MOPAN 2024

MOPAN ASSESSMENT REPORT
World Health Organization (WHO)

Part II. Technical and Statistical Annex

June 2024

Explanatory Note

MOPAN is the only collective action mechanism that meets member countries' information needs regarding the performance of multilateral organisations (MOs). Through its institutional assessment report, MOPAN provides comprehensive, independent, and credible performance information to inform members' engagement and accountability mechanisms.

MOPAN's assessment reports tell the story of the multilateral organisation (MO) and its performance. Through detailing the major findings and conclusions of the assessment, alongside the MO's performance journeys, strengths, and areas for improvement, the reports support member's decision-making regarding MOs and the wider multilateral system.

MOPAN assessment reports consist of two parts: the 'Analysis Summary' and a 'Technical and Statistical Annex'. The Analysis Summary provides the key findings of the assessment. The Technical and Statistical Annex provides detailed background on how the individual scores have been calculated, whilst providing the complete list of evidence documents and the full survey results.

This is Part II: Technical and Statistical Annex of the World Health Organization (2023). It contains the detailed underlying analysis of each score, the list of supporting evidence documents, as well as the summarised results of the external partner survey that fed into this assessment.

For the Analysis Summary of the MOPAN Assessment of the World Health Organization, including organisational context, key findings and the assessment methodology and process, refer to Part I.

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ABBREVIATIONS AND ACRONYMS

AC	Assessed contributions
ACT-A	Access to COVID-19 Tools (ACT) Accelerator
AFRO	WHO Regional Office for Africa
AMR	Antimicrobial resistance
AMRO	WHO Regional Office for the Americas
ARG	Action Results Group
ASEAN	Association of Southeast Asian Nations
BMS	Business Management System
CCS	Country Cooperation Strategies
CDC	Centres for Disease Control and Prevention
CFE	Contingency Fund for Emergencies
CO	Country Office
COVAX	COVID-19 Vaccines Global Access
CPCP	Core Predictable Country Presence
CRE	Office of Compliance, Risk Management and Ethics
CSO	Civil society organisation
DAF	Director of Administration and Finance
DDI	Division of Data, Analytics and Delivery for Impact
DG	Director-General
DOA	Delegation of Authority
DPSEEA	Driving Force, Pressure, State, Exposure, Effect, Action
DRC	Democratic Republic of the Congo
EB	Executive Board
ECH	Department of Environment, Climate Change and Health
EMRO	WHO Regional Office for the Eastern Mediterranean
EURO	WHO Regional Office for Europe
EVL	Evaluation Office
EWEC	Every Woman Every Child
FENSA	Framework of Engagement with Non-State Actors
GAP	Global Action Plan
GAVI	Global Vaccine Alliance
GBA	Global Board of Appeal
GEM	Gender equality marker
GER	Gender, equity and human rights
GIMAC	Global Information Management, Assessment and Analysis Cell

GPW	General Programme of Work
GRE-DEI	Departments of Gender, Rights and Equity - Diversity, Equity and Inclusion
GSM	Global Management System
HQ	Headquarters
HRM	Human rights marker
HRT	Human Resources and Talent Management
IAASB	International Auditing and Assurance Standards Board
IASC	Inter-Agency Standing Committee
IATI	International Aid Transparency Initiative
IEOAC	The Independent Expert Oversight Advisory Committee
IHR	International Health Regulations
IIA	Institute of Internal Auditors
ILO	International Labour Organisation
IOAC	Independent Oversight Advisory Committee for Health Emergencies
IOM	International Organisation of Migration
IOS	Office of Internal Oversight Services
IPSAS	International Public Sector Accounting Standards
ISA	International Standards on Auditing
JEE	Joint external evaluation
KPI	Key performance indicator
M&E	Monitoring and evaluation
MI	Micro-indicator
MOPAN	Multilateral Organisation Performance Assessment Network
MoU	memorandum of understanding
MTR	Mid-term report
NAPHS	National Action Plan for Health Security
NCD	Non-communicable diseases
NGO	Non-government organisations
NHPSP	National Health Policies, Strategies and Plan
OECD	Organisation for Economic Co-operation and Development
OMB	Office of the Ombudsman
OSC	Output scorecard
PAAC	Policy on Addressing Abusive Conduct
PAHO	Pan American Health Organization
PASM	Policy on Preventing and Addressing Sexual Misconduct
PB	Programme budget
PBAC	Programme, Budget and Administration Committee
PIP	Personal improvement programme
PMDS	Performance Management Development System
PRP	Planning, Resource Coordination and Performance Monitoring
PRS	Prevention and response to sexual misconduct

PRSEAH	Preventing and Responding to Sexual Exploitation, Abuse and Harassment
PSEA	Prevention of sexual exploitation and abuse
PSEAH	Prevention of sexual exploitation, abuse and harassment
PSH	Prevention of sexual harassment
QCPR	Quadrennial comprehensive policy review of operational activities for development of the United Nations system
RBM	Results-based management
RD	Regional Director
RO	Regional Office
SAF	The Survivor Assistance Fund
SDG	Sustainable Development Goal
SEA	Sexual exploitation and abuse
SEAH	Sexual exploitation, abuse and harassment
SEARO	WHO Regional Office for South-East Asia
SH	Sexual harassment
SPRP	Strategic Preparedness and Response Plan
SSTC	South-South and triangular cooperation
STAR	Strategic Tool for Assessing Risks
STI	Sexually transmitted infection
TB	Tuberculosis
UHC	Universal health coverage
UHCP	Universal Health Coverage Partnership
UN	United Nations
UN DESA	United Nations Department of Economic and Social Affairs
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UN-RIAS	United Nations Representatives of Internal Audit Services
UN-SWAP	United Nations System-wide Action Plan
UNDP	United Nations Development Programme
UNF	UN Foundation
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
UNOIOS	United Nations Office of Internal Oversight Services
UNSDCF	United Nations Sustainable Development Cooperation Framework
USAID	United States Agency for International Development
USD	United States dollar
VC	Voluntary contributions
VCSA	Victim and survivor-centred approach
VSSO	Victim Survivor Support Officer
WASH	Water, sanitation and hygiene
WHA	World Health Assembly
WHE	WHO Health Emergencies Programme

WHO	World Health Organization
WPRO	WHO Regional Office for the Western Pacific
WR	WHO Representatives

PART II: Technical and Statistical Annex

Part II: Technical and Statistical Annex provides the background to the key findings and scores presented in the first part of the report. It starts by outlining the underlying analysis of each score by key performance indicators, micro-indicators and elements. Then, it lists the documents used as evidence for analyses and scores. Last, it summarises the results of the external partner survey that fed into the assessment.

ANNEX A – PERFORMANCE ANALYSIS

Methodology for scoring and rating

The approach to scoring and rating under MOPAN 3.1 is described in the 2020 Methodology Manual,1 which can be found MOPAN's website.

Each of the 12 key performance indicators (KPIs) contains several micro-indicators (MIs), which vary in number. The KPI rating is calculated by taking the average of the ratings of its constituent MIs.

Scoring of KPIs 1-8

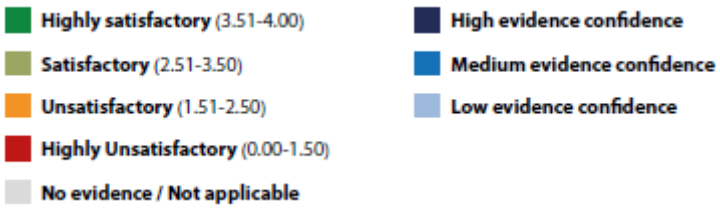
The scoring of KPIs 1-8 is based upon an aggregated scoring the MIs. Each MI contains a several elements, which vary in number, that represent international good practice. Taking the average of the constituent scores per element, a score is then calculated per MI. The same logic is pursued at aggregation to the KPI level, to ensure a consistent approach. Taking the average of the constituent scores per MI, an aggregated score is then calculated per KPI.

Scoring of KPIs 9-12

MOPAN's approach is to base scoring of KPIs 9-12 upon a meta-analysis of evaluations and performance information. For this assessment, we did not find sufficient coverage of evaluations and annual performance reporting to provide a robust assessment, hence these KPIs are not scored.[2]

Rating scales

Whenever scores are aggregated, rating scales are used to translate scores into ratings that summarise the assessment across KPIs and MIs. The rating scale used under MOPAN 3.1 is shown below.



A score of "N/E" means "no evidence" and indicates that the assessment team could not find any evidence but was not confident of whether or not there was evidence to be found. The team assumes that "no evidence" does not necessarily mean that the element is not present (which would result in a zero score). Elements rated N/E are excluded from any calculation of the average. A significant number of N/E scores in a report indicates an assessment limitation (see the Limitations section at the beginning of the report).

[1] MOPAN 3.1 Methodology Manual, 2020 Assessment Cycle, http://www.mopanonline.org/ourwork/themopanapproach/MOPAN_3.1_Methodology.pdf

[2] We note that WHO was intending to publish an evaluation of GPW13, but this was not available at the time of our assessment.

A note indicating “N/A” means that an element is considered to be “not applicable”. This usually owes to the organisation’s specific nature.

Changes to MOPAN’s rating system

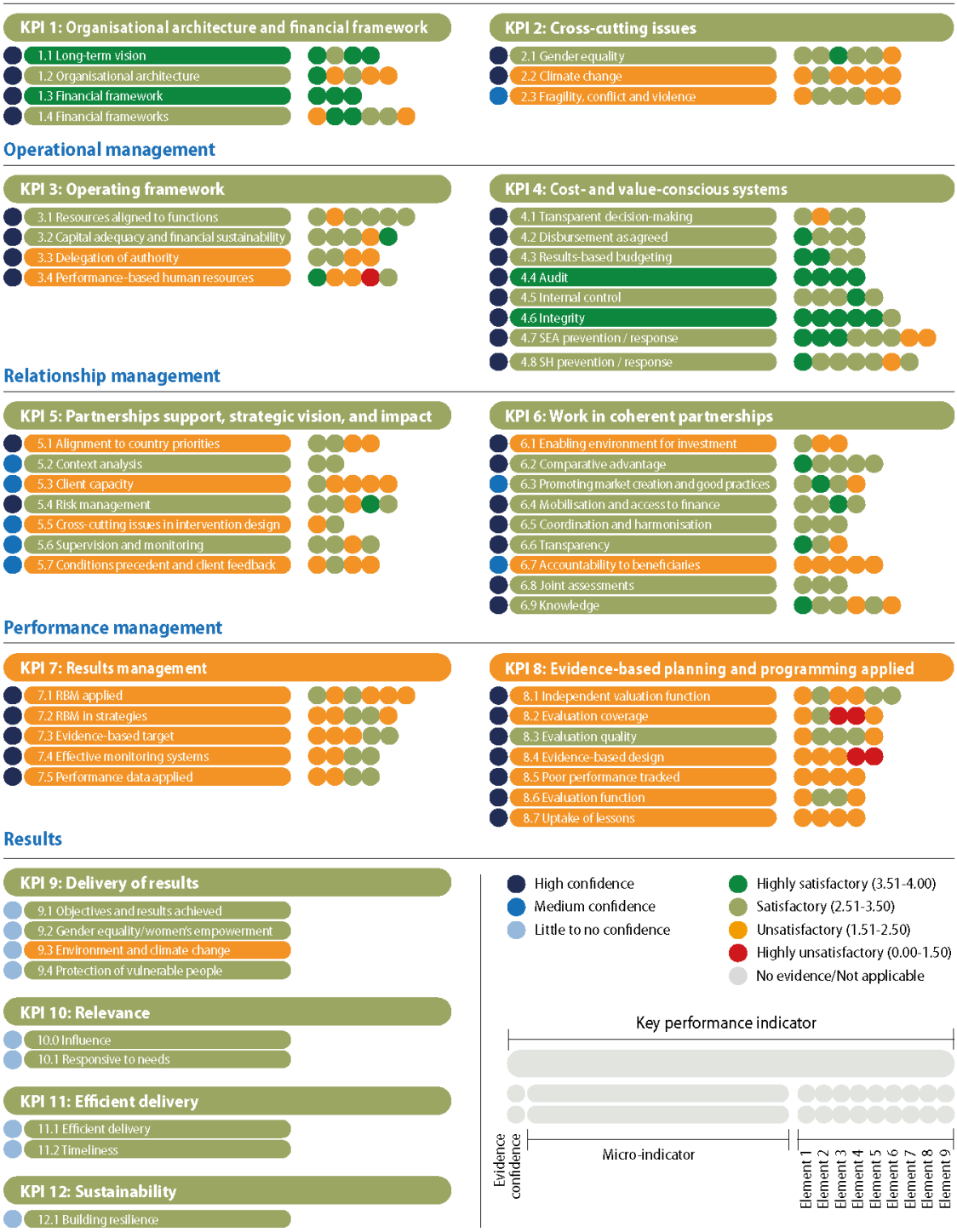
MOPAN’s methodology is continuously evolving, and a notable change concerns how ratings (and their corresponding colours) are applied based on the scores at micro-indicator (MI) and key performance indicator (KPI) levels. Compared to the pre-2019 rating scale, the threshold for each rating has been raised to reflect the increasing demands of organisational performance in the multilateral system. The underlying scores and approach to scoring are unaffected.

The World Health Organization’s scoring overview

The graphic below provides a “snapshot” of the World Health Organization’s (WHO) scoring against the MOPAN framework of key performance indicators (KPIs), Micro-Indicators (MIs), and elements by the five performance areas (Strategic Management, Operational Management, Relationship Management, Performance Management, and Results).

The Performance rating summary indicates that WHO performs particularly well (the assessment of “satisfactory”) in KPI 1 (*Organsational Architecture and Financial Framework*). WHO is also assessed as performing well under KPI 4 (*Cost and value consciousness, financial transparency*). WHO achieves the highest scores across several MIs and at the element level for both KPI 1 and 4, albeit that the SEA and SH prevention MIs under KPI 4 were unsatisfactory for much of the period under review. WHO is also assessed as performing well (at the “satisfactory” level) in KPI 3 (*Operating model and resourses support relevance and agility*), and KPI 6 (*Work in Coherent Partnerships*), albeit for both there are a few MIs that scored poorly, for instance 6.7 *Accountability to Beneficiaries*. KPI 5 (*Planning and intervention design support relevance and agility)* is rated unsatisfactory overall, though we note that there was considerable variation in achievement between different MIs of the framework for this KPI, with scores for 5.2 *Context analysis*, 5.4 *Risk Management* and 5.6 *Sustainability* being satisfactory according to the MOPAN criteria. The KPIs provding the greatest challenge for WHO were KPI 7 (*Transparent results focus, explicitly geared to function*) and KPI 8 (*Evidence-based planning and programming applied*), both of which were rated unsatisfactory, as were the majority of their MIs and elements, with the exception of 8.3 *Evaluation Quality* which was satisfactory.

The World Health Organization's performance rating summary



Performance analysis table

This section provides the background to the scoring of individual key performance indicators across the five performance areas, by including detailed analysis and score justifications at the level of micro-indicators and elements. It also highlights the key sources of information used for analysis and scoring. For more information on the assessment methodology, please refer to Chapter 4, Part I of the MOPAN Assessment of the World Health Organization (2023).

Certain indicators have been adapted to fit the organisation's context. Any adaptations and interpretations to the standard methodology are underlined within the performance analysis table.

Strategic Management

Clear strategic direction geared to key functions, intended results and integration of relevant cross-cutting priorities.

KPI 1: Organisational architecture and financial framework enable mandate implementation and achievement of expected results	**KPI score**
Satisfactory	**3.34**
MI 1.1 Strategic plan and intended results based on a clear long-term vision and analysis of comparative advantage in the context of the 2030 Sustainable Development Agenda	**Score**
Overall MI rating	**Highly Satisfactory**
Overall MI score	**3.75**
Element 1: A publicly available strategic plan (or equivalent) contains a long-term vision	4
Element 2: The vision is based on a clear analysis and articulation of comparative advantage	3
Element 3: The strategic plan operationalises the vision and defines intended results	4
Element 4: The strategic plan is reviewed regularly to ensure continued relevance and attention to risks	4
MI 1.1 Analysis	**Evidence documents**
1.1.1. A publicly available Plan, the 13th General Programme of Work (2019-23), sets out WHO's strategic vision and directions in line with its three strategic priorities, namely achieving universal health coverage, addressing health emergencies, and promoting healthier populations. It also provides a framework for its implementation with a proposed budget for all levels of the organisation. GPW13 was approved by the WHA in May 2018. Given the delays in implementation and disruptions due to the COVID-19 pandemic, the lifespan of GPW13 was extended to 2024-25. The long-term vision, aiming to achieve the "Triple Billions", identifies clear strategic and operational priorities and outcomes. One of the priorities in the Transformation Plan is to strengthen WHO's capacity at country level. WHO also has developed a range of Specific Strategies (e.g., non-communicable diseases; global HIV, Hepatitis, and Sexually Transmitted Infections (STI); TB; Women, Children and Adolescents, etc.), all approved by WHA, which are explicitly linked to the vision, targets and outcomes of the GPW13. In our survey, 90% of interviewees strongly agreed that WHO's strategic directions and priorities are clear and well communicated. WHO's Strategic Preparedness, Readiness and Response Plan (SPRP) outlines crucial steps needed to global, national and local levels, to tackle the COVID-19 pandemic.	17 18 19 20 39 41 52 62 63 64 73 78 121 134 164
1.1.2. The strategic vision has been developed following an extensive consultative process (within WHO at all levels, and with partners) and on an analysis of WHO's comparative advantage as a science- and evidence-based organisation. Internally, an extensive consultation process took place, involving staff at regional and country offices. In that process the need for a range of priorities and strategic actions was identified to enhance and optimise the way WHO functions and delivers at all levels, expressed in the Transformation Plan, issued in 2018, which is publicly available. There is no documented evidence of an independent analysis of comparative advantages of WHO. In late 2022, the DG, informed by WRs at their global reunion, made a commitment to enhance efforts to strengthen WHO's delivery capacity at country	176 193 284 290 612 613 614

level and established a WR group (ARG) to develop a 100-day plan to propose concrete, specific and time-bound action. The ARG Plan was released in March 2023 and shared with all staff through a dashboard that contains a timeline for each action and a staff with assigned responsibility.	
1.1.3. WHO develops its Programme Budget (PB) on a biennial basis. These Plans contain tables on outcomes, outputs and activities aligned to each strategic pillar to guide timely implementation. In addition to the overall PB, there are multiple operational frameworks to implement the strategic vision in different areas, including WHO's Emergency Response Framework and the SPRP laying out strategic adjustments to enable the world to end the pandemic. Clear consideration has been given on how WHO would address COVID-19 in line with its comparative advantage, sometimes during peak pandemic period to the detriment of other health areas and programmes. In the country partner survey, more than 90% of partners indicated that the strategic directions and outcomes are clear and relevant.	
1.1.4. A Triple Billion Dashboard is being used to monitor progress and to operationalise the vision. Mid- and end-term reviews presented in programmatic and financial reports, including audited financial statements and biennial budget performance assessments, document status and progress on the implementation of the biennial plans, providing evidence on what has been done and achieved, and allowing for accountability including on the use of resources. There is evidence, both documented and from interviews with staff, that adjustments are being made to ensure continued relevance, to adapt to changing needs, to assess risks, and to address gaps. It may be concerning that reporting at higher level outcomes (stated in the programme budget) makes it difficult to visualise and account for progress in specific health areas (e.g., mental health, disease-specific areas like HIV, TB, etc), and require separate monitoring and reporting to allow for this to happen. A January 2024 evaluation of GPW noted in particular that setting specific targets for healthy life expectancy (HALE) would have enhanced its utility. COVID-19 has been demanding for WHO, yet, at the same time, has been an extraordinary moment to provide evidence of its adaptability, relevance and leadership. The strategic plan has been updated to reflect the impact of COVID-19, and a specific and detailed Emergency Response Plan guided concrete activities. Annual reports documented progress and updates were reported to the Executive Board (EB).	
MI 1.1 Evidence confidence	**High confidence**

MI 1.2: Organisational architecture congruent with a clear long-term vision and associated operating model	**Score**
Overall MI rating	**Satisfactory**
Overall MI score	**2.60**
Element 1: The organisational architecture is congruent with the strategic plan	4
Element 2: The operating model supports implementation of the strategic plan	2
Element 3: The operating model is reviewed regularly to ensure continued relevance	3
Element 4: The operating model allows for strong cooperation across the organisation	2
Element 5: The operating model clearly delineates responsibilities for results	2
MI 1.2 Analysis	**Evidence documents**
1.2.1. WHO's operating model is, in essence, congruent to support the implementation of its strategic plans, the GPW13 and an up-to-date description of the organisational architecture is available. The organisation is organised across three levels, headquarter, regional, and around 150 country offices, each headed by a WR. WHO headquarters in Geneva is overall responsible for management and administration of the organisation, and takes the lead in developing its normative public goods. The six Regional Offices, with elected Regional Directors, traditionally take the lead in guiding country offices in policy, planning, reporting.	39 62 63 64 78 81 158
1.2.2. Major adaptations to the operating model have been made or are underway (Transformation Plan, ARG Action Plan) to support the implementation of the strategic plan, however, overall, these adaptations are only partly implemented. Over successive GPWs, namely GPW12, WHO had undergone extensive internal reforms to facilitate effective delivery of that strategy and to build a strong and responsive WHO. Previous Multilateral Organisation	283 320 336 347 375

Performance Assessment Network (MOPAN) assessments found limited progress on implementing the change management plan, with critical weaknesses around the capacity of country offices to deliver effectively. In 2017 the need for further "transformation" was recognised by the incoming DG. Implementation of GPW13 is supported by a strategy for optimising WHO's capacity and operating model, laid out in a Transformation agenda. This agenda identified seven strategic shifts in accountability and management, data, organisational design and operating model, processes and tools, culture, partnerships, workforce and financing. Central and inherent to this Transformation was the intent and the promise to strengthen the capacity at country level and to adjust the operating model to grant greater decision-making power to the WRs. 602 754

As mentioned under 1.1.2., in late 2022, the DG, informed by WR at their global reunion, made a commitment to enhance efforts to strengthen WHO's delivery capacity at country level and established a WR group - the Action for Results Group (ARG) to develop a 100-day plan to propose concrete, specific and time-bound action to strengthen WHO's country capacity. Released in March 2023, this action plan was developed by the ARG for country office strengthening and transformation, and for which the organisation is now acting on individual actions.

The Transformation Agenda has brought about a range of positive changes. For example, in 2022, an Agile Member States Task Group was established that plays a key role in ensuring that WHO's architecture is congruent with its strategic plan. It advises on strengthening WHO's budgetary, programmatic and financial governance, and analyses challenges in governance for transparency, efficiency, accountability and compliance. The Division of Data, Analytics and Delivery for Impact was established to improve measurement, results focus and delivery of impact (an areas of weakness in the previous MOPAN assessment. The Office of the DG's Envoy for Multilateral Affairs was set up in 2019 to coordinate and professionalise WHO's systematic engagement with intergovernmental partners. WHO has developed an Emergency Response Framework Implementation tool, which specifies the elements that WHO headquarters, regional and country offices must have in place to perform predictably and effectively WHO's critical emergency response functions and deliver on time-bound performance standards. Yet, the Independent Oversight Advisory Committee for Health Emergencies (IOAC) points out that stronger coordination across WHO's organisational levels, specifically between headquarters and Regional Directors for Emergencies, are needed to ensure it works as one WHO. The IOAC in its latest report to the WHA identified "internal power dynamics as an obstacle to clarifying accountabilities" between the WHE Programme and the wider WHO.

1.2.3. Regular updates on the implementation and progress on the implementation of the Transformation plan have been prepared and published, and there is annual reporting to the EB and WHA. With COVID-19 understandably absorbing attention and resources, progress with transformation slowed in 2020-21 (as acknowledged in interviews with key decision makers, in the transformation updates and the 2024 evaluation of GPW13). Some of the changes affecting country capacity were not implemented as expected. At the global WRs meeting in late 2022 in Geneva, the WRs urged the DG to address these deficiencies. The DG subsequently established a WR group (consisting of six WRs, one from each Region) to identify, within 100 days, concrete lines of action. The ARG 100-day plan was delivered to the DG in March 2023.

Staff mobility, a new model of Delegations of Authority (DOA - granting greater decision-making to the WRs to increase efficiency and effectiveness of their work, and, among other aspects, reinforcing the sharing of information and open communication between all levels of the organisation without any filter) , upgrading and regularising country staff capacity (Core Predictable Country Presence [CPCP] based on a typology of countries leading to identification of contexts and adequate Country Office [CO] staffing and role), and budget increases are among the changes requested by the ARG group. The DG responded in June 2023 by developing and announcing a revised model of DOA (signed by the DG and the five Regional Directors), and the launching the staff mobility scheme starting with an initial trial phase (a previous trial in 2018 was abandoned). The DG also announced that the first $100 million of AC increases would be channelled directly from headquarters to country offices.

A results-based-management (RBM) evaluation conducted in 2022 pointed out specific challenges for WHO Country Offices when it comes to identifying and delivering results. Respondents identified disconnects related to RBM in WHO, and specifically the disconnect between headquarters and country offices.

As stated by a considerable number of staff in interviews with the MOPAN team, the changes towards strengthening country capacity, including the mobility scheme and new delegated authority model, were

received positively and with the expectations that they would be fully and rapidly implemented. It was however also noted by many staff that some of these changes should have happened much earlier. Senior management staff pointed towards COVID-19 as the major factor for these delays. At the time of the interviews, it was unclear which criteria would be applied to decide on the distribution of the $100 million to countries.

More than three quarters (79%) of WHO staff in a staff survey considered that processes related to GPW13 had enabled the organisation to more effectively manage itself to deliver results.

1.2.4. The operating model bears the potential for seamless and effective collaboration across the organisation. However, certain deficiencies and capacity gaps still have to be addressed to facilitate effective delivery of the Global Strategy and corresponding plans.

WHO is a complex organisation with three working levels. While the division of responsibilities seems clear on paper, in practice this is often not the case. Budget is rather centralised at headquarters level, and there are regular negotiations with the senior management of Regional Offices; the Directors of Administration and Finance (DAFs) do, however, have significant responsibilities in the budgetary process. For the development of the Programme Budget (PB) for 2024-25, changes have been made towards a more bottom-up approach. Staff in country offices reported feeing rather disempowered in this process. Reporting lines from Country offices have traditionally been directly to Regional Offices, and only in exceptional circumstances directly to headquarters staff, which has hindered direct provision of advice to country offices. The revised Delegation of Authority announced by the DG in May 2023 aims to increase the level of authority and decision-making at the WR level, as well as, the flow of resources, communication, and provision of advice and support to countries. These changes, approved by the DG and the five Regional Directors may imply a diminution of the role and authority of the regional level. They also have the potential, if well and rapidly implemented, to improve the WHO's capacity to adequately respond to country needs and demonstrate leadership at the country level. These changes have the potential to make a positive difference, but it is too early to assess their implementation and impact.

