixed at 7%) and the Project Management and Reporting cost (10%) are also subject to WHO management prioritization which does not necessarily include HAC requirements27.

### 8.3.1 Current Funding Status of HAC

The overwhelming majority of HAC’s income is for response to either acute or chronic emergencies. The country-driven fund-raising mechanisms have become a major source of funding in the past three years. The humanitarian funds for both acute and chronic emergencies are tightly earmarked and tied to the place and duration of the emergency. Efforts to maintain stability in terms of staffing levels is greatly undermined due to lack of regular and sustained finances.

WHO sources of funding are as follows:

- The **WHO Regular Budget** contribution28 over the three biennium is shown in Table 3. The reported increase for the 2008/09 biennium is attributable in part to the inclusion of additional “Areas of Work” managed by other technical units contributing to the Strategic Objective Five (approximately 30% of the total)29 an estimated 70% will be managed by HAC, representing a significant increase over the present biennium.

On one hand, some of financing agencies supporting the TYP expect WHO to raise its Regular Budget contribution proportionally to the increase in extra-budgetary of humanitarian funding it raises. This is not realistic given that WHO assessed regular budget does not even keep pace with the rising costs (inflation). There is no short-term elasticity in the WHO Regular Budget approved by Member States.

On the other hand, the current and projected biennial amounts allocated to HAC are not commensurate with the health impact of the disasters worldwide, the high visibility of an effective response and the expectations of Member States in terms of support to reduce their risk and prepare their institutions to respond. Comparatively to other clusters and special initiatives, HAC is grossly under-funded.

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27 The Project Management and Reporting cost is divided equally between HAC in headquarters and the Regional offices. At the EMRO regional level, this fund is not accessible to HAC for its activities.
28 The WHO Regular Budget refers to the assessed contributions of Member States, which adopted a zero-growth policy.
Paradoxically, the more successful HAC is in raising funds, the less incentive there is for WHO and Member States to increase their contributions through the assessed quotas. The most effective avenue for TYP donors to break this cycle is through lobbying their Ministries of Health (plus Foreign Affairs and Finances) to support in the Executive Board and the World Health Assembly an increase of the overall assessed contributions for 2010-2011, especially for humanitarian action. If Member States wish WHO to assume this significant humanitarian role on a permanent basis, it should be reflected in their assessed contribution. Meanwhile donor direct support to HAC will be required.

There are palliative mechanisms to provide HAC with stable funding. Advance of a credit line (opening allotment) on firm commitment of funds by a credible donor is allowed under present rules but seems rarely done.\textsuperscript{30} HAC total global available resources in the biennium 2004-2005 amounted to US$ 273 million\textsuperscript{31} compared to 354 million in this biennium.\textsuperscript{32} WHO can reasonably anticipate mobilizing an average of 200 to 300 million per biennium producing a potential unearmarked income of 20 to 45 million from the Programme Support Cost\textsuperscript{33} and Project Management and Reporting fee.\textsuperscript{34} With the existence of those mechanisms and anticipated income over the years, it is surprising that WHO found increasing the number of field experts with fixed term contracts (one year renewable) a risk financially unacceptable.

Most of HAC income is coming from voluntary contributions (as opposed to assessed contributions). The distribution of HAC income by sources is illustrated in the following figures 2, 3 and 4 (Biennium 2006-2007).

\begin{table}[h]
\centering
\caption{Regular Budget contribution WHO HAC}
\begin{tabular}{|c|c|c|c|}
\hline
 & 2004/05 & 2006/07 & 2008/09 \\
\hline
AFRO & 3 415 000 & 2 296 000 & 4 172 000 \\
AMRO* & 0 & 397 000 & 1 599 000 \\
EMRO & 994 000 & 1 091 000 & 2 050 000 \\
EURO & 588 000 & 772 000 & 2 014 000 \\
SEARO & 1 437 000 & 1 739 000 & 3 356 000 \\
WPRO & 139 000 & 395 000 & 1 813 000 \\
HQ & 1 759 000 & 1 517 000 & 2 627 000 \\
\hline
Total & 8 332 000 & 8 207 000 & 17 631 000 \\
\hline
\end{tabular}
\end{table}

\begin{table}[h]
\centering
\caption{Regular Budget versus Total Budget (in USD Thousands)\textsuperscript{1}}
\begin{tabular}{|l|c|c|c|}
\hline
 & RB & Total & \% \\
\hline
Immunization and Vaccine development & 14 914 & 882 898 & 1.7 \\
HIV/AIDS & 15 017 & 216 407 & 6.9 \\
Communicable diseases research & 3 610 & 74 439 & 4.8 \\
Tuberculosis & 10 169 & 233 207 & 4.4 \\
HAC & 9 022 & 354 027 & 2.5 \\
Malaria & 15 539 & 127 909 & 12.1 \\
\hline
\end{tabular}
\end{table}

\textsuperscript{30} Up to 80% of the pledged amount.
\textsuperscript{31} It should be noted that this figure included the tsunami funds.
\textsuperscript{32} 2004/05 WHO financial management report as at 31 August 2005, i.e. comparable to the figure used for the current biennium (31 August 2007).
\textsuperscript{33} The Programme Support Cost, normally at 13%, is reduced to 7% for humanitarian action. Only 1% is returned to HAC in headquarters and still less in some regions.
\textsuperscript{34} The 10% Project Management and Reporting fee is not always included in proposals or projects.
• The Central Emergency Response Fund (CERF) has contributed approximately 20% of the total voluntary contributions received by HAC during the current biennium. These funds are tightly earmarked. Grants from the CERF for the biennium 2006/07 amounted to US$ 61 million as of November 2007. Of this total, 38 million were granted under the rapid response window and 23 million under the under-funded emergencies window. This source is exclusively for short-term humanitarian response by UN agencies. In the countries visited, WHO does not usually redirect some of those funds towards other Cluster partners. Part of the problem is the lack of a flexible and rapid procedure to channel funds to non-governmental organizations.

Finally, the Consolidated Appeal Process (CAP) is providing another annual source of income in some countries. The Evaluators were not in position to determine the differences between TYP and CAP activities as requested in their Terms of Reference. Most of the HAC experts and administrators were apparently not aware of which activities were funded by the TYP and CAP respectively.

**Member States:** The contribution of Member States to WHO through mechanisms such as Flash Appeals or the CAP is the most important and valued source of income. There is usually little flexibility in those funds as they are directed to specific emergencies. The Annual Report 2006 (page 33) lists the multitude of Members States that contributed a total of US$ 120 million to HAC in 2006.
• The **DG or RD Development funds** can also be channelled in specific situations, such as in the case of the occupied Palestinian territory.

• **The TYP funding and support to the Global Cluster** were the main sources of funds for core activities and capacity building. Although they offered more flexibility, they require over-detailed and constraining work plans for both the release of funds by donors and their redistribution by HAC to countries and regional offices. No further funding for Global Cluster activities appears to be secured.

Each regional or country office has to be creative to overcome the lack of flexibility in the funding: Sudan for example raised a total of US$ 33 million for the 2006/07 biennium with a contribution of 250 000 from the Regular Budget while all other funds were earmarked for emergency response. HAC staff was therefore costed primarily to selected bilateral funds (Finland, Ireland) where flexibility was permitted with two posts paid by the TYP for the biennium. This exercise complicates an accurate tracking of TYP funds at the global level.

### 8.3.2 Comparison with Other Agencies

WHO does not have stable non-earmarked funding like most other agencies. The Regular Budget is tightly allocated by the governing bodies to traditional and critical health development priorities. Discretionary funding available to the DG or RD consists of (i) Development Fund (a small percentage of the Regular Budget authorized by the governing bodies), (ii) income from Programme Support Cost levied on all extra-budgetary projects (barely sufficient to cover the overhead administrative cost) and (iii) 10% of the Project Monitoring and Reporting fee assessed by HAC on its humanitarian projects.

An overview of earmarking of funds received by selected humanitarian agencies shows the following picture: besides the assessed contributions (or the agencies’ “regular budget”), WHO receives about 7% of “regular” or “core” unearmarked or lightly earmarked thematic funds received by for the 45% to 80% received by other agencies.

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35 Data provided by HAC.

36 Graphs prepared by WHO are of an indicative value only. Data is based on information made publicly available by each agency, but has not been screened by WHO for consistency of criteria nor verified by the Evaluators. All data is for 2006, with the exception of OCHA, which is for 2005. All graphs are limited to government donations (including the European Commission), and exclude receipts through private donors and national societies of the relevant agencies (UNICEF, ICRC).
8.3.3 TYP Contribution

Four countries provided financial support to the TYP. Among them DFID and ECHO contributed over 80% of the total amount of over US$ 30 million (Table 5).

<table>
<thead>
<tr>
<th>Agency</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIDA</td>
<td>427 350</td>
</tr>
<tr>
<td>DFID</td>
<td>11 106 011</td>
</tr>
<tr>
<td>ECHO</td>
<td>13 175 471</td>
</tr>
<tr>
<td>SIDA</td>
<td>610 378</td>
</tr>
<tr>
<td>Total</td>
<td>30 319 210</td>
</tr>
</tbody>
</table>

Through the TYP, WHO was given for the first time predictable, slightly earmarked funds. Although the assessment is still ongoing, progress is evident. The TYP was instrumental in providing not only more solid funding for human resources but also an opportunity to consolidate field presence with the additional advantage of leveraging bilateral and emergency response funds at regional and country levels.

Was the TYP funding a stable predictable source? There are some doubts in the views of the Evaluators who could not reconcile the firm multi-year commitment (predictable funding) made by some donors to headquarters with the apparent difficulty in making more than a few months contractual commitments. On one hand, only DFID made a firm pledge for the duration of the three-year project. The others, despite their intention to provide sustained support, were not in position to commit sufficiently formally to convince WHO’s administrators and financial managers to advance the funds. On the other hand, HAC did not “share this predictability” with the regions and countries, who remained uncertain of how much would actually be available for the following year. Funding to regions, where most recruitment was taking place, was made contingent to the approval of an annual work plan, adding a layer of uncertainty. In a risk-adverse administrative environment, a strong and written donor pledge is required and should be reflected in a multi-year allocation to regional and country offices.

The flexibility of TYP funding was limited by the detailed annual planning required from the various actors. The more details are required or provided on the location, number and type of activities, the less flexibility remains to adjust to changing needs or availability of additional earmarked funding. It is unclear whether this is the natural bureaucratic tendency to over-plan and control or a requirement from donors. What was meant as a flexible support to a strategic initiative of the entire Organization turned into a vertical project with activities, expected results and measurable indicators at every level. Flexibility was lost in the process. The Evaluators do not question the usefulness and importance of planning but the incompatibility of old-fashioned financial management with core-funding for emergency activities.

8.3.4 Conclusions

WHO is in a particularly unfavourable situation compared to other agencies of the UN system. Its regular budget is tightly allocated by Member States that are more willing to respond generously crisis after crisis than to accept a meaningful increase of their assessed contributions. Visible operational activities are much easier to fund than capacity building

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37 Nine joint assessment missions have taken place over the last two and half years between WHO, ECHO, DFID and independent experts to assess progress made possible through the TYP based on the MTE and Final Evaluation.

38 Considerable delays were occurring in the disbursement of the 2006 DFID instalment contributing to additional cash flows for HAC.
or preparedness. There is little elasticity in WHO’s regular funding, making difficult any significant increase of Regular Budget for HAC in the absence of strong political support from the traditional contributors to HAC.

Member States’ extrabudgetary contributions to the TYP at the global level and the multi-year grants to AMRO’s preparedness programme at the regional level are examples of flexible funding, clearly demonstrating the benefit and feasibility of lightly earmarked funding for capacity building.

Flexibility should be accompanied by increased transparency. The present WHO management system does not facilitate a consolidated managerial reporting to multi-sources contributions such as the TYP. WHO’s expense tracking of extrabudgetary funds could not reply to simple queries: how many posts were funded, where and for how long? How was it used as seed or leverage with other sources such as the CERF or the CAP? Estimates of 60% of TYP funding for staffing are probably realistic but difficult to substantiate with details. In summary, the Evaluators are still unable to assess how those funds were actually managed at strategic level.

8.4 Standard Operating Procedures (SOPs)

The Standard Operating Procedures are addressing most of the administrative inefficiencies of WHO. Their impact will only be felt once they are actually enforced and implemented at all levels.

In its TYP proposal to donors, WHO indicated that “An Organization-wide review of administrative and financial mechanisms and procedures is now underway so that standard operating procedures enable crisis-related work to be given appropriate priority.”