1.2.5. While the programme budget delineates responsibilities for results, there have been issues on what level of the organisation takes the lead, how the resource flow and decision-making affect implementation, and how existing capacity gaps in certain technical areas as well as in many country offices, would allow effective delivery. WHO points out that in addition to the PB, the Output Delivery Teams (and formerly Category Networks) along with existing and active internal networks as the Planning; DAF/DPM; Budget, CSS; HR; DDI global networks all are part of the operating model for results and different parts of the results chain, at a higher level. PRP has ultimate responsibility for managing and coordinating the planning, budgeting and results reporting functions, with Regional Offices. ADG/BOS has a key responsibility, along with DAFs. WHO's 2024 GPW 13 evaluation also points to current confusion and overlapping mandates, saying that WHO needs to "*clarify the respective roles and responsibilities of the department of Planning Resource Coordination and Performance Monitoring, the department of Country Strategy and Support, and the Data Analytics and Delivery for Impact division in planning, monitoring and reporting in order to improve coherence and avoid duplication*".

MI 1.2 Evidence confidence	**High confidence**

MI 1.3: Strategic plan supports the implementation of global commitments and associated results	**Score**
Overall MI rating	**Highly Satisfactory**
Overall MI score	**4**
Element 1: The strategic plan is aligned to the 2030 Sustainable Development Agenda, wider normative frameworks and their results (including, for example, the Grand Bargain and the QCPR)	4
Element 2: A system is being applied to track normative results for the 2030 Sustainable Development Agenda and other relevant global commitments (for example, the QCPR and the Grand Bargain, where applicable)	4
Element 3: Progress on implementation and aggregated results against global commitments are published at least annually	4

MI 1.3 Analysis	Evidence documents
1.3.1. GPW 13 articulates clear alignment to the SDG Agenda and has strong emphasis on multisectoral work. It explicitly states that "the purpose of GPW 13 is to seize the opportunity to dramatically improve the health of the world. WHO will only succeed if it bases its work on the SDGs". The Implementation Framework for the Triple Billion Target of the GPW 13 supports the 2030 vision for attaining universal health coverage and the 2030 Agenda for Sustainable Development. Documentary evidence suggests that the Triple Billion vision was created to accelerate the SDGs and the stocktake summary of the Triple Billion target is intended to accelerate achieving SDGs by 2030. The Triple Billion Dashboard facilitates the tracking of normative health-related results of the SDGs. WHO also has a Corporate Grand Bargain log-frame which is an internal tool designed to provide a comprehensive analysis of the progress made against all Grand Bargain commitments. The log-frame includes indicators for each of the Grand Bargain's main outputs and provides a reference to the GPW13 for each output. The data and analytical narrative of WHO's contributions were made publicly available in 2023 for the analysis of 2022. Disease-specific strategies, such as the Global health sector strategy on HIV, viral Hepatitis and STIs for the period 2022-30 (as an example) promote synergies under a universal health coverage and primary health care framework and contribute to achieving the goals of the 2030 Agenda for Sustainable Development. At Regional level, Regional Strategic Plans (including the PAHO Strategic Plan 2020-25) are explicitly linked and aligned with the SDG targets. WHO strongly articulates its commitment to supporting the Secretary-General's agenda for the United Nations (UN) to work as "one UN", to improve efficiency and effectiveness at country level and support countries' achievement of the SDGs and was among the early signatories of the Mutual Recognition Statement. WHO, according to the Programme Budget for 2022-23 Report, routinely and proactively engages as part of UN country teams within the Resident Coordinator system. In the Programme Budget for 2022-23, the alignment with UN Reforms at country level and the integration of health in the UN Development Agenda are seen as an opportunity and a priority to support the joint delivery of the SDGs and the GPW13. WHO also strives to more proactively include non-state actors (including civil society and the private sector) in dialogue on health in the context of the SDGs. According to the DG's "Collaboration with the UN system" report, WHO provided support to various Member State discussions, including the Economic and Social Council, the Security Council and others, to anchor health in the global development agenda, linking it to development priorities such as sustainable development, eradication of poverty, climate change, gender equality, migrants, youth and others. The report also discussed WHO's engagements with multilateral organisations such as the African Union, Association of Southeast Asian Nations (ASEAN), the Organisation Internationale de la Francophonie, and the Commonwealth of Nations. The report also discusses WHO's engagements with multilateral organisations such as the African Union, ASEAN, the Organisation Internationale de la Francophonie, and the Commonwealth of Nations. **1.3.2. WHO publishes the World Health Statistics report annually, which is an annual compilation of most recent data on health and health-related indicators from 194 Member States**. The 2022 edition features the latest data from the more than 50 health-related Indicators from the SDGs and the Triple Billion Targets. A total of 35 indicators present at least data from 2020 (from estimates or primary sources) and 16 indicators include older data from between 2017 -19. The 2022 report also includes data on progression and impact of the COVID-19 epidemic (including excess mortality), as well as on country-specific statistics on burden of disease overall, on risk factors for health, and the pathway to Universal Health Coverage (UHC) (in line with the Triple Billion targets and indicators). The compilation of these data stems from databases primarily managed by WHO or UN partner entities and is supplemented with data and analyses from peer-reviewed publications. This report is an impressive example of WHO demonstrating leadership in tracking, generating, analysing, interpreting, and publicising health-related information, an area that was identified as weak during the previous MOPAN assessment. The report is obviously an important advocacy instrument to inform on progress, and lack thereof, towards the SDGs, but also the Triple Billion targets – in 2022 a key message being that the "world is off track to reach the Triple Billion Targets from the GPW13 and most health-related SDGs''. The European Health Report of 2021 presents an example of how WHO tracks and reports on normative SDG	13 52 67 145 172 187 211 375 561 651 652

results from a regional level. This report focuses on regional progress towards achieving health-related SDGs as it serves as a comprehensive direction-setting resource to inform regional work. As alluded to under 1.3.1., over the past seven years, WHO has consistently participated in the Inter-Agency Standing Committee's (IASC) Grand Bargain Self-Reporting Exercise. Through the IASC self-reporting exercise, WHO reports on its progress against each workstream of the overall Grand Bargain initiative. **1.3.3. The world health statistics report has been published annually by WHO since 2005, with progressive adaptations to accommodate health-related SDG indicators, as well as Triple Billion targets and indicators to monitor implementation and present aggregated results.** It attempts to have the most country-specific information on more than 50 indicators. WHO also actively reports progress on an annual basis on the implementation of the quadrennial comprehensive policy review of operational activities for development of the United Nations system (QCPR) through the United Nations Department of Economic and Social Affairs (UN DESA) survey of UN Agencies' headquarters for the Secretary-General report on the implementation of the QCPR resolution. In addition, WHO publishes a Grand Bargain Self Report yearly to share progress made against each of the individual Grand Bargain commitments and enabling priorities.	
MI 1.3 Evidence confidence	**High confidence**

MI 1.4: Financial framework supports mandate implementation	**Score**
Overall MI rating	**Satisfactory**
Overall MI score	**3**
Element 1: Financial and budgetary planning ensures that all priority areas have adequate funding in the short term or are at least given clear priority in cases where funding is very limited	2
Element 2: A single integrated budgetary framework ensures transparency	4
Element 3: The financial framework is reviewed regularly by the governing bodies	4
Element 4: Funding windows or other incentives in place to encourage donors to provide more flexible/un-earmarked funding at global and country levels	3
Element 5: Policies/measures are in place to ensure that earmarked funds are targeted at priority areas	3
Element 6: [UN] Funding modalities with UN reform: 15% of total resources are from pooled funding	2
MI 1.4 Analysis	**Evidence documents**
1.4.1. While financial and budgetary planning is consultative and intends to ensure that all priority areas have adequate funding, in practice, given resource limits, this is difficult to guarantee. "Pockets of poverty" and budgetary imbalances remain. WHO is funded through assessed contributions from Member States, as well as by voluntary contributions from both states and non-states actors. High earmarking of voluntary contributions has over the years been a key challenge in ensuring full funding for base programs and priority areas where funding has traditionally been weak. Significant efforts have been made to increase predictability, flexibility, and transparency of funding, as well as strategic alignment with health priorities. These include a regular financing dialogue with key donors, efforts to increase the level of AC, efforts to broaden the donor base, improving transparency and accountability in its reporting modalities, developing an investment case, as well as proposing new approaches to replenishment of the budget. At the end of the first year of the Programme Budget for 2022-23, at its annual report to the WHA in May 2023, WHO reported good levels (87%) of financing of its base programmes, representing the core work of the organisation, but also a funding gap of USD 660 million, reporting that "the current gap was compounded by persisting pockets of poverty – underscoring the urgent need for sustainable financing". The top 10 contributors to the base programme budget (both through AC and VC) are the USA, Bill & Melinda Gates Foundation, the Global Vaccine Alliance (GAVI), Germany, European Commission, United Kingdom, China, Japan, France, and the Republic of Korea, most of them with large proportions of VC, underpinning the issue of flexible use of resources.	17 18 19 20 40 53 64 89 239 283 367 399 458 541 659 660

1.4.2. The biennial programme budget (PB) which is developed in a consultative, bottom-up process in WHO, and made available in public domain, provides a single budgetary framework with high transparency, including both assessed as well as extrabudgetary contributions. Linked to it, a results framework was created to measure country progress and to identify the contribution of the WHO Secretariat. Over successive budget cycles, major improvements have been made to how the PB is developed, increasingly involving all levels of the organisation, and going through a much-needed process of prioritisation and budget allocation in a consultative and increasingly bottom-up process. The consultation is now initiated at country level, presented to all six Regional Committees, and ultimately presented to the EB for review and approval. Consultations with Member States also take place at different stages of the development of the PB.

1.4.3. The programme budget (PB) is regularly reviewed by the governing bodies of WHO (i.e., Executive Board and World Health Assembly) for comments and approval. WHO reports annually on the framework. In addition, delivery stock takes which are tracking country progress are available, and mid- and end term reviews and reports of the Programme budget are published and shared with the governing bodies. In addition, changes to the Financial Regulations and Financial Rules are approved by Member States.

1.4.4. WHO has been successful in providing incentives to increase AC, and to steer voluntary funding towards priority areas in greatest need. A major achievement and breakthrough was the recent adoption of an AC increase of 20% at the WHA in May 2023, justifiably interpreted as substantial trust by Member States in WHO to take necessary action to enhance impact at country level. The DG subsequently announced that the first USD100 million in increased AC income would be channelled to country offices to strengthen their delivery capacity. This can be seen as an important, yet initially comparatively small step towards increasing flexibility and capacity. It is uncertain to what extent and how proactively fundraising takes place at country level to identify local resources to help address funding gaps, yet it appears to be limited and WRs should be capacitated and encouraged to engage with local donors in that regard.

The COVID-19 pandemic has not only provided strong incentives for donors to increase their funding, but also demonstrated the need for sustainable financing. Hence a Member State-led Working Group on Sustainable Financing was established by an EB decision in 2021. That working group makes suggestions on how WHO should be funded sustainably, and who should provide the funding. In addition, a new investment case (IC 2.0) was developed to attract funding for the Programme Budget for 2022-23.

1.4.5. Measures are in place to encourage donors to channel their earmarked funds towards WHO's priority areas, so far with varying degrees of success. Regular Financing Dialogues take place with key donors, to discuss WHO and donor priorities, and to encourage donors to decrease earmarking overall, and if needed, channel donor funding towards underfunded WHO priorities. Reportedly this has been successful in some but not all instances.

The Contributor Engagement System, a system that was launched in 2021-22 across all three levels, has allowed WHO to track in real time future voluntary funding to the Programme budget. It is intended to allow WHO to better manage resource mobilisation and its grant management process.

The WHA in May 2023 decided that a replenishment mechanism would be created as part of the work to improve the sustainable financing of WHO, and to proceed with a first WHO investment round (its preferred term) for 2025-28 in the second half of 2024 – a strong and encouraging signal to creative incentives and opportunities for longer term funding (beyond the usual biennial cycle).

In interviews with staff, a common concern among managers was budget shortfalls, both from managers of technical areas and some cross-cutting areas. While the financing dialogue with donors (Member States and others) is centrally organised and managed, it is obvious that at the budget centre level (department or programme) individual negotiations, often with the very same donors, take place to ensure earmarking of funding to these technical programmes. These dual or triple negotiations with the same donors may be somewhat counterproductive, encourage donors to use earmarking to ensure their priorities receive sufficient resources, to the detriment of the overall allocative efficiency of the budget. This suggests some misalignment of incentives within WHO and the need for streamlined communication internally and vis-a-vis donors.
Overall, the measures taken at executive level are commendable, yet certain donors themselves appear to have significant barriers to unearmarked large portions of their extrabudgetary contributions, thus

contributing to budget distortions and misalignment of incentives within WHO.	
1.4.6. Some evidence exists that WHO is attracting country office funding through UN's pooled funding modality, yet it is unclear whether overall this amounts to 15% of total country office funding. WHO receives voluntary non-core (earmarked) contributions from UN inter-agency pooled funds, e.g. USD 133 million in 2021. In addition, in 2021-22, two thirds of WHO country offices applied to the UN Multi-Partner Trust Fund Office and 81% of these successfully received funds.	
MI 1.4 Evidence confidence	**High confidence**

KPI 2: Structures and mechanisms in place and applied to support the implementation of global frameworks for crosscutting issues at all levels, in line with the 2030 Sustainable Development Agenda principles	**KPI score**
Satisfactory	**2.55**
MI 2.1 Corporate/sectoral and country strategies respond to and/or reflect the intended results of normative frameworks for gender equality and women's empowerment	**Score**
Overall MI rating	**Satisfactory**
Overall MI score	**3.00**
Element 1: Dedicated policy statement on gender equality available and showing evidence of application	3
Element 2: Gender equality indicators and targets fully integrated into the organisation's strategic plan and corporate objectives	3
Element 3: Accountability systems (including corporate reporting and evaluation) reflect gender equality indicators and targets	4
Element 4: Gender equality screening checklists or similar tools inform the design for all new interventions	3
Element 5: Human and financial resources are available to address gender equality issues	3
Element 6: Capacity development of staff on gender is underway or has been conducted	2
MI 2.1 Analysis	**Evidence documents**
2.1.1. A dedicated Gender Policy statement is available, and there is evidence of its application. WHO has identified gender equality as a strategic priority that underpins their global objectives. The Strategy for integrating gender analysis and action into WHO's work (2017) presented WHO's policy was followed by a new Gender Parity policy (2023-26), effective 1 March 2023, focusing on internal gender parity within WHO. The key changes envisaged by the new policy include: the establishment of new targets per professional level; an intersectional approach to highlight diversity factors; temporary measures to be applied by hiring managers; regular reporting on the compact for senior managers to strengthen accountability; higher reliance on disaggregated data for gender; nationalities and disability reporting supported by human resources systems at each stage of a selection; and a corresponding Implementation Plan for the next two years. Reporting against the new Policy and Implementation Plan will begin with reports including data from 2023 onwards. WHO's 13th General Programme of Work (2019-25) recognises the need to promote gender equality and to mainstream gender in all of the organisation's work, reflected also in successive programme budgets, clearly underpinning a mainstreaming approach. WHO regularly reports on the United Nations system-wide Action Plan (UN-SWAP) for Mainstreaming Gender Equality and the Empowerment of Women to foster accountability and monitor progress towards gender equality, on the required 17 indicators. An evaluation commissioned by the WHO Evaluation Office (EVL) in 2021 pointed out that "while there have been continuous efforts to reach gender parity in staffing and equitable geographical representation in the WHO workforce, more generally, key issues in terms of promoting inclusion and diversity in the organisational culture were not addressed (including discrimination related to gender, sexual orientation and gender identity)". In response to this evaluation WHO embarked on the development of a Roadmap on Advancing Gender Equality, Human Rights and Health Equity 2023-30. The Roadmap was launched in	6 14 16 28 50 71 72 98 99 143 161 228 352 355 362 443 472 481 628 629 630 631 633 634

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Regional offices also have regional strategies for integrating gender analysis and actions into their work, e.g. WHO Regional Office for the Americas (AMRO) and WHO Regional Office for Europe (EURO). As a concrete example, EURO, has stated that they aim to achieve greater impact on health and reduce inequities by a) collecting and using quantitative and qualitative sex disaggregated data; b) understanding and analysing the differences (gender analysis); c) developing gender responsive policies and interventions.

To ensure inclusion of gender equality considerations into the development of the Country Cooperation Strategies (CCS), WHO updated the CCS guide accordingly in 2020 (a further revision of the CCS guide was ongoing in 2023). However, according to the report of the "Evaluation of integration of gender, equity and human rights in the work of WHO" in late 2021, a "great majority of the CCS did not systematically integrate gender, equity, and human rights considerations", which obviously constitutes a major gap in the application of the global policy framework.

The Gender Equality, Human Rights, Health Equity and Diversity, Equity and Inclusion (GRE-DEI) Department is responsible to catalyse, support and coordinate the mainstreaming of gender, equity and human rights approaches in health at all levels of WHO in coordination with the Regional Offices. There are several guidance documents available to support the operationalisation of WHO's gender strategy including technical documents, guidelines and manuals on how to integrate gender analysis and mainstreaming into WHO's programming, and how to undertake barrier assessments. Several of these documents have not been updated within the last five years, and certainly do not yet reflect the key changes envisaged by the new global Roadmap under development, however reviews for key resources are planned for the current and next biennia.

The "Addressing violence against women in health and multisectoral policies" (2021) report presents "an assessment of the extent to which countries' policies align with WHO's recommendations, evidence-based strategies, and with international norms and standards related to human rights and gender equality". The report also addresses WHO's response measures to violence against women during the pandemic.

In terms of achieving gender parity in the WHO work force, the DG has demonstrated commitment by initially appointing a fully balanced senior leadership team (DDG/ADG). While overall parity has been achieved across WHO, progress has been modest in some key areas. As at 31 July 2023, 36.8% of heads of country offices were women, a very small increase compared with December 2022 of 36.3%. The 2017 figure was 35%. As at July 2023, 36.8% of the candidates on the WHO Representative roster are female. Measures are being taken to overcome this; for the 2023 selection process, additional outreach was conducted to high-potential female staff. Women accounted for about 36% at P6, D1 and D2 across the organisation, which represents only a 4% increase in a five-year period; at P4 level and above, women represent 44% falling slightly short of the 45% target established in 2017. WHO (as of late 2023) aims to increase women's representation at these levels by 3% per year. KPIS for gender parity now form part of the country KPIs for achievement by Regional Directors and WRs.

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2.1.2. **GER indicators and targets have been incorporated into the corporate results architecture and its frameworks**. The recently issued (March 2023) WHO's gender policy and implementation plan include updated targets as well as actions to achieve them (including temporary recruitment measures, reliance on HR Business Intelligence tool for monitoring and formulated actions and accountability mechanisms for achieving parity by 2026).

Within the GPW 13 and successive corresponding programme budgets (PB), gender is considered at the outcome level (Outcome 1.1) related to corporate aspects of GER, yet not specifically and exclusively on gender and women's empowerment. At the output level, there is consideration of ensuring people-centred health services (output 4.2.6.).

WHO's GPW13 Output Scorecard consists of 6 dimensions, GER being one of them. In an effort to achieve impactful integration of GER, gender has been incorporated into the organisation's scorecard. The GER dimension contains a criterion and scoring scale for the following attributes: i) gender equality and empowerment analysis; ii) Reducing inequities; iii) meaningful participation and; iv) increasing inclusion in the health sector for persons with disabilities. GER criterion is also included in other dimensions to ensure reporting by the whole of the organisation. Additionally, WHO has adopted gender and human rights markers

in line with UN recommendations which has required all departments to reflect on their workplan's effective contribution to gender equality and human rights. This would allow the organisation to assess financial expenditure in this area.

WHO, in its report to the EB in 2023, committed to aim to have at least one high-level transformative outcome indicator on gender equality and women's empowerment in the next general programme of work in 2026, to showcase its commitment to fast-tracking progress towards gender equality. UNSWAP scores provide evidence of the incorporation into most indicators.

From interviews and surveys, stakeholders hold mixed opinions to what extent and whether gender is sufficiently mainstreamed in operational reporting.

2.1.3. Accountability systems reflect gender equality indicators and targets and WHO regularly reports on 17 indicators of the UN-SWAP framework. An evaluation of the integration of GER work in WHO was conducted. Integrated audits conducted in 2022 included GER on the work of UN entities like WHO. There is also evidence that WHO's management has taken stock of corporate reporting through the Accountability Overview reports released by the DG in 2022 and 2023.

WHO regularly reports on status and progress on 17 indicators within the UN-SWAP 2.0 framework focusing on institutional processes and actions at the individual entity level, as a common method to advance towards the goals of gender equality and women's empowerment. Progress in each United Nations entity is monitored against a progressive sliding scale as part of each performance indicator. In 2022, WHO increased its score on six of the performance indicators and reached the highest score on an additional two indicators. The Accountability Overview progress report (2023) presents a table showing WHO's performance in the UN-SWAP 2.0. The table tracks performance indicators yearly from 2018 to 2022.

The United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) also conduct yearly reviews and provide feedback on the performance of UN entities, where WHO was commended for positive efforts made towards integrating and mainstreaming gender equality. However, some stakeholders have stated that opportunities for optimisation, such as those arising through UNSWAP evaluations, have not been sufficiently taken up. WHO's performance on UN-SWAP has improved in 2022 and in 2023. In 2021, it went from meeting or exceeding 44% of its UN-SWAP requirements to further exceeding its indicators by 63% in 2022 and now 81% in 2023.
Additional aspects:

- WHO headquarters set up a global network on accountability-transparency in health systems with participation of UN agencies and civil society and coordinated development of a chapter on gender and equity in the 2019 UHC Monitoring Report.
- Each year, UN-WOMEN reviews and provides feedback on the performance of United Nations entities and publicises the summary to the United Nations system and public as a matter of transparency and accountability. UN-WOMEN has commended WHO for several achievements, including the UN-SWAP clinics and its rigorous UN-SWAP reporting, enhanced organisational culture and the development of the output scorecard related to gender, human rights and health equity mainstreaming.
- "To foster compliance with the requirements of the UN-SWAP on Gender Equality and the Empowerment of Women, integrated audits conducted in 2022 include specific tests in relation to the integration of equity, gender, human rights, and social determinants into the work of the audited entity. In 2022, the Office noted that general awareness was growing and that efforts were made to mainstream gender in operations".
- An evaluation of the integration of gender, equity and human rights in the work of the organisation (commissioned by the WHO Evaluation Office) was conducted with the overall objective of assessing the extent to which gender, equity and human rights considerations have been meaningfully integrated into the work of WHO at all levels of the organisation, how effective such integration has been in contributing to health outcomes at country level, and how optimally the organisation has operated (both internally and with key partners) towards the achievement of its objectives in this area. The Evaluation identified several areas that required considerable strengthening. WHO subsequently prepared a management response, leading to a set of action points that have been or are now being implemented.
- The PB for 2020-21 implementation and mid-term review provide an example of how GER has been measured in the SEA Region output scorecard.
- Based on Every Woman Every Child's (EWEC) Indicator and Monitoring Framework for the Global

Strategy on MCAH, gender equality is integrated into the strategic plan, targets and indicators.
- Stakeholders agree that gender considerations are routinely identified in the design of strategies operations and opportunities for optimising the organisation's gender framework.

2.1.4. Guidelines development in WHO now requires the systematic consideration of gender, equity and human rights. The Guideline Review Committee (GRC) systematically reviews that this criterion is met prior to approving any guideline. WHO has a Gender Equality Marker (GEM) that tracks the extent to which products/services contribute qualitatively to GER and disability and the financial expenditure towards these aims. The RESPECT framework provides guidance on how policymakers can integrate gender considerations into their programming. The implementation guide consists of materials that can be used to develop strategy summaries in programmes, such as a design and implementation checklist.

2.1.5. Gender is considered in Outcome 1.1 of the programme budget; thus, funding is made available to address issues of gender equality in the base segment of the PB. Overall, human and financial resources appear insufficient to comprehensively and proactively address gender equality issues.

The evaluation of the integration of gender, equity and human rights report in 2021 noted that while senior leadership was supportive, expertise existed and was recognised and utilised by Ministries of Health, "hindering factors included low and decreasing levels of investment and insufficient Human Resources dedicated to this area" and that "GER was not adequately supported by flexible funding and sufficient Human Resources at the three levels of the organisation".

In 2022, according to the Accountability report of 2023, important preparatory work was carried out by the Gender, Diversity, Equity and Human Rights Department and the Department of Planning, Resource Coordination and Performance Monitoring towards implementing a gender marker to improve tracking of expenditure on, and quality of, gender-related activities. A resource tracking marker will be integrated into the new business management system and a new marker was rolled out in 2023.

Within the UN-SWAP reporting, WHO advanced its rating from "approaching" to "meeting the requirement" for the Performance Indicator on gender architecture, following several important actions: Importantly, the Gender, Diversity, Equity and Human Rights team was upgraded to a fully-fledged department in the Office of the Director-General, highlighting its priority on the gender mainstreaming agenda. In 2022-23 interim staff were recruited on loan to cover the position of Director of the Department (D2), and to head partner engagement and programme management. In addition, three unit heads were recruited formally to drive the work on gender equality, human rights, and health equity; a senior P5 position for diversity, equity, and inclusion has also been raised and is currently in the internal mobility repository. In 2022-2023, two calls for applications for the D2 position were made, the post proving hard to fill.

Some technical Departments, such as the Polio Programme do include specific budget lines for gender mainstreaming as a priority area.

Over the five years of this MOPAN assessment period, important leadership and resource gaps and disruptions have been noted, documented and reported, despite some progress in certain aspects. From 2022 onwards, important commitments have been expressed and initial steps taken by senior leadership towards strengthening both the allocation and tracking of financial, as well as enhancing the human resource base to elevate gender mainstreaming towards achieving gender equality. These include the increasing staffing and direct oversight of the Gender Equality, Human Rights, Health Equity and Diversity, Equity and Inclusion (GRE-DEI) Department in the DG's office, support to and initial work on introducing a gender resource tracking marker, and the expression to "progressively increase financial resources for GER". WHO report that during 2022-23 the DG has strengthened the work of the department through allotment of core funding and human resources supplemented by additional staff loans. Furthermore, the global network of gender equality, human rights and health equity focal points was re-invigorated in 2022, ensuring appointed staff are at P4 level or above, allocating 20% of their time to integrating gender, equity and human rights into their programme's work and having these commitments outlined in their annual work plans and performance evaluations. WHO is in the process of building similar capacity in country offices. Noteworthy also the provision of oversight in the DG's office the "prevention of, and response to, sexual exploitation and abuse and sexual harassment" and the "diversity, equity, and inclusion initiative".

2.1.6. Despite the lack of a capacity development plan, WHO offers optional capacity-building opportunities and online learning. As part of the capacity-building plan (currently under development) and

in collaboration with the WHO Academy, WHO reportedly intends to develop a dedicated capacity-building course on gender, human rights and health equity. It currently has a WHO does an iLearn learning series on gender, equity and human rights. Furthermore, the gender policy commits to introducing a mandatory training on gender, rights and equity in the organisation (to also fulfil the requirement of the UN-SWAP performance indicator). Currently there is compulsory training on PSEAH, which does include sessions that address gender issues, and we note there is some gender training in induction. As a smaller, yet relevant initiative, in 2022, collaborative mentoring initiatives continued to take place through the International Training Centre Mentoring process, where ten WHO staff members joined the Training Centre's mentoring programme for women as mentors or mentees. This programme aims to increase gender parity and empower women at all stages of their careers through one-to-one mentoring, mentoring circles and various learning events and workshops offered to mentees. Noteworthy are efforts at regional level to intensify regional diversity, equity and inclusion: for example, in WHO Regional Office for Africa (AFRO), an exclusive female staff cohort of the AFRO Pathways to Leadership Programme was launched towards the end of 2021, increasing the percentage of female staff equipped with the requisite leadership competencies from 38% in 2019 to 48% in 2022. The subsequent launch of the WHO AFRO Women in Leadership Speaker Series further complemented these leadership development efforts. A draft DEI strategy was under development at the time of the MOPAN review.	
MI 2.1 Evidence confidence	**High confidence**

MI 2.2: Corporate/sectoral and country strategies respond to and/or reflect the intended results of normative frameworks for environmental sustainability and climate change	**Score**
Overall MI rating	**Unsatisfactory**
Overall MI score	**2.17**
Element 1: Dedicated policy statement on environmental sustainability and climate change available and showing evidence of application	2
Element 2: Environmental sustainability and climate change indicators and targets fully integrated into the organisation's strategic plan and corporate objectives	3
Element 3: Accountability systems (including corporate reporting and evaluation) reflect environmental sustainability and climate change indicators and targets	2
Element 4: Environmental screening checklists or similar tools inform design for all new interventions	2
Element 5: Human and financial resources are available to address environmental sustainability and climate change issues	2
Element 6: Capacity development of staff on environmental sustainability and climate change is underway or has been conducted	2
MI 2.2 Analysis	**Evidence documents**
2.2.1. WHO has a Global Strategy on Health, Environment and Climate Change that provides the organisation's vision on how the world and its health communities should respond to environmental health risks and challenges until 2030. The WHO Environmental and Social Safeguards Framework (ESSF) was launched during 2023. **T**he evidence on application, particularly at country level, remains moderate. The Strategy was developed following an extensive consultation process and was presented to the WHA in 2019, and following comments and further consultation, finalised and published in 2020. The document is consistent with and amplifies the vision and directions of the GPW13, it sets out an integrated approach covering all relevant environmental determinants and provides the framework for the transformation needed to improve lives and well-being through healthy environments. It proposes 6 strategic objectives which include focusing on primary prevention, on the central role of health sector leadership, on cross-sectoral action, and monitoring progress towards the SDGs. Despite the extensive and excellent strategic leadership by WHO and engagement and consultation with partners and stakeholders, leading to comprehensive, forward looking, and interconnected strategic documents, the evidence on application, particularly at country level, remains somewhat patchy. Feedback from various stakeholders shows that although the global strategy on climate change exists, its implementation remains unclear, that the strategy is not implemented as priority, and that WHO has not	15 77 79 120 121 207 208 218 240 284 361 440 446 650

followed up by allocating sufficient resources to allow full-scale implementation, specifically at country level.

WHO also has a Water, Sanitation and Hygiene Strategy (WASH) 2018-25, and a supplement "Addressing Climate Change" was issued in 2023, with the intent to inform future strategies and action in the area of climate, WASH and health, and addresses the role of various stakeholders, including other UN and collaborative entities, and national partners. A central element is the building of climate-resilient WASH in health care facilities. The supplement contains a comprehensive annex listing an impressive wealth of relevant guidelines, technical manuals, and training materials, and toolkits on climate change, WASH and health.

Salient examples of relevant and strategic additional documents are a recently published comprehensive "Framework for the quantification and economic valuation of health outcomes originating from health and non-health climate change mitigation and adaptation action" (2023); and guidance on building climate-resilient and environmentally sustainable health facilities, among others.

As an example of Regional Adaptation and Response to rapidly emerging needs, WHO Regional Office for South-East Asia (SEARO) developed A Regional Plan of Action, with a 10-year set of action to implement the Global Strategy on Health, Environment and Climate Change in the countries of the SEARO Region.

2.2.2. WHO has clearly aligned its Global strategy on health, environment and climate change with the SDGs and lays out how action in this area would contribute to achieving the SDGs and indicators. In addition, the Strategy presents 12 goals and corresponding targets to concretely link with activities and targets in the GPW13 and corresponding targets. These range from achieving UHC, air pollution, climate change, WASH, to a climate-resilient health work force and health care settings, to managing environmental health services in Emergencies. Climate change and environmental sustainability are linked to relevant outputs in PB 2022-23.

The Universal Health Coverage Partnership (UHCP) Annual Report (2020) provides some examples of how climate change has been addressed in its operations in SEARO, WHO Regional Office for the Western Pacific (WPRO) and WHO Regional Office for the Americas (AMRO). Although the output scorecard explicitly measures for GER, it does not measure for environmental outputs across all levels of the organisation.

2.2.3. Climate change and environmental sustainability is reflected on a limited scale in WHO's result architecture and happens primarily at the output level. Progress on the implementation of the strategy is required regularly to its governing bodies. WHO has made efforts to align some of its work specifically in climate-vulnerable regions like WPRO, SEARO and the Caribbean (via AMRO) with their climate resilience priorities: Yet, overall, there is insufficient evidence of WHO integrating climate change activities in its reporting frameworks and global operations, and corporate evaluations. While the EVL has commissioned an evaluation on GER, to date no evaluation on climate change and environmental sustainability has been carried out.

2.2.4. Although the output scorecard measures for GER, until 2022, it did not measure for environmental outputs across all levels of the organisation. In June 2022, WHO developed health and environment scorecards which aimed to provide highlight some of the major environmental health issues at country level. However, these scorecards are limited by the lack of data reported on environmental threats like air pollution, WASH, climate change, exposure to chemicals, radiation and occupational health. Overall, there was insufficient evidence on the extent to which sector and thematic strategies implement and measure climate change action and progress and whether a tool (e.g., a checklist) exists that needs to inform the design of all new interventions.

Other tools do exist, yet only inform certain aspects of climate change: e.g., a checklist to assess climate change vulnerability in health care facilities launched in 2021); the supplement report to the WHO WASH strategy 2018-23 contains a draft Driving Force, Pressure, State, Exposure, Effect, Action (DPSEEA) Framework for understanding the broader context and causal links between climate change, WASH and health impact.

Progress on the implementation of the SEARO Regional Plan of Action is monitored against indicators defined for each strategic action and targets and incorporate those of relevant SDGs.

2.2.5. Climate change Is a unit within the ECH department with 5-6 professional staff. ECH has a mandate

for advocacy and partnerships so there is work being done which includes interaction on climate negotiations. Designated staff work on monitoring, evidence, country support and environmental safeguards. Within each Regional Office there is designated staff working on climate change activities. The budget for the headquarters unit is, reportedly, around USD 3 million per year (all voluntary contributions) which includes salary costs. This is clearly insufficient to advance a coherent agenda across key programmes technical areas. There is no data available to determine the level of resources allocated to climate change and environmental sustainability at country level; anecdotally, however, it appears to be quite limited. Overall, from the limited evidence available to the assessment team, and from feedback in the staff and partner interviews, it appears that lack of resources, both human and financial, hampers wider implementation of the climate change agenda, and quite severely undermines credibility, specifically when it comes to appropriate mainstreaming across the organisation, the provision of technical support and implementation at country level. **2.2.6. There is limited evidence about the capacity development of staff on environmental sustainability and climate change, yet it is obvious that this is not happening routinely and frequently and is also not included in the list of WHO's mandatory trainings.** This may be linked to the already limited resources allocated to environmental sustainability and climate change issues, and to the broader issues linked to the lack of an inclusive and comprehensive strategic capacity building plan within WHO.	
MI 2.2 Evidence confidence	**High confidence**

MI 2.3: Corporate/sectoral and country strategies respond to and/or reflect the intended results of normative frameworks for human rights including protection of vulnerable people (those at risk of being "left behind")	**Score**
Overall MI rating	**Unsatisfactory**
Overall MI score	**2.50**
Element 1: Dedicated policy statement on human rights available and showing evidence of application	2
Element 2: Human rights indicators and targets fully integrated into the organisation's strategic plan and corporate objectives	3
Element 3: Accountability systems (including corporate reporting and evaluation) reflect human rights indicators and targets	3
Element 4: Human rights screening checklists or similar tools inform design for all new interventions	3
Element 5: Human and financial resources are available to address human rights issues	2
Element 6: Capacity development of staff on human rights is underway or has been conducted	2
MI 2.3 Analysis	**Evidence documents**
2.3.1. WHO's 13th General Programme of Work (2019-25) recognises the need to promote human rights, a rights-based approach to programming, and stipulates the mainstreaming of human rights in all of the organisation's work, reflected also in successive programme budgets (PB). There appear to be major gaps in the application, especially at country level. WHO was, at the time of the MOPAN review, developing a Roadmap for the WHO Secretariat on Advancing Gender Equality, Human Rights and Health Equity 2023-30 (published late 2023). WHO's operational guidance note on the development of the PB 2024-25 contains information about the four new markers: gender equality, and human rights, health equity and disability inclusion including how to ensure these priorities are integrated into programmatic plans. There are multiple documents where WHO has made clear statements on its commitment to upholding human rights standards and principles in its work, such as: Code of Ethics and Professional Conduct (2017) (a further revision was published in September 2023); Regional Strategies and Reports (e.g., Pan American Health Organization [PAHO] Quintennial Report; AFRO Regional Strategy for Health security and Emergencies; AFRO annual report); and thematic strategies e.g., the health sector strategies on HIV, viral Hepatitis and STI, TB, etc. The "Evaluation of the integration of gender, equity and human rights in the work of WHO" from 2021	6 14 59 76 112 114 145 187 228 285 337 352 355 356 362 472 629 641 642

concludes that "while human rights are well captured in policy documents, when it comes to actual strategies and operational plans, there is less consistency". 643 644 645

To ensure inclusion of human rights programming and considerations at country level into the development of the Country Cooperation Strategies (CCS), WHO updated the CCS guide accordingly in 2020 (a further revision was underway in 2023). However, according to the evaluation report, a "great majority of the CCS did not systematically integrate gender, equity, and human rights considerations", which obviously constitutes a major gap in the application of the global policy framework. 647 666

WHO reports that it has seen a steady increase in GRE integration in its work in countries. The 2023 output scorecard analysis shows that 105 countries are implementing at least two WHO-supported activities to integrate gender, equity and human rights in their health policies and programmes – up from 58 in 2021. It reports that, in addition to strengthening policies and capacity, WHO has strengthened the integration of GRE in its operational planning and reporting processes in 2023. WHO introduced markers for gender equality (mandatory), human rights, and disability inclusion to better plan, assess, and mobilize resources, and trace and enhance the contribution of related WHO interventions, actions, products, and services. WHO has also developed an annex to the operational planning guidance on GRE and updated the output scorecard questions to align with the GRE Roadmap and enhance questions based on user feedback. As yet there is insufficient evidence to report that these new approaches are being implemented across the organisation to reach the threshold of this element yet being implemented in the majority of cases so the score remains at a 2.

2.3.2. GER indicators and targets have been incorporated into the corporate results architecture and its frameworks. Within the GPW13 and successive corresponding programme budgets (PB), the area of human rights is considered at the outcome level (Outcome 1.1) related to corporate aspects of GER. At the output level there are outputs on human rights and "leave no-one behind". WHO's GPW13 Output Scorecard consists of six dimensions, GER being one of them. In an effort to achieve impactful integration, cross-cutting areas like GER, have been incorporated into the organisation's scorecard. Human Rights has a Human Rights Marker (HRM). The GER dimension contains a criterion and scoring scale for the following attributes: i) gender equality and empowerment; ii) Reducing inequities; iii) Meaningful participation and iv) increasing inclusion in the health sector for persons with disabilities. The WHO Output Assessment Scores for the dimension of gender, equity, human rights and disability are reflected in WHO Results Reports and the annual PB reports.

2.3.3. Integrated audits conducted in 2022 included GER in the work of UN entities like WHO. There is evidence that WHO's management has taken stock of corporate reporting through the Accountability Overview reports released by the DG in 2022 and 2023. This includes reporting in the Mid Term Report (MTR) and through the Output Scorecard on WHO's work to advance gender, human rights and health equity. It also includes the introduction of four Markers in WHO's planning process—for gender equality, human rights, health equity and disability inclusion. WHO has also established a Steering Committee in 2023 to oversee WHO's work to advance gender, rights and equity that reports to the DPMs and GPG, and the Roadmap has a monitoring framework with indicators, baselines and targets. A Human Rights Marker was launched in end 2023.

2.3.4. Guidelines development in WHO requires the systematic consideration of gender, equity and human rights. The Guidelines Review Committee normally assesses this criterion prior to approving any new guideline. For other (non-GRC reviewed) interventions no clear evidence was available to assess to what extent human rights considerations have been consistently incorporated.

WHO has a Gender Equality Marker, a Human Rights Marker and a Disability Marker (and is in the process of developing an Equity Marker) that track the extent to which products/services contribute qualitatively to GER and disability. A range of tools and resources exist that support the systematic consideration of GER in programme development such as, the Health Equity Assessment. The Health Equity Assessment Toolkit is a free and open-source software application that facilitates the assessment of within-country health inequalities, i.e., differences in health that exist between different population subgroups within a country. Through innovative and interactive data visualisations, the toolkit makes it easy to analyse and communicate data about health inequalities. Disaggregated data and summary measures are visualised in a variety of graphs, maps and tables that can be customised according to your needs. Results can be exported to

communicate findings to different audiences and inform evidence-based decision making in countries.

2.3.5. The evaluation of the integration of gender, equity and human rights report in 2021 noted that despite progress "hindering factors included low and decreasing levels of investment and insufficient human resources dedicated to this area, and that GER was not adequately supported by flexible funding and sufficient Human Resources at the three levels of the organisation". Resource tracking for expenditures related to gender, equity and human rights activities remain novel with the roll out of the markers only occurring in late 2023 . Current data is available on resources expended by the Gender Equality, Human Rights, Health Equity and Diversity, Equity and Inclusion Department (GRE-DEI), but there is little visibility on GER related spending across the whole of the organisation. WHO report that this data "will emerge progressively with the institutionalisation of the markers". Currently, however, feedback from interviews clearly points to under-resourcing of GER in WHO at all levels.

According to the evaluation report, resources for conducting gender, equity and human rights-related activities have been lacking at the country office level, which is also reflected in the fact that current CCSs integrate these dimensions to a varying extent. This has hindered the capacity of WHO country offices to conduct impactful activities, such as to support the piloting of technical guidance produced on gender, equity and human rights and conduct coordination, capacity development and advocacy work. The assessment team was however informed that new CCS guidance would be launched in late 2023 and that GER would be adequately reflected.

The DG, in 2022, took important steps to increase visibility and capacity of the former Gender, Equity and Human Rights team, by upgrading it to a fully-fledged Gender Equality, Human Rights, Health Equity and Diversity, Equity and Inclusion (GRE-DEI) department in the Office of the Director-General. The department's staffing consists of a D2 post, three additional senior experts at P5 level, and the still-vacant post for the DEI Unit Head. In the meantime, the DG has strengthened the work of the department through allotment of core funding and human resources supplemented by three staff loans on critical posts. Furthermore, the global network of gender equality, human rights and health equity focal points was re-invigorated in 2022, ensuring appointed staff are at P4 level or above, allocating 20% of their time to integrating gender, equity and human rights into their programme's work and having these commitments outlined in their annual work plans and performance evaluations.

In terms of GER staff, at headquarters, the gender, equity and human rights architecture is composed of the GER Unit (now upgraded to a department for Departments of Gender, Rights and Equity - Diversity, Equity and Inclusion (GRE-DEI)) and designated focal persons in each department. At Regional level, at least one person is responsible for managing and coordinated the GER portfolio. Some regions have been able to recruit additional staff during 2023. At Country level, GER focal points are designated in most countries, yet often do not have 20% of their time designated to devote to GER work. In essence, the HQ Department and the Regional Focal points serve as the coordinating network across the organisation. Yet with differing set-ups and levels of institutional capacity among the regions and countries posing some challenges. There appear to be strong regional disparities and lack of clear roles and responsibilities at country level, although again the situation is highly variable from country to country. 53% of the survey respondents felt that the GER focal point position was not well placed at Country Office level to make the most positive impact possible. Regional and headquarters levels architecture was perceived better, although notably 36% of respondents had no opinion on the headquarters situation.

Over the five years of this MOPAN assessment period, important leadership and resource gaps and disruptions have been noted, documented and reported, despite some progress in certain aspects. It needs to be recognised that, specifically from 2022 onwards, commitments have been expressed and initial steps taken by senior leadership towards strengthening both the allocation and tracking of financial, as well as enhancing the human resource base to elevate GER work, and human rights. These include the increasing staffing and direct oversight of GEHR in the DG's office, support to and initial work on introducing resource tracking markers, and the expression to "progressively increase financial resources for GER". The assessment team was informed that a "Roadmap on Advancing Gender Equality, Human Rights and Health Equity 2023-2030" was in advanced stage of development, and is now being implemented. WHO reports (in 2024) that for the next biennium there is now be an increased assessed contributions to GRE department and Increased voluntary funding thanks to Canada, Germany, Switzerland

It is, for this assessment, too early to establish whether these commitments have been fully implemented

and already show impact.	
2.3.6. GER is not among WHO's list of 5 mandatory trainings, although there are two mandatory training courses specific to Preventing and Responding to Sexual Exploitation, Abuse and Harassment (PRSEAH)-. WHO's self-driven iLearn platform includes a module on SEAH as well as aspects of HR. There is however, a non-mandatory 3.5-hour e-learning series on equity, gender and human rights that aims to increase WHO staff competencies to develop and implement gender responsive, equity enhancing, and rights-based health programmes. The MOPAN team does not have information on utilisation of this optional GER training. Important capacity gaps have been repeatedly pointed out (by evaluations and reviews). In 2022 a GER capacity assessment of WHO staff was undertaken which identified capacity needs across the organization to support systematic action on GRE. In 2023 a capacity building plan was developed which will support the development of capacities of technical staff as well as focal points across all levels of the organization. The plan which includes a range of learning opportunities (from online self-paced courses, to mentoring) is based on experiences in capacitating WHO staff on GRE. MOPAN were also informed that a course was under development with the WHO Academy and Mentoring sessions, workshops with departments and regular on-line Help Desk are available. Given the plan has yet to be implemented, we are only able to score this as a 2 "element is partially implemented".	
MI 2.3 Evidence confidence Evidence confidence was assessed as "Medium" because evidence related to human rights including protection of vulnerable people is fragmented across multiple processes and mechanisms. As noted above, GER is not among WHO's mandatory training courses. Also, there were insufficient evaluations available to determine the extent in which WHO strategies respond to and/or reflect the intended results of normative frameworks for human rights.	**Medium confidence**

Operational management

Assets and capacities organised behind strategic direction and intended results, to ensure relevance, agility and accountability

KPI 3: The operating model and human and financial resources support relevance and agility	**KPI score**
Satisfactory	**2.68**
MI 3.1: Organisational structures and staffing ensure that human and financial resources are continuously aligned and adjusted to key functions	**Score**
Overall MI rating	**Satisfactory**
Overall MI score	**2.83**
Element 1: Organisational structure is aligned with, or being reorganised to, requirements set out in the current strategic plan	3
Element 2: Staffing is aligned with, or being reorganised to, requirements set out in the current strategic plan	2
Element 3: Resource allocations across functions are aligned to current organisational priorities and goals as set out in the current strategic plan	3
Element 4: Internal restructuring exercises have a clear purpose and intent, aligned to the priorities of the current Strategic Plan	3
Element 5: [UN] Engagement in supporting the resident coordinator systems through cost sharing and RC nominations	3
Element 6: [UN] Application of mutual recognition principles in key functional areas	3
MI 3.1 Analysis	**Evidence documents**
3.1.1. The overall structure of the organisation has been reorganised in line with the Triple Billion targets set out in GPW 13 (2018-23), which has now been extended to 2025 due to the interruption of progress due to the COVID-19 pandemic. Most Regional offices have also followed this structure, which is well documented in the Transformation document of 2018, with an emphasis on the country level. This is also	15 17 18 19

reflected in the redesigned format of the Programme Budged 2020-21 and 2022-23. The structural re-design conducted in 2018-19 at headquarters-level has three main objectives: a functional structure reflecting the new strategic direction of headquarters, focusing on global health goods, surge and technical assistance, global leadership and corporate services; a standard structure for increased accountability through a common set of management levels, titles and roles; and a flatter structure for increased agility that breaks down silos. WHO's Transformation Progress Report provides an overview of the clear roles and pillars that anchor its new, aligned, three-level operating model.

The Secretariat has centralised the enabling functions as part of the Transformation Agenda, such as dedicated teams for the WHE Programme with dual reporting lines to the Executive Director of the WHE Programme and the directors of enabling functions with common KPIs. COVID-19 revealed the value of having a health emergency programme embedded within WHO and in 2021, the Independent Oversight Advisory Committee for Health Emergencies (IOAC) recognised that WHO improved the decision-making process and internal communication across headquarters, the six regional offices and the 149 country offices.

3.1.2. Staffing is in the process of being aligned to the current strategic plan - GPW 13. The focus of GPW13 is to strengthen the work of WHO at country level, and through the transformation it was expected that the geographical distribution of WHO's workforce would be adjusted, and mobility would be aligned accordingly, however this has been delayed by the COVID-19 pandemic. Recent progress has been made through the ARG in defining CPCP. Regions are signing up to the CPCP in order to strengthen the work in countries, this needs to be continued. The work of the Health Emergency Department has been greatly expanded with the response to the COVID-19 pandemic and subsequent health emergencies in countries (including the war in Ukraine, Earthquakes in Syria and Turkey) many of the staff are employed at headquarters and sent to countries, there is also recognition that preparedness has to be adequate and requires adequate staffing. Many departments, regional and country offices have long standing staff vacancies, they need additional human resources to improve operations resulting in an increase in short-term and consultant contracts.

At the end of 2022, the total number of WHO staff was 8,983 (8,688 end of 2021). The percentage of staff at headquarters increased from 32.7% in December 2021 to 33.1% in December 2022; with a decrease in the percentage of staff employed at regional offices 24.1% in 2021 to 23.7% in 2022; and the percentage at country offices remained the same at 43.2%. Despite a modest increase in staff from the end of 2021 to the end of 2022, many departments and programmes within WHO are not fully staffed, having multiple vacant positions and delayed recruitment processes. Documentation suggests that the heavy workloads placed on overstretched staff are leading to burnout and a further loss of staff, also arising from a lack of career development pathways and talent retention policy. There has been a noted shift towards short- and medium-term contracts for technical experts, with an increase in the number of consultant arrangements and agreements for performance of work. 64 out of 152 country offices reported having vacancies that lasted more than one year due to lack of funding for an existing position and slow recruitment processes.

Although processes have improved, more is needed to align staffing and more carefully thought through plan and addressing contracts, delays in recruitment etc. The average time to recruit globally was 187 calendar days in both 2019 and 2020. In the first half of 2023, the average time to recruit across all Major Offices significantly improved to 114 calendar days, with a range of 17 to 245 days. The HR BI (Business Intelligence) dashboard was launched in early 2023, providing users with workforce data, new HR data analysis tools and HR performance measurement services. The first version of the external HR portal for Member States was rolled out in May 2023. In line with strengthening staffing in regions and countries, the DG has announced the long-awaited mobility policy, although the first phase is to be voluntary. This needs to be followed closely.

From the survey results over 65% agree that WHO has sufficient staff to deliver intended results, within or available to the countries where it operates. However, across the groups there is a substantial proportion of respondents that disagreed with the question (approximately 20% National government, approximately 20% implementing organisations). Highlighting the need for strengthening country offices. Commentary from respondents a national government level noted that the WHO does not have sufficient, competent, motivated stuff across all three levels. Their opinion was that the organisation relies mostly on short term contractors and Consultants which compromises it to deliver on its mandate, with Country offices being particularly negatively impacted and relying heavily on support from regions and headquarters. There was a particular challenge over staffing in the WHO Africa Region as it lags far behind and off track in meeting the Triple Billion Targets, with low indicators on non-communicable diseases (NCDs), under five mortality and maternal mortality among others. Misuse of contract types impacted by financial constraints is expected to

be addressed through implementation of the new contractual framework developed by HRT Human Resources and Talent Management (HRT).

3.1.3. The resources allocation across the Triple Billion is clearly defined in the successive programme budget documents, 2020-21 and 2022-23 with alignment to the organisational goals and priorities. The bottom-up approach allows countries to set out their priorities. The Resource Allocation Committee (RAC), composed of both HQ and Regional Offices, jointly decide on allocations throughout the biennium. In the 2022-23 biennium, 46% of the total budget was allocated to country work, 51% of the total Base programmes budget segment to be allocated to country level and an incremental increase (1.6%) set for the next biennium. However, the third billion Healthy Populations receives <10% of the budget making it difficult to address these priorities (e.g., NCDs, climate change) adequately at all levels of the organisation. Resource allocation to programmes is mainly historical and effort is needed to change it. Polio and funding for Emergencies have their own allocation mechanisms. However, as mentioned elsewhere the high proportion of the budget that is earmarked through voluntary contributions acts to restrict the distribution of the budget according to overall objectives. The correlation between priority-setting at the country level and the bottom-up built budget for 2020-21 shows that the highest number of Member States rank outcomes 1.1 (Improved access to quality essential health services), 2.1 (Country health emergency preparedness strengthened) and 3.2 (Reduced risk factors through multisectoral approaches) as high priority. These outcomes have the highest budget within their respective priorities. While efforts are underway to more clearly align resource allocations, and decisions taken to do so for the next biennium, resources are were not fully aligned during the period of our review and the Health Population outcome was seen as underfunded. However, we have scored this element a three as the process defines how the alignment takes place.

3.1.4. There is clear purpose and intent with a recognition that the Transformation Agenda will take time to implement and will require a number of strategic decisions about how WHO deploys its human and financial resources, but will ultimately make WHO a more agile, adaptive and accountable organisation. The structural re-design conducted in 2018-19 at headquarters level has three main objectives: a functional structure reflecting the new strategic direction of the organisation, focusing on global health goods, surge and technical assistance, global leadership and corporate services; a standard structure for increased accountability through a common set of management levels, titles and roles; and a flatter structure for increased agility that breaks down silos. The restructuring of Regional Offices WHO Regional Office for the Eastern Mediterranean (EMRO), EURO, AFRO, in line with the strategic priorities of GPW13, has led to improved efficiency, accountability, collaboration, and effectiveness. An example from the interviews highlights the country focus “All proposals have to be linked now to country prioritisation. Now having a three-level facilitation process – prioritisation process which emerges from countries. Look at prioritisation in terms of technical support required. Serve as a basis to identify what new products needed – and if they might be already available in the pipeline. We are also asking all technical departments to allocate resources from the development part for the capacity and the implementation at the country level as well. So, they are targeting the 20 countries with a particular product, they should elevate sources and ensure that indication in consultation with the country’s for the uptake and implementation of that as well.”

The working group on sustainable financing and the recent agreement by Member States to increase their assessed contributions will facilitate strengthening of the country offices. It is work in progress.