8.4.1 A Work in Progress

The SOPs detail the proposed procedures and delegation of authority to be adopted in case of emergency. Initially, theses special procedures were to be activated upon the formal declaration of emergency by the Director General of a Regional Director. The Evaluators could not identify circumstances where a formal written declaration of emergency has been declared. HAC, recognizing the shortcoming of this approach, opted recently to seek a blanket application of the SOPs to all projects funded by the CERF, Flash Appeals, the CAP or others on a case by case approach.

A massive effort was made by HAC towards the formal implementation of the SOPs. Recently, HAC and HSE joined forces to promote their application also in emergencies related to the International Health Regulations. A revised draft text for the WHO Manual of administrative procedures will incorporate the changes agreed during a HAC-HSE meeting. The SOPs and the revised text for the WHO Manual are the result of arduous negotiations with the WHO administration. Most important is the unequivocal support offered by the Director General to the implementation of the SOPs. This support was reiterated to the Evaluators in their meeting on 26 November 2007. As a compromise, they will not meet all emergency needs but

39 AMRO HAC professionals currently enjoy fixed-term two-year contracts. There is a justified regional concern that should DFID’s current grant be channelled through WHO, this region will share the same uncertainty than others in terms of predictability.

40 Three-Year Plan, Executive Summary, paragraph 1.2, page 8.
are nevertheless critical and welcome steps towards making WHO more responsive in case of crisis. They might well serve as a model for an overall review of the antiquated administrative system of WHO.

Workshops were organized at headquarters and country level (for instance in September 2007 in the Democratic Republic of the Congo) to familiarize key staff with the SOPs and consultations are ongoing with the designers of the new real time web-based General Support Management system of WHO. Evaluators could not assess the extent to which the SOPs will be compatible with the GSM modelled on existing routine procedures and processes.

The progress is surprisingly encouraging but still short of resulting in concrete operational changes. During the visits in the countries and regional offices, few interlocutors (administrators, WHO Representatives, etc.) were familiar with the content of the SOPs, although all supported its principle.\[^{41}\] In no instance were they actually implemented.

### 8.4.2 Conclusions

The development and negotiation of the SOPs is a remarkable achievement, going far beyond the many previous attempts to improve the heavy and inefficient WHO administrative system.\[^{42}\] However, this effort will bear its fruit only once the SOPs are formally included in the *WHO Manual of administrative procedures*, the only binding document for administrators and managers.

Presently, it is like a text of law approved by all relevant committees but not formally voted in Parliament and promulgated in the Official Journal!

### 9 General Conclusions

#### 9.1 Progress Achieved

Earlier evaluations were extremely useful to determine the baseline before the TYP. One evaluation predating the conception of the TYP is particularly noteworthy: *The review of WHO in emergency and humanitarian action*, the result of a four-month consultative process by Margareta Wahlström in 2002. Many of the conclusions and recommendations of this current evaluation confirm her earlier findings.

The most important achievement is the ongoing cultural change across WHO.

Improvements in countries visited are remarkable in response management but modest in risk reduction and preparedness. TYP funding has played a critical role to increase WHO presence and leadership where it is most needed: at country level.

HAC should be praised for the new practice of joint reviews of lessons learned in disaster situations carried out during the TYP. The participation of donors in those crisis evaluations should be pursued. Most of the observations of a managerial nature noted by the earlier reviewers have been corroborated by this evaluation.

\[^{41}\] The WHO Representatives’ meeting held in Geneva from 12 to 14 November 2007 formally endorsed the SOPs.

\[^{42}\] The Evaluators were able to experience first-hand the shortcomings of WHO in the administrative processing of this mission.
The mere presence of WHO in the countries is in itself a major wave change over past practices. The TYP funded approximately 70 staff around the world with the biggest presence in Africa.\textsuperscript{43} It is a giant leap forwards for the coordination of the health sector. In addition, it made possible the technical support and backstopping from regional offices and headquarters.

During the later period of the TYP, WHO’s performance in coordination of the health sector/Cluster and assessment of health needs (information) was dramatically strengthened. WHO’s presence in the field, that is in disaster-affected areas and not only the capital, is felt and appreciated by all Cluster partners. The Evaluators noted those improvements in every country visited, including in the Democratic Republic of the Congo, considered as the most problematic country for TYP achievements.

Considerable strengthening was also noted in most of the regional offices although little information was available regarding WPRO. The unsatisfactory situation in AFRO,\textsuperscript{44} the region which received the most funding, merits special attention.

Progress at headquarters level was difficult to gauge. Clearly, in the last two years, HAC has evolved favourably but accurate information on the changes brought about by the TYP was lacking. The impact of selected guidelines and publications was not assessed at field level.\textsuperscript{45}

**Improvements in building the institutional capacity of ministries of health are uneven and modest.**\textsuperscript{46} During interviews, national counterparts, while appreciative of WHO’s effort in the response, pointed out a certain amount of dissatisfaction with the assistance provided to improve the ministries of health’s preparedness and management capacity. Their perception is that WHO operational involvement on behalf of the humanitarian community at large may be at the detriment of its technical support to the country.

Several factors contributed to this overall progress. They include:

- The strong political commitment of senior management to strengthen WHO’s operational presence (the four key functions), the TYP concept!
- The TYP as a “predictable” source of funding; and
- The Humanitarian Reform and in particular the designation of WHO as leader of the Health Cluster.

It is difficult to differentiate which achievements are attributable to each of these three factors. The use of TYP funding at country level is hard to trace. WHO financial tracking system is designed for auditors and accountants, not for Evaluators.\textsuperscript{47} Administrators in the countries visited were unaware of the TYP (The term is not a financial concept) and unable to identify activities or posts funded under this initiative.

\textsuperscript{43} This statistic was difficult to confirm. Data on posts funded are available only at the global, regional or country levels according to the type of personnel (international or national). Many posts may also be “guaranteed and temporarily funded by the TYP until either other less “flexible” sources of funds are identified. For follow-up funding, the best statistics will be month/international and month/national experts actually funded.

\textsuperscript{44} The visit to AFRO was brief (half a day), but the team’s itinerary did not allow a longer visit.

\textsuperscript{45} As indicated under Methodology, the Evaluators were never refused any documentation once its existence was brought to their attention outside HAC in Geneva, such as the proceedings of a key meeting held recently, scheduled policy meetings, draft policies in preparation, etc.

\textsuperscript{46} While AMRO maintained its focus on local emergency preparedness with limited input from the TYP, EMRO, EURO and SEARO progressed in this direction with TYP support. Little investment in capacity building was noted in AFRO. In the Democratic Republic of the Congo, WHO remained too much focused on high-profile donations of emergency kits or routine epidemiological surveillance and control. The Evaluators were not in a position to assess directly the contribution to disaster risk reduction and emergency preparedness made by the AFRO sub-regional offices and the inter-country staff funded by the TYP. No information was available regarding WPRO.

\textsuperscript{47} TYP funds are distributed over 78 inter-country or global TYP allotments and an unknown additional number at country level. Trying to determine a pattern of management was not possible.
The TYP funding was timely to create a synergy between the various factors. It was the last element required for the “perfect storm” of cultural change. The TYP vision and the Reform without TYP funding would not have achieved the same impact.

9.2 Involvement of Different Organizational Levels and Players

It is encouraging to note the many initiatives launched by HAC to involve and strengthen cooperation with other WHO departments. Colleagues in programmes and departments such as Nutrition, Mental Health, Environmental Health and Cholera credited HAC for initiating a positive engagement. Health Systems recognized the need for active partnership with HAC while acknowledging the critical impact of joint planning. In the area of communicable diseases, key players in headquarters expressed their satisfaction at the change of style brought by the new Assistant Director General in charge of HAC. In this regard, the joint HSE/HAC support for the Standard Operating Procedures is an encouraging sign. Managers at headquarters felt, however, that this new spirit of collaboration did not trickle down at lower level in HAC in the extent desirable.

This is worrisome in light of the recent reorganization within headquarters whereby the former cluster for Communicable Diseases has been renamed Health Security and Environment Cluster with the explicit responsibility for disease control and surveillance in humanitarian emergencies as well as management of environmental disasters or Global climate changes affecting Health. Cooperation between both clusters leave ample room for improvement at headquarters level.

HAC, with its comparably more developed presence at country level ends up doing basic routine epidemiological surveillance work distracting resources and attention from its prime responsibility. It is interesting to note that fear of epidemics has been one of the most effective tools for emergency fund-raising by HAC. The response to the latest Ebola outbreak in the Democratic Republic of the Congo has enhanced greatly the reputation of HAC and WHO.

The Evaluators understand the respective strengths of HAC and HSE as follows:

HAC’ expertise:

- Liaison with the humanitarian community and mobilization of resources from humanitarian sources (including for instance CERF requests, Flash Appeals, Consolidated Appeals and others);
- Overall coordination of WHO emergency or crisis response involving several WHO departments (clusters) regardless of the nature or cause of the crisis;
- Coordination of the Health Cluster (or sector) in all humanitarian crises;
- Overall assessment of needs in all humanitarian crises and dissemination of information to the international community;
- Building the capacity of Member States for disaster risk reduction and for health

48 In the regional or country offices interviewed or visited, there appears to be a good cooperation between all technical units and in particular with those responsible for communicable diseases surveillance and control. The main factor is the willingness of the HAC representative to assign full authority on humanitarian funds to the respective technical units. It is a wise and brave decision as only authority and not responsibility (accountability to donors) can be delegated.
response preparation and coordination;
• Monitoring and reporting to donors on the use of humanitarian funds;

HSE’ expertise:
• All technical aspects and activities pertaining to its area of expertise: communicable diseases and environmental emergencies;
• Allotment control and expenditures authorization for all funds mobilized by HAC for activities in HSE area of expertise;
• Epidemiological surveillance of communicable diseases of potential risk during crises;
• Dissemination of epidemiological information to all parties;
• Building capacity of the countries to reduce the risk of environmental disasters and epidemics and to respond in case of environmental crises.

A major step towards full cooperation would be the willingness of HAC to fully transfer the financial authority on funds raised for activities falling under the area of expertise of other departments (clusters) while maintaining the responsibility vis-à-vis donors. A risk worth taking!

9.3 The TYP and the Humanitarian Reform

Three of the core functions that the TYP aimed to strengthen in WHO (i.e. coordination, assessment and gap filling) are identical to those expected from the agencies leading the Clusters. The TYP and the Reform process are closely interconnected and synergic. The main difference resides in the fact that the TYP is aimed to serve WHO by building its capacity while the Cluster Approach is serving the international community and not WHO in particular.

As noted in the findings, WHO’s mobilization of resources at country level has often competed with its function of impartial leader of the Cluster. In several instances, projects taken on by WHO could have been implemented by non-governmental organizations more effectively, rapidly and at a lower cost. To quote the WHO Director General, “If we want to lead, we should give away some implementation”. This requires a firewall between the function of WHO Operations Manager and that of Cluster Coordinator as is rightly proposed by HAC in the revised version of the *WHO Manual of administrative procedures*. Other UN agencies are facing the same conflict of interest but, contrarily to WHO, they subcontract operational activities to other partners, mostly non-governmental organizations.

At headquarters level, it was surprising to note that both overarching initiatives (Health Cluster and TYP) were managed independently and with some duplication of efforts. This duplication is reflected in the general observation by the Evaluators of a compartmentalized distribution of roles in HAC with limited dialogue and information-sharing between departments in spite of the efforts of the Assistant Director General.

Both the TYP follow-up and the Cluster initiative would gain from a common central management in the future.

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49 National capacity building and the role of national institutions in leading the Clusters seem to have been overlooked in the Reform process, which was developed without meaningful participation of developing countries vulnerable to disasters. The Reform process was perceived by some of the national interviewees as external and donor driven.
9.4 **Support Services and Management**

The WHO administrative system is antiquated and inefficient in emergencies. These shortcomings seriously affect WHO’s ability to deliver on its core commitments to the affected populations and the international community during crises.

The administrative and managerial support to emergency operations has been constantly singled out as the weakest link in the chain towards a more effective technical WHO role in crises. This shortcoming was identified in almost all the evaluations and reviews conducted in the last five years to no avail. The system so far has resisted any changes.

The area most in need of drastic changes is the recruitment and management of human resources. WHO is bleeding its best skilled professionals to other agencies. Contractual conditions, technical or logistical support are falling short of minimum accepted standards. This may be particularly so in AFRO based on the limited example of the Democratic Republic of the Congo.

Procurement remains centralized with little willingness at the regional level to consider other approaches. The result is delays and feeling of powerlessness for the staff told that the supplies are due to arrive anytime. HAC’s progress in logistics and in particular the set up of a decentralized platform jointly with WFP is a major step forward. Logistics is a common requirement for both HSE and HAC. Perhaps, a logical step would be to consider joining forces to establish a joint emergency logistic unit at headquarters level.