3.1.5. There is engagement in supporting the resident coordinator systems through cost sharing and RC nominations. WHO engages proactively with UN country teams and 45% of WHO representatives supported the UNRC system by taking on the role of acting RC when required. WHO Representatives lead the health response in the country and thus are supporting the UNRCs. WHO participates in United Nations development system cost-sharing arrangements. United Nations agency shares are calculated through a three-step formula: (i) annual base fee; (ii) entity staff size and expenditures; and (iii) participation in the United Nations Sustainable Development Cooperation Frameworks at the country level. Based on this formula, the WHO allocation for 2022-23, including the Pan American Health Organization, amounted to USD 8,341,143 annually or 10.77% of the total share (an increase of USD 1,363,033 over the 2019-21 allocation period). This allocation makes WHO the third largest contributor (following the United Nations Secretariat and the United Nations Development Programme) to the United Nations development system.

3.1.6. Application of mutual recognition principles in key functional areas

WHO signed the statement on Mutual Recognition with the UN in 2018. WHO leads on the health sector response in the country especially in health emergencies as was evidenced during the COVID-19 pandemic.

The WR and team lead the UN country team for the covid response in all countries and in countries with other health emergencies.	
MI 3.1 Evidence confidence	**High confidence**

MI 3.2: Resource mobilisation efforts consistent with the core mandate and strategic priorities	**Score**
Overall MI rating	**Satisfactory**
Overall MI score	**3**
Element 1: Resource mobilisation strategy/case for support, with clear targets and monitoring and reporting, explicitly aligned to current strategic plan	3
Element 2: Resource mobilisation strategy/case for support reflects recognition of need to diversify the funding base	3
Element 3: Resource mobilisation strategy/case for support seeks multi-year funding within mandate and strategic priorities	3
Element 4: Resource mobilisation strategy/case for support prioritises the raising of domestic resources from partner countries/institutions, aligned to goals and objectives of the strategic plan/relevant country plan	2
Element 5: [UN] 1% levy systematically collected and passed on to the UN Secretariat	4
MI 3.2 Analysis	**Evidence documents**
3.2.1. As part of the Transformation Agenda, the DG called for a strengthened corporate approach to resource mobilisation in line with the organisational priorities set out in GPW13. The process for allocation and monitoring of resources spent is clearly set out in the programme budget documents, PB 2020-21 and 2022-23, with reports to Programme, Budget and Administration Committee (PBAC), the EB and WHA. WHO has an active process for mobilising resources reflected in setting up the WHO Foundation during the COVID-19 pandemic to facilitate acceptance of funds from public donations. The investment case developed to support the GPW 13 indicates hitting the Triple Billion targets would result in 30 million lives saved, 100 million healthy life-years improved and 2-4% economic growth in low- and middle-income countries over the implementation period of GPW 13. 24.4 million lives would be saved through universal health coverage (with a return on investment of USD 1.4 for every dollar spent); 1.5 million through better protection from health emergencies (with a return of USD 8.30 for every dollar spent); and 3.8 million through healthier populations (with returns ranging from USD 1.50 to USD 121 for every dollar spent). In phasing out support from the Global Polio Eradication Initiative, WHO has accelerated resource mobilisation efforts aligned with the priorities of GPW13 and is monitoring needs and gaps. Costs of essential functions in the regional and country office that support the Strategic Action Plan were integrated into the appropriate technical outputs and outcomes of the base segment of the Programme Budget 2022-23. It is expected that countries will continue use their base budgets in a similar way in 2024-25, with a particular emphasis on sustaining surveillance capacities. The WHO Resource Mobilization Strategy presented to the EB in 2019 aims to increase both flexibility and predictability of funding through a four-pillar approach. i) Established government partners: a tailored approach to grow, diversify or maintain funding ii) Philanthropic partners: building on effective partnerships and reach out to new philanthropies; iii) Funds, international development banks and multilaterals: maintaining funding from mature partnerships and developing funding streams from new sources and mechanisms; iv) Innovative financing and revenue-producing activities: exploring the potential in these. To implement this strategy WHO built up a network which included HQ and Regional Office (RO), and some move towards CO (especially in AFRO). It has a focus on different groups of donors, including sovereign donors, but also increased focus on foundations and philanthropies, banks and multilaterals and the private sector. WHO foundation was set up to support the funding from the latter group and avoid any undue influence. A key focus by the mid-term evaluation of the Strategic Action Plan is the development of a resource mobilisation strategy to generate predictable and flexible funding to sustain polio assets. The Secretariat is taking steps to action this, including through advocacy for predictable and flexible resources to fund the programme budget; articulation of the importance of sustaining polio assets within the WHO investment case and strategic dialogues; increasing the capacity of WHO regional and country offices for fundraising and	18 20 37 40 45 47 53 59 67 81 95 100 213 239 283 285 321 322 330 331 329 350 355 426 455 458 757

advocacy; and enhancing coordination with the Global Polio Eradication Initiative on resource mobilisation. The Secretariat is also continuing to advocate for domestic resources as the most feasible long-term strategy to sustain essential functions at the country level.

3.2.2. WHO recognises the need to diversify its funding sources and continues to seek flexible and predictable funding from Member States and non-state actors. This is reflected in the increased number of bilateral donors giving unearmarked funds, as well as through the pooled-fund and Contingency Fund for Emergencies (CFE) which were established during the COVID-19 pandemic. Also building on the CFE set up in 2015 and the collaboration with the UN Foundation (UNF). WHO has established a working group on sustainable financing and aims to move to a longer replenishment mode from the biennium cycle. The resource mobilisation strategy has included the various funding which can be solicited (government partners, philanthropic partners, international banks and multilaterals, innovative financing. The FENSA framework ensures that funding received is in line with organisational principles. The Working Group on Sustainable Financing recommends 6 principles to guide a replenishment mechanism: 1) it is member state-driven, approved by the Health Assembly and open to all donors who comply with FENSA. Strategy is based on the GPW and includes a target funding envelope and general timeline. 2) the mechanism addresses the need for flexibility and accountability and transparency for results. 3) mechanism ensures efficiency and no competition between parts of the organisation by ensuring equitable allocation of resources and reducing high transaction costs associated with administering grants and reporting. 4) mechanism prioritises the financing of the needs (as defined by WHO governing bodies) of the base budget. 5) mechanism and replenishment timeline align with global health architecture and avoids competition with other global actors. 6) mechanism aligns with resolutions of the Health Assembly. To help make financing more predictable in the medium term, it's proposed that the GPW14 and first investment round cover the period 2025-28. GPW14 structure, objectives and outcomes should be developed in close consultation with Member States and should have a clear narrative of work with a results structure.

3.2.3. Resource mobilisation strategy/case for support seeks multi-year funding within mandate and strategic priorities. The WHO Resource Mobilization Strategy aims to increase both the quantity of funding and improve the quality of funding with a view to increased flexibility and predictability, this encourages multi/year funding linked to the timeline of the GPW, as well as unearmarked funding. The status of collection of assessed contributions as of 31 December 2022 provides an account of the status of collection of assessed contributions from Member States, as well as their outstanding balances in 2022. WHO encourages multi-year funding commitments within its resource mobilisation strategy, not just the two-year programme budget horizon, multi-year commitments are carried forward from the biennial programme budget to the following programme budget cycle. An evaluation of WHO's RBM framework found that resource allocation processes at all levels hinder the effective implementation of the RBM approach. Biennial planning cycles are shorter than other UN agencies but attempts to lengthen the cycles are reportedly hindered by the reluctance of Member States to commit to longer cycles; short cycles hinder use of results and learning in planning, budgeting and prioritisation; financial and human resources are not being used to deliver maximum results. An increasing number of the bilateral donors are now giving flexible voluntary contributions. In future WHO hopes to move towards what Member States have termed "Investment Rounds"; closure to a replenishment model of funding.

3.2.4. The resource mobilisation strategy includes prioritisation of mobilising domestic resource. The assessed contributions of Member States come from their domestic resources and increasing these contributions demonstrate a commitment to the organisation. The WHO Working Group on Sustainable Financing recommended that Member States should increase their assessed contributions to 50% of WHO's base programme budget, this has been adopted with the first increment of 20% increase approved by the WHA76 in May 2023. Furthermore, the programme budget provides ways in which the Secretariat can increase fundraising at the country level, including raising awareness of the comparative advantage of WHO's work at the country level, and aligning with UN reform at country level. There are numerous examples including the India Country Office fills resource gaps by co-financing with the government and partnering with agencies that provide flexible funds. Country office resource mobilisation is aligned to strategic/relevant country plans but skewed because of how the overall strategic plan is financed. e.g., countries should spend more on NCDs, but the overall budget is small resulting in countries not having focal points, this is being addressed by the CPCP and needs to be monitored. Country funding is tracked on dashboards and publicly available. The interviewees at both headquarters and country level commented that some funds can only be raised at the country level or regional level, while some funds can only be raised at headquarters level. One interviewee noted they are actively involved in fund raising including for the pandemic fund, and there is support from the highest level of government – President and Prime Minister for investment in health.

3.2.5. WHO upholds its financial commitments to the UN, notably the contribution to the cost-sharing of the financing for the Resident Coordinator System and 1% coordination levy.

MI 3.2 Evidence confidence	High confidence

MI 3.3: Resource reallocation/programming decisions responsive to need can be made at a decentralised level	Score
Overall MI rating	**Unsatisfactory**
Overall MI score	**2.50**
Element 1: An organisation-wide policy or guidelines exist which describe the delegation of decision-making authorities at different levels of the organisation	3
Element 2: Policy/guidelines or other documents provide evidence of a sufficient level of decision-making autonomy available at the country level (or other decentralised level as appropriate) regarding resource reallocation/programming	3
Element 4: The organisation has made efforts to improve or sustain the delegation of decision-making on resource allocation/programming to the country or other relevant levels	2
MI 3.3 Analysis	**Evidence documents**
3.3.1. There is a policy on delegation of authority, at the different levels of the organisation, and this is set out in the WHO manual (including financial authority, recruitment of staff, procurement). DOAs and Letters of Representation exist for all Directors across the Organization and for WRs, with Specific DOAs are identified within the Health Emergency Programme. Following the recommendation of the ARG, in June 2023 the DG and five Regional Directors signed an increased DOA to WHO Representatives/heads of WHO country office, which have now been approved. In addition, KPIs to accompany the DOA have been published on the WHO member States page.	64 197 198 205 239 283 313 356
3.3.2. There is evidence that during the COVID-19 pandemic decision-making was further decentralised to country level and a greater flexibility in resource reallocation/programming. GPW aims to strengthen country capacity, particularly in relation to the effects of COVID-19. During the extension period, the Secretariat stated its intention to increase its support to countries to scale-up implementation of their public health priorities, establish sustainable financing and accountability for results, and undertake monitoring and coordination. Authority is already delegated as in 3.3.1, to different levels of the organisation, including to country level, however, the recently agreed increase in DOA at country level (June 2023) will need to be carefully monitored for both implementation and effectiveness. It is recognised that the Emergency Programme, particularly Emergency Response has a greater flexibility in decision making (staffing, procurement, resource distribution), than the other strategic pillars. The proposed programme budget for 2024-25 notes that Regional Directors have the delegated authority for strategic allocation/reallocation of flexible funds within the region, particularly to address funding gaps. The revised approach adds three principles, including that the commitment to funding high-priority outputs will enable the strengthening of capacity at the country level and the ability for country offices to increase their workforce resources. There were many positive comments on decentralisation from the interviewees e.g. “I feel like a lot of things have been too centralised. I feel like we need some decentralisation. We need some decision making to be made at the levels of directors you know from raising money, HR issues, the bottlenecks.”. “Countries are at the centre of resource allocation, it is WR led. The ARG is removing some of the bureaucratic steps and the DG asked the WRs what the country offices should need”. There was also a recognition that delegation comes with more accountability: Now, DOA comes with more responsibility and more accountability. “At country level the DOA has moved from USD 50, 000 to USD 300,000 for direct financial corporations and mechanisms. Thus, the level of financial risk has increased as well. The reputational risks are there as well of course. From the survey approximately 57% agree that country offices have sufficient authority to make critical decisions without needing headquarters or regional approval. Approximately 15% of national gov counterparts disagreed.	436 438 456 483 618 620 621 622 623

3.3.3. The programme budget monitoring is the main mechanism for tracking resource flows across strategic domains and tracking the reallocation of resources and contribution to specific outcomes. WHO conducts country programme evaluations to identify key achievements, challenges, areas for improvement, best practices and innovations, however although the number of these evaluations is few, only seven per annum, they help reveal systemic issues for organisational learning. Lessons learned during the COVID-19 pandemic particularly related procurement and to stock management were used to improve processes in countries and other levels of the organisation. While the budgeting process is designed to include both top-down and bottom-up elements, with country priorities informing the budget framework, an independent evaluation of WHO's RBM Framework found that the bottom-up chain of budget prioritisation does not function well. Many feel that there has not been a clear strategy to strengthen country office practice and capacity to deliver results, despite the budgetary efforts to increase funding for country offices. As previously indicated, this is now being redressed in the preparation of Programme Budget 2024-25, which already started late 2022. Implementation will need to be monitored.

3.3.4. GPW13 emphasises strengthening the country level to achieve country-level impact and is supported by the Transformation Agenda. GPW13 emphasises strengthening the country level to achieve country-level impact and is supported by the Transformation Agenda. The Programme Budget 2020-21 presented an increase in the budget allocated to the country office level from 39.3% to 44% of the base segment of the budget. As described above the increased DOA to country offices has only just been approved, May 2023, hence will need to be monitored for implementation. In the proposed programme budget for 2024-25, there is a greater focus on countries, with 49% of the budget allocated to the country level based on strengthened priority-setting at the country level. Interviewees were positive about the increased DOA to country level. Most of the regions have signed on for the new DOA to WRs. "There has been an increase in the DOA, with funding sitting at the country level that only country offices can mobilise". "With the increased DOA, money can flow directly from headquarters to country offices, and the WR can manage amounts and hire staff."

MI 3.3 Evidence confidence	**High confidence**

MI 3.4: HR systems and policies are performance-based and geared to the achievement of results	**Score**
Overall MI rating	**Unsatisfactory**
Overall MI score	**2.40**
Element 1: A system is in place which requires the performance assessment of all staff, including senior staff	4
Element 2: There is evidence that the performance assessment system is systematically implemented by the organisation across all staff and to the required frequency	2
Element 3: The performance assessment system is clearly linked to organisational improvement, particularly the achievement of corporate objectives, and to demonstrate ability to work with other entities	2
Element 4: The performance assessment of staff is applied in decision making relating to promotion, incentives, rewards, sanctions etc.	1
Element 5: A clear process is in place to manage disagreement and complaints relating to staff performance assessments	3
MI 3.4 Analysis	**Evidence documents**
3.4.1. There is a performance management and development system, PMDS, which is systematically used by all staff who meet three times a year with their supervisor to set their objectives, review mid-term and end of year progress. Senior management have accountability compacts with the DG, which include KPIs, to monitor their performance and to which they are held accountable. The ADG's meet with DG annually, both individually and with their directors, to discuss progress and priorities. WHO's human resources annual report from 2023 provides several examples and figures of how HR systems have been applied and improved to achieve performance-based results. These include: a survey to seek input from the workforce on their performance management challenges; collaboration with the UN System Staff College; mandatory training including PSEAH, security awareness, cybersecurity and ethics; a global mentoring programme; and a global	2 6 7 10 36 37 50 83 86

internship programme. 156 227

3.4.2. Staff work plans are linked to organisation-wide results and outputs in the electronic Performance Management Development System (ePMDS), and it is linked to grade increase. It is not the purpose of the PMDS to use the system for staff distribution, though personal development is built into the appraisal. In a PricewaterhouseCoopers survey in 2022, only half of respondents considered that the staff performance management system supported WHO to deliver results and 13% felt it had hindered WHO to effectively manage itself to deliver results. Furthermore, a PwC review noted that supervisors decide not to report underperformance, which undermines the link to organisational improvement. Staff members have said that they would like to see a performance system that is used honestly by all staff, as the proper use of the system is not enforced and without accountability on supervisors or supervisees to honestly assess performance. AFRO conducted 360-degree feedback for participants of the Pathways to Leadership Programme, enhancing their awareness on their personal development. The 360-degree feedback process used in the Programme informed the headquarters 360-feedback exercise launched in 2022. WHO has implemented "Goals Week, reminders to all staff and tracking by senior management of completion of PMDS". Further improvements are being made (including through integration with the BMS project). 232 244 270 279 280 283 299 302 418

3.4.3. Reforms to strengthen performance management are underway. WHO has made efforts in testing a 360-degree performance evaluation to improve accountability, transparency and cultural change, but has not yet rolled out. WHO now says that clear linkages are applied between individual PMDS' with Outputs in the GPW13. This is a new development since the last assessment. Team Objectives are required for all staff, and teamwork is assessed regularly. ARG is clear on the need for improving accountability of WRs. The country dashboards allow comparisons between country offices and are linked to corporate results. Also, the forthcoming BMS will help increase efficiency of WHO. All these steps that are in process will need to be monitored to follow progress and assess implementation. It is also proposed to integrate geographical mobility into performance appraisal criteria and career development schemes with the assumption that these will be effective tools to foster a geographical mobility culture. The primary usage of the Performance Management system is to keep an administrative record of people's past performance, there is a perception that purpose of the PMDS is punitive, however in 2022 out of 8 370 staff members who completed their ePMDS, 26 were placed on a personal improvement programme (PIP) which is only 0.3%.

The 2023 evaluation of WHO's RBM framework also coordinated closely with a management review of WHO's staff performance management system. WHO may take steps to prioritise the implementation of initiatives linked with the career pathway initiative. Performance management is viewed as an essential piece to building the skills required to achieve the ambitious goals set out in the GPW13.

3.4.4. The performance assessment of staff is applied in decision making relating to promotion, incentives, rewards, sanctions etc. A 2021 annual report stated that the career pathways initiative comprises a global career development programme linked to enhancements and reforms in performance assessment, succession planning, mobility, learning and development. However, an assessment of the performance management system indicated that, while the primary usage of the Performance Management system is to keep an administrative record of people's past performance, in practice it is often punitive and not developmental. The performance management system is perceived as a tick-box exercise. Outputs from collective performance are not communicated transparently and there is a lack of a personal development culture in WHO, with limited consequences for both high and low performance (no reward or recognition). It is not clearly linked to the performance evaluation and there is no systematic development program for high performing staff. Mobility also tends to be misused by managers to relocate underperforming staff. To redress this a revised career management framework is being used to inform the job architecture and harmonise position descriptions within the CPCP approach. A new career development programme was delivered in 2022 to promote women's leadership and address specific career development needs and challenges of national officers.

3.4.5. Documentation exists on handling staff grievances and dispute resolution and a clear process is in place, encompassing Office of the Ombudsman (OMB), Head of Ethics, global board of appeal. Set out within the 2017 Code of Ethics and Professional Conduct, work-related disagreement is dealt with under the provisions of the Performance Management and Development Framework. Staff members can include statements should they disagree with anything within their performance evaluation report, which become part of their performance file. The OMB provides confidential and impartial assistance for the informal resolution of concerns and conflict related to employment for all employees, regardless of contract or location. A staff survey of use of the OMB office found the system appropriate and very supportive. It is

noted however that WPRO underutilised the services of the OMB.

MI 3.4 Evidence confidence	High confidence

KPI 4: Organisational systems are cost- and value-conscious and enable financial transparency and accountability	KPI score
Satisfactory	3.33
MI 4.1: Transparent decision-making for resource allocation, consistent with strategic priorities over time (adaptability)	Score
Overall MI rating	Satisfactory
Overall MI score	2.75
Element 1: An explicit organisational statement or policy is available which clearly defines criteria for allocating resources to partners	3
Element 2: The criteria reflect targeting to the highest priority themes/countries/areas of intervention as set out in the current strategic plan	2
Element 3: Resource allocation mechanisms allow for adaptation in different contexts	3
Element 4: The organisational policy or statement is regularly reviewed and updated	3
MI 4.1 Analysis	**Evidence documents**
4.1.1. The programme budget (PB) outlines resource allocation and is aligned to strategic priorities in line with GPW13. The programme budget is also publicly available online. The programme budget development process has been redesigned to be more bottom up and outcome oriented. This is evidenced in Programme Budget 2020-21 and 2022-23. Management guidance for resource management include mobilisation of resources in line with the PB, matching the Country Cooperation Strategies (CCS), priorities and budget to work plans, with use of more strictly earmarked resources first, with more flexible resources being used to address underfunded areas. Documents exist describing WHO's policies for financing indirect administrative and management costs (category 6 costs), including cost recovery. As of December 2022, USD 3.8 billion was made available for WHO country-level activity under the WHO Programme Budget for 2022-23. This represents 54% of WHO's total available funds across levels of the organisation and is 85% of the planned country-level costs for the biennium. Of the total funding available for country-level work, 36% was allocated to base programmes, 51% for emergency operations and appeals, and 13% for polio. At the mid-point of the biennium, flexible funding accounted for 13% of total distributed funds for country offices. Although still low, it has increased from 10% to 13% over the past two years. The Secretariat is committed to making concerted efforts to further increase flexible funding for country offices to ensure strong and predictable country presence and country-level work." (The increased assessed contribution (flexible funds) approved by WHA76 in May 2023, will be focussed on countries (USD 200 million) and the proportion of budget allocated to countries is more than to regions in Programme Budget 2024-25. **4.1.2. The GPW13 and Transformation Agenda are reflected in the reorganised programme budget (PB) documents outlining the bottom-up and outcome-oriented approach.** The Programme Budget 2020-21 implementation reports that WHO focused on financing outcomes defined as priorities by Member States. High priority outcomes were allocated 87% of the total budget and 86% of the resources distributed to technical outcomes; and 50% of these priority outcomes reached over 75% financing. The CPCP criteria include income classification, development indices, risk indices, vulnerability indices, as well as an indicator for whether a country is a Small Island Developing State. These criteria will be used for resource allocation to countries for the Programme Budget 2024-25. A number of staff interviewed at different levels of the organisation expressed concern that pillar 3 – one billion healthier population is underfunded. In addition, whilst Covid a good example of high adaptability, there is still a problem with issues such as Climate Change – which fall outside the Emergency Programme definition and hence do not receive the necessary resource allocation. **4.1.3. Resource allocation mechanisms allow for adaptation in different contexts. The adaptability of the organisation's resource allocation methods was challenged by the COVID-19 pandemic.** The response	17 18 36 37 40 45 51 53 81 138 156 166 250 283 316 321 367 368 404 417 419 436 464 469 470

allowed WHO to demonstrate its ability to be agile across the organisation and especially in Regional and Country Offices e.g., WPRO technical divisions came together to support the Incident Management Support Team and agile teams were formed for developing tools for contact tracing and delivery health services. This demonstrated flexible allocation and use of resources in an emergency. There is also evidence of flexibility in funding and corresponding resource allocation to respond to emergencies in line with the Emergency Response Framework. The Working Group on Sustainable Financing recommendations refer to a set of six principles to guide any WHO replenishment mechanism, including that it addresses both WHO needs for flexibility and donor needs to show accountability for results to their own constituents. This evidence is corroborated by the survey results Overall, approximately 85% of respondents agree that WHO appropriately adapts its work as the context changes and 91% agree that WHO has been able to adapt its programming and activities to respond to COVID-19 in an agile and responsive way. "What WHO was able to achieve in reaction and response to COVID-19 was incredibly impressive given how constrained it was financially. Business continuity was just about maintained at an acceptable level (i.e., it could have been worse). This performance speaks to the enormous effort of the WHO workforce who were stretched to breaking point. This must not happen again. A more sustainably financed and better prepared WHO must be stood up now. Strategies, finance, systems and processes and governance must be pre-programmed for absorbing such strains in future." "The WHO was able to shift its priorities and respond to COVID-19 in a way that supported Member States. The expert guidance and technical assistance provided by the WHO in the context of COVID-19 has been invaluable. One note is that while we know the programmatic impact was positive, the reporting on the WHO's tangible accomplishments was often lacking. From a donor's perspective, perhaps this was a missed opportunity for the WHO to really showcase its reach and the life-saving impact it had throughout the pandemic**".** **4.1.4. The organisation policy or statement is regularly reviewed and updated. WHO has included learnings from the rapid changes required in the COVID-19 pandemic to revitalise the focus on strengthening country offices and financing at country levels.** Priorities are reviewed in line with the biennial PB process and on an ad hoc basis in-between. A budget line was reintroduced for emergency operations in the Programme Budget 2020-21, also WHO moved towards an annual appeal for the budget to address the impacts of the COVID-19 pandemic. The discussions around replenishment model and a shift from VC to AC, are ongoing. The recommendations of the Working Group on Sustainable Financing refer to a set of six principles to guide any WHO replenishment mechanism, including that it addresses both WHO needs for flexibility and donor needs to show accountability for results to their own constituents.	
MI 4.1 Evidence confidence	**High confidence**

MI 4.2: Allocated resources disbursed as planned	**Score**
Overall MI rating	**Satisfactory**
Overall MI score	**3.25**
Element 1: The institution sets clear targets for disbursement to partners	4
Element 2: Financial information indicates that planned disbursements were met within institutionally agreed margins	3
Element 3: Clear explanations, including changes in context, are available in relation to any variances against plans	3
Element 4: Variances relate to external factors rather than to internal procedural blockages	3
MI 4.2 Analysis	**Evidence documents**
4.2.1. The Programme Budget (PB) is the basis and target for allocation and distribution of resources across all levels of the organisation. WHO has a PB web portal which provides quarterly financial information on the application of funding, increasing WHO's transparency as they support Member States to better understand and track the PB, expenditures and results. A heatmap on the web portal shows WHO's Regional and headquarters financing gaps and the capacity to which its strategic priorities in various regions have been achieved (snapshot 31 March 2022). The heatmap also notes that despite headquarters being fully funded, that does not necessarily mean that all funds will be used at headquarters but may be disbursed to priority regions as needed. It is noted that disbursement is reliant on the timing of receipt of voluntary contributions and whether they are specified for specific activities or countries, thus even with a fully funded	15 17 41 48 51 53 59 160 270

PB there can be "pockets of poverty'. Following the increase in assessed contributions agreed at WHA 76 in May 2023, the DG has pledged to allocate an additional $100 million to countries in 2023. **4.2.2. Disbursements against the planned Programme Budget (PB) are monitored via regular reporting against the PB, as well as on the PB web portal.** At the mid-term review of the Programme Budget for 2022-23, the base programme was financed to 82% with a utilisation level of 38%. Emergency operations were financed to 264% with a utilisation level of 136%; Polio eradication financed to 182% with a utilisation level of 91%; and special programmes financed to 112% with a utilisation level of 33%. The Mid-term review of the Programme Budget for 2022-23 indicated a funding gap of USD 660 million, after including projections of voluntary contributions at the end of December 2022. Levels of utilisation of the budget available for base programmes was at 38% at the end of the first year of the biennium 2022-23 linked with financing levels and time of arrival of funds. Ideally this mid-term utilisation would be 50%, although given the delays in receipt of funds the utilisation is within acceptable margins. **4.2.3. In monitoring the receipt and disbursement of funds, WHO also includes an explanation for deviation from the expected, e.g., the health systems category was 105% funded and implemented 95% of its approved budget in 2018-19.** The high level of funding was attributable to the UHC Partnership. Regional funding and expenditure were concentrated in the National health policies, strategies and plans and the integrated people-centred health services programme area. Overall, within the health systems category, all programme areas were similarly funded, and investments were high across all major offices, with matching budget implementation. However, COVID-19 strained health systems and hampered plans to extend UHC. A WHO survey of 105 countries conducted in 2021 found that services were disrupted in almost every country between March and June 2020. In a 2020 financial report, WHO acknowledged that the implementation rate for the base budget was 85% while the implementation of emergency response was unprecedentedly high due to COVID-19 response activities. In the survey, 57% of respondents agreed that WHO communicates clearly on payment timeframe and on any variations associated with payments. **4.2.4. Variances relate to external factors rather than to internal procedural blockages is evidenced by major variances in WH implementing emergency response activities with knock-on effects caused by the COVID-19 pandemic which complicated supply chains and deployments in 2020-21.** This included procurement and delivery delay due to non-availability of staff in supplier production facilities, customs clearances, and limited transport. Health system resources which were diverted as a result of the pandemic, which disrupted the delivery of health services and exposed weaknesses of national health systems. Furthermore, there were setbacks in achieving the Triple Billion targets (and subsequent rationale to extend GPW13 to 2025). COVID-19 strained health systems and hampered plans to extend UHC. A WHO survey of 105 countries found that services were disrupted in almost every country between March and June 2020. In the 2022 Results Report, it was noted that revenue and expenditure increased due to COVID-19. In country-level results reporting, WHO documents instances of conflict, and how the emergency response impacted overall financing. Another example of the effects of COVID-19 included the suspension of the global internship programme. WHO reports it regularly briefs Member States on such variances.	405 425 436 450 454 464
MI 4.2 Evidence confidence	**High confidence**

MI 4.3: Principles of results-based budgeting applied	**Score**
Overall MI rating	**Satisfactory**
Overall MI score	**3.50**
Element 1: The most recent organisational budget clearly aligns financial resources with strategic objectives/intended results of the current strategic plan	4
Element 2: A budget document is available which provides clear costings for the achievement of each management result	4
Element 3: Systems are available and used to track costs from activity to result (outcome)	3
Element 4: There is evidence of improved costing of management and development results in budget documents reviewed over time (evidence of building a better system)	3
MI 4.3 Analysis	**Evidence documents**
4.3.1. WHO has made good progress in results-based budgeting with financial resources aligned with	18

strategic objectives (Triple Billion targets and SDGs). WHO has used an integrated budget and results-based budgeting over the past 20+ years as documented in the RBM evaluation. WHO recognises that the development of the programme budget should be Member State-driven, based on needs, with lessons learned from COVID-19 response applied, also to be flexible to respond to emerging information and needs, to maintain a consultative process and be ambitious to match WHO's mission. The revision to the Programme Budget for 2022-23 was made with these considerations. The budgets are made against strategic priorities, polio, special programmes, emergency operations at the highest level it is set against clear outcomes. There is however a significant difference in the level of financing between the four strategic priorities for 2022-23. For example, approved allocations for Universal health coverage, Health emergencies, emergency operations, and a more effective and efficient WHO each individually came to over USD 1 billion, while special programmes came to USD 199 million.	19 45 158 283 332 353 354 355 356 436 450 758
4.3.2. A budget document is available which provides clear costings for the achievement of each management result. The secretariat provides the Programme, Budget and Administration Committee (PBAC) and World Health Assembly (WHA) with this costing and the governing bodies review the budget income and expenditure twice yearly. The programme budget (PB) presents clear costing for each category of work, which is reviewed by a global policy group. The current biennium (2022-23) report has the financial status, contributions, special programmes and shows the budget and percentage share of financing of the budget by strategic objective with the country programmes listed. It is very comprehensive; and it is possible to link expenses at management level to overarching objectives. This system continues to be improved and refined; with the forthcoming BMS the reporting will be more transparent with dashboards. **4.3.3. Transparent systems are in place to track costs from activity to results. Details of WHO's work, financing and implementation progress can be found on the WHO Programme budget web portal.** Included is an internal dashboard for programme implementation monitoring. This is updated monthly. Additional monitoring and assessment mechanisms include a six-monthly internal review of operational plans, an annual mid-term results report, a biennial programme budget (PB) implementation and financing update, and an end of biennium performance assessment, or "results report". Outcome narratives are produced to provide a more integrated view of progress on cross-cutting outcomes. It is noted however that the integrated approach of GPW13 may have made it more complex to track from PB to regional or programme thematic priorities (e.g., a WPR thematic priority is antimicrobial resistance, but it is difficult to identify what the region is funding in that area through the PB, some headquarters programme areas made the same comment). The Secretariat presented an overview of the Results Report 2022, the financial report and audited financial statements for 2022. The Committee commended the quality of the report, the simpler presentation of data, the highest-ever recorded levels of funding and the organisation's healthy financial position. In the lessons learned from the COVID-19 pandemic it was noted that emergency preparedness is a weakness, there continues to be a funding gap for this area of work. **4.3.4. The Development of the Programme Budget for 2024-25 evidenced the improvements made to the costing of management and provides evidence of building a better system.** WHO has significantly increased the transparency of the programme budget (PB) development process and details contained within (including explainers, real time data) - done through several portals and dashboards on the Member States Portal on the WHO website. Also, the Secretariat has made improvements in the process of costing resolutions and decisions. The percentage increase in financing for 2022-23 nearly doubles when compared to financing for base programmes in PB 2020-21. The Secretariat presented an overview of the Results Report in 2020-21 and 2022-23, and the Financial Report and audited financial statements. Member States have commended the quality of the recent reporting the simpler presentation of data, the highest-ever recorded levels of funding and the organisation's healthy financial position. Feedback loops are encouraged to improve organisational learning and allow practice to be adapted based on learnings. Feedback loops are dependent on time dedicated to learning and the organisational culture surrounding learning and adapting. Although according to an independent evaluation of WHO's RBM framework, these are not yet fully recognised in WHO and there are major bottlenecks that limit learning at WHO. The new BMS system will allow for following and monitoring of funds beyond a biennial period, this will facilitate RBM with the proposed replenishment model of financing.	
MI 4.3 Evidence confidence	**High confidence**

MI 4.4: External audit or other external reviews certifies the meeting of international standards at all levels, including with respect to internal audit	**Score**
Overall MI rating	**Highly Satisfactory**
Overall MI score	**4**
Element 1: External audit conducted which complies with international standards	4
Element 2: Most recent external audit confirms compliance with international standards across functions	4
Element 3: Management response is available to external audit	4
Element 4: Internal audit functions meet international standards, including for independence and transparency	4
MI 4.4 Analysis	**Evidence documents**
4.4.1. The external audit of the WHO is conducted in a manner which complies with international standards. The appointed External Auditor holds the post for four years which covers two budgetary periods and can be renewed for an additional four-year term. The external auditor is currently the Indian Auditor General. In the report it is quoted "In line with our mandate, we audited the financial statements of WHO in accordance with the Financial Regulations and in conformity with the International Standards on Auditing (ISA) issued by the International Auditing and Assurance Standards Board (IAASB). **4.4.2. A 2023 report of the External Auditor confirms compliance with international standards across functions,** the report concluded that "the financial statements present fairly, in all material respects, the financial position of WHO for the financial year ended 31 December 2022, and its financial performance, the changes in net assets/equity, the cash flows, and the comparison of budget and actual amounts, in accordance with the International Public Sector Accounting Standards (IPSAS)." **4.4.3. The WHO Secretariat provides a management response to both the external audit and internal audit through its annual status report and tracks progress in implementation of recommendations.** At each WHA, the Secretariat produces a report on implementation of both internal and external audit recommendations. At WHA76, this report also contained identification of top 10 issues. The External Auditor also requires business owners to complete updates on actions and validates the responses, and then also consolidates some of the recommendations and their status in the External Auditors own annual report each year (also provided to the WHA). The Secretariat has plans to launch a digital integrated platform that consolidates audit recommendations issues by both internal and external auditors and other accountability/oversight bodies. The platform includes management responses and tracks the status of implementation of recommendations. The internal dashboard is shared with DG, audit tracks response, and as above is presented to the WHA annually. 16 May 2022 annex tracks previous recommendations by year and WHO response. It noted a lot of "pending" responses. The Independent Expert Oversight Advisory Committee (IEOAC) urged senior management to continue tracking and addressing external audit recommendations in a timely manner and initiate corrective measures as needed. **4.4.4. IOS has dual reporting lines to the EB and to the DG and conducts its work in accordance with the International Standards for the Professional Practice of Internal Auditing** promulgated by the Institute of Internal Auditors and adopted for use throughout the United Nations system, and with the Uniform Principles and Guidelines for Investigations endorsed by the 10th Conference of International Investigators. The Charter of WHO's Internal Oversight Services provides clear instructions that IOS investigations must comply with international standards including the Institute of Internal Auditor (IIA), United Nations Representatives of Internal Audit Services (UN-RIAS).	87 89 90 92 259 270 327 370 387 442 443 447 478
MI 4.4 Evidence confidence	**High confidence**

MI 4.5: Issues or concerns raised by internal control mechanisms (operational and financial risk management, internal audit, safeguards etc.) adequately addressed	**Score**
Overall MI rating	**Satisfactory**
Overall MI score	**3.2**

Element 1: A clear policy or organisational statement exists on how any issues identified through internal control mechanisms/reporting channels will be addressed (including misconduct such as fraud, sexual misconduct)	3
Element 2: Management guidelines or rules provide clear guidance on the procedures for addressing any identified issues, and include timelines	3
Element 3: Clear guidelines are available for staff on reporting any issues identified	3
Element 4: A tracking system is available which records responses and actions taken to address any identified issues	4
Element 5: Governing body or management documents indicate that relevant procedures have been followed/action taken in response to identified issues, including recommendations from audits (internal and external) with clear timelines for action	3
MI 4.5 Analysis	**Evidence documents**
4.5.1. Code of Ethics and Professional Conduct (2017) was active during the MOPAN assessment period, and was updated in July 2023 and is publicly available. The Code outlines the conduct, competence and performance expected of all WHO staff members. Also, a Policy on Prevention, Detection and Response to Fraud and Corruption (2022) exists and is publicly available. The policy builds on an earlier policy and identifies actions that constitute misconduct, corruption, and fraud, as well as mechanisms to prevent, detect and respond to cases. This is supported by internal procedures for investigating by the IOS. WHO has an internal justice system with formal and informal components. The informal component includes the OMB for mediation solutions involving staff complaints. If a solution cannot be met via informal mediation, complaints escalate to the formal tier, which includes the Global Board of Appeal should a staff member to appeal an administrative decision. WHO is developing a new Code of Ethics and Professional Conduct that describes ethical standards and conduct of all personnel, including respect for the law; personal conduct and private life; management of conflict of interest; protection of WHO resources; protection of WHO interests and reputation; and post-employment obligations. For sexual misconduct, WHO has a number of policies and statements, including in the revised WHO Policy on Preventing and Addressing Retaliation (July 2023), updated WHO Policy on Preventing and Addressing Abusive Conduct (June 2023), Code of Conduct to prevent harassment, including sexual harassment, at WHO events, and the WHO Policy on Preventing and Addressing Sexual Misconduct (March 2023). **4.5.2. Standards for how to administer responses exist, with timelines for responses.** For instance, there is an updated Policy on Preventing and Addressing Retaliation (2023) which outlines procedures and mechanisms to report instances of misconduct and suspected wrongdoing. The policy is publicly available online. The policy allows for reports to be made confidentially, as well as anonymously through an Integrity Hotline, which was moved during the assessment period from CRE to IOS, in line with JIU recommendations on the WHO investigation function and good practice. The policy also outlines protection measures available to whistle-blowers. The policy outlines the sequence and timeline of Office of Compliance, Risk Management and Ethics (CRE) preliminary review. IOS carries out the investigation of cases and seeks to submit a completed investigation report within 120 days from the date of referral by CRE. There is currently (June 2023) no backlog in the Global Board of Appeal (GBA) well within that timeframe to issue reports "To address allegations of sexual exploitation and abuse and sexual harassment, investigative capacity was scaled up to manage a backlog of investigations, putting in place a 120-daybenchmark for completing investigations. The WHO ombudsman reports annually to the EB, outlining trends for potential systemic issues that have been identified, as well as following up on management responses to previously identified issues. The Ombudsman is independent and neutral and provides confidential and impartial assistance to staff. It is understood from interviews that there is a functional appeal process in place for staff. Also, a mechanism in place for how things will be processed (e.g. how soon to reply, process of appeal to GBA). There is a Global Board/Committee which helps improve the efficiency and accessibility of the internal assessment system. The Policy on whistleblowing active throughout the assessment period did not include information on the rights and protections of accused staff. There were legal concerns over how broad the policy on whistleblowing and protection from retaliation was and there is a lot of room for ambiguity and a lack of clarity regarding definitions. The revised Policy on Preventing and Addressing Retaliation was launched in July 2023 to address gaps and align with associated policies. **4.5.3. Clear guidelines are available for staff on reporting issues identified.** There is a risk management strategy in place, and risk management tools outline escalation procedures and level of authority required to decide on risk response. If staff suspect instances of fraud, corruption, breach of integrity, abuse of WHO resources or other misconduct have occurred, they should report it to their supervisor. If they are concerned	6 12 21 22 30 31 40 44 84 89 92 156 189 227 229 238 270 271 299 302 305 316 327 328 349 443 461 471 547 654 681 682 686 687 758

that their supervisor may be implicated in the misconduct or fear retaliation, they may seek guidance from HR**T** on human resource issues, CRE on issues related to retaliation as per the policy on whistleblowing and protection against retaliation or through the Integrity Hotline, or the IOS. (For PSEAH see 4.7 and 4.8). The interview informed that the GBA system is underutilised in Western Pacific region and the new GBA has had no new cases from the region. Outreach missions were conducted to WPRO confirming that the region was generally unaware of the internal justice system. There was also fear of retaliation connected to filing reports of misconduct through the IOS. Many non-staff are not aware that they have access to the Ombudsman, so in their outreach efforts, the Ombudsman has taken steps to ensure that all members of the workforce are aware of the support available to address or highlight their particular workplace concern. Although staff feedback on OMB services 2022 indicated that 90% of staff agreed that they were given clear information about the independent, confidential, impartial and informal role of OMB.

4.5.4. Progress indicators are monitored and tracked using the monitoring framework. Reports made by the internal auditor show typology of fraud schemes reported as well as an overview of investigation activities and caseloads undertaken. Information regarding actions taken on investigative reports for sexual misconduct and abusive conduct can be found on the WHO intranet. AFRO (and reportedly other ROs) has developed KPI systems and dashboards that routinely track action on internal audit, external audit, risk management and other systems. Business Owners enter the management response and follow up to audits. These are now tracked for all audit recommendations (using TeamMate). Annual reports made by the internal auditor on IOS activities, including investigations of misconduct, are submitted to the WHA and are publicly available Recommendations are made and if not completed, these will be mentioned in follow up reporting. These have now been put onto a consolidated platform and are reported on every six months. Internal and external audits track the status of open recommendations and whether they are overdue in progress.

4.5.5. Internal and external audit reports are presented to the governing bodies. Internally, IOS and the External Auditor track recommendations and their follow up with validation using TeamMate+ and a dedicated platform. IOS and the External Auditor submit annual reports to WHA, which includes tracking and summaries of previously open recommendations. Also, the Independent Expert Oversight Advisory Committee (IEOAC) uses the WHO consolidated platform, which is available on the Member States Portal, for managing and tracking implementation of recommendations and submits their tracking of open recommendations, status and follow up each year to the January PBAC meeting. CRE and OMB submit annual reports to the May and January sessions of the PBAC respectively, and the OMB also submits to the EB. The IEOAC reviews risk management systems (CRE) and HRT submits annual reporting alongside the OMB report with a management response. The 2023 report noted that about 50% of its previous recommendations have already been fully implemented. The external audit report 2021 noted that there was “an increasing trend of cases of misconduct, especially relating to fraud, harassment, non-compliance to professional standards and sexual misconduct” and delays in investigation and taking disciplinary action. This has been addressed, as above 4.5.1 and 4.5.2.

New JIU reports and rolling tracking of open recommendations from the previous 5 years of JIU reporting are presented in the May PBAC. The IOAC for Health emergencies submits reporting to the WHA including now tracking of open recommendations, and WHO also maintains the public PRS dashboard for investigation cases and disciplinary action. PRS also submits an annual report to governing bodies on progress and issues.

MI 4.5 Evidence confidence	**High confidence**

MI 4.6: Policies and procedures effectively prevent, detect, investigate and sanction cases of fraud, corruption and other financial irregularities	**Score**
Overall MI rating	**Highly Satisfactory**
Overall MI score	**3.83**
Element 1: A clear policy/guidelines on fraud, corruption and any other financial irregularities is available and made public	4
Element 2: The policy/guidelines clearly define the roles management and staff in implementing/complying with the guidelines	4
Element 3: Staff training/awareness-raising has been conducted on policy/guidelines	4

Element 4: There is evidence of policy/guidelines implementation, e.g. through regular monitoring and reporting to the governing body	4
Element 5: There are channels/mechanisms in place for reporting suspicion of misuse of funds (e.g. anonymous reporting channels and "whistle-blower" protection policy)	4
Element 6: Annual reporting on cases of fraud, corruption and other irregularities, including actions taken, ensures that they are made public	3
MI 4.6 Analysis	**Evidence documents**
4.6.1. WHO has a Policy on Prevention, Detection and Response to Fraud and Corruption (2022) which is publicly available. The policy identifies actions that constitute misconduct, corruption and fraud, as well as mechanisms to prevent, detect and respond to cases. The updated the Code of Ethics and Professional Conduct, published in September 2023, is publicly available. As part of the prevention mechanism of the Policy on Prevention, Detection and Response to Fraud and Corruption (2022), WHO states it implements strong internal controls, including risk-based due diligence processes, mandatory staff training, accountability framework, fraud and corruption risk assessment processes. To facilitate detection and reporting of fraud and corruption, the Policy on fraud and corruption states that regular monitoring of programme results is conducted through compliance reviews, internal control assessments, audits and other assurance activities. In 2022, WHO launched an updated anti-fraud and anti-corruption policy to strengthen the fraud risk management cycle and introduce contemporary definitions of fraud that extend beyond financial perimeters. The toolkit for headquarters staff includes information on the IOS and the services they provide to staff, with emphasis on misconduct including fraud and corruption. Individuals who report are entitled to protection against retaliation in accordance with the WHO Whistleblowing and protection against retaliation policy. In addition, the Staff Regulations and Staff Rules include information on misconduct, fraud and corruption and the Code of Ethics and Professional Conduct 2017 (a further revision was published in September 2023) provides information on the Fraud Prevention Policy and Fraud Awareness Guidelines. Some survey respondents voiced concerns regarding corruption and nepotism during the hiring process, noting the need to conduct thorough internal and external audits to ensure accountability in recruitment decisions. Significant work being done by WHO to apply process and procedures to staffing processes aligned with the UN Clear Check programme to screen relevant staff, in an effort to prevent and respond to SEA and SH.	6 7 12 30 31 37 40 31 59 87 89 156 299 302 328 418 443 445 473 481 608 609
4.6.2. The 2015 Policy on the prevention, detection and response to fraud and corruption clarifies roles, activities and requirements for the prevention, detection, reporting, investigation and sanctioning of fraud and corruption. Roles outlined include the DG, Regional directors, Directors of Business Operation Services, Directors of Administration and Finance, Comptroller, and general staff. The Whistleblowing policy clarifies the responsibilities of the administration. A clear description on the human resources reform of IOS is provided (e.g., leadership, structure, decentralisation, hybrid model of mixed term and short-term staff, roles and responsibilities). The Policy explicitly states a reporting mechanism for suspicion of fraud or corruption, including reporting concerns to the IOS, BOS, DAF or Comptroller/Director of Finance, or reporting through the Integrity Hotline. The Code of Ethics and Professional Conduct outlines the role and responsibilities of managers and supervisors, particularly in encouraging reporting of instances of wrongdoing. There is an approved structure for the investigation function within the Office of Internal Oversight Services outlined in a 2023 internal auditor report, outlining the roles and responsibilities of staff in the IOS for carrying out investigations. The DG and Regional Directors have overall responsibility for the implementation of the policy on prevention, detection and response to fraud and corruption as well as other components of the WHO anti-fraud/anti-corruption framework. Senior management and delegated authority are accountable to the DG and Regional Directors (RD). In July 2023, a revised Policy on Addressing and Responding to Retaliation was published, however as this was not active and enforced during the timeframe being assessed, the policy is not within the scope of this assessment.	
4.6.3. The Office of Compliance, Risk Management and Ethics provides training to raise awareness of workplace ethics, conduct and expectations. Focused sessions are also held with senior managers, mid-level managers and all staff. Visits were based in the regional offices (New Delhi and Cairo), the country offices for India and Egypt, and virtually. WHO launched a training programme to train anti-fraud and anti-corruption ambassadors to raise awareness on fraud and corruption, and on WHO's policy. The CRE launched two awareness raising campaigns in the context of International Fraud Awareness week and International Corruption Day in 2022. Additional communication materials are being developed, as well as an e-learning module which will launch in Q2 of 2023. The mandatory online training module on Ethics Empowerment was	

also finalised by the Ethics Team in December 2022 and launched Q2 of 2023. Further evidence of the training is provided in the 2023 Annual HR report which indicates that: a) the PSEA training started in November 2021 is 93% complete; b) United to respect – preventing sexual harassment and other prohibited conduct (general and managers version) commended in March 2022 to all members of the WHO workforce is 91% complete for managers and 92% for general version; and c) the United Nations B-SAFE security awareness training course is 92% complete since starting in November 2022, the Cybersecurity essentials and preventing phishing training course is 91% completion and d) the Cybersecurity refresher training course 93.5% completion.

4.6.4. Compliance systems are monitored and reported on to governing bodies at Regional and Global levels. Reports of the Internal Auditor report trends in cases by allegation type, including the number of cases of corruption and fraud. Reports include figures on the number of new allegations each year, the number of open cases under investigation, and the number of cases closed. Reports also include the number of cases that were unsubstantiated/unsolved/unfounded. Reports of the Internal Auditor report trends in cases by allegation type, including the number of cases of corruption and fraud. Reports include figures on the number of new allegations each year, the number of open cases under investigation, and the number of cases closed. Reports also include the number of cases that were unsubstantiated/unsolved/unfounded, e.g., Annual report of the regional director indicates the number of internal audits conducted in AFRO and activities to implement recommendations.

4.6.5. Regarding reporting on the suspicion of misuse of funds, the policy on prevention, detection and response to fraud and corruption provides information on reporting mechanisms in cases of suspected fraud or corruption. There is also a policy on whistleblowing and protection against retaliation which provides information on reporting mechanisms (see above) and staff may use the integrity hotline to report instances of suspected misconduct. The whistleblowing policy of 2015 was still in effect during the assessment period, and was updated in July 2023 under the WHO Policy on Preventing and Addressing Retaliation. Country-level imprest accounts are monitored and evaluated by the regional offices and by headquarters finance to ensure adequate internal control practices. Contingency funds for emergencies are subject to strict oversight and accountability measures. Funding allocations are tracked through the Global Management System (GSM) with full financial reporting submitted to the WHA annually.

4.6.6. Annual reporting on cases of fraud, corruption and other irregularities, including actions taken, are presented to the WHA and made public. As noted above the reports of the Internal Auditor report trends in cases by allegation type, including the number of cases of corruption and fraud. Reports include figures on the number of new allegations each year, the number of open cases under investigation, and the number of cases closed. Reports also include the number of cases that were unsubstantiated/unsolved/unfounded. CRE issues an annual report outlining actions taken pertaining to the whistleblowing policy. The report of the internal auditor includes information on the investigation activities and caseloads undertaken by the IOS.

MI 4.6 Evidence confidence	**High confidence**

MI 4.7: Prevention and response to sexual exploitation and abuse (SEA)	**Score**
Overall MI rating	**Satisfactory**
Overall MI score	**3.12**
Element 1: Organisation-specific dedicated policy statement(s), action plan and/or code of conduct that address SEA are available, and are aligned to international standards, and applicable to all categories of personnel	4
Element 2: Mechanisms are in place to regularly track the status of implementation of the SEA policy at HQ and at field levels	4
Element 3: Dedicated resources and structures are in place to support implementation of policy and/or action plan at HQ and in programmes (covering safe reporting channels, and procedures for access to sexual and gender-based violence services)	4
Element 4: Quality training of personnel / awareness-raising on SEA policies is conducted with adequate frequency	3
Element 5: The organisation has clear standards and due diligence processes in place to ensure that implementing partners prevent and respond to SEA	3

Element 6: The organisation can demonstrate its contribution to interagency efforts to prevent and respond to SEA at field level, and SEA policy/best practice coordination fora at HQ.	3
Element 7: Actions taken on SEA allegations are timely and their number, related to basic information and actions taken reported publicly	2
Element 8: The organisation adopts a victim-centred approach to SEA, and has a victim support function in place (stand-alone or part of existing structures), in line with its exposure/risk of SEA	2
MI 4.7 Analysis	**Evidence documents**
4.7.1. Over the last year, WHO has significantly invested in and improved its PSEA policy suite with support of experts, to be based on best practice and international standards, applicable to all categories of personnel. WHO did so in response to gaps in the policy framework that were acknowledged in previous years. Whilst this policy framework was not in place throughout the period assessed, and is yet to permeate across all levels, WHO now has a strong foundation upon which to embark on its journey of institutionalisation. In 2022-23, following the Decision EB148(4) adopted by the Executive Board at its 148th session (January 2021) and recommendations from a range of independent sources, WHO has undergone a PSEA policy review. An interim Policy Directive on Protection from sexual exploitation and sexual abuse was issued in December 2021 whilst the new policy was being created, which acknowledged that there were gaps, loopholes and lack of clarity that needed to be addressed. This accompanied an implementation plan, and a specific Management Response Plan to the report of the Independent Commission on Allegations of Sexual Exploitation and Abuse in the Democratic Republic of the Congo (DRC) during the Response to the Tenth Ebola Outbreak. In 2023, The Policy for Preventing and Addressing Sexual Misconduct (PASM) came into force. It covers Protection against Sexual Exploitation and Abuse (PSEA) and Protection against Sexual Harassment (PSH) under the banner of Protection against Sexual Misconduct (PRS). It aligns with UN requirements and protocols, outlining the responsibilities of staff members, collaborators, managers, supervisors and the organisation. WHO published a 2023-25 Strategy for preventing and responding to sexual misconduct, which is accompanied by annual implementation plans that also function as monitoring and evaluation frameworks, as well as an annexed accountability framework. With these efforts, WHO aims to create a singular policy framework and plan, to ensure consistency and eliminate ambiguity or opportunity for interpretation. During the timeframe assessed, WHO had a Code of Ethics and Professional Conduct (2017) which was applicable to all WHO collaborators and staff who adhere to the policies on signing their contract. Whilst we do not have specific evidence of the codes of conduct being signed and agreed to by personnel, we were advised of other opportunities for staff to commit to the policies - staff renew this vow three times a year as part of the ePMDS and staff were instructed to reaffirm their commitment to the Code of Conduct during the 2022 WHO Goals Week. WHO also has a range of policies beyond the PASM that are relevant to PRS. As the PASM was updated in 2023, it took a few months to align the accompanying policies with the new standards. This includes the 2017 Code of Ethics and Professional Conduct, which was replaced by a Code of Ethics (2023) on 1 July 2023, the 2015 Whistleblowing and Protection against Retaliation Policy and Procedures, revised replaced in July 2023 by the Policy on Precenting and Addressing Retaliation, and the Legal Framework for Addressing Non-Compliance with Standards of Conduct. In June 2023, a revised Policy on Addressing Abusive Conduct (PAAC) was published. In the same month, a new Accountability Framework for the 2023-25 PRSEAH strategy was published. Both tools identify and clarify team and individual accountabilities that will be applied to staff and WHO collaborators in the coming years, although they were not applicable to the timeframe under assessment. Whilst WHO is proactively improving its policy infrastructure, it acknowledges in the three-year strategy that the Organisation is currently at the “institutionalisation” stage of their PRSEAH journey and aims to meet its own standards and raise them by 2028. The 2023 PASM policy and three-year strategy recognise the broader organisational and institutional change required. **4.7.2. WHO has a strong and transparent infrastructure for reporting on PSEA activities to various bodies and audiences. Country and Regional offices are engaged in policy implementation and in feedback mechanisms related to reporting on policy implementation.**	6 19 30 44 59 63 67 69 84 90 92 106 145 156 237 238 259 260 261 262 263 264 265 266 267 271 272 273 274 275 277 278 294 295 296 297 298 299 300 307 316 327 328 358 359 360 418 419 422 432

WHO regularly reports on PRS matters to governing bodies in multiple ways. For example, in 2021, the WHO Programme/Budget committee requested that the Secretariat provide quarterly reports on PSEAH and to place the subject as a standing item on the agendas of the EB and WHA. Additionally, the WHO Secretariat has issued various reports to the EB in relation to specific actions taken in response to EB decisions. These reports are listed publicly on the WHO website.