However, HAC should not revert to the past misconception that WHO’s response to disasters is primarily a logistic and supplies matter. Coordination and information must remain the cornerstone responsibility of a technical agency like WHO.

Existing financial procedures are cumbersome in their design to avoid any potential risk for the Organization. However, while the financial risk may be minimized, the damage to the function and credibility of WHO is very high. The problem is not only a lack of delegation of authority. WHO Representatives in AFRO (and also in AMRO) are occasionally reluctant to make use of the authority delegated by fear of later audits or evaluations questioning their judgments. Risk adversity is widespread outside HAC.

The Standard Operating Procedures, once enforced and actually implemented, will offer a tool to improve management. Given the WHO culture, it will still require dedication and courage on the part of regional offices and WHO Representatives to actually use the increased authority and flexibility provided by the Procedures. HAC’s support will be essential.

9.5 **Political Commitment**

The Evaluators noted a high level of commitment to the four key functions of WHO in crisis situations. This commitment was observed at all levels. Partners in the field appreciated the change and now consider WHO as a serious partner in the humanitarian field.

In Geneva, the elevation of HAC as a WHO cluster is the clearest manifestation of the importance that the WHO Director General attach to this core function. Adopting the reduction of health consequences of emergencies, disasters, crises and conflicts as Strategic Objective Five in the Medium-Term Strategic Plan translates this commitment into measurable targets. The vision and commitment of the Director General was critical to ensure the level of achievements.
At the regional level, resolutions adopted in almost all regions and, perhaps more significantly, the in-depth awareness of the senior management on the importance of risk reduction are very encouraging. The evaluators were not able to document a senior management commitment in AFRO. The apparent lack of AFRO contingency planning for the continuation of field staff services in case of gap in the funding does not suggest appropriate commitment.

At country level, all WHO Representatives or Heads of office have taken on a pro-active role. Their direct involvement in the activities of the Health Cluster and their very successful mobilization of resources explain the positive opinion of the interviewees.

9.6 Impact of the Termination of a TYP-like Support

The positive change in corporate culture is likely to persist.
The investment in improved presence and services will be lost if bridge funding is not provided early.

Undoubtedly, many intangible improvements (corporate culture changes) will persist. Others, such as increased staffing in regional and country offices and immediate surge presence in disasters, are not sustainable in the absence of regular (and larger) unearmarked humanitarian funding for WHO.

The TYP demonstrated that the humanitarian community has no credible alternative to WHO for leading a diverse and somewhat unruly Health Cluster, while WHO cannot contemplate renouncing to its health leadership when it is most needed, such as during crises. All parties will gain from a stable and flexible source of funding remaining available to WHO.

Discontinuation of support, even an extended suspension, will jeopardize the most WHO’s valuable contribution, one that is felt directly by affected populations and partners active in disaster-affected communities, provinces or states across the world: a core of increasingly professional WHO experts. This resource at country level is likely to be lost should those funds be interrupted for a significant period of time.50

Those experts need backing and support. Due to the uniquely decentralized WHO structure, this support is provided mostly by the regional offices, which are also unlikely to be in position to sustain it at the present level in the absence of truly predictable long-term funding.

Regional offices cannot operate efficiently and consistently without policy and technical guidance or support from headquarters. HAC’s coordination at global level, an area of concern mostly to donors, is vulnerable to the lack of “sustained” funding. Strengthening headquarters becomes therefore a legitimate priority once the frontline actors are secured.

9.7 The TYP Follow-up Funding Proposal

What WHO needs is unearmarked funding. Funds should be granted by the donors and channeled to the regions by HAC on a multi-year basis and without the pre-requisite of an overly detailed annual work plan.

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50 As said earlier, it is estimated that approximately 60% of the TYP funding is used for staffing.
WHO has proved its capacity to serve the humanitarian community effectively if not always efficiently. Interlocutors in the fields overwhelmingly welcomed a still more visible and proactive role for WHO. This will not materialize without a significant support (sustained and predictable) from those countries interested in a better coordinated response (less chaotic would be more accurate but perhaps not politically correct).

The Evaluators have been requested to review and comment on the proposal to be submitted by HAC for follow-up TYP funding. There was no proposal to review except a compilation of perceived financial needs from the regional offices, amounting to a total almost three times the TYP funding.

The approach adopted by HAC in preparing this draft proposal is perhaps not the most appropriate. Predictable funding is not supposed to meet each and every of the “funding gaps” as perceived by the regions but it must primarily ensure the sustainability of the services of competent experts for assessment of needs, coordination and capacity building of national counterparts before emergency funding starts flowing or between crises. That is what field partners require and it may be lost in the absence of decisive action from the donors.

If HAC wishes to keep unchallenged its resource mobilization pre-eminence within WHO, it should ensure that the new proposal is the product of true negotiation and consultation throughout WHO. It is of the interest of donors to monitor this aspect closely.

In other words, “predictable and flexible” funding should not be “wasted” on technical punctual activities which can wait for other sources. These funds should be used to:

- **Maintain and support key staff presence through fixed-term contracts at country level.** The staff covered under this funding should do genuine humanitarian or preparedness work. A better differentiation between development (routine local crises caused by poverty) and humanitarian activities (Cluster coordination, needs assessment, preparedness) will be required to focus TYP funding on the second.

- **Provide a surge capacity from the regions and headquarters** including activities such as the maintenance of roster.

- **Train and support field staff** through induction courses and other means.

Primarily, this funding should be used for a stable core of regional experts to be assigned to a given emergency for a sustained period of time (variable according to specific circumstances). This approach is not reflected in the overly comprehensive preliminary follow up budget shared with the Evaluators.

## 10 Recommendations

“There is also a great deal of cynicism towards the number of reviews, evaluations and other studies that have scrutinized [HAC] over the past years”... “This perceived lack of progress would appear to be THE main challenge”

*Review of WHO in Emergency and Humanitarian Action, 2002*  
*by Margareta Whahlström*

*The change of culture initiated by TYP encourages the evaluators to believe that it will not be the case with the following recommendations.*
10.1 **Recommendations to WHO**

10.1.1 **Recommendations to HAC and WHO Representatives in countries**

**Recommendation 1.** WHO at country level should streamline its currently all-inclusive definition of humanitarian action. Not all life-saving activities caused by chronic poverty or minor crises qualify for extraordinary measures and funding. Determining WHO’s operational priorities should not be driven by the availability of humanitarian funding.

**Recommendation 2.** HAC and the WHO Representatives should continue their efforts to mobilize funding locally. However, they should avoid competing with other Health Cluster partners by limiting WHO’s operational involvement to activities that cannot be done by other partners or for which it has a definite comparative advantage (last resort). In other words, WHO should mobilize resources for public health and not uniquely for WHO as an institution.

**Recommendation 3.** HAC should improve the analysis and interpretation of the data collected in the assessment of needs to identify gaps for action and to provide partners and donors with clear guidance for their decision-making.

**Recommendation 4.** The WHO Representatives and HAC should provide increased WHO support to capacity building in the ministries of health by mainstreaming, when appropriate, this component in all humanitarian proposals submitted to donors.

**Recommendation 5.** The WHO Representatives and HAC should give the highest priority to the provision of sufficient administrative and logistic support as well as technical backup to the HAC experts at local level.

10.1.2 **Recommendations to the Regional Offices**

**Recommendation 6.** Regional offices that did not do so should include the post of HAC Regional Adviser under their Regular Budget.

**Recommendation 7.** Regional Directors should formally activate the Standard Operating Procedures in all ongoing crises in their region. In particular, they should decentralize international procurement of supplies and recruitment of consultants to the Country Offices with large chronic humanitarian crises.

**Recommendation 8.** Regional offices should explore the convenience of setting up a Regional Emergency Fund on the model of those established in AMRO and more recently in SEARO.

**Recommendation 9.** Regional offices should offer fixed-term contracts to a pre-established percentage of the national and international professionals presently employed on a temporary basis. International experts offered fixed-term contract should be regional and available for extended assignment in any country of the region to adjust to the changing needs and funding. The pre-established percentage should be based on a conservative estimate of the humanitarian funding anticipated in the coming biennium.

**Recommendation 10.** Regional offices should include capacity building for preparedness and mitigation as a standard activity in all relevant humanitarian projects. A fixed 10% is suggested.

10.1.3 **Recommendations to Headquarters**

**Recommendation 11.** HAC should continue mobilizing humanitarian resources but should devolve full authority (allotment) for implementation to the respective technical clusters.
and departments while retaining the responsibility for reporting to donors.

**Recommendation 12.** Roles and responsibilities between the two WHO clusters with primary emergency capability, HAC and HSE, should be better defined stressing the coordination and resource mobilization responsibility of HAC and the thematic specialization of HSE.

**Recommendation 13.** HAC’s Global Cluster coordination should focus on a more limited number of initiatives (guidelines and others) keeping in mind that the real challenge and investment are not compiling technical documents but ensuring their use in current practice.

**Recommendation 14.** HAC should intensify its effort to implement its risk reduction and preparedness strategy in support to the ministries of health in particular through the Safe Hospitals Awareness Campaign launched by the UNISDR.

**Recommendation 15.** The WHO Director General should give necessary instructions for the immediate application of the Standard Operating Procedures for all humanitarian projects, including the necessary adjustments that may be required in the Global Management System.

**Recommendation 16.** WHO should consider submitting for the Executive Board’s approval a significant increase of HAC budget for the biennium 2010-2011 as well as the establishment of an Emergency Fund at the global level.

**Recommendation 17.** HAC should finalize without delay a proposal for securing flexible and predictable funding unearmarked to specific activities or work plans. Priority should be given for sustaining WHO’s field and regional humanitarian presence in countries most vulnerable to disasters by increasing the proportion of fixed-term contracts.

**Recommendation 18.** WHO should convene a Pledging Conference with donors to seek long-term follow-up funding to the TYP.

**Recommendation 19.** WHO should give full authority to the new Assistant Director General in charge of HAC to reassign functions, change posts and incumbents in order to minimize duplications and competition within HAC and achieve efficient communication and cooperation between units or persons.

### 10.2 Recommendations to Donors

**Recommendation 20.** Donors should allocate immediate bridge funding for one year to permit the retention of the most critical humanitarian staff.

**Recommendation 21.** Donors should consider a favourable and generous response to a five-year proposal to further strengthen WHO’s overall humanitarian capacity provided:

i. WHO has effectively implemented the Standard Operating Procedures;

ii. The proposal is the result of a joint consultation between the two major emergency actors in WHO, HAC and HSE;

iii. The provision and retention of expertise directly available at field level is a priority.

**Recommendation 22.** Donors should provide this follow-up funding unearmarked or lightly earmarked. Annual instalments for institutional strengthening of WHO should not be linked to detailed work plans denying WHO the necessary flexibility and predictability.
WHO’s institutional capacity building programme for Health Action in Crises, also called the Three Year Programme (TYP), concludes at the end of 2007. In order to appropriately assess the progress that was made as well as to learn lessons for future programming, WHO is commissioning a final, independent evaluation that is to be carried out during the last quarter of the programme. To make sure that the final evaluation will produce an analysis that is relevant to all key stakeholders a Contact Group, made up of representatives of the donor community as well as the different WHO organizational levels, was set up and prepared the following terms of reference.

I. Background

Since its official start in September 2004, the TYP attracted approximately USD 31million contributed by four humanitarian donors. These resources were expected to address some of the major organizational shortcomings of WHO’s humanitarian assistance programme. An evaluation that had been conducted before the TYP had highlighted the following key shortcomings:

- Minimal resources for HAC: practically no un-earmarked, institutional money leading to very few dedicated field staff outside emergency response operations
- Insufficient organizational support in terms of location of the area of work in the institutional set-up, as well as in terms of WHA resolutions with the subject of emergency work
- No clear marketable strategy or plan: the role of WHO in emergency response was neither documented nor verbally communicated inside or outside WHO
- System for crises work (recruitment, finance, admin) were not in place or not performing optimally
- No system was in place capable of pre-financing response activities

Therefore, the TYP was designed to bring about changes in the following areas:

- Enhanced ability of WHO to respond well and quickly to emergencies
- Improved collaboration of WHO with other UN agencies and key partners
- Streamlined administrative procedures for emergency operations
- Better transparency and information flow amongst organizational levels and structured exchange of information and lesson-learning
- Availability of adequate resources (people, equipment, funds) for immediate and effective response
- Streamlining of “emergency issues” into the work of key technical programmes of WHO
- Concrete and predictable support to countries for preparedness, response, and recovery

While the above clearly was the point of departure of the TYP, it was never meant to be a static programme to be implemented in a linear approach. Some very important changes within WHO and in the external environment where WHO works such as humanitarian reform and the introduction of the cluster approach, occurred during the same time period and emerging challenges had to be integrated into the scope of work of the TYP.
Similarly, programme implementation needed to reflect adjustments required based on real-time feedback that was generated through (Funding Partner/WHO) Joint Evaluation Missions and an external mid-term evaluation. As a consequence of these developments, the TYP “goalposts” moved substantially and the scope of this evaluation will have to be broader than the initial scope of the programme.