The 28 recommendations of the Independent Commission were followed up by WHO in its management response plan (MRP) and its implementation plan until the stated close of end 2022. The WHO Secretariat reported implementing 111 of 127 actions included in the MRP between 2021 and end 2022. However, over the last three years, there have been multiple sources of recommendations and WHO acknowledges that they must try to triangulate and follow up across all sources to ensure alignment with the new policy and plan. Since January 2023, progress is being tracked against the 2023-25 strategy and a specific monitoring and evaluation (M&E) Framework Implementation Plan launched to align with the new strategy and policy. WHO also has a public PRSEAH Dashboard where activities on key policy areas, such as case reporting and training activities, are updated regularly. A range of reports are available on the website, including updates by the Secretariat and Secretary-General, internal and external audits, and independent reports.

The Policy commits to releasing annual work plans and in September 2023, WHO had conducted a lesson learned exercise which fed into the following annual work plan. The M&E Framework also has specific targets for inclusion of regional and departmental teams in PRSEAH reporting and WHO has made efforts to incorporate country and regional level inputs. For example, the Director of the PRSEAH department attended face-to-face regional workshops and retreats. There have also been a range of open-door sessions, for which questions asked are shared with the Organisation, regular monthly network meetings and opportunities for direct feedback from Heads of WHO Country Office (HWCOs) and WHO Representatives (WRs). In November 2023, WHO also hosted an international stakeholder review conference that brought together lessons from civil society, academia, and UN agencies. However, interviews suggest that not all staff in country offices know what the process is to feed into monitoring, or how to share feedback and lessons that can inform others, including their Heads of Office.

4.7.3. WHO has secured substantial financial resources and put in place dedicated structures to support the implementation of its new policy across both prevention and response to SEA.

Resourcing and capacity

In 2021, WHO established a three-level task team to respond to the Independent Commission's recommendations and has made significant efforts to resource prevention of, and response to sexual misconduct. A formal Department for PRS was then created in 2022 to coordinate organisation-wide efforts on PRSEAH. The documented budget of USD 50 million per biennium for the PRS Department, with a large proportion allocated to country operations, is particularly noteworthy. WHO endeavours to make PRS funding part of its regular budgets, going forward. If it succeeds, it would be one of only very few agencies who have managed to secure predictable funding for these efforts.

Since 2022, WHO has made efforts to improve expertise in specific areas. There is strong coordination across multiple relevant headquarters departments, operational teams such as the WHO Health Emergencies Programme (WHE), the Polio Eradication Initiative, and representatives nominated by all six regional directorates such as Country Directors and all six regional PRSEAH Coordinators. Interviewees highlighted the collaborative relationship between departments as a strength, in particular, between PRS and Gender Equality, Human Rights and Health Equity (GRE). To contribute to the core capacity, a United States Agency for International Development (USAID) P5 secondee supported PRS for six months from September 2022, and three other approved positions are under recruitment.

Additionally, WHO has made great strides to address significant gaps in the investigations function, as the Independent Commission had suggested that the investigations team lacked specific expertise on sexual exploitation, abuse, and harassment (SEAH). WHO has recruited a new Head of Investigations and a team of 19 full-time and external investigators. It has a documented commitment of USD 10 million for the investigations function. A temporary suspension of a Financial Rule XII 112.1 has also allowed the Head of Investigations/Senior Advisor to the DG on Sexual Exploitation and Abuse and Sexual Harassment to exercise the same authority as the IOS and for the significant backlog in SEA cases to be addressed.

Beyond headquarters, Heads of Offices and Emergency response incident managers and other Management

positions have PRSEAH responsibilities which are detailed on the website and in the WHO PRS Accountability Framework. Since 2022, WHO has paid specific attention to resourcing PSEA efforts in emergencies, with a senior staff member assigned within the polio programme to work with the PRS team, the co-financing by the polio program of WHO PSEA coordinators in high-risk polio countries, and funding requests from WHO CFE required to include a PRSEAH budget and plan in the WHE programme.

In its report, the Independent Expert Oversight Advisory Committee (IEOAC) suggested that PRSEAH capacities still needed to be reviewed across the three levels of the organisation. To address this, WHO improved the capacity, recruiting regional and country-level P4 and P5 coordinator positions throughout 2023. WHO has also grown the number of PSEA focal points. Between November 2021 and March 2024, the focal point network grew 730% from 50 focal points in 30 offices to 415 PRS focal points across 155 country offices, 41 of which are full time positions. In interview, it was suggested that non-headquarters offices still struggle to understand and implement procedures – an issue the 2023 Accountability framework aims to clarify.

Reporting and support to victims

WHO has improved reporting and support structures in several different ways following the independent commission report and created a variety of ways to file complaints. These include the independent WHO Integrity Hotline, the Office of Staff Health and Wellbeing Services, and Staff Counsellors. The Office of the Ombudsperson can also support victims in a medically privileged or confidential setting, ahead of formal reporting. All SEA allegations are ultimately referred to IOS. However, in a 2021 report of the reports of the External and Internal Auditors, the Secretariat acknowledges that the hotline is not fit for purpose in emergency settings where the local population does not have easy access to the internet, and it is not clear where victims/survivors would find information on non-headquarters-based mechanisms.

On support for victims, WHO set up a readily accessible Survivor Assistance Fund of USD 2 million in September 2021. Approximately USD 500,00 has been used to directly support 115 survivors identified in the SEA allegations during the 10th Ebola outbreak. The fund has also been used to support victims from other cases as requested by COs, ROs and HQ. A Victim/Survivor Support Officer (VSSO) role to support SEA and SH victims has been approved for recruitment in 2024.

Overall, whilst both WHO and independent bodies have historically highlighted the weaknesses in the area of resourcing and structures, significant efforts are being made to resource PRSEAH. However, the Independent Oversight Advisory Committee for Health Emergencies (IOAC) 2022 Report also highlighted that responsibilities and accountabilities are not well understood across the organisation, which is facilitated by the hierarchical culture and lack of transparency. WHO's own 2023 PASM Strategy acknowledges that WHO's sexual misconduct management system needs "a deep think-through and overhaul" and in a 2023 briefing to Member States, WHO also acknowledged the need to focus more on improving guidance and resourcing at the operational level.

4.7.4. Overall, WHO has established strong mandatory training at headquarters level, country level and for focal points, tailored to its staff. However, it is unclear how training modules are reviewed based on feedback.

In mid-2023, WHO published a comprehensive "learning pathway" for PRSEAH, which outlines five mandatory training modules and five bespoke training packages. Those are designed for different risk profiles of personnel including staff, collaborators, PSEA Focal Points, Heads of Country offices, Managers and Directors, Community facing high-risk operations and Accountability functions. Training includes the UN mandatory training on PRSEAH which all personnel, including WHO collaborators (interns, consultants, etc.) must complete within three months, and all new personnel working in emergencies must complete before they can work in or be deployed to the field. It also includes WHO-specific training, embedded in the WHO Global Induction Programme. Since 2022, mandatory training has been required every three years, with a specific version for managers/supervisors. Additionally, a targeted leadership coaching opportunity for 22 women leaders was rolled out to address the issue of male-dominated leadership positions, which is seen as a barrier to PRSEAH. Such an initiative is unique within the sector and has the aim of reducing inequalities; however, such initiatives also place the responsibility of PSEAH on women.

The WHO Intranet site clearly lists the mandatory and optional training courses. Information on the uptake and completion of these pathways across the profiles is not yet available given the recency of its launch. However, WHO confirmed that 141 out of 415 focal points have completed their training requirement on

assessing and mitigating risks. As of September 2022, 95% of WHO Country Offices had ensured that personnel had completed mandatory training on SEAH, and 94% had appointed or identified a focal point. An Electronic SEA Training Passport for Focal Points was piloted in AFRO in March 2022, however feedback on the relevance and usefulness of the training has not yet been captured. Furthermore, the awareness of PRSEAH training varied amongst interviewees.

Optional training and engagement activities are mentioned in the Action plan, including PAAC workshop and training sessions. Over 30,000 participants attended PRS live webinars, ad-hoc events and briefings from January to December 2022. This included the #NoExcuse webinar series, which aimed to ensure that the message of zero-tolerance for SEAH reached WHO personnel.

WHO has also engaged in training activities within the communities where it operates, and in partnership with other agencies. A public dashboard on the WHO website includes high-level reporting of outreach and education activities conducted by IOS, per region. As part of the 2021 Management Response Plan, WHO also partnered with the United Nations Children's Fund (UNICEF) and social mobilisation leads to create awareness raising materials and tools as part of in-country PSEA coordinated activities, as mentioned in 4.7.6. Accessible to implementing partners, WHO hosts PRSEAH-related training content on its OpenWHO platform. In collaboration with UK FCDO and the Open University, WHO made available the "Introduction to safeguarding in the International Aid Sector" online course in six languages.

4.7.5. In the 2023 PASM, WHO acknowledges the area of PRSEAH standards and due diligence for partners as a weaker area, describing a decreased "sphere of control" for implementing partners, that will take system-wide change to improve. Progress has been made to mitigate against these risks.

Whilst acknowledging this is a weaker area, much of the risk of SEA lies within the supply chain, including short-term contractors and implementing partners. According to interviewees, the previous policy did not adequately address the differences between staff and contractors, leaving room for interpretation. Furthermore, a finding from the December 2020 IASC PSEA Support Mission states that during the Ebola response, control over WHO assets such as clothing, logos and vehicles, was weak, and it was unclear who were staff or not staff. This risks confusion in identifying perpetrators but also lends itself to potential perpetrators taking advantage of weak systems and potentially operating under the guise of the WHO banner.

The 2023 PASM aims to address these issues by making it clear that the policy adheres to all personnel associated with WHO, and requiring specific standards from implementing partners.

Standard contracts for all types of non-staff personnel have been revised to include a clause on zero tolerance for all types of abusive conduct and now make an explicit reference to the PASM Policy. Similarly, standard procurement/partnership agreements were revised across the organisation to include such a standard clause and refer to the PASM Policy. Provisions in collaboration agreements also require WHO to be informed of criminal allegations. Whilst the IOS Charter states that IOS might investigate wrongdoing by contractors and implementing partners, it does not contain any specific provisions for SEA, and there are no details of investigations capacities required from partner organisations in contractual clauses. However, WHO does apply standards in line with the Interagency PSEA IP Protocol and partner organisations' investigations capacity is appropriately assessed at due diligence stage.

Along with many other UN Entities and IASC partners, WHO is a part of the IASC UN Partner Portal PSEA Module and Capacity Assessment initiative since 2023, conducting assessments in priority countries. Where not already administered through another UN entity via the UN portal, capacity assessments are completed for implementing partners, and where improvements are required, a capacity improvement plan is initiated. Training is provided to IPs in high-priority countries. For non-priority countries, IPs are checked in a non-systematic way at the point of contract. These systems target NGO partners, however, government entities remain WHO's main implementing partner. Therefore, WHO are actively finding ways to introduce accountability for Members States on PRSEAH, on the request of the Programme Budget and Administrative Committee (PBAC).

4.7.6. WHO has a specific commitment to inter-agency collaboration within the PASM Policy, engaging with UN and interagency working groups to address sexual misconduct at both HQ and field-levels.

The three-year strategy lists a specific action on inter-agency engagement among the responsibilities of

managers / supervisors. Within the M&E Framework and Implementation Plan, there is a specific activity for cooperation with external systematic reviews, such as the MOPAN assessment process, and WHO are committed to delivering the minimum inter-agency annual reporting requirements. Statements describing inter-agency initiatives are also shared by the DG in his reports to the Executive Board.

At HQ level, WHO joined the Inter-agency Steering Committee (IASC) Technical Advisory Group (TAG) on PSEAH in the second half of 2021, works closely with the Office of the Victims Rights Advocate (OVRA) and has joined the UN SEA Working Group in 2021. At field-level, the Independent Oversight Advisory Committee for Health Emergencies (IOAC) noted that WHO had incorporated PRSEAH into its updated Emergency Response Framework, mainstreaming in emergency operations. However, the IOAC also recommended more collaboration with other UN entities. Much of WHO's inter-agency engagement has been in direct response to the issues of SEA unearthed during the Ebola Outbreak in DRC. As well as funding the IASC PSEA Coordinator in DRC, in 2020, the WHO Director of Ethics and Risk Compliance joined the IASC PSEA support mission and following the release of the IC report in September 2021, The Director of PRS joined the IASC PSEA support mission that took place in November 2021 which led to the negotiation of an MoU between WHO and UNFPA for strengthening support services.

On training, among other initiatives, WHO moderated the UNPP PSEA module launch event at ECOSOC and hosted face-to-face training on the module. WHO also delivered, facilitated and hosted webinars and workshops, with the Implementing Partners Protocol Working Group, training more than 2,400 UN and NGO staff on the UNPP PSEA module since June 23.

Overall, 62% MOPAN survey participants responded, "strongly agree", "agree" or "somewhat agree" that WHO participates in joint / inter-agency efforts to prevent, investigate and report on any sexual misconduct by personnel in relation to the host population, however 32% of participants responded, "don't know/no opinion".

4.7.7. Overall, WHO has improved its response to allegations by increasing its investigations capacity, clearing the existing backlog of cases, creating benchmarks for timeliness, and through sharing information on a public dashboard. However more could be done to enforce timeliness across the entire process and prevent rehiring of perpetrators through joint mechanisms and stronger internal processes.

WHO classifies SEA cases as high priority for investigations and commits to this publicly on its online Dashboard for Sexual Misconduct, where it acknowledges the need for timeliness, responsiveness and fairness. In 2023 a new "swim lane" was designed which illustrates the high-level end-to-end process for action against sexual misconduct, from T- (when an incident occurs) and T0 (when a complaint is reported), through to T4 (where an outcome is reached). The "swim lane" maps all relevant stakeholders against each stage of response and offers timeline goals for each stage of the process. For example, there is a benchmark of 120 days for investigations, and 60 days for conclusion of the disciplinary process from initiation of the disciplinary proceedings, excluding the Subject's response time. The "swim lane map" was recently published with the Accountability framework, outlining how responsible teams will be held accountable for the activities assigned to their department.

In December 2021, WHO signed a memorandum of understanding (MoU) with the United Nations Office of Internal Oversight Services (UN OIOS) to complete the investigation related to the 10th Ebola outbreak in DRC and share with WHO the investigation reports for those cases in which there was linkage with WHO, so that WHO could take action. According to the WHO management Response Implementation plan, after some the alleged perpetrators were cleared of charges, WHO requested UN OIOS to review and further investigate, in line with a victim centred approach.

In the three-year PRS strategy, it is stated that structural adjustments to existing divisions of labour and workflows will be necessary to achieve progress. The strategy also cites other challenges, such as geographical and linguistic ones that affect timeliness of responses, which WHO are addressing with a decentralised, multi-cultural team of investigators. This has cleared the backlog of cases and bringing the status of investigations to a point where new complaints can be received and addressed in real time. In the first 6 months of 2023, WHO received 48 allegations of sexual misconduct, 6 of which were substantiated, and the benchmark of 120 days was met in 69% of investigations. In interview it was suggested that timeliness is impacted when departments involved in other parts of the process are under resourced.

Externally, the 2022 IOAC Report on PSEA criticised the investigations process on both transparency and

timeliness, stating that investigations were taking up to two years to complete compared to other UN agencies with a lower average, and that staff on fixed term contracts were less likely to be held accountable. However, since transparently publishing the disciplinary actions of SEA and SH cases on the online Dashboard from 2022, it is clear that those with Special Service Agreements (SSAs) have been held accountable.

When it comes to reporting, WHO regularly feeds into the UN Database on PSEA alongside other UN entities, although most of the fields for case information have been marked 'unknown'. Additionally, the WHO website dedicated Sexual Misconduct dashboard has a range of publicly available statistics, including the number of cases opened and closed per month, and disciplinary action taken. On monitoring, the MOPAN team found that the WHO public dashboard was updated regularly. Quarterly Member States briefings include updates on reporting, investigation and disciplinary action. The latest of these briefings includes allegation data from 2022-23, UN OIOS reports, and specific actions related to the DRC cases. Other publicly available reports include the reports of the external and internal auditors, the latest being 2021, where statistics and case trends for sexual misconduct cases are described. Internally, an information note with updates on disciplinary action against personnel (for all misconduct including SEA) are communicated with the workforce every quarter by the Director HRT.

Since 2021, WHO has used ClearCheck, the joint mechanism used by UN entities to register perpetrators of sexual misconduct, with WHO entering 14 perpetrators into ClearCheck between 2021-22. The mandatory use of ClearCheck is referenced in the 2023 PASM and various action plans. At Regional level, responsibility for ClearCheck lies with the Regional Directors and at Country level with the Heads of WHO Country Office. However, only major offices have trained ClearCheck users, and WHO acknowledges that the use of ClearCheck outside of headquarters is low and that operationalising the use of the mechanism has been challenging. WHO does not partake in other joint mechanisms for the prevention of re-hiring former perpetrators (such as the Misconduct Disclosure Scheme, which also includes NGOs), but is part of the One HR initiative for recruiting P5 and above on all fixed-term P/D recruitments managed by HRT/HQ. The statement of a zero-tolerance approach to SEAH is required in all job advertisements.

4.7.8. Whilst strong commitments have been made to a victim-centred approach, and systems have been introduced, WHO has yet to create an environment of trust that would allow victims to feel safe in reporting and confident in receiving support from the organisation.

Whilst the former 2018 policy lacked explicit written provisions covering assistance for victims, including support and resources, the new 2023 PASM and Three-Year Strategy explicitly commit to a victim and survivor centred approach (VSCA). They state a definition and list the ways in which victims will be supported by WHO. Those include formulating a safety plan and communications regarding services for support, which is supported by the "swim lane" map created in mid-2023. However, as highlighted in the 2022 Accountability Overview, the VCSA is at the stage of being "introduced", suggesting it is not yet embedded, and WHO are at the stage of taking first steps in their commitment, such as endorsing the victims' rights statement.

To embed a victim and survivor centred approach (VSCA) with specialist support, WHO has approved a Victim Survivor Care Officer (VSCO) role for recruitment, but it has not yet been advertised. In the interim, sexual misconduct focal points are seen as a support function. However, in a 2022 report by the Independent Oversight and Advisory Committee, WHO accountability functions were described as difficult to navigate and mainly a system of verifying and dispatching complaints to different mechanisms, as opposed to providing tangible support throughout the process. Furthermore, staff and partners interviewed for the report raised concerns about the lack of transparency in the process, and WHO's propensity for protecting institutional reputation. A lack of clarity on due process and victim protection was also mentioned during this assessment's interview phase, as well as a lack of feedback from and to victim/survivors except in the context of DRC. WHO will therefore still have a long way to go to establish a functioning VSCA and a trusted environment.

On a field-level, WHO established its own victim support fund, "The Survivor Assistance Fund" (SAF), in September 2021 (complementing the existing UN Trust Fund in Support of Victims of SEA of 2016). WHO used the SAF in some countries to provide immediate medical, legal, socio-economic and psychosocial support. The DG pledged an initial USD 2 million to the fund from WHO core funds for the 2022-23 biennium. The one example use case of this fund is in the DRC, where WHO has a MoU with the United Nations Population Fund (UNFPA) who supervises the implementation of the USD 350,000 fund and collaborates with women-led legal aid NGOs. WHO has also initiated collaboration within the Inter-agency PRSEAH Network, including the creation of hospital-based safe spaces and in Ukraine, has produced a PSREAH training for public health practitioners, including a core module on the tenets of a VSCA. In 2024, WHO has also begun a

process of mapping referral services with the intention of strengthening them.

MI 4.7 Evidence confidence	High confidence

MI 4.8: Prevention of and response to sexual harassment (SH)	Score
Overall MI rating	**Satisfactory**
Overall MI score	**3**
Element 1: Organisation-specific dedicated policy statements and/or codes of conduct that address SH available, aligned to international standards and applicable to all categories of personnel	4
Element 2: Mechanisms are in place to regularly track the status of implementation of the policy on SH at HQ and at field levels	3
Element 3: The organisation has clearly identifiable roles, structures and resources in place for implementing its policy/guidelines on sexual harassment at HQ and in the field: support channel for victims, a body coordinating the response, and clear responsibilities for following up with victims	3
Element 4: All managers have undergone training on preventing and responding to sexual harassment, and all staff have been trained to set behavioural expectations (including vis-à-vis sexual harassment)	3
Element 5: Multiple mechanisms can be accessed to seek advice, pursue informal resolution or formally report allegations of sexual harassment	3
Element 6: The organisation ensures that it acts in a timely manner on formal complaints of allegations of sexual harassment	2
Element 7: The organisation transparently reports the number and nature of actions taken in response to SH in annual reporting and feeds into inter-agency human resource mechanisms	3
MI 4.8 Analysis	**Evidence documents**
4.8.1. WHO addresses Sexual Harassment (SH) in the revised policy suite described in 4.7.1, which brings SH under the umbrella term of "Sexual Misconduct". This improved policy suite marks a significant evolution in understanding of sexual harassment amongst leadership at the HQ level. Due to its recent launch, it will take time for the policy to permeate across the Organisation. WHO uses the term Sexual Misconduct and SEAH interchangeably, as it considers that the term 'sexual misconduct' is easier to communicate and translate. However, they also have a specific UN-aligned definition of SH which is described on the online WHO PSEAH Dashboard. Prior to 2023, SH was covered by the WHO Policy on Preventing and Addressing Abusive Conduct (PAAC). In 2023, a new policy, the WHO Policy on Preventing and Addressing Sexual Misconduct ("PASM"), was adopted to cover all types of sexual misconduct including SH and SEA under one policy". The action plans mentioned in 4.7.1 encompass both SEA and SH under the umbrella of sexual misconduct, however this means actions are not specific to address sexual harassment. The 2023 PRSEAH Strategy states that in late 2022, WHO commissioned an external diagnosis of organisational culture with a focus on the prevalent leadership culture in WHO and the impact of the organisational culture on sexual misconduct incidents by the workforce. Whilst such an analysis is beneficial to target sexual harassment, the findings are not externally published. The 2017 Code of Ethics and Professional Conduct was in force during this assessment period and explicitly states that sexual harassment is not permitted, and that the standard applies to all WHO staff members and collaborators regardless of contractual relationship or remuneration status. This was replaced on 1 July 2023 with a new Code of Ethics with revised wording in line with the latest PASM policy and was in force from July. WHO also have a Code of Conduct specific to preventing harassment, including Sexual Harassment at WHO Events which is applicable to all involved in these events. The 2022 Africa Region Annual Report stated that all WHO surge staff as well as Government ministry counterparts are also required to sign a code of conduct, however the MOPAN Assessment Team did not see examples of this practice as part of the document review. **4.8.2. There are a range of tracking mechanisms for PSEAH, including SH, at HQ level, with recent efforts to incorporate country and regional level inputs into policy implementation.** The headquarter-based PRS Department is ultimately the body appointed to track the implementation of sexual misconduct prevention activities, including sexual harassment, and answers directly to the DG. The	4 6 30 32 44 59 84 92 104 106 156 229 232 238 259 260 261 262 263 265 266 271 273 274 293 294 295 296 297 300 302 307

PRSEAH M&E Framework specifically states an activity of regular stakeholder consultations and surveys to receive feedback that will help strengthen measures, and the public Dashboard is regularly updated, reporting to the policy areas of case management and training.

As specified in 4.7.2, WHO has a range of activity reporting mechanisms for sexual misconduct including reports to the Executive Board and quarterly updates to Member States. A Human Resources annual report also summarises specific SH activities taken under the implementation plan. Updates are also embedded into other reports such as the annual report of the Internal Auditor, last published in May 2023, and the Annual report of the Regional Director on the work of WHO in the Africa Region. The M&E Framework also has specific targets for inclusion of Regional and Departmental teams in PRSEAH reporting and WHO have made efforts to incorporate country and regional level inputs, the examples of which are detailed in 4.7.2.

4.8.3. WHO have a range of resources and dedicated capacity for sexual misconduct, including sexual harassment, across both prevention and response.

Resourcing, capacity and budget

The core capacity for Sexual Misconduct including SH is the Department for Prevention and Response to Sexual Misconduct (PRS). This team coordinates the response to SH cases. The 2023 PASM policy also outlines the responsibility of staff, non-staff and WHO to prevent and respond to all sexual misconduct including SH. To support this, a new Accountability Framework for the 2023-25 strategy was published in August 2023. Both the policy and Accountability Framework identify and clarify team and individual accountabilities that will be applied to staff and WHO collaborators in the coming years, including on sexual misconduct including sexual harassment, but are not applicable to the timeframe assessed during the assessment period.

During their time as owners of PSEAH, the Ethics Department informed the External Auditor in 2021 that it was facing resource constraints and understaffing for their outreach activities on harassment and sexual misconduct. Since then, and with the introduction of the PRS department, there have been significant efforts to resource work to address sexual misconduct. To improve capacity, the DG's 2022 PSEAH Update to the Executive Board details the budget allocated and necessary for activities, including the request for an initial core budget of USD 50 million allocated to work on PSEAH for the biennium 2022-23 (see also Element 4.7.3). While this does not break down the budget between SEA and SH, or reference specific SH initiatives that require budgetary commitments, WHO's approach covers both forms of sexual misconduct as they are intrinsically linked. WHO's USD2 million Survivor Assistance Fund (SAF) was set up to address both SEA and SH, however WHO confirmed that most use cases for the SAF are for SEA, while other support services such as health insurance and an employee assistance programme which is available for all personnel and eligible dependents.