II. Scope of the Evaluation

Five areas will need to be independently evaluated by the TYP Evaluation Team (TET). For each of the areas the TET will be expected to provide a detailed assessment, as well as to provide recommendations on how to increase the impact of WHO’s work in the future. The TET is expected to carry out these tasks in a collective and accountable way, but will not accept instructions from non-TET members.

At Country Level

1. Assess the changes in WHO’s performance in countries - on national government, local authorities, beneficiaries and on other humanitarian agencies, partners and donors - and determine the contributions of the TYP to those changes

   a. Clarity of mandate and strategy
      Country Cooperation Strategy and reflection of HAC priorities
      How do you respond to partner agency requests vis a vis direction
   b. Political commitment of senior management in WHO and MoH
      i. Implementation of recommendations from joint evaluations
      ii. Upholding of Humanitarian reforms principles incl accountability and transparency
   c. Specialized presence and reach of WHO (incl HAC) presence into the “deep field”
      i. competence,
      ii. Impact of training & capacity building
      iii. knowledge of existing guidelines,
      iv. HR retention and implications of turnover
   d. “New” roles played by HAC vis-à-vis partners –
      i. Effectiveness of WHO internal coordination
      ii. External responsibilities, particularly in the framework of the cluster approach
      iii. Collaboration with other UN agencies, NGOs and Peacekeepers
      iv. Differences between CAP and TYP activities
   e. Reliance of partners on WHO services and readiness to rely on WHO services
   f. Recourse by other key actors (esp MoH) to advice and additional assistance in case of unanticipated need
   g. With respect to the CERF and CAP, WHO’s ability to ensure that health needs receive adequate consideration in allocation decisions at the country level
   h. WHO’s effectiveness in facilitating the delivery of funds to implementing partners who do not have direct access to the CERF themselves
In the International Humanitarian Arena (HQ & Regional level)

2 Assess changes in WHO’s global set-up to work in the emergency and humanitarian context in a predictable manner and to respond well and quickly to emergencies and determine the contribution of the TYP to those changes. (Lead: Claude de Ville de Goyet) Sub-components in this area will be focusing on the TYP’s effect at regional and global level on:
   a. Clarity of mandate and strategy at global and regional levels
   b. Political commitment of senior management
   c. Appropriateness of managerial structures
   d. Adequacy of staffing
   e. Administrative procedures, including Standard Operating Procedures (SOPs)
   f. Flow of financial resources (incl. predictable humanitarian funding for institutional capacity)
   g. Human resources management
      i. From recruitment to exit
      ii. Training and Support
      iii. Working conditions
      iv. Turn over & exit management of personnel

3 Assess changes in WHO’s ability to respond to the key requirements of the Humanitarian Reform and in particular to collaborate with other UN agencies and key humanitarian partners and in building operational capacity and political commitment and to determine the contribution of the TYP to these changes. (Lead: Ann Canavan) Sub-components in this area could be focusing on:
   a. Interaction between the HR and TYP
   b. Clarity of mandate and strategy
   c. Political commitment of senior management (Regional and Headquarter levels)
   d. Appropriateness of interventions to bring about closer collaboration
   e. Role of WHO intervention in overall emergency and humanitarian effort, including Health cluster leadership

4 Assess WHO’s effectiveness in standard setting and developing guidelines for overall improved emergency health care response and determine the contribution of the TYP to those changes. (Lead: Emmanuel Eben-Moussi) Sub-components in this area will be focusing on:
   a. Relations with technical departments and their involvement in humanitarian affairs as an effect of the TYP
   b. Means employed to stimulate buy-in by technical departments and their effectiveness
   c. Mechanisms to identify gaps in technical standards and their applicability at field level
   d. Relation of WHO guidelines with existing standards such as SPHERE
   e. Outputs of TYP funded collaboration and their dissemination
On Management & Financing

Assess the overall management of the TYP by WHO and funding partners. Subcomponents in this area could be focusing on:

- Appropriateness and effectiveness of WHO’s management mechanisms and tools employed for the implementation of the TYP including Global Steering Committee.
- Coherence amongst actions implemented and key goals of the TYP
- Transparency of operations and reporting
- Use of and involvement in “open door policy” for programme management and in key events by funding partners
- Use of field reviews as a tool for real-time learning and programme adjustments
- Donor management of funding mechanisms and predictability of financial flows

The “HAC Benchmarks for WHO Performance” are based on WHO’s priority functions in crises at Country level. The TET will make use of these benchmarks as appropriate.

III. Output

The evaluation will result in the drawing up of a single report with annexes, written in a straightforward manner in English. The report will need to include a tightly-drafted, to-the-point and free-standing Executive Summary. The evaluation report is the primary output of the evaluators and once finalised the executive summary is placed in the public domain on the Internet.

The Executive Summary should be short, no more than seven pages. It should focus on the key purpose or issues of the evaluation, outline the main points of the analysis, and clearly indicate the main conclusions, lessons learned and specific recommendations.

The main body of the report shall elaborate the points listed in the Executive Summary. It would include references to the methodology used for the evaluation and the context of the Global/Intervention Plan. In particular, for each key conclusion there should be a corresponding recommendation. Conclusions should be fully substantiated with findings from the evaluation. Recommendations should be prioritised, directed at specific users and where appropriate include an indicative timeframe. Recommendations should be as realistic, operational and pragmatic as possible; that is, they should take careful account of the circumstances currently prevailing and of the resources available to WHO to implement them both at field, regional and global levels.

All confidential information shall be presented in a separate annex.

The report will need to provide an analysis useful to WHO and its partners in continuing to improve the organization’s ability to prepare for and respond to emergencies. To do this, it should specify the strengths and limitations found to date and identify major tasks to better address the limitations and capitalize on its strengths going forward. It needs to focus not only on country experiences, but on regional and headquarter functions and the relations among the different levels.
The conclusions/recommendations will consider among others:

a. The value added by funds made available for the TYP at different levels
b. The impact of discontinuation of TYP-style (predictable) funding at different levels
c. A Comparison of levels of predictable humanitarian funding between WHO and other key players
d. Alternatives to “predictable” voluntary funding to sustain progress made on the long run
e. Assessment of sufficiency of resources allocated by WHO to allow HAC to play a useful role in humanitarian action
f. Proposed changes to the design and appropriateness of the TYP follow-up funding proposal in terms of the relevance of proposed actions and funding items, the coherence and logic of overall framework, the involvement of different organizational levels and players, the realism of targets and means to be employed and its flexibility vis-à-vis unforeseen developments

IV. Timing and Key Parameters of the Evaluation

The evaluation is scheduled to take place during the last quarter of 2007. The initial time-frame approved by the Contact Group foresees the work of the TET to take place between week 40 (starting on Monday, 1st of October 2007) and week 48 (ending on Friday, 30th of November 2007).

While the structuring and division of labour amongst TET members is left to the evaluation team, the following parameters are to be respected:

- One week after the beginning of the evaluation the TET is to provide the Contact Group with an evaluation work plan, identifying timing, methodology, and responsibilities of TET members
- At least 50% of time should be spent on field missions. All visits will need to include opportunities for debriefing of field teams
- Evaluation findings will need to be presented in the following formats:
  o Detailed report with executive summary (max. 7 pages) and summary list of recommendations by the evaluation team.
  o PowerPoint presentation on evaluation process and key findings and recommendations
  o Presentation and Q&A session for the Contact Group
  o Presentation and Q&A at Donor Forum (planned during week 47)
- Following receipt of the report at the end of November, the Contact group will offer its comments that will be considered and included, as appropriate, in a revised version.

V. Field Visits and Stakeholder Consultation

The evaluation is to be based on the study of background documents as well as on extensive dialogue with stakeholders that can contribute towards the formation of a founded assessment
of the impact of the TYP. The Contact Group considers that for this purpose extensive field visits are indispensable. After consultation of its members, the Contact Group came up with the following ranking of countries in order of priority for consideration by the TET:

- **A- Democratic Republic of the Congo** – a visit to the DRC was considered indispensable given the serious humanitarian challenges combined with the roll-out of several initiatives under the humanitarian reforms. The DRC was a priority country from the outset of the TYP, but WHO continues to struggle with achieving an optimal impact. DRC is expected to be able to crystallise some of the short-comings of the TYP and for the TET to analyse possible ways to deal with existing roadblocks in future programmes.

- **B- Sudan** – was the first country visited by a Joint Field Mission (22/02 to 02/03/2005). While the humanitarian situation in the country remains similarly serious, the mission should be able to identify changes in the WHO programme since the former review and assess the impact the TYP has had on this particular intervention.

- **C- Pakistan** – is considered a telling example of a country that went through a sudden onset emergency and for which some baseline data has been gathered through a Joint Field Mission.

- **D (a) occupied Palestinian territory** – have been suggested for the complexity of the political and humanitarian situation and the long-standing WHO programme that pre-dates the TYP. While the oPt programme did not benefit from a major allocation of TYP resources, it will need to be seen to what extent TYP-influenced strategies and policies impacted on this operation.

Two Regional Offices (AFRO and EMRO) will be included in the travel schedule of the TET in order to be able to assess structures and mechanisms put in place through the TYP.

Contacts with WHO Representatives from selected countries will be arranged by HAC, in the extent possible, at the occasion of the meeting of WHO Representatives late November.

As to the stakeholders to be consulted, the Contact Group has compiled the following, tentative, list:

- Country-level NGOs
- Country-level UN
- Country level health cluster
- Government counterparts/MoH
- Country-level donors
- Country-level WHO
- Sub-regional co-ordination mechanisms
- Sub-regional donor hubs
- Regional offices
- International NGOs’ HQs or hubs
- UN agencies HQs or hubs
- Donor HQs or hubs
- WHO HQ HAC
- WHO HQ technical and admin departments
- Author of mid-term evaluation report
- Participants in Joint Review Missions
- Co-author of the pre-TYP evaluation
VI. Composition and Profiles of TYP Evaluation Team

The Contact Group recommended the recruitment of an evaluation team of three external consultants. The selection of the team was based on the complementarity of team members and the selection criteria established beforehand included the following: at least one evaluator in the team was expected to have a solid public health background. At least one other team member was to have a background and track record in institutional capacity building or change management. Intimate knowledge of donor policies and the humanitarian reform process need to be reunited within the team. TET members were expected to have extensive emergency response experience, and would need to have some previous work experience within the countries/regions to be visited in field missions. The team needed to be operational in English and French. Also it was felt beneficial to have at least one female evaluator in the team to appropriately reflect gender issues that may be relevant to the programme.

Based on the above, the Contact Group selected the following experts:

- Dr Claude de Ville de Goyet (Team Leader)
- Ms Ann Canavan (Team Member)
- Dr Emmanuel Eben-Moussi (Team Member)

VII. Preliminary Costing of TYP Final Evaluation

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## Annex 2: List of Contacts

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<thead>
<tr>
<th>WHO</th>
<th>GENEVA</th>
</tr>
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<tbody>
<tr>
<td>AL WARD, Nadia</td>
<td>Technical Officer, VAM, Emergency Preparedness and Contingency Planning, HAC/EPC</td>
</tr>
<tr>
<td>ALWAN, Ala Din</td>
<td>Assistant Director General, HAC</td>
</tr>
<tr>
<td>ANNUNZIATA, Giuseppe</td>
<td>Medical Officer, HAC.</td>
</tr>
<tr>
<td>BARTRAM, Jamie</td>
<td>Head of Environmental Health Department</td>
</tr>
<tr>
<td>BEN YAHMED, Samir</td>
<td>Director SPS, Acting Director HAC/EPC</td>
</tr>
<tr>
<td>BOERMAN, Ties</td>
<td>Head of Health Statistics Unit</td>
</tr>
<tr>
<td>CHAIGNAT, Claire Lise</td>
<td>Medical Officer, HTM/NTD/IDM</td>
</tr>
<tr>
<td>COLOMBO, Alessandro</td>
<td>Medical Officer, HAC/REC</td>
</tr>
<tr>
<td>DEL Pueyo, Cristina</td>
<td>Donor Relations Officer, HAC</td>
</tr>
<tr>
<td>DIAZ-HERRERA, Cinthia</td>
<td>Donor Relations Officer, HAC</td>
</tr>
<tr>
<td>DIEPART, Michaline</td>
<td>Public Health officer (HIV Department)</td>
</tr>
<tr>
<td>DIOUF, Marie-Andre</td>
<td>Director, CCO</td>
</tr>
<tr>
<td>DRURY, Pat</td>
<td>Operations Director, ARO</td>
</tr>
<tr>
<td>ELO, Olavi</td>
<td>Consultant, Emergency Preparedness</td>
</tr>
<tr>
<td>FORMENTY, Pierre</td>
<td>Medical Officer, Emerging Pathogens, ARO.</td>
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<tr>
<td>GAMHEWAGE, Gaya</td>
<td>Technical Officer, HAC</td>
</tr>
<tr>
<td>GARFIELD, Richard</td>
<td>Interim Project Manager HAC/HNTS</td>
</tr>
<tr>
<td>GREIN, Thomas</td>
<td>Medical Officer, ARO</td>
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<tr>
<td>GRIEKSPOOR, Andre</td>
<td>Evaluation Officer, AEP</td>
</tr>
<tr>
<td>HEYMANN, David</td>
<td>Assistant Director-General, HSE</td>
</tr>
<tr>
<td>KELLY, Karen</td>
<td>Evaluation Officer, AEP</td>
</tr>
<tr>
<td>KENNEY, Erin</td>
<td>Programme Officer, Health Cluster, HAC</td>
</tr>
<tr>
<td>KORMOSS, Patricia</td>
<td>PH Officer, Recovery and Transition Programmes, HAC/REC</td>
</tr>
<tr>
<td>LAURANCE, Tony</td>
<td>Health Cluster Partnership Manager, HAC</td>
</tr>
<tr>
<td>LLOYD, Annie</td>
<td>Consultant, Training Emergency Response and Operations, HAC/ERO</td>
</tr>
<tr>
<td>LOPEZ ACUNA, Daniel</td>
<td>Director, Recovery and Transition Programmes, HAC/REC</td>
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<td>Director a.i. HAC/ERO</td>
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<td>MCARDLE, Dudley</td>
<td>Adviser to Assistant Director-General, HAC</td>
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<tr>
<td>MICHEAL, Markus</td>
<td>Consultant: Emergency Response, Emergency Response and Operations, HAC/ERO</td>
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<tr>
<td>SAILAS, Jukka</td>
<td>External Relation Officer, HAC</td>
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<tr>
<td>Name</td>
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<tr>
<td>SCHLUNDT, Jorgen</td>
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<td>SCHMIDT, Heidi</td>
<td>Human Resource Officer, HAC</td>
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<td>SHIBIB, Khalid</td>
<td>Technical Officer, HAC/REC</td>
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<tr>
<td>SLEEUVENHOEK, Tanja</td>
<td>Technical Officer, Interagency Affairs, HAC</td>
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<td>SOPER, Paula</td>
<td>Administrative Officer, HAC</td>
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<tr>
<td>VAN LERBERGHE, Wim</td>
<td>Director, Health Systems Department</td>
</tr>
<tr>
<td>VAN OMMEREN, Mark</td>
<td>Medical Officer, Mental Health Department</td>
</tr>
<tr>
<td>WEISE PRINZO, Zita</td>
<td>Nutrition in Emergencies, NHD</td>
</tr>
<tr>
<td>ZAGARIA, Nevio</td>
<td>Normative &amp; Technical Coordinator, HAC/REC</td>
</tr>
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<td>ZOUITEN, Ahmed</td>
<td>Medical Officer, HIV, Recovery and Transition Programmes, HAC/REC</td>
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<td>BRUSSELS</td>
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<tr>
<td>MARTIN, John</td>
<td>Head of WHO/EU Office</td>
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<td>STUCKE, Oliver</td>
<td>TYP Manager</td>
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<td>CHRISTINA</td>
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<td>BIGOT, Marc</td>
<td>Procurement and Supply Officer, AFRO</td>
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<tr>
<td>DA SILVA DURAO, Alvaro</td>
<td>Chief of Personnel, AFRO</td>
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<td>KALAMBAY, Kalula</td>
<td>EHA Unit</td>
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<td>KATHURIMA, Gitonga</td>
<td>Budget and Finance Officer, AFRO</td>
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<td>KHATIB, Omar</td>
<td>Regional Adviser, HAC</td>
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<tr>
<td>LUSAMBA-DIKASSA, P-S</td>
<td>Director, Programme Management, AFRO</td>
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<td>NGENDA MWIKISA, Chris</td>
<td>Director DES, AFRO</td>
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<td>ALLEN, Dominic</td>
<td>Technical Officer, EHA</td>
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<tr>
<td>ASSA’EDI, Abdulla</td>
<td>Assistant Regional Director</td>
</tr>
<tr>
<td>ASSAI, Mohammed</td>
<td>Regional Adviser, Community Based Initiatives</td>
</tr>
<tr>
<td>BAGCHI, Kunal</td>
<td>Regional Adviser Nutrition</td>
</tr>
</tbody>
</table>
Evaluation of the Three-Year Programme to Improve the Performance of the World Health Organization (TYP)

BAGHDADI, Samiha  Medical Officer STOP TB  Baghdadis@emro.who.int
BASSIRI, Susan  Planning, Monitoring, & evaluation  bassiris@emro.who.int
GEBREEL, Ashur  Consultant on Complex Emergencies  Gebreela@emro.who.int
GHAFFAR, A. Eman  Information Management Officer, EHA  ghaffare@emro.who.int
HAMMoud, Susanne  Budget & Finance Officer  hammouds@emro.who.int
HUda, Qudsia  Risk Reduction, EHA  hudaq@emro.who.int
JAMA, Mohamed Abdi  Deputy Regional Director  jamam@emro.who.int
KHOSHCHASHM, K.  WHO Consultant PME  khoshchash@emro.who.int
LAFIF, Hichem  Director, General Management  lafifth@emro.who.int
MAHER, Osama Ali  Director Communicable Diseases  mahero@emro.who.int
MAHJOUR, Jaoud  Emergency Environmental Health  mahjourj@emro.who.int
MALIK, Mamunur Rahman  Epidemiologist, DCD  malikm@emro.who.int
MOSHNI, Ezzedine  Regional Adviser, EPI  moshnie@emro.who.int
MUSANI, Altaf  Regional Adviser, Humanitarian Action  musanaj@emro.who.int
OPOKA, Martin  Epidemiologist – STP/CSR  opokal@emro.who.int
SHAMS, Khaled  Communications Administrator  shamsk@emro.who.int
VOGEL, Joanna  Women in Health and Development  vogelj@emro.who.int

EURO

ROCKENSCHAUDB, Gerald  Regional Advisor, Disaster preparedness  gro@euro.who.int

SEARO

OFRIN, Roderic  Regional Focal Point, EHA  ofrinr@searo.who.int
SINGH, Poonam  Deputy Director  Singhpoonam@searo.who.int

INTERNATIONAL AGENCIES, DONORS AND PARTNERS

ARGUOLO, Isobele  Migration Health Advisor, IOM.  Arguoloi@iom.org
BATTAS, Sophie  ECHO Darfur  battas@echosudan-nyala.org
BISHOP, James  Director of INTERACTION  jlbishop@interaction.org
BRICENO, Salvano  Director, ISDR  Briceno@un.org
CARVELL, Victor  Counsellor, Canada Permanent Mission  Victor.carvell@international.gc.ca
<table>
<thead>
<tr>
<th>Name</th>
<th>Title and Organization</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHAUVIN, Bruce</td>
<td>Director of Health, IFRC</td>
<td><a href="mailto:brucechauvin@ifrc.org">brucechauvin@ifrc.org</a></td>
</tr>
<tr>
<td>CUTTS, Marc</td>
<td>Humanitarian Reform Support Unit, OCHA</td>
<td><a href="mailto:cutts@un.org">cutts@un.org</a></td>
</tr>
<tr>
<td>DAKKAK, Henia</td>
<td>Technical Specialist, New York, UNFPA</td>
<td><a href="mailto:dakkak@unfpa.org">dakkak@unfpa.org</a></td>
</tr>
<tr>
<td>DAVIN, Thomas (teleconference)</td>
<td>Regional Emergency Advisor, UNICEF</td>
<td><a href="mailto:tdavin@unicef.org">tdavin@unicef.org</a></td>
</tr>
<tr>
<td>EGELAND, Jan</td>
<td>Former UN ERC</td>
<td><a href="mailto:egeland@un.org">egeland@un.org</a></td>
</tr>
<tr>
<td>GETMAN, Tom</td>
<td>Director, Humanitarian Affairs, WORLD VISION.</td>
<td><a href="mailto:thomas_getman@wvi.org">thomas_getman@wvi.org</a></td>
</tr>
<tr>
<td>GODIN, Catherine</td>
<td>Ministry of Foreign Affairs, Canada</td>
<td></td>
</tr>
<tr>
<td>HEFFINCK, Johan</td>
<td>Senior Expert, Sector Policies, Nairobi ECHO</td>
<td><a href="mailto:Johan.heffinck@ec.europa.eu">Johan.heffinck@ec.europa.eu</a></td>
</tr>
<tr>
<td>KAPILA, Mukesh</td>
<td>Special Representative of the SG (HIV) IFRC</td>
<td><a href="mailto:Mukesh.kapila@ifrc.org">Mukesh.kapila@ifrc.org</a></td>
</tr>
<tr>
<td>KHALIKOV, Rashid</td>
<td>Director of Operations, New York. UNOCHA</td>
<td><a href="mailto:khalikov@un.org">khalikov@un.org</a></td>
</tr>
<tr>
<td>LE QUERE, Lise-Marie</td>
<td>Intern, Unit 01 ECHO</td>
<td><a href="mailto:Lisemarie_lequere@yahoo.fr">Lisemarie_lequere@yahoo.fr</a></td>
</tr>
<tr>
<td>LE Guillouzic, Herve</td>
<td>Director of Health, ICRC.</td>
<td><a href="mailto:hleguillouzic.ICRC_GVA@icrc.org">hleguillouzic.ICRC_GVA@icrc.org</a></td>
</tr>
<tr>
<td>MARSHANG, Adelheid.</td>
<td>Senior Officer, Health in Emergencies, IFRC</td>
<td><a href="mailto:Adelheid.Marshang@ifrc.org">Adelheid.Marshang@ifrc.org</a></td>
</tr>
<tr>
<td>MCGOLDRICK, Jamie</td>
<td>Head, Humanitarian Reform Support Unit, OCHA</td>
<td><a href="mailto:mcgoldrickj@un.org">mcgoldrickj@un.org</a></td>
</tr>
<tr>
<td>MISTER, Robert</td>
<td>Coordinator of InterAgency Cooperation, IFRC</td>
<td><a href="mailto:mister@ifrc.org">mister@ifrc.org</a></td>
</tr>
<tr>
<td>MOHAGHEGH, Mostafa</td>
<td>Head Regional ISDR Office for West-Asia &amp; N. Africa</td>
<td><a href="mailto:mostafa.mohaghegh@unisdr-wana.org">mostafa.mohaghegh@unisdr-wana.org</a></td>
</tr>
<tr>
<td>MOLIN VALDES, Helena</td>
<td>Deputy Director, ISDR</td>
<td><a href="mailto:molinvaldes@un.org">molinvaldes@un.org</a></td>
</tr>
<tr>
<td>MURRAY, George (teleph)</td>
<td>Regional Disaster Response Advisor, OCHA</td>
<td><a href="mailto:Murray1@un.org">Murray1@un.org</a></td>
</tr>
<tr>
<td>NANDY, Robin</td>
<td>Senior Advisor, Health in Emergencies, UNICEF</td>
<td><a href="mailto:nandyr@unicef.org">nandyr@unicef.org</a></td>
</tr>
<tr>
<td>NIZER, Gaelle</td>
<td>Desk Officer, OPT ECHO</td>
<td><a href="mailto:Gaelle.nizery@ec.europa.eu">Gaelle.nizery@ec.europa.eu</a></td>
</tr>
<tr>
<td>NORTON, Leslie (CIDA)</td>
<td>Director International Humanitarian Assistance Canada</td>
<td><a href="mailto:Leslie_norton@acdi-cida.gc.ca">Leslie_norton@acdi-cida.gc.ca</a></td>
</tr>
<tr>
<td>Von OELRICH, Eva</td>
<td>Executive Secretary, SCHR</td>
<td><a href="mailto:schr@ifrc.org">schr@ifrc.org</a></td>
</tr>
<tr>
<td>PAULSSON, Carl Nikolaj</td>
<td>Emergency Preparedness and Response, WFP</td>
<td><a href="mailto:Carl.paulsson@wfp.org">Carl.paulsson@wfp.org</a></td>
</tr>
<tr>
<td>RAMSTAD, Tine</td>
<td>ISDR Regional Programme Officer, W.Asia &amp; N. Africa</td>
<td><a href="mailto:Tine.ramstad@unisdr-wana.org">Tine.ramstad@unisdr-wana.org</a></td>
</tr>
<tr>
<td>SCHENKENBERG, Ed</td>
<td>Humanitarian Affair Officer, ICVA</td>
<td><a href="mailto:Ed.schenkenberg@icva.org">Ed.schenkenberg@icva.org</a></td>
</tr>
<tr>
<td>SPIEGEL, Paul</td>
<td>Director of Health, UNHCR</td>
<td><a href="mailto:spiegel@unher.org">spiegel@unher.org</a></td>
</tr>
<tr>
<td>THOMAS, Manisha</td>
<td>Coordinator ICVA</td>
<td><a href="mailto:manisha@icva.ch">manisha@icva.ch</a></td>
</tr>
<tr>
<td>VAN HATTUM, Walter</td>
<td>Policy Coordinator, ECHO</td>
<td><a href="mailto:Walter.van-hattum@ec.europa.eu">Walter.van-hattum@ec.europa.eu</a></td>
</tr>
<tr>
<td>VIVIANI, Marilena</td>
<td>Head of the IASC Secretariat</td>
<td><a href="mailto:viviani@iasc.org">viviani@iasc.org</a></td>
</tr>
</tbody>
</table>
DEMOCRATIC REPUBLIC OF THE CONGO