Reporting systems, case management and victim support structures

The Sexual misconduct management system "swim lane graph" displays the responsibilities of various stakeholders at different points of the process but does not distinguish between SH and SEA or consider informal reports. For most of the assessment period, up until March 2023, a Global Advisory Committee (GAC) was the formal mechanism through which investigation reports on formal allegations of abusive conduct, including sexual harassment, were reviewed and recommendations on course of action are provided to the DG. A TOR of the GAC was annexed in the 2021 PAAC (which has since been revised in June 2023). The Committee was made up of 5 elected staff, 5 staff designated by the DG, and 5 senior staff members in consultation with the Regional Directors. This instrument is not used for sexual misconduct under the 2023 PASM as the cases are particularly sensitive, the GAC do not have training to review SH investigations and to ensure efficiencies. and whilst investigations are conducted exclusively by IOS, follow-up actions are managed by HRT with involvement from other relevant departments. According to the WHO Accountability Overview, following the opening of a case, regular case review meetings are held between the Investigations Unit, Ethics Unit and Department of Human Resource and Talent Management, to discuss individual cases and explore solutions.

Victims/survivors who wish to obtain advice ahead of choosing a reporting route can do so through the Office of Staff Health and Wellbeing, the Staff Counsellors and the Office of the Ombudsman and Mediation Services who can be contacted in a confidential and medically privileged setting. The PASM policy then allows for both formal and informal routes of resolution for SH concerns. In terms of follow-up support to victims of SH, both the Survivor Assistance Fund and internal health and mental health support systems are available, however, it was suggested in interviews that the Employee Assistance Programme (EAP) has received

negative feedback, and that solutions for victim support need to be improved.

4.8.4. The WHO 2023 Learning Pathway outlines the five mandatory training courses and learning paths for 5 different risk profiles of staff, illustrating a bespoke approach to training.

It includes UN training and the WHO's own training on PRSEAH. It is a requirement within the PASM policy and the PAAC policy for staff and non-staff personnel to undertake training, with a specific lens on the harassment faced by LGBTQ+ communities. The mandatory training course for Managers "United to Respect: Preventing Sexual Harassment and Other Prohibited Conduct" ["United to Respect"] has been made available by the UN and is used by WHO since March 2022. As of December 2022, WHO registered a compliance rate of 91% of the WHO workforce with supervisor responsibilities, and 92% for the general version. According to the 2022 WHO report of the programme budget and Administration Committee, follow-ups are issued to those who have not completed the training, to address cases of non-compliance.

In the Annual Report of the Africa Region, it was stated that each WHO team is presently required to identify one performance objective related to PRSEAH for assessment in the staff annual performance review process. While the assessment team did not see any specific examples of the objectives to assess the quality and understanding of responsibilities, it is clear that this is a mandatory, centrally managed system that requires managers to fulfil all the stages of the process, before being marked as complete.

WHO also conducts a range of non-training-based awareness raising activities and regularly shares internal email communications with staff, such as the PRSEAH newsletter. The #NoExcuse campaign was observed during WHO Goals Week in 2022 and aims to increase the awareness of managers concerning their responsibility to create and maintain an environment that prevents SEAH, and all WHO supervisors were required to hold a team meeting on the subject. The PRS also conduct a series of OpenDoor sessions, attracting 2,000+ attendees and answering 100+ questions from staff and collaborators. The Code of Conduct to prevent harassment, including Sexual Harassment, at WHO Events is available on the PAAC intranet page in all 6 WHO official languages and is shared with participants of WHO events.

Training and culture change activities are a key activity which is well-reported on, through the public WHO Dashboard on Sexual Misconduct, the annual Human Resources Report, PRSEAH reports by the DG to the Executive Board, and Briefings to Member States. Furthermore, the 2021 Report of the External and Internal Audit Report commended WHO's efforts to implement mandatory training and capacity building on PSEAH.

4.8.5. WHO detailed a range of formal and informal reporting mechanisms for sexual misconduct within the 2023 PASM Policy, which includes options that apply for both SEA and SH, however broader organisational culture issues form a barrier to improving the trust staff have in the systems.

In the 2021 report of the External Auditor, the Office of the Ombudsman reported a decline in the use of their channels across 2018 to 2020. SEAH was the reason least cited for use of the Integrity hotline, compared to other categories of misconduct reports. Other reporting systems include direct reporting to the Office of Internal Oversight Services, reporting through the WHO Integrity hotline, or via established internal mechanisms for both anonymous or medically privileged and confidential settings. Since the establishment of the new investigations function, reporting on sexual misconduct, including SH, has increased. The WHO Ombudsman recommends an "informal first" approach to SH reporting to minimise the psychological struggle of those reporting and offers confidential support to victims or witnesses as well as mediation and resolution options. A process for reporting SH within the context of WHO Events is laid out in the WHO Code of Conduct to Prevent Harassment, including Sexual Harassment at WHO Events, advising the victim or witness to report to the WHO event organiser or relevant security authority, with a range of possible actions laid out.

During the period assessed by this MOPAN assessment, protection against retaliation was addressed in the 2015 Whistleblowing and Protection against Retaliation Policy and procedures. In July 2023, this was replaced by an updated version which is aligned with the newer Policy on Sexual Misconduct and Policy for Addressing Abusive Conduct. The WHO Office of Compliance, Risk Management and Ethics (CRE) owns the policy and process, referring cases of retaliation to the IOS, and recommending protection or relief measures to the DG or Regional Director as appropriate. The 2015 Policy that was effective during the assessment period did not consider specific provisions for retaliation against victims or whistle-blowers reporting sexual misconduct such as sexual harassment, however the July 2023 policy does contain such provisions. The Office of the Ombudsman, in their 2022 report, suggests that one of the main reasons why informal resolution is

recommended and then chosen for harassment cases, including sexual harassment, is a fear of retaliation if formal channels are used, by the person against whom a formal complaint is made, but also a fear of retaliation from external networks outside of WHO's protection sphere.

Broader organisational and cultural workplace issues have been raised by both WHO and its employees, which have an impact on the reporting by and support given to victims of SH. Through various documentation, WHO recognises that the lack of gender parity across the leadership affects the perception and reporting of Sexual Misconduct. In the 2023-25 three-year Strategy, WHO acknowledges that the organisation needs to "address structural barriers such as gender inequity, lack of diversity, equity and inclusion, and human resource management practices that create unchecked power differentials," which in turn affect a victim's trust in WHO's systems and confidence to report. Furthermore, the 2022 Report of the Ombudsman describes that staff felt that whilst much attention has been placed on SEA and SH by WHO, a broader issue of a toxic workplace environment and other forms of harassment must also be addressed by the organisation. WHO is actively looking to address these.

4.8.6. WHO classifies SH cases as high priority and commits to this publicly on its online Dashboard for Sexual Misconduct. However, WHO acknowledges the need for major improvements in timeliness, responsiveness and fairness.

In 2023 a new "swim lane" was designed which illustrates the high-level end-to-end process for action against sexual misconduct, from T- (when an incident occurs) and T0 (when a complaint is reported), through to T4 (where an outcome is reached). It does not address informally reported concerns of SH. The "swim lane" maps all relevant stakeholders against each stage of response and offers timeline goals for each stage of the process. For example, there is a benchmark of 120 days for investigations, and 60 days for conclusion of the disciplinary process from initiation of the disciplinary proceedings, excluding the Subject's response time. WHO is actively tracking against the benchmark timelines and in 2022, for investigations specifically, 100% investigations were completed within 6 months. Delays in post-investigation processes were acknowledged as a challenge.

The WHO PRSEAH Dashboard has a range of publicly available statistics including the number of cases opened and closed per month, and disciplinary actions taken. It doesn't explicitly disclose how long it took for each case to be resolved but decision dates for disciplinary measures are published. In interviews, WHO personnel acknowledged that a confusion between SEA and SH in the field, and the need to ensure due process has led to delays in cases being acted on. Furthermore, the 2022 Report of the Office of the Ombudsman states that there is a concern about the timeliness of making and implementing decisions for resolution of informal reports, including that of informally reported sexual harassment cases. The three-year-strategy acknowledges that major improvements need to be made and shows a good understanding of bottlenecks and challenges the Organisation is looking to address.

4.8.7. WHO has clearly invested in transparency, and regularly reports publicly and to its governing bodies on the topic of sexual misconduct, most of which disaggregate between SEA and SH.

WHO has dedicated Public Dashboard on Sexual Misconduct on its website, which is to be updated monthly. It includes disciplinary actions taken where SH and/or SEA and/or abusive conduct have been substantiated. On monitoring, the MOPAN team found that this dedicated dashboard was updated as per this commitment. The publicly available reports of the Internal Auditors, the latest being in 2023, also detail case trends for sexual misconduct and statistics for SH. Those show an increase in allegations from six allegations in 2020 to 16 in 2021 and 46 in 2022, and attribute increased reporting to awareness raising efforts. An annex of substantiated cases gives a summary for each SH allegation and the management decision taken. The publicly available reports of the external auditor, the latest being in 2021, also provides a breakdown of SH cases from 2016 to 2020. The Quarterly Member States briefing includes updates on statistics related to reporting, investigations and disciplinary actions, however, does not disaggregate between SEA and SH.

In terms of WHO's interaction with inter-agency HR mechanisms, the use of ClearCheck is clearly mandated within the PASM policy. The associated M&E Framework sets out an activity to cooperate with development actors to facilitate information exchange with the view to screen potential job applicants and partner collaborators. The target set is 99% of staff and consultants screened, with 95% of cases meeting ClearCheck criteria in 2023, however it is not clear how this is monitored. As of April 2024, WHO has entered 27 former staff members and non-staff personnel in ClearCheck including 11 perpetrators of SH. As mentioned in 4.7.7,

only major offices have trained ClearCheck users and WHO acknowledges that the use of ClearCheck outside of headquarters is low and there have been challenges in operationalising the use of the mechanism. WHO does not partake in other joint mechanisms for the prevention of re-hiring for staff but is part of the One HR initiative for recruiting P5 and above at HQ level. At a 152nd Session of the 2023 Executive Board meeting, a Member State also expressed their concern regarding the rehiring of an alleged perpetrator and urged WHO to address the issue.

MI 4.8 Evidence confidence	High confidence

Relationship management

Engaging in inclusive partnerships to support relevance, leverage effective solutions and maximise results

KPI 5: Operational planning and intervention design tools support relevance and agility within partnerships	KPI score
Satisfactory	2.60

The Country Cooperation Strategy (CCS) is WHO's strategic framework to guide the organisation's work in and with a country. It responds to that country's National Health and Development Agenda and identifies a set of agreed joint priorities for WHO collaboration, covering those areas where the organisation has a comparative advantage in order to assure public health impact. The CCS is WHO's corporate framework strategy to implement the Thirteenth General Programme of Work (GPW13) with a response to country needs and priorities and addresses the Sustainable Development Agenda in health-related Sustainable Development Goals (SDGs). WHO's role in the National Development Plan process varies from country to country including lead role, active partner and/or contributor. The preparation of the CCS, which is usually a five-year strategy, is aligned to the national government e.g., National Development Strategy, and the CCS is prepared in close collaboration with government priorities. Translation into outputs and outcomes is done through the development of the programme budget on a biennial basis. Strengthening WHO's presence in countries has been core to the Transformation Agenda over the past five years but made limited progress during the COVID-19 pandemic. This has been recognised through the formation of the Action for Results Group (ARG) and the development of a roadmap for strengthening country offices through the Core Predictable Country Presence (CPCP). The CPCP is informed by systematic analysis of country context, based on capacity, complexity and vulnerabilities. For instance, Small Island and Development States have special arrangements. Criteria such as development indices, income classification, etc. are applied. The COVID-19 pandemic highlighted weaknesses in national capacities, particularly related to pandemic preparedness and response. WHO is supporting countries to strengthen their capacity for preparedness, and the CPCP with its predictable funding should facilitate this.

CCSs are informed by analysis of country context, including the top ten causes of death/burden of disease, and health issues, including gender, equity and human rights. Additional considerations are included in the CCS guide for countries in fragile situations, including additional analysis to service delivery, governance, health information systems, human resources, health financing, and pharmaceutical products. Key considerations when preparing a new CCS include "country context, including the feasibility of developing the CCS and the presence of any immediate competing government priorities. In the formulation of CCSs, capacity is a key consideration. This includes the capacity of the Country Office to undertake CCS development; International Health Regulations (IHR) capacity and health emergency preparedness; health financing in fragile states; capacity. There are however limitations of CCS: "At country level, given that the CCS timeframe is not aligned to the GPW, implementation in some countries is still around disease areas rather than expected outputs and outcomes." The independent evaluation of the RBM framework noted that although new CCSs are better aligned to the current GPW results framework, even those monitoring frameworks are not fully aligned to the output level.

Regional processes for integrating risk management with operational planning were put in place for the 2022-23 biennium; however, they remain manual and resource intensive. The new risk management tool

that is being developed in the context of the enterprise resource planning system will establish a direct link between the risk identification interface and the workplans where mitigation measures are defined and resourced, which will greatly facilitate monitoring of mitigation measures during the implementation of operational plans. The Office of Compliance, Risk Management and Ethics continues to support WHO programmes to develop context-specific risk-management tools and guidance, as was done for the prevention of sexual misconduct. For example, work is ongoing to develop risk management guidance and tools in the context of WHO's Environment and Social Framework agenda. Similar initiatives are planned for prioritised Principal Risks in line with the Proposed Programme Budget for 2024-25.

There is evidence that the new risk-management tools cover reputational risk. Due diligence and risk assessments, particularly for reputational risks, are conducted when proposing new partnerships. The organisation has increased its engagement with non-state actors, based on due diligence and risk assessments designed to preserve the integrity of WHO. The Framework for engagement with non-state actors (FENSA) from 2016 outlines the principles for partnering with non-state actors. FENSA serves to protect and preserve WHO's integrity, reputation and public health mandate. Engagement with non-State actors must not compromise WHO's integrity, independence, credibility and reputation.

WHO has acknowledged SEAH to be an increasing risk for the organisation, its staff and beneficiaries. WHO's 2023 Policy on Preventing and Addressing Sexual Misconduct (PASM) explicitly commits to prioritising a range of risk management approaches to safeguard from sexual misconduct. These include a requirement for leadership to assess and manage risk at a corporate level, for tools to be developed to support adaptive and contextual risk assessment and mitigation activities at both country level and programme level, conduct trainings on risk management, and collaborate at the inter-agency level to manage SEA risk through joint mitigation measures. This will be supported by the Accountability Framework published in August 2023, which details the responsibilities and accountabilities of WHO staff in relation to the management of WHO's principal risks, including risks of sexual misconduct.

Institutional procedures have remained a challenge, including systems for hiring staff, procuring project inputs, disbursing payment, logistical arrangements, and in particular procedural delays in the hiring of staff. A number of measures have been put into place to reduce recruitment time, though as already been indicated this remains unacceptably long.

MI 5.1: Interventions/strategies aligned with needs of beneficiaries and regional/ country priorities and intended national/regional results	**Score**
Overall MI rating	**Unsatisfactory**
Overall MI score	**2.50**
Element 1: Organisation's country or regional strategies refer to national/regional body strategies or objectives	3
Element 2: Reviewed interventions/strategies refer to the needs of beneficiaries, including vulnerable populations	3
Element 3: Organisation's country strategies or regional strategies link the targeted results to national or regional goals	2
Element 4: Structures and incentives in place for technical staff that allow them to invest time and effort in alignment process	2
MI 5.1 Analysis	**Evidence documents**
5.1.1. The Country Cooperation Strategy (CCS) is WHO's strategic framework to guide the organisation's work in and with a country. It responds to that country's National Health and Development Agenda and identifies a set of agreed joint priorities for WHO collaboration, covering those areas where the organisation has a comparative advantage in order to assure public health impact. The CCS is WHO's corporate framework strategy to implement the Thirteenth General Programme of Work (GPW13) with a response to country needs and priorities and addresses the Sustainable Development Agenda in health-related SDGs. The 2020 CCS guide (a further revision of the CCS guide was ongoing in 2023) on implementing the 13th General Programme of Work for driving impact in every country the CCS promotes country ownership in achieving health-related SDGs, with jointly identified priorities being negotiated, agreed, endorsed and monitored through the CCS by senior Government and WHO officials. Also, according to the 2021 report to the WHA 74 on WHO reform, of the 108 WHO country offices with country cooperation strategies that are	1 17 73 121 158 160 180 283 470

valid or under development, 78% aligned those strategies with country support plans. In addition, 70% of WHO country offices had full incorporation of health at the outcome level in the United Nations Sustainable Development Framework, showing the added value of country cooperation strategies in achieving integration of health in national development agendas and in the United Nations Sustainable Development Frameworks.

WHO's role in the National Development plan process varies from country to country including lead role, active partner and/or contributor. An example from pacific island countries on CCS: "The CCS was drafted in consultations with the governments of Pacific Island Countries, UN agencies and key development partners." Another example from SE Asia "The WHO South-East Asia Regional Plan of Action for implementing the Global Strategy for Health, Environment and Climate Change is a ten-year set of actions for realising the Global Strategy at the regional level. It is fully aligned with the Global Strategy but tailored to the priorities, situations and contexts of Member States in the Region".

There are however limitations of CCS. The independent evaluation of the RBM framework noted that although new CCSs are better aligned to the current GPW results framework, even those monitoring frameworks are not fully aligned to the output level indicators at corporate level, and the new CCS aims to rectify this "The new CCS will make this link explicit between the country cooperation strategy and the WHO corporate planning process. But not necessarily will follow GPW cycle."

Challenges noted by one interviewee indicated duplication between the CCS and other planning documents with other UN agencies and multilateral funders. This highlights the need for good communication on the role of different planning documents at country level as the UNDSF does not replace CCS. It rather contributes to health component of UNDSF and is an institutional requirement to have CCS for WHO's focused technical cooperation in each country. Another challenge noted in the interviews is that due to the biennial operational planning process of the programme budget the biennial plan is not necessarily aligned to the CCS, as a result, it loses the value that it was set out for and becomes more a symbolic document rather than helping WHO country offices set the strategic vision for what they're going to do in the medium to long term with the respective countries or Member States. To address this the CCS team is emphasising on the strategic deliverables being the starting point of a country's operational planning with a focus on the results framework, this is ongoing work and also recommendation in the ARG plan.

5.1.2. The design process caters for the beneficiaries and vulnerable groups, the high level of consultation in development of CCSs with stakeholders, including WHO representatives from all three levels, Ministry of Health/key health agencies, representatives from other relevant sectors, UN representatives/development partners, non-government organisations (NGOs)/ civil society organisations (CSOs) including those defending marginalised groups, health experts for fragile states that have an understanding of the specific country context. Also, disease specific programmes have guidelines on how to include vulnerable groups, E.G. The Department of Mental Health and Substance Abuse have a framework of how to interact with people with lived experience (mental health issues). These are taken into consideration in the development of the CCS, and in the biennial planning process. Also, the WHO Global health sector strategies on HIV, viral hepatitis and sexually transmitted infections (2022-30) use evidence-informed guidance and service delivery innovations to accelerate access to and the uptake of a continuum of high-quality essential services tailored to meet the needs of people in diverse populations and settings, ensuring that no one is left behind. Another example of vulnerable populations being targeted: emergency in Northern Ethiopia in 2022. WHO has scaled up its humanitarian assistance, providing life-saving and essential health services. Children are also a focus (vaccination against measles, in the three regions). COVID-19 vaccination processes had continued. Medical supplies were delivered to regions who were greatly affected by drought and food insecurity. From the survey results – stakeholders agreed on this, with nearly 90% agreeing that WHO's work responds appropriately to the needs of beneficiaries, including the most vulnerable populations.

5.1.3. Organisation's country strategies or regional strategies link the targeted results to national or regional goals. **From the survey, 88% of stakeholders agree that WHO's work aligns with the national programmes and intended results of countries it works in**. The CCS defines, for each outcome, the country's strategic priorities and indicators (SDG and others) to measure progress and impact. The country itself, working together with the WHO Country Office, decides which specific targets and indicators will be chosen to track and evaluate a milestone (target). However, a synthesis of country programme evaluations in 2021 concluded that CCSs do not have theories of change nor results frameworks to give a clear picture of what

WHO will do (outputs), what it will contribute to (outcomes) and how it will be assessed, although this may be improved in the new generation of CCS as the new guideline requires CCS to be built on theories of change, but they will remain at strategic level. The evaluation of the RBM framework (2023) noted that CCSs are cast in a broad way to allow country offices to adjust flexibly within this framework depending on available funding and emerging country priorities.	
5.1.4. Strengthening WHOs presence in Countries has been core to the Transformation Agenda over the past 5 years, it is acknowledged that with the COVID-19 pandemic, this area did not move forward as anticipated, however is being addressed by the ARG and the newly agreed Core Predictable Country Presence (CPCP). It is clearly recognised that human resources are critical/key to deliver CCS on the ground. "The ultimate test of a CCS is whether the organisation has the right capacity on the ground to effectively identify needs, deliver support and make the best use of the resources available to deliver results at the country level" (PB 2018-19). In preparation of their new CCS Nepal noted the need to enhance the scale and capacity of the human resources at the country office. The alignment of resources with the new country platform guidance is underway but has not yet been achieved, and while we commend WHO for its intentions and actions in this area, the assignment of staff and resources to country offices according to the new criteria had not been implemented across the organisation in most country offices, hence we are not able to give this score more than a 2.	
MI 5.1 Evidence confidence	**High confidence**

MI 5.2: Contextual/ situational analysis (shared where possible) applied to shape the intervention designs and implementation	**Score**
Overall MI rating	**Satisfactory**
Overall MI score	**3**
Element 1: Intervention designs contain a clear statement that positions the intervention within the operating context	3
Element 2: Reflection points with partners take note of any significant changes in context	3
MI 5.2 Analysis	**Evidence documents**
5.2.1. Analysing the country context is a key step in developing CCSs, including key political, social, cultural, demographic, environmental, economic and technological implications for health. This includes reviewing the top ten causes of death/burden of disease, and analysis of the health and equity situations of countries, including addressing national priorities, strategies and plans and issues related to gender, equity and human rights. Additional considerations are included in the CCS guide for countries in fragile situations, particularly additional analysis considering service delivery, governance, health information systems, human resources, health financing, pharmaceutical products. Key considerations when preparing a new CCS include "country context, including the feasibility of developing the CCS and the presence of any immediate competing government priorities, e.g., forthcoming election, acute political instability, civil unrest or humanitarian crisis. Examples include SEARO undertaking a situation analysis to feed into a regional plan of action on Health, Environment and Climate Change (2019). Also, in development of the Global Regulatory & Fiscal Capacity Building Programme (RECAP) for each country (2022), WHO has undertaken a Needs Assessments /Situation Analysis, including an external desk review, stakeholder interviews (in collaboration with IDLO) and delivered a report drawing on the existing work and networks of WHO country and regional offices. All countries have a country plan whether or not they have an CCS and whether or not it has been updated, the country plan is agreed with the government for the priority areas of work for the biennium. Situation assessments were also carried out in the COVID-19 Strategic Preparedness and Response Plan 2019, and countries are updating their situation analyses for their applications to the Pandemic Preparedness Fund. **5.2.2. Structures are in place to take note of any significant change in context: e.g., Local context and changes in context are taken into account during the design of CCS and country priorities.** The CCS Guide 2020 states that the CCS will be reviewed regularly (a further revision of the CCS guide was ongoing in 2023), including mid-term review. "Progress in CCS implementation should be reviewed at the country level at least once every year. The CCS should also be reviewed whenever there are significant changes at the country level, e.g., a change in health situation and risks, i.e. humanitarian crisis or outbreak''. Stakeholders feedback from the survey corroborate this, in which WHO is adept at gauging the pulse of the political economy and placing itself strategically to keep its agenda moving.	73 95 101

MI 5.2 Evidence confidence *There were insufficient evaluations to determine the extent to which contextual/situational analysis were applied to shape the intervention designs and implementation. Evidence was rated as "Medium" because evidence relies on only a few documents.*	**Medium confidence**

MI 5.3: Capacity analysis informs intervention design and implementation, and strategies to address any weakness found are employed	**Score**
Overall MI rating	**Unsatisfactory**
Overall MI score	**2.20**
Element 1: Intervention designs contain a clear statement of capacities of key national implementing partners	3
Element 2: Capacity analysis, from the perspective of using and building country systems, considers resourcing, staffing, monitoring and operating structure.	2
Element 3: Capacity analysis statement has been jointly developed with country partners and shared with development partners	2
Element 4: Capacity analysis statement includes clear strategies for addressing any weaknesses, with a view to sustainability, where applicable developed jointly with development partners	2
Element 5: Reflection points with partners take note of any significant changes in capacity	2
MI 5.3 Analysis	**Evidence documents**
5.3.1. Analyses of capacity are embedded in planning processes for specific areas, e.g. in emergencies UHC, communicable diseases, NCD AMR, polio etc. The strategic prioritisation process should consider the type of support needed in countries based on factors such as capacity, health system maturity and stability. For example: the rolling out an acceleration plan about the prevention and management of obesity over the life course and related targets. First, WHO identified 28 fore-runner countries (based on epidemiological data and strategic priorities, policy environment and their expressed interest in / need for technical support). Then WHO started the RO-led intercountry dialogues with these selected countries to accelerate their progress through the development of tailored country road maps with identified priority interventions tracked across mid-term (2025) and long-term (2030) targets. A platform was established to unite countries and stakeholders. **5.3.2. Analysing the country context is a key step in developing CCSs, including key political, social, cultural, demographic, environmental, economic and technological implications for health. It does not, yet, analyse the capacity of country delivery systems in a fully systematic way, nor do guidelines set out a standardised approach how to do so.** Guidance for country strategies includes alignment with the National Plan, also include reviewing the top ten causes of death/burden of disease. WHO also recognises the importance of to analyse the health and equity situations of countries, including addressing issues related to gender, equity and human rights. e.g., Timor Leste's CCS considers the weaknesses in the country's health system and evolving socioeconomic contexts to set out the WHO country approach. In addition to CCS, WHO's work and plans consider the capacities of national partners. This is a critical aspect of upstream JEE processes and IHR requirements for national capacity strengthening, as well as health emergency programming. A number of interviewees commented that country office capacity is critical in helping to build country systems. The WHO Core Predictable Country Presence is a good example of decoding a country's capacity and making relevant follow-up. The CPCP itself is informed by systematic analysis of country context "Countries are placed into categories based on capacity, complexity and vulnerabilities." Small Island and Development States have special arrangements. Criteria such as development indices, income classification, etc. are applied. There is a typology from A to E reflecting a range in the level of support required, for each type, e.g., "targeted (B)"; "full technical support with emergency response (D)" "full support including field operations". In a way this reflects capacity analysis is being considered. This is a very recent development and progress will need to be followed across the CCS. WHO's emergency technical units have provided support to the Ministry of Health at national and subnational levels for strengthening health services to deliver effective, safe and quality interventions. This collaboration has included capacity-building by Health Cluster partners and government counterparts on	73 153 250 428 575 593 614

integrated disease surveillance and response, sustained support to the early warning and response system and policy guidance on emergency preparedness and response. **5.3.3. Capacity analysis is not standardised or defined in the guidance for WHO's country strategy development and is not clearly set out in the CCS, although examples exist of joint work.** WHO is supporting countries to strengthen their capacity for preparedness. E.G. As a State Party to the 2005 IHR, Timor-Leste is legally obliged to build national capacity for the detection and investigation of, and response to, public health risks. In 2018, a joint external evaluation (JEE) was undertaken to assess Timor-Leste's core capacities in relation to the IHR (2005). To address the recommendations of the JEE, the government made a commitment to strengthen its core capacities related to the IHR (2005) and developed the National Action Plan for Health Security (NAPHS 2020-24) with technical support from WHO. The NAPHS will serve as a framework for strengthening capacities for preparedness for public health emergencies and for health security by addressing the gaps identified by the JEE across the 19 technical areas." The COVID-19 pandemic has highlighted the weaknesses in national capacities, particularly related to pandemic preparedness and response. **5.3.4. The objectives of the CPCP are to strengthen the capacities that serve as the foundation to make WHO country offices fit-for-purpose, to ensure that country offices have the technical, leadership and managerial capacities to support the country based on their needs for WHO support to ensure that these capacities are reliable, predictable, sufficient and high quality by providing stable funding and support from all levels of the organisation.** To implement the CPCP, the ARG worked with each WR to determine the gaps that are based on what capacities are unavailable in country offices against the core positions required for the specific type of country office (regardless of funding source). Nearly all country offices provided feedback, either individually or through the Country Support Units. The inputs were processed, and a feedback loop was established on the gap analysis between the country or regional office and the respective ARG member. The WRs were also engaged to make their proposal for the grades of the CPCP positions, especially those which are to be established in their respective country offices. This has been approved by the DG and signed off by the Regional Directors (4 as of June 2023). WHO's work at the country level also supports assessments of IHR and preparedness/response capacity must come up with plans. Joint planning that identifies capacity weaknesses and solutions are inherent to large programmes such as polio, emergency response, HIG/AIDS, and NCDs, as well as part of the CCS development and renewal process. **5.3.5. The CCS process includes a mid-term review during which the external situation and capacity for implementation is assessed, e.g., a mid-term evaluation of Thailand's CCS 2017-21 was conducted, which reflects on capacity to implement the CCS and deliver against priorities.** As indicated above, national capacities have been assessed in relation to the COVID-19 pandemic and pandemic preparedness, and strengthening this capacity is part of the CPCP.	
MI 5.3 Evidence confidence *Evidence was rated as "Medium" because our methodology sampled CCS documentation and guidance. For a full assessment, analysis would include all contributing documentation to country strategy development.*	**Medium confidence**