KINSHASA

MAKWENGE KAPUT, Victor
Minister of Health
Makwenge@hotmail.com

DONORS

BARONCELLI, Leonardo
Ambassador, Italy
Leonardo.baroncelli@esteri.it

BOKOKO, Marie-Jeanne
Medical Advisor, ACDI- Canada
ebongo@usaid.gov

BONGO BENI, Emile
Infectious Diseases Spec. USAID
ebongo@usaid.gov

CARTIER, Paul
Ministre Conseiller- Belgian Cooperation
Paul.carter@diplobel.org

COOPER, Ros
Human Development Advisor, DFID
Ra-cooper@dfid.gov.uk

DECOUX, Alain
Technical Assistant, ECHO
alain.decoux@cec.eu.int

DESMET, Martinus
Health Sector, Belgian Cooperation
Martinus.desmet@diplobel.be

HAYKIN, Stephen
USAID Mission Director
shayhin@usaid.gov

PALMGREN, Asa
Desk Officer, SIDA Sweden
asa.palmgren@foreign.ministry.se

St-LAURENT, Luc
Second Secretary (Development), Canada

RED CROSS AND NGOS

CHIKURU, Albert
National Coordinator, PSI/ASF
achikuru@yahoo.fr;
achikuru@psicongo.org

DONOFRIO, Lise
Provincial Coordinator, IRC Kinshasa
Lisa.donofrio@thelRC.org

GRUBER-TAPSOBA
Administrateur Délégué PSI/ASF
tgtapsoba@his.com;
tgtapsoba@psicongo.org

KAROTTKI, Beatriz
Health Coordinator, ICRC
Kinshasa.kin@icrc.org

KASHITSHI, Jacques
General Secretary National Red Cross
Sgerde2006@yahoo.fr

LONCAS, Sylvaine
Health Coordinator, MSF/B
Msfb-kinshasa-med@brussels.msf.org

MBODJ, Bachir
Health Director, MERLIN
chd@merlin-congo.org

MCHUGH, Katharine
Special Programmes Manager, PSI/ASF
kmchugh@psicongo.org

NGOY LEYA, Pascal
PHC Advisor, IRC
PascalN@thelRC.org

PRIO TIO Josep
Head of Mission, MSF/B
Msfb-kinshasa-hom@brussels.msf.org

TUMBA, Vicky
Health assistant coordinator
Vicky.tumba@yahoo.fr

UN AGENCIES

FERNANDES, Gloria
HEAD, OCHA
Fernandez11@un.org

HOUNSOKOU, Eusèbe
UNHCR Representative
hounsoko@unhcr.org

MOUNTAIN, Ross
Humanitarian Coordinator
Ross.mountain@undp.org
<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verna, Daniel</td>
<td>Chief, Health Section, UNICEF</td>
<td><a href="mailto:dverna@unicef.org">dverna@unicef.org</a></td>
</tr>
<tr>
<td>Vincent, Charles</td>
<td>WFP Representative</td>
<td><a href="mailto:Charles.vincent@wfp.org">Charles.vincent@wfp.org</a></td>
</tr>
<tr>
<td>Essombe, Thomas</td>
<td>Administrator</td>
<td><a href="mailto:essombet@cd.afro.who.int">essombet@cd.afro.who.int</a></td>
</tr>
<tr>
<td>Mukinda, Valentin</td>
<td>HAC Assistant</td>
<td><a href="mailto:mukindav@cd.afro.who.int">mukindav@cd.afro.who.int</a></td>
</tr>
<tr>
<td>Ncharre, Chouaiboug</td>
<td>Polio Coordinator</td>
<td><a href="mailto:ncharrecc@cd.afro.who.int">ncharrecc@cd.afro.who.int</a></td>
</tr>
<tr>
<td>Nguessan, Francois</td>
<td>HAC Coordinator</td>
<td><a href="mailto:nguessant@cd.afro.who.int">nguessant@cd.afro.who.int</a></td>
</tr>
<tr>
<td>Roungou, Jean Baptiste</td>
<td>WHO Representative</td>
<td><a href="mailto:Roungou@cd.afro.who.int">Roungou@cd.afro.who.int</a></td>
</tr>
<tr>
<td>Confalone, Nicoletta</td>
<td>Regional Coordinator, COOPI, Ituri</td>
<td><a href="mailto:coordbunia@coopi.org">coordbunia@coopi.org</a></td>
</tr>
<tr>
<td>Diallo, Sidy</td>
<td>MSF/CH Kampala-Uganda</td>
<td><a href="mailto:dupin@un.org">dupin@un.org</a></td>
</tr>
<tr>
<td>Dupin, Jean-Charles</td>
<td>Head of Office, OCHA</td>
<td><a href="mailto:dupin@un.org">dupin@un.org</a></td>
</tr>
<tr>
<td>Kyroussis, Eustace</td>
<td>WHO-HAC coordinator, Ituri</td>
<td><a href="mailto:kyroussise@yahoo.fr">kyroussise@yahoo.fr</a></td>
</tr>
<tr>
<td>Lattouf, Sandra</td>
<td>Head of Bunia Sub-Office UNICEF</td>
<td><a href="mailto:slattouf@unicef.org">slattouf@unicef.org</a></td>
</tr>
<tr>
<td>Lonema Vajeru, Roger</td>
<td>District Medical Officer (Bunia)</td>
<td><a href="mailto:Rogersophie2000@yahoo.fr">Rogersophie2000@yahoo.fr</a></td>
</tr>
<tr>
<td>Losa Lona, Gustave</td>
<td>District Medical Officer (Djugu)</td>
<td><a href="mailto:lonagus@yahoo.fr">lonagus@yahoo.fr</a></td>
</tr>
<tr>
<td>Mambo Kodjo, Theophile</td>
<td>Coordinator, MEMISA/Bunia</td>
<td><a href="mailto:tkmambo@yahoo.fr">tkmambo@yahoo.fr</a></td>
</tr>
<tr>
<td>NSibula Kirhero, Arsene</td>
<td>Liaison Officer, OCHA</td>
<td><a href="mailto:kirhero@un.org">kirhero@un.org</a>;<a href="mailto:knsibula.kirhero@un.org">knsibula.kirhero@un.org</a></td>
</tr>
<tr>
<td>Payne, Norbert</td>
<td>Head of Mission, MSF/CH Bunia</td>
<td><a href="mailto:Msfch-bunia-sat@msf.org">Msfch-bunia-sat@msf.org</a></td>
</tr>
<tr>
<td>Rousseau, Dominique</td>
<td>National Director, MEDAIR-Congo</td>
<td><a href="mailto:cd-congo@medair.org">cd-congo@medair.org</a></td>
</tr>
<tr>
<td>Van der Snoek, Marian</td>
<td>Medical Coordinator, MEDAIR-Congo</td>
<td></td>
</tr>
<tr>
<td>Bairi, Redouan</td>
<td>Logistic Officer, MSF/B</td>
<td><a href="mailto:reduanbairi@yahoo.fr">reduanbairi@yahoo.fr</a></td>
</tr>
<tr>
<td>Bamouni, Dieudonné</td>
<td>Head of Office</td>
<td><a href="mailto:diedouanneb@un.org">diedouanneb@un.org</a></td>
</tr>
<tr>
<td>Frans, Elke</td>
<td>Emergency Response officer, MSF/B</td>
<td><a href="mailto:elkefrans@hotmail.com">elkefrans@hotmail.com</a></td>
</tr>
<tr>
<td>Garavelli, Achille</td>
<td>Project Director, Haut Katanga, IRC</td>
<td></td>
</tr>
<tr>
<td>Hollo, Roger G.</td>
<td>Protection Administrator, UNHCR</td>
<td><a href="mailto:hollo@unhcr.org">hollo@unhcr.org</a></td>
</tr>
<tr>
<td>Ilunga, Kahyla</td>
<td>Advisor, Public Health and Hygiene, MOH</td>
<td><a href="mailto:kablyilunga@yahoo.fr">kablyilunga@yahoo.fr</a></td>
</tr>
<tr>
<td>Kabanda, Christine</td>
<td>Health Coordinator, MSF/E</td>
<td><a href="mailto:msfe-lubumbashi-msfco@barcelona.msf.org">msfe-lubumbashi-msfco@barcelona.msf.org</a></td>
</tr>
<tr>
<td>Kitoi Kimpinde, Adalbert</td>
<td>“Directeur de Cabinet”, MOH</td>
<td></td>
</tr>
<tr>
<td>Lajous, Lionel</td>
<td>Head of Office, CRS</td>
<td><a href="mailto:llajous@CRSCOONGO.org">llajous@CRSCOONGO.org</a></td>
</tr>
<tr>
<td>Leclerc, Arnaud</td>
<td>Head Sub office, CICR</td>
<td><a href="mailto:lubumbashi.lu@icrc.org">lubumbashi.lu@icrc.org</a></td>
</tr>
<tr>
<td>Leclerc, Elena</td>
<td>CICR</td>
<td><a href="mailto:kinshasa.kin@icrc.org">kinshasa.kin@icrc.org</a></td>
</tr>
<tr>
<td>Lelubre, Valerie</td>
<td>Health Coordinator, MSF/H</td>
<td><a href="mailto:mshf-southdc-medco@field.amsterdam.msf.org">mshf-southdc-medco@field.amsterdam.msf.org</a></td>
</tr>
<tr>
<td>Mabiala, Micheline</td>
<td>Provincial Health Inspector, MOH</td>
<td><a href="mailto:maeleyi@yahoo.fr">maeleyi@yahoo.fr</a></td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Email</td>
</tr>
<tr>
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</tr>
<tr>
<td>MOKHTAR, Mahamat Younous</td>
<td>Programme Coordinator, JOHANNITER</td>
<td><a href="mailto:lubumbashi@thejohanniter.org">lubumbashi@thejohanniter.org</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:mokthar3@hotmail.com">mokthar3@hotmail.com</a></td>
</tr>
<tr>
<td>NGONGALAH, Victor S.</td>
<td>Programme Administrator, UNICEF</td>
<td><a href="mailto:vngongalah@unicef.org">vngongalah@unicef.org</a></td>
</tr>
<tr>
<td>SIPULA MAYENGO, Godelieve</td>
<td>Field Humanitarian Assistance, OCHA</td>
<td><a href="mailto:sipula@un.org">sipula@un.org</a></td>
</tr>
<tr>
<td><strong>NORTH KIVU (GOMA)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BAABO, Dominique</td>
<td>Provincial Medical Inspector, MoH</td>
<td><a href="mailto:domihodieu@yahoo.com">domihodieu@yahoo.com</a></td>
</tr>
<tr>
<td>BAKATUBIA, Pierre</td>
<td>Administrator, Survival programme, UNICEF</td>
<td><a href="mailto:bpkanku@unicef.org">bpkanku@unicef.org</a></td>
</tr>
<tr>
<td>DELOR, Jean-Marie</td>
<td>Technical assistant, ECHO</td>
<td><a href="mailto:Echo-goma@oceanpost.net">Echo-goma@oceanpost.net</a></td>
</tr>
<tr>
<td>JACOT, Francois</td>
<td>Health Delegate, ICRC</td>
<td><a href="mailto:Assist.gom@icrc.org">Assist.gom@icrc.org</a></td>
</tr>
<tr>
<td>LAVAND’HOMME, Patrick</td>
<td>Head of Mission, OCHA, North Kivu</td>
<td><a href="mailto:lavandhomme@un.org">lavandhomme@un.org</a></td>
</tr>
<tr>
<td>LUBUTU, Alimasi</td>
<td>Health Field Officer, SC/UK</td>
<td></td>
</tr>
<tr>
<td>LUMANGAMANGA, Gaby</td>
<td>HAC, WHO</td>
<td><a href="mailto:Gaboul2002@yahoo.fr">Gaboul2002@yahoo.fr</a></td>
</tr>
<tr>
<td>MASINDE, Vicky</td>
<td>Health programme Manager, SC/UK</td>
<td><a href="mailto:ymasinde@gmail.com">ymasinde@gmail.com</a></td>
</tr>
<tr>
<td>MUKENDI, Mbuyi</td>
<td>Programme Assistant, ECHO</td>
<td><a href="mailto:Mukendi20@yahoo.fr">Mukendi20@yahoo.fr</a></td>
</tr>
<tr>
<td>NAKWAFIO KASAI, Francis</td>
<td>Liaison Officer, OCHA</td>
<td><a href="mailto:nakwafio@un.org">nakwafio@un.org</a></td>
</tr>
<tr>
<td>NDAGI, Prosper</td>
<td>Senior Field Officer, SC/UK</td>
<td></td>
</tr>
<tr>
<td>NDUNDULA NGALULA, Robert</td>
<td>National Expert, UNFPA</td>
<td><a href="mailto:Robert.ndundula@undp.org">Robert.ndundula@undp.org</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:robertngalula@unfpa.org">robertngalula@unfpa.org</a></td>
</tr>
<tr>
<td>NEMBUNZU Jean-Pierre</td>
<td>Epidemiological Medical Officer, WHO</td>
<td><a href="mailto:mnembunzu@yahoo.fr">mnembunzu@yahoo.fr</a></td>
</tr>
<tr>
<td>NKIKO, Rose</td>
<td>Health Officer, UNICEF</td>
<td><a href="mailto:rmnkiko@unicef.org">rmnkiko@unicef.org</a></td>
</tr>
<tr>
<td>SARR, Birame</td>
<td>Head of Mission, IMC</td>
<td><a href="mailto:bsarr@imcworldwide.org">bsarr@imcworldwide.org</a></td>
</tr>
<tr>
<td>SAUVAL, Guillaume</td>
<td>Emergency Officer, UNICEF</td>
<td><a href="mailto:gsauval@unicef.org">gsauval@unicef.org</a></td>
</tr>
<tr>
<td><strong>SOUTH KIVU (BUKAVU)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADANDJI, André</td>
<td>Focal point, HAC/WHO</td>
<td><a href="mailto:andreadandji@yahoo.fr">andreadandji@yahoo.fr</a></td>
</tr>
<tr>
<td>BURHOLE, Manu</td>
<td>Provincial Health Inspector, MOH</td>
<td><a href="mailto:manuburhole@yahoo.fr">manuburhole@yahoo.fr</a></td>
</tr>
<tr>
<td>KERMER, Ronald</td>
<td>Head of Mission, MSF/H</td>
<td><a href="mailto:Msfh_bukavu.pc@field.amsterdam.msf.org">Msfh_bukavu.pc@field.amsterdam.msf.org</a></td>
</tr>
<tr>
<td>MAHANGAIKO, Etienne</td>
<td>Programme Administrator, Head of Office, UNICEF</td>
<td><a href="mailto:emahangaiko@unicef.org">emahangaiko@unicef.org</a></td>
</tr>
<tr>
<td>MAKAKALA, Constantin</td>
<td>Emergency Medical Officer, HAC/WHO</td>
<td><a href="mailto:costamakakala@yahoo.fr">costamakakala@yahoo.fr</a></td>
</tr>
<tr>
<td>MAKAY, Jean Paul</td>
<td>National Expert, UNFPA</td>
<td><a href="mailto:jeanpaul@unfpa.org">jeanpaul@unfpa.org</a></td>
</tr>
<tr>
<td>MASUMBUKO, Timothée Kwalysa</td>
<td>Ministre provincial de la santé</td>
<td></td>
</tr>
<tr>
<td>N’DETÉ LEMBANDI, Thierry</td>
<td>Public Health Emergency Manager, RRM(rapid response mechanism), IRC</td>
<td><a href="mailto:thierrynrete@yahoo.fr">thierrynrete@yahoo.fr</a></td>
</tr>
<tr>
<td>PRIETO, Fausto</td>
<td>Technical Assistant, ECHO</td>
<td><a href="mailto:echobukavu@oceanpost.net">echobukavu@oceanpost.net</a></td>
</tr>
<tr>
<td>RAKOTOVAZAHA, Salomon</td>
<td>Head of Programme, AXxes</td>
<td><a href="mailto:srakotovaza@crscongo.org">srakotovaza@crscongo.org</a></td>
</tr>
</tbody>
</table>
RUHMICH, Christophe  | Programme Coordinator, MALTESER | mailtesrbkvmed@kivu.online.com
SHAMAVU, Rick  | Medical Officer, Epidemiological Surveillance, MOH | rickshamavu@yahoo.fr
TRAORE, Modibo  | Head of Office, OCHA | traorem@un.org
WAKENGE, Roghas  | Nutrition Programme Manager | wwakenge@yahoo.fr

**OCCUPIED PALESTINIAN TERRITORY**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABDEEN, Hani</td>
<td>Dean of Faculty of Medicine, Al-Quds University, Gaza</td>
</tr>
<tr>
<td>AL NAHALL, Issa</td>
<td>Director in the ICD, MOH, Gaza</td>
</tr>
<tr>
<td>MAANI, Qasem</td>
<td>Director Int. Cooperation, MOH West Bank</td>
</tr>
<tr>
<td>MOGHLI, Fathi Abul</td>
<td>Minister of Health, Palestinian Authority</td>
</tr>
<tr>
<td>LEVAV, Itzhak</td>
<td>Ministry of Health / Israel</td>
</tr>
<tr>
<td>LEVANTHAL, Alex</td>
<td>Director Public Health Services, MOH/Israel</td>
</tr>
<tr>
<td>SHAGURA, Walid</td>
<td>Director Internat. Cooperation, MOH Gaza</td>
</tr>
</tbody>
</table>

**DONORS**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>BERGLUND, Anna-Klara</td>
<td>Consul/ Development Cooperation SIDA</td>
</tr>
<tr>
<td>FREIXA, Enric</td>
<td>Regional Health Expert, ECHO/Amman</td>
</tr>
<tr>
<td>GHNEIM, Lubna</td>
<td>Programme Assistant</td>
</tr>
<tr>
<td>MERZOUK, Mamar</td>
<td>Technical assistant, ECHO</td>
</tr>
<tr>
<td>NIZERY, Gaelle</td>
<td>DESK Officer, ECHO 1 Brussels</td>
</tr>
<tr>
<td>NOUR, Nassim</td>
<td>Deputy Programme Manager, DFID</td>
</tr>
<tr>
<td>SIGNE, Marie Breivik</td>
<td>Program Advisor, NORWAY</td>
</tr>
<tr>
<td>VUILLEMIN, Gerald</td>
<td>Directeur Adjoint, Groupe Agence Française de Développement</td>
</tr>
<tr>
<td>WESTERBERG, Karin</td>
<td>SIDA</td>
</tr>
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**RED CROSS AND NGOs**

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<th>Name</th>
<th>Position and Affiliation</th>
</tr>
</thead>
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<tr>
<td>DALY, Eileen</td>
<td>Health Coordinator, ICRC</td>
</tr>
<tr>
<td>KHARMA, Rania</td>
<td>End Gaza Siege</td>
</tr>
<tr>
<td>MIÑANA, Cristina</td>
<td>Project Coordinator, MDM/Spain</td>
</tr>
<tr>
<td>SARRAJ, Eyad</td>
<td>End Gaza Siege</td>
</tr>
<tr>
<td>ZIV, Hadas</td>
<td>Exec. Director, Physicians for Human Rights</td>
</tr>
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**UN AGENCIES**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>AL-BAYARI, Hamada</td>
<td>Humanitarian Affairs Assistant, OCHA</td>
</tr>
<tr>
<td>CHAPUIS, Laurent</td>
<td>Project Officer, UNICEF</td>
</tr>
</tbody>
</table>
Evaluation of the Three-Year Programme to Improve the Performance of the World Health Organization (TYP)

CHEKIR, Hafedh
UNFPA Representative
Hafedh.chekir@undp.org

COSTY, Alexander
Head of Coordination, UNSCO
costy@un.org

KHAMMASH, Umayeh
Chief, Health Department, UNRWA
u.khammash@unrwa.org

KOLB, Henriette
Programme Officer, UNSCO
kolbh@un.org

LEWIS, Gwyn
Acting Head of Office, OCHA
lewsg@un.org

SHAAR, Ali Nashat
National Programme Officer UNFPA
shaar@unfpa.org

SHAWWA, Iman
Aid Coordination Officer, Local Aid Coordination Secretariat, UNSCO
ishawwa@lacs.ps

WHO

AL-MIMI, Yousef
District Pharmaceutical Officer
vom@who-health.org

DAHER, Mahmoud
National Health officer, Gaza
mda@who-health.org

DELAUDE, Christophe
Pharmaceutical Supply Officer
cde@who-health.org

FANYO, Rosalie
Drug Procurement Specialist
ria@who-health.org

HANTASH, Thair
Pharmaceutical Officer
Drthair_1977@yahoo.com

JENKINS, John
Mental Health Project Manager
jee@who-health.org

LAURENT, Anne
Pharmaceutical Field Monitoring Officer
ala@who-health.org

LHERISSON, Christian
Administrative Officer
clh@who-health.org

MANENTI, Ambrogio
Head of Office
ama@who-health.org

MANNEH, Majed Abu
Nutrition Officer
mam@who-health.org

MUHAISEN, Yousef
Health Coordination Officer
ymu@who-health.org

PARENZI, Alessandro
Health planning and Policy Officer
up@who-health.org

RAJIAH, Abu Sway
Mental Health training
ras@who-health.org

SCHEMIONEK, Katja
Public Health Officer
ksc@who-health.org

SREEDHARAN, Rajesh
Health information and Coordination Unit
rsri@who-health.org

STEFANINI, Chiara
Human Rights and Health Research Officer
cst@who-health.org

PAKISTAN

ISLAMABAD

AHMED, Ashfaq
Deputy Director General, Ministry of Health
ashamed@jhsphs.edu;ddgih@hotmail.com

AURAKZAI, Jehanzeb Khan
Emergency Preparedness, Ministry of Health
jehanzebaurakzai@hotmail.com

CHAUDHARY, N. Ahmed
Ministry of Health
Naved9800@hotmail.com

JILANI, Osman
Director Health, ERRA
jilani@erra.gov.pk

LASHARI, Khushnood Akhtar
Secretary of Health
secretary@health.gov.pk

NADEEM, Ahmed
Deputy Chairman ERRA
nadeem@erra.gov.pk
DONORS

MOORE, John  Counsellor & Head of Aid, CANADA  John.moore@international.gc.ca
RASMUSSEN, Bruce  Project Director, PRIDE – USAID  Bruce.rasmussen@pride.org.pk
RELTIEN, Christophe  Head of Office, ECHO  Christophe.reltien@ec.europa.eu
SKARIE, Mary  Director Health Office, USAID  mskarie@usaid.gov
ZAIDI, Raza  Health & Population adviser, DFID  r.zaidi@dfid.gov.uk

RED CROSS AND NGOS

ALVI, Arifa  Health Officer (ISLAMIC RELIEF – UK)  Arifa.alvi@irp.org.pk
GALER, Maria-Luiza  Country Health Director, MERLIN  chd@merlin-pakistan.org
HADI, Hussein, Syed  Senior Health Manager, IFRC  Hussain.hadi@ifrc.org
MEHMOOD, Arif  Programme Strategy Coordinator, (CARE)  amehmoood@careinternational.org.pk
PATERSON, Louise  Country Director, ARC  louise@arcpakistan.org
SADRUDDIN, Salim  Senior Health Manager, SC/USA  sadruddin@savethechildren.org.pk
SIMONS, Sandra  Medical Coordinator, MSF-B  medco@msfpakistan.org
VENTURA, Erick  Medical Director, ARC  erick@arcpakistan.org
WAHEED, Shahina  Health & Gender Adviser, CARE  swaheed@careinternational.org.pk
ZAFAR, Sana  Programme Coordinator, ARC  Sana.zafar@arcpakistan.org

UN AGENCIES

DONNAY, France  UNFPA Representative  France.donnay@un.org.pk
FARIZ, Ghaith  Director Office of Resident Coordinator  Ghaith.fariz@undp.org
MCLEOD, Andrew  UNDP Advisor to ERRA  mcleoda@undp.org
MUEENUDDIN, Tamur  Health Specialist, UNICEF  tmueenuddin@unicef.org
PARKER, Andrew  Senior Project Officer WES, UNICEF  acparker@unicef.org
SALEEM, Zarak Jan  Coordination Specialist, UNRC Office  Zarak.saleem@undp.org
VANDEMOORTELE, Jan  UN Resident Co-ordinator  Jan.vandemoortele@undp.org

WHO ISLAMABAD

ABID, Nima, Saeed  Polio Eradication Programme Medical Officer  abidn@pak.emro.who.int
AWAN, Shabbir Ghulam  Technical Advisor, UNFPA  Nst.moh@dslplus.net.pk
BILE, Khalif Mohamud  WHO Representative  bilek@pak.emro.who.int
BOUHAKA, Rayana  Chief of Operations/Team Leader EHA  bouhakar@pak.emro.who.int
EGAMI, Yuriko  Technical Officer, Stop TB  egamiv@pak.emro.who.int
HASAN, Quamarul  Technical Officer, Media Communications  hasang@pak.emro.who.int
KHAN, M. Fawad  Surveillance Coordinator  khanmu@emro.who.int
KHAN, Shahzad, Alam  Tobacco Control National Programme Officer  khans@pak.emro.who.int
KHAN, Zulfiqar  Technical Officer, JPRM  zulfiqar@whopak.org
KHATTAK, Rahman  IMCI National Programme Officer  Rahman.khattak@gmail.com
## Evaluation of the Three-Year Programme to Improve the Performance of the World Health Organization (TYP)

### MUZAFFARABAD

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Details</th>
<th>Email Address</th>
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<tbody>
<tr>
<td>KIYANI, Shelina</td>
<td>PHC National Programme Officer</td>
<td><a href="mailto:kiyanis@pak.emro.who.int">kiyanis@pak.emro.who.int</a></td>
</tr>
<tr>
<td>SHAHEEN, Mateen Ahmed</td>
<td>Consultant Health Sector to ERRA</td>
<td><a href="mailto:mateen@erra.gov.pak">mateen@erra.gov.pak</a></td>
</tr>
<tr>
<td></td>
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<td><a href="mailto:Shaheenm@pak.emro.who.int">Shaheenm@pak.emro.who.int</a></td>
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<tr>
<td>AHMED NISAR, K.</td>
<td>Asst Project Officer WatSan, UNICEF</td>
<td><a href="mailto:knisarahmed@unicef.org">knisarahmed@unicef.org</a></td>
</tr>
<tr>
<td>AHMED SHAH, Timur</td>
<td>Field Programme Manager, UN Area Coordinator Office</td>
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<tr>
<td>CALNY, Jerome</td>
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<td><a href="mailto:jcalny@gmail.com">jcalny@gmail.com</a></td>
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<tr>
<td>CHEEMA, Shafqatullah</td>
<td>UN Area Coordinator UAC</td>
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<td>DEVLIN, Frances</td>
<td>BHC Project Manager, ICRC</td>
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<td>Head of WHO Office</td>
<td><a href="mailto:issea@pak.emro.who.int">issea@pak.emro.who.int</a></td>
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<tr>
<td>KINYANJUI, Victor</td>
<td>WES Specialist UNICEF</td>
<td><a href="mailto:vkinjyajui@unicef.org">vkinjyajui@unicef.org</a></td>
</tr>
<tr>
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<td>Admin-Finance Assistant WHO</td>
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<td>SARDAR, Mehmood Khan</td>
<td>District Health Officer, MOH</td>
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### SIND PROVINCE

#### WHO

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<tr>
<td>HABIB, A.</td>
<td>Data Assistant, DEWS</td>
<td><a href="mailto:habibaswt@gmail.com">habibaswt@gmail.com</a></td>
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<tr>
<td>KHALID, Masood</td>
<td>DEWS Focal Person (Provinical MoH/WHO)</td>
<td></td>
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<tr>
<td>SHAHID, Ali</td>
<td>DEWS Focal Person (Provinical MoH/WHO)</td>
<td><a href="mailto:Shahid58@hotmail.com">Shahid58@hotmail.com</a></td>
</tr>
<tr>
<td>SOOMAR, Khosoo</td>
<td>Surveillance Officer, Sind Province</td>
<td><a href="mailto:khosom@pak.emro.who.int">khosom@pak.emro.who.int</a></td>
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#### MOH

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<tr>
<td>JATOI, Bus Hadi</td>
<td>Director General of Health</td>
<td><a href="mailto:Dg_health@yahoo.com">Dg_health@yahoo.com</a></td>
</tr>
<tr>
<td>KHAN, Abdul Majid</td>
<td>Special Secretary, Public Health Secretariat</td>
<td></td>
</tr>
<tr>
<td>LOGHERI, Mohammed Ali</td>
<td>Deputy Director of Public Health</td>
<td><a href="mailto:logherali@hotmail.com">logherali@hotmail.com</a></td>
</tr>
<tr>
<td>SOLANGI, Masood</td>
<td>Director of Public Health</td>
<td><a href="mailto:massolangi@yahoo.com">massolangi@yahoo.com</a></td>
</tr>
<tr>
<td>THESO, Aligm, Bux</td>
<td>EDO, Dadu District, Sind Province</td>
<td><a href="mailto:drrtheso@aol.com">drrtheso@aol.com</a></td>
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### UN AGENCIES

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<td>Project Medical Coordinator, MERLIN</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:kabedsa@merlin-pakistan.org">kabedsa@merlin-pakistan.org</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:khaledaislam@dhaka.net">khaledaislam@dhaka.net</a></td>
</tr>
<tr>
<td>ISSE, A</td>
<td>Head of WHO Office</td>
<td><a href="mailto:issea@pak.emro.who.int">issea@pak.emro.who.int</a></td>
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<td>Environmental Engineer, WHO</td>
<td><a href="mailto:jank@pak.emro.who.int">jank@pak.emro.who.int</a></td>
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<td><a href="mailto:khanjav@pak.emro.who.int">khanjav@pak.emro.who.int</a></td>
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<td>Admin-Finance Assistant WHO</td>
<td><a href="mailto:rehmans@pak.emro.who.int">rehmans@pak.emro.who.int</a></td>
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KIERNAN, Deirdre  Head of Health, UNICEF  dkierman@unicef.org
ONSKAZI, Ammar  Reporting Officer, UNOCHA/RCO  onskazi@un.org.pk
SHALLWANI, Shahnaz  Provincial Coordination Officer, UNFPA  Shahnaz-shallwani@un.org.pk

NGOs -
BIRGHMANI, Mashook  Director, Sujag Sansur (NGO)  Sujag.sansur@yahoo.com
PAUHCOOR, Ali Akbar  Chief Executive, Gorakl Welfare NGO  Gorakl_organization@hotmail.com
RUSTAMANI, Nobi  General Sec,  Sujag.sansur@yahoo.com

BALOCHISTAN

WHO BALOCHISTAN

NOUSHERWANI, Masood  WHO Head of Office, Quetta.  Nousherwanm@pak.emro.who.int

MOH – BALOCHISTAN

BALOCH, Abdul Rasheed  Director General, Provincial Health Services
JAFFAR, Mohammed Tariq  Chief Planning Officer
PRACHA, Sultan Mahmood  Epidemiologist/DEWS Focal Person
ZEHRI, Shafi Mohammed  Secretary, Health Department of Balochistan

UN AGENCIES

QAZI, Suleman  Provincial Representative, UNFPA  qazis@unfpa.org
YOUNNUS, Mohammed  Health & Nutrition Chief, UNICEF  myounnus@unicef.org

NGOs

BALUCK, Sabina  Chief of Training/ PAIMAN Project, Save US  sbaluck@qta.savechildren.org.pk
RASHIF, Sami  Project Director, Mercy Corps  srashif@qt-pak.mercycorps.org
SHAH, Ali  Health Programme, Mercy Corps  mashah@qt-pak.mercycorps.org
SIDDIQ, Mohammed  Project Director, Save the Children US  msiddiq@qta.savechildren.org.pk

SUDAN

WHO KHARTOUM

ABDUR RAB, Mohammed  WHO Representative  abdurrahm@sud.emro.who.int
BADDIN, Mehbob, Ali  Surveillance Officer  baddinn@sud.emro.who.int
BANLUTA, Christine  Communications Officer  banlutac@sud.emro.who.int
EL GANAINY, Ahmed  EHA Coordinator  elganainya@sud.emro.who.int
Evaluation of the Three-Year Programme to Improve the Performance of the World Health Organization (TYP)

RUSHFORD, Adrienne  Country Director, Malaria Consortium  a.rushford@malariaconsortium.org
SAYED, Sam  Medical Director, NCA/CARITAS
SMITH, Sara  Medical Coordinator, GOAL  smiths@goal.org
WHITNALL, Marianne  Programme Manager Darfur, ICRC  Nyla.nyala@icrc.org
WOKOLI, Benson  Medical Director, CARE  benson@sud.care.org
WOLDE, Dyan  Medical Coordinator, IMC  dwoldemichael@imcworldwide.org

(Footnotes)
2 Estimates based on the WHO maximum rate of USD 400/day during 61 days (01/10/07-30/11/07).
3 Estimate based on UN per-diem rates and stays at locations mentioned under section V above, as well as for stays in Geneva.
### Annex 3 - List of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AMRO</td>
<td>Regional Office for the Americas (WHO)</td>
</tr>
<tr>
<td>AFRO</td>
<td>Regional Office for Africa (WHO)</td>
</tr>
<tr>
<td>CAP</td>
<td>Consolidated Appeal Process</td>
</tr>
<tr>
<td>CERF</td>
<td>Common Emergency Response Fund</td>
</tr>
<tr>
<td>CHF</td>
<td>Common Humanitarian Fund</td>
</tr>
<tr>
<td>CIDA</td>
<td>Canadian International Development Agency</td>
</tr>
<tr>
<td>DEWS</td>
<td>Diseases Early Warning System</td>
</tr>
<tr>
<td>DFID</td>
<td>Department For International Development (United Kingdom)</td>
</tr>
<tr>
<td>DPA</td>
<td>Darfur Peace Agreement</td>
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<tr>
<td>DRC</td>
<td>Democratic Republic of the Congo</td>
</tr>
<tr>
<td>EC</td>
<td>European Commission</td>
</tr>
<tr>
<td>DG ECHO</td>
<td>European Commission Humanitarian Office/Directorate General for Humanitarian Aid</td>
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<tr>
<td>EMRO</td>
<td>Regional Office for the Eastern Mediterranean (WHO)</td>
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<tr>
<td>ERC</td>
<td>Emergency Relief Coordinator</td>
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<tr>
<td>EU</td>
<td>European Union</td>
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<td>ERRA</td>
<td>Earthquake Reconstruction and Rehabilitation Authority (Pakistan)</td>
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<tr>
<td>EURO</td>
<td>Regional Office for Europe (WHO)</td>
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<tr>
<td>GSM</td>
<td>Global Support Management (WHO)</td>
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<tr>
<td>HAC</td>
<td>Health Action in Crises (WHO)</td>
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<tr>
<td>HAC/Sudan</td>
<td>Humanitarian Aid Commission (Government of Sudan)</td>
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<tr>
<td>HEARNET</td>
<td>Health Emergency Action Response Network</td>
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<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>HNTS</td>
<td>Health and Nutrition Tracking System</td>
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<tr>
<td>HR</td>
<td>Humanitarian Reform</td>
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<tr>
<td>HSE</td>
<td>Health Security and Environment (WHO cluster)</td>
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<td>IASC</td>
<td>Inter Agency Standing Committee</td>
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<td>ICRC</td>
<td>International Committee of the Red Cross</td>
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<td>ICVA</td>
<td>International Council of Voluntary Agencies</td>
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<td>IFRC</td>
<td>International Federation of Red Cross and Red Crescent Societies</td>
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<td>IRC</td>
<td>International Rescue Committee</td>
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<td>International Health Regulations</td>
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<td>LSS</td>
<td>Logistic Support System</td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>MSF</td>
<td>Médecins Sans Frontières</td>
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<td>MTE</td>
<td>Mid-Term Evaluation</td>
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<td>IOM</td>
<td>International Organization for Migration</td>
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<td>OFDA</td>
<td>Office Foreign Disaster Assistance (United States)</td>
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<td>PAHO</td>
<td>Pan American Health Organization – Regional Office for the Americas (WHO)</td>
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<td>PHC</td>
<td>Primary Healthcare</td>
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<td>PMR</td>
<td>Project Monitoring &amp; Review</td>
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<td>SEARO</td>
<td>Regional Office for South-East Asia (WHO)</td>
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