MI 5.4: Detailed risk (strategic, political, reputational, operational) management strategies ensure the identification, mitigation, monitoring and reporting of risks	**Score**
Overall MI rating	**Satisfactory**
Overall MI score	**3**
Element 1: Intervention designs include detailed analysis of and mitigation strategies for operational risk	3
Element 2: Intervention designs include detailed analysis of and mitigation strategies for strategic risk	3
Element 3: Intervention designs include detailed analysis of and mitigation strategies for political risk	2
Element 4: Intervention designs include detailed analysis of and mitigation strategies for reputational risk	4
Element 5: Intervention design is based on contextual analysis that includes analysis of potential risks of sexual abuse and other misconduct vis-à-vis host populations	3
MI 5.4 Analysis	**Evidence documents**
5.4.1. WHO is in the process of strengthening its approach to managing operational risk. Regional processes for integrating risk management with operational planning were put in place for the	17 44

2022–23 biennium; however, they remain manual and resource intensive. The new risk management tool that is being developed in the context of the enterprise resource planning system has features which should establish a direct link between the risk identification interface and the workplans where mitigation measures are defined and resourced, which will greatly facilitate monitoring of mitigation measures during the implementation of operational plans. WHO reports that the inclusion of risk appetite in the Proposed programme budget 2024–2025 as a key principle for resource prioritization should help to ensure that mitigation measures defined at corporate level to manage Principal Risks are adequately resourced and prioritized. 58 59 73 247 304 470 473 547 580

The Country Cooperation Strategies (CCS) take risk into consideration, particularly in engagement with key stakeholders: the guidelines state to highlight any key issues and risks that may hinder implementation of the CCS (i.e., the key strategies and interventions) and prevent targets being reached, e.g., liaising with other sectors may bring to light policy barriers that need to be addressed. The Office of Compliance, Risk Management and Ethics continues to support WHO programmes to develop context specific risk management tools and guidance, as was done for the prevention of sexual misconduct. For example, work is ongoing to develop risk management guidance and tools in the context of WHO's Environment and Social Framework agenda. Similar initiatives are planned for prioritised Principal Risks in line with the Proposed Programme Budget (PB) for 2024–25." Furthermore, the Report of the Internal Auditor includes an annex with an assessment of coverage of WHO's principal risks, flagging which risk area (e.g., financing of the PB, WHO health emergencies programme), the current level of risk criticality as well as the examples of the IOS-specific audit work related to the risks (2021). 583

The WHO Governing Bodies Risk Response Action Table 2023 is evidence to show that operational risks to governing bodies have been identified by WHO with corresponding responses and actions. A Risk Appetite Statement has been developed and was piloted in the context of strategic decision-making; it has been incorporated into the Risk Management Strategy. The Risk Appetite Statement seeks to guide the workforce in their daily decision-making and related resource prioritisation, especially when facing complex situations and dilemmas. The application of the draft Risk Appetite Statement in programmes and operations would help the organisation to adopt a consistent approach to ensure that it takes the right kind and quantity of risks while reinforcing the accountability of key decision-makers at all levels across the organisation by providing them a harmonised framework to balance risks and rewards in decision-making and planning processes. An operational guide and training materials are under development to increase awareness in relation to the application of the proposed methodology across the three levels.

It is acknowledged that WHO faces increased operational risks, which needs to adopt an expanded and different approach: "risk management cannot be a separate administrative process but must be embedded into the daily decision-making of all actors who contribute to delivering health outcomes, informing their strategic and operational choices as well as related resource prioritisation." One feedback from survey, however, notes that the applied risk mitigation plan is either very generic or non-adaptable to promptly accommodate the dynamic local context.

5.4.2. The successful implementation of GPW13 requires a fit-for-purpose risk management approach. WHO is in the process of defining an enhanced and more ambitious enterprise risk management approach. In 2019, a concept note was developed that aims to strengthen the organisation's risk culture while ensuring that risk management is effectively embedded in the accountability mechanisms for delivering results. Furthermore, the inclusion of risk appetite in the Proposed Programme Budget 2024–25 as a key principle for resource prioritisation helps to ensure that mitigation measures defined at corporate level to manage Principal Risks are adequately resourced and prioritised. As above the strategic risk framework is applied to risk across all levels of the organisation. The Risk Management Committee reviews the various risks, also the risk registers and internal control self-assessment checklists contain the various relevant risks where BOs across the organisation must complete each year.

Guidance on strategic risk assessments provided in Strategic Toolkit for Assessing Risks which is a comprehensive toolkit for all-hazards health emergency risk assessment published in 2021. Strategic risk assessments can be conducted at all stages of emergency preparedness and response cycle, including during an ongoing emergency.

The Strategic Tool for Assessing Risks (STAR) offers a comprehensive, easy-to-use toolkit and approach to enable national and subnational governments to rapidly conduct a strategic and evidence-based assessment of public health risks for planning and prioritisation of health emergency preparedness and disaster risk

management activities. This guidance describes the principles and methodology of STAR to enhance its adaptation and use at the national or subnational levels.

WHO's work in health emergencies Public health emergencies/preparedness and response report to WHA 76 in May 2023 reported a total of 95 all-hazards strategic risk assessments had been undertaken by the end of the reporting period using WHO's STAR, which since its publication has helped countries to develop all-hazards country risk profiles to provide real-time evidence in planning and interventions in order to prepare for and respond to multiple hazards, including by reviewing pandemic response plans and prioritising actions. WHO has developed an emergency and disaster risk calendar to complement the tool by mapping the seasonality of hazards, which enables national and subnational authorities to better plan.

5.4.3. The political situation is one of the themes in the country context, as stated in the CCS. The CCS can provide a steadfast focus on a given country's priorities and public health impact despite changes in the political agenda. The CCS is a political instrument to promote national ownership and intersectoral approaches to achieve all health-related SDGs. Thus, when preparing a new CCS, the country context, including political instability, civil unrest or humanitarian crisis, should be considered. Political considerations include government structure, public participation in governance, financial structures, and influence of the country on the subregional, regional and global development agenda. Additionally, in developing the Principal Risks (by the WHO Global risk Management Committee), and the development of the risk appetite framework, WHO considered, quantified and voted on political risks.

5.4.4. There is evidence that the design includes the dimension of considering reputational risk. Due diligence and risk assessments, particularly for reputational risks, are conducted when proposing new partnerships. The organisation has increased engagement with non-State Actors, at the heart of this progress are due diligence and risk assessments which are consistently conducted to preserve the integrity of WHO. FENSA outlines the principles with which WHO partners with non-state actors. It serves to protect and preserve WHO's integrity, reputation, and public health mandate. Engagement with non-State actors must not compromise WHO's integrity, independence, credibility, and reputation.

A Handbook was published in 2018, with the purpose to guide non-State actors in engaging with the World Health Organization (WHO) by walking them through The Framework of engagement with non-State actors' principles and processes and ensure smooth implementation of the Framework. A step-by-step process (a total of five steps) and principles of engagement are key sections in the Handbook. Proposals for non-state engagement are reviewed for compliance through well-defined processes to ensure consistent and coherent implementation of WHO's policies. Interviewees felt the process is very rigorous to the point of deterring collaboration with NSAs. Interviewees commented that they need to balance the risks vs the benefits when dealing with non-state actors, ensuring that the organisation's reputation is preserved.
The FENSA agreement includes a red line which says that the WHO does not engage with tobacco industry and associated non-state actors, e.g. lobbying, or NGOs that further the interests of the tobacco industry. Also, WHO does not engage with the arms industry.

5.4.5. SEAH risk has been acknowledged by WHO to be an increasing risk. As of 2022, appropriate risk management tools are being implemented and monitored across the levels of the Organisation.

SEA has been included as an enterprise-wide risk to WHO in 2022. WHO's 2023 Policy on Preventing and Addressing Sexual Misconduct (PASM) explicitly commits to prioritising a range of risk management approaches to safeguard from sexual misconduct. These include a requirement for leadership positions to assess and manage risk at a corporate level, for tools to be developed to support adaptive and contextual risk assessment & mitigation activities at both country level and programme level, conduct trainings on risk management, and collaborate at the inter-agency level to manage SEA risk through joint mitigation measures. This is supported by the Accountability Framework published in July 2023, which details the responsibilities and accountabilities of WHO staff in relation to the management of WHO's principal risks, including risks of sexual misconduct.

In 2022, a sexual misconduct risk assessment tool was launched and piloted in 30 countries. All country offices, except in the PAHO region, completed assessments in 2023. An online version of the annual risk assessment was then piloted in 2023 for roll out in 2024 and our now mandatory. An SEA risk management tool has also been developed and implemented, including for the use in emergencies. These country exercises are used by Regional Coordinators to support funding and mitigation for PRSEA. On inter-agency collaboration, since the on-set of the COVID-19 pandemic, WHO have prioritised bilateral collaborations with

UN entities and other agencies who are a part of the Risk Communication and Community Engagement collaborative service on integrating PRSEAH. In MOPAN's partner survey, overall, 75% "Strongly Agree", "Agree" or "Somewhat agree" that WHO manages risks at country level effectively. Close to 20% responded "don't know/no opinion".	
MI 5.4 Evidence confidence	**High confidence**

MI 5.5: Intervention designs include the analysis of cross-cutting issues (as defined in KPI 2)	**Score**
Overall MI rating	**Unsatisfactory**
Overall MI score	**2.50**
Element 1: Approval procedures require the assessment of the extent to which cross-cutting issues have been integrated in the design	2
Element 2: Plans for intervention monitoring and evaluation include attention to cross-cutting issues	3
MI 5.5 Analysis	**Evidence documents**
5.5.1. The development of the CCS takes into account cross-cutting issues. The 2020 Country cooperation strategy guide states that cross-cutting issues (e.g., equity, gender, human rights) should be analysed, especially when they complicate or impinge on efforts to address key health challenges which have been identified. Further guidance is provided in the analysis of health and equity. Gender a focus for inclusion in all plans, however it is expected that the gender markers would be in place for the 2024-25 cycle. The Polio Eradication Strategy 2022-26 has identified key factors in creating an enabling environment, such as "investing in R&D of new innovations that support eradication; applying a gender equality lens to the implementation of programme activities". The interviewees informed that for disability there is an accountability framework from the UN. Disability is part of the output scorecard. There is a steering committee, at ADG level with the DDG chairing. It also includes the Executive Director on Emergencies. This governance structure is key to its success. However, a number of survey respondents mentioned that WHO needs to put more focus on disability issues. E.g., reporting and activities for increasing access and participation for people with disabilities and most vulnerable groups need to be improved, and that the Disabled People Organisations should be included in planning and implementation. WHO needs to pay more attention to people with disabilities in its operations and programmes. **5.5.2. Cross-cutting themes are monitored in the Country cooperation strategies.** Key milestones for monitoring and evaluation are included throughout the CCS cycle and include a CCS evaluation, midterm evaluation, and final evaluation. These evaluations monitor CCS implementation by assessing how the operational plans are accomplished. The main focus of the evaluation is to determine whether the CCS has contributed towards the triple billion goals and identify any risks to the strategic priorities. Three overarching principles (human rights-based approach, mainstreaming a gender perspective and equity in health) underpin evaluation design. Human Rights and equity are fundamental underpinning the CCS and monitored through a number of disaggregated indicators. Regarding monitoring of gender as a cross-cutting issue the interviewee indicated "It is expected that the gender markers will be in place for the 2024-25 cycle and will be included in the new BMS tool. Important to note that, however, not all programmes will explicitly highlight their budget in this area, or saying they use a 'leave no-one behind' approach or they are using the gender tools, so it may be difficult to monitor the indicator. However, there is a narrative report and scorecard which can be used to reflect how gender is applied.	9 47 73 189 715
MI 5.5 Evidence confidence *Evidence was rated as "Medium" because our methodology sampled CCS documentation and guidance. For a full assessment, more evaluations on the topic are required. In addition, evidence relies heavily on interviews with key informants, which are supplemented by some documentation.*	**Medium confidence**

MI 5.6: Intervention designs include detailed and realistic measures to ensure sustainability (as defined in KPI 12)	**Score**
Overall MI rating	**Satisfactory**
Overall MI score	**2.75**
Element 1: Intervention designs include statement of critical aspects of sustainability, including institutional framework, resources and human capacity, social behaviour, technical developments and trade, as appropriate	3
Element 2: Intervention design defines key elements of the enabling policy and legal environment that are required to sustain expected benefits from successful implementation	3
Element 3: The critical assumptions that underpin sustainability form part of the approved monitoring and evaluation plan	2
Element 4: Where shifts in policy and legislation will be required for sustainability, the intervention plan directly addresses these reforms and processes in a time sensitive manner	3
MI 5.6 Analysis	**Evidence documents**
5.6.1 Intervention designs include statement of critical aspects of sustainability, including institutional framework, resources and human capacity, social behaviour, technical developments and trade, as appropriate: Sustainability underpins the GPW13 and the Transformation Agenda, specifically as the goals are aligned to the SDGs as evidenced in KPI 1. Also, the CCS in aligning with and supporting the National Health Development plans foster sustainability. One interviewee noted ''Under Tedros' leadership, WHO really built the sustainability agenda.". Sustainability was considered when reallocating resources for SARS-CoV-2 surveillance, also it is recognised that in designing local responses, ensuring sustainability is fundamental. In order to ensure sustainability of their human resources the European Observatory (hosted partnership) their model is evolving with progress on creating a middle tier of technical staff who can manage projects, increase capacity and ensure long term continuity. **5.6.2. Intervention design defines key elements of the enabling policy and legal environment that are required to sustain expected benefits from successful implementation.** WHO supports countries to change or update policies and their legal framework in order to adopt key interventions. There are several examples of WHO designs in identifying an enabling environment (in policy and legal environment): The WHO global reproductive health strategy emphasises that creating supportive legislative and regulatory frameworks and removing unnecessary restrictions from policies and regulations is likely to contribute significantly to improved access to services**.** To do this, Member States review and, if necessary, modify laws and policies to ensure that they facilitate universal and equitable access to reproductive and sexual health education, information and services. Another example is the support to countries in establishing their National AIDS Councils for the prevention and management of HIV and AIDS which in many countries required changes in legislation and has resulted in massive upscale of people on treatment for HIV and AIDS and resulting reduction in morbidity and mortality. **5.6.3. The critical assumptions that underpin sustainability form part of the approved monitoring and evaluation plan. Individual programmes include monitoring of sustainability in their programme areas, however the RBM report indicated that there is insufficient monitoring, and this area needs to be strengthened.** **5.6.4. Where shifts in policy and legislation will be required for sustainability, the intervention plan directly addresses these reforms and processes in a time sensitive manner.** Examples of successful shifts in policy and legislation for sustainability include the International human rights standards that require that states not only refrain from activities that interfere with individuals' pursuit of their own health needs, but also remove legal and regulatory barriers to access to sexual and reproductive health services, such as laws or regulations that limit access to contraceptives. States must also ensure that both state-supported (public) and private health services are regulated and monitored for adherence to health and human rights standards. Barriers to sexual health that are susceptible to regulation by law include: access to essential medicines, conscientious objection by health-care providers, availability and quality of health-care providers and facilities, and criminalisation of certain services. WHO supports countries in changing policy and legislation in this respect. Another example is the Framework Convention for Tobacco Control where changes in legislation are needed and are monitored by WHO. These have been regularly reported to the WHA since	14 52 56 77 107 189 224 257

its adoption in 2005. Another example is the International Health Regulations, IHR, last updated in 2005, with 100% of countries reporting to the WHO, these are now undergoing updating in light of experiences gained during the COVID-19 pandemic.	
MI 5.6 Evidence confidence *We would have expected a higher volume of documents to be available for this MI at country level, but were unable to access these, hence "medium" confidence. More evaluations on the topic would be required to assess to what extent the interventions have ensured sustainability.*	**Medium confidence**

MI 5.7: Institutional procedures (including systems for hiring staff, procuring project inputs, disbursing payment, logistical arrangements etc.) positively support speed of implementation and adaptability in line with local contexts and needs	**Score**
Overall MI rating	**Unsatisfactory**
Overall MI score	**2.25**
Element 1: Organisation has internal standards set to track the speed of implementation	2
Element 2: Institutional procedures are adaptable to local contexts and needs	3
Element 3: Organisation benchmarks (internally and externally) its performance on speed of implementation across different operating contexts	2
Element 4: Evidence that procedural delays have not hindered speed of implementation across interventions reviewed	2
MI 5.7 Analysis	**Evidence documents**
5.7.1. Systems are in place that combine to track how resources are used, and are linked to KPIS. These include for finance, PRP, HRT, procurement, Global Service Center for implementation, as well as the KPI dashboards available on Regional Office websites. Implementation is also done across the Organization, inclusive of Regional Offices and Country Offices. WHO reflects that these were successfully enabled increased organizational agility during COVID-19, as well as enable a 90% implementation rate for the 2022-2023 biennium. Each have KPIs/benchmarks that track implementation progress. Implementation in country remains an issue, however, we heard. This is one of the areas flagged in the interviews by senior management that will be addressed by the forthcoming new BMS; they report this will be far more intuitive and comprehensive than the current GMS the first module of which will be procurement, due to be rolled out in 2024. We look forward with interest to see the new system in action.	73 81 91 160 248 254 406 418 706 764 785
5.7.2. WHO aims to adapt to local contexts and needs, in view of the COVID-19 pandemic the Country Offices prioritised their support, between January and February 2020, for the preparation of a national response strategy by providing assistance to Ministries of Health and partners. By March 2020, more than three quarters of WHO CO worldwide had initiated support for logistics, supply chain and procurement, as well as the production of situation reports. and the development of a monitoring framework for the response. As the COVID-19 pandemic continued a review of all workplans was undertaken in May- June 2020 to understand the implications of the pandemic on non-emergency work in relation to Programme Budget for 2020-21, which deliverables that might require postponement, to refocus original plans, and ensure consistent support to Member States and to approach donors and partners if any of the projects need adjustments or repurposing. The review showed that despite the organisation-wide response to COVID-19, commitment to the base programme activities remained strong. Another example of adaptability is the recently agreed ARG recommendation on the Core Predictable WHO country presence, CPCP with procedures being set up to adapt to local context and needs. Individual programme areas have strategies that will be adapted to the country needs E.G. The Multisectoral Accountability Framework - to accelerate progress to end tuberculosis by 2030: The four components of the framework and the elements listed under each component should be adapted, adopted and agreed at country level within the context of constitutional, legal and regulatory frameworks, as well as political, social, professional, moral and ethical codes of conduct and uncodified traditions and conventions. Most of the elements have been defined in general terms only, because there is a need for country adaptation. There will be differences among countries in the extent to which different elements already exist, need strengthening or are relevant, and how they are put into practice.	

5.7.3. This element focuses on the use of benchmarks towards internal and external clients. WHO has internal benchmark systems included for HR, finance, PRP and the Global Service Centre, which has had a set of KPIs for user satisfaction for all of its services. Benchmarks are applied to recruitment, though are mainly unmet, it is anticipated that performance tracking against benchmarks will be addressed by the forthcoming new BMS, the first module of which will be procurement, due to be rolled out in 2024. WHO also report that systems such as the AFRO Regional KPI platform (intranet) has been operational for 5+ years and captures many of the managerial and accountability systems and reports this system has been replicated in other Regional Offices. KPIs have been published (on the Member States Portal) for WR accountability. WHO also reports there are also many KPIs and benchmarks that are part of the Emergencies Programme, including for response time and the ERF.	
5.7.4. It is recognised that procedural delays in the hiring of staff have been a problem and a number of measures have been put into place to reduce recruitment time, though as already been indicated this remains unacceptably long. Furthermore, over a quarter of WHO country offices (26%) cited the internal challenge posed by the limited availability of staff or the skill set required to meet the unprecedented needs of COVID-19 preparedness and response. Furthermore, 33 WHO CO (22%) reported the disruptive effect of a lack of funds, or disbursement delays, and 13 WHO CO (9%) shared the challenge of difficult working conditions (including working remotely and staff burnout)." Although the COVID-19 pandemic was an exceptional time, it challenged the organisation and lessons learned are being used to improve the systems. WHO points out its ability to execute its budget as evidence that implementation is not impaired; we take the view that procedural delays did hinder the pace of implementation in a sufficient number of country offices to be unable to award a 3 for this indicator.	
MI 5.7 Evidence confidence *Evidence was assessed as "Medium" because as noted above, the evidence related to implementation and monitoring across interventions is fragmented, and therefore not all relevant evidence may have been identified. More evaluations would be required to determine the extent in which institutional procedures had contributed positively to implementation and adaptability in line with local contexts and needs.*	**Medium confidence**

KPI 6: Working in coherent partnerships directed at leveraging and catalytic use of resources	**KPI score**
Satisfactory	**2.85**
MI 6.1: Planning, programming and approval procedures enable agility in partnerships when conditions change	**Score**
Overall MI rating	**Unsatisfactory**
Overall MI score	**2.33**
Element 1: Procedures in place to encourage joint planning and programming	3
Element 2: Mechanisms, including budgetary, in place to allow programmatic changes and adjustments when conditions change	2
Element 3: Institutional procedures for revisions permit changes to be made at the appropriate level to ensure efficiency	2
MI 6.1 Analysis	**Evidence documents**

6.1.1 WHO has procedures that can enable agility in partnerships when conditions change. WHO uses the Country Cooperation Strategy (CCS) process to facilitate coordination, joint planning and programming with country partners, but evidence is mixed on how well they are updated. Procedures in the CCS help align WHO with countries' priorities. The guide for implementing CCS lists six stages of "a successful" CCS process; conducting dialogue, drafting, launching, implementing the CSS and finally, monitoring and evaluation. The CCS seeks to harmonise WHO cooperation in countries with the work of other UN agencies and development partners, as guided by the CCS. We found that not all CCS are kept fully up to date, nor are they necessarily modified as conditions change. For instance, in 2020, there were 28 countries under WPRO where the CCSs were not yet aligned with GPW13, nor had they been revised according to the 2020 WHO Guidelines. By mid-2023, only 46 out of 190 offices had a 'valid' CCS according to WHO's own Global Tracker of CCS, with only 24 in total being drafted to include 2023. The United Nations Sustainable Development Cooperation Framework ("Cooperation Framework") (UNSDCF) determines a country's development priorities as well as the UN development system's contributions to them. WHO's guidance is explicit that the CCS is to informs and reinforce the health dimension of the UNSDCF. It serves as the main instrument for harmonising WHO's activities in a given country with the work of other UN agencies and development partners to deliver the SDGs. Key among those is UNAIDS, and the framework of the Grand Bargain. Owing to specific WHO technical mandates, the CCS sets out strategic priorities which exceed those of the UNSDCF. It also uses the UNDSCF for particular thematic work such as Antimicrobial Resistance (AMR). A new guidance for UN country teams builds the case for AMR as a development issue and component of broader issues such as One Health, UHC and health security, food systems and planetary health: it aims to establish AMR as a higher priority on the policy and development agenda; stimulate multi-stakeholder interest; and attract funding. For all graded and protracted emergencies, WHO policy is that it will develop strategic response and joint operations plans together with national authorities and partners, using mechanisms such as health clusters for coordination. WHO has proved it can be agile if required, and there are multiple examples from the COVID-19 pandemic of it being so at country, regional and global level. The rapid creation in 2020 of multiple new partnership mechanisms and platforms for co-ordinated action on reporting, vaccine development and clinical management in response to the pandemic was unprecedented (e.g., WHO SPRP for COVID-19, COVID-19 Vaccines Global Access (COVAX) and Access to COVID-19 Tools (ACT) Accelerator (ACT-A) as platforms to enable joint planning) In its emergency response work there is a culture of rapid adaptive management responding to changing conditions.

37 39 62 73 81 86 95 145 158 190 214 238 302 313 314 438 612 613 667 669 683

6.1.2. The Covid-19 pandemic demonstrated WHO can adjust what it does to respond to change, but funding modalities constrain agility under normal conditions. Many stakeholders interviewed, mentioned that WHO's current business as usual resourcing mechanisms constrains its agility, specifically because of the high proportion (over 80%) of the budget provided through VC by funders. These funds are earmarked for specific activities or thematic actions; this results in a lower score for this indicator. WHO and its funders have formally committed to reduce the proportion of funds that are VC over the next biennium, as well as move to a replenishment model which will also seek to enable financial flexibility, but during the period under review, the high VC spend was seen as a key constraint to agility at activity level. In contrast, there is evidence that proposals to increase the PB can be made, with a condition that the proposal has to be explained to Member States. When COVID-19 hit, investments in catalytic partnerships and resource mobilisation capacities of the Secretariat increased, for instance the rapid mobilisation of USD 331.8 million for WHO's pandemic response in African region and WHO strengthened its partnership with Africa Centres for Disease Control and Prevention (CDC)and diversified the funding base to include global and continental private sector actors. COVAX and ACT-A. It is notable that in response to our survey, 88% of respondents "strongly agree", "agree" or "somewhat agree" that WHO has successfully used new and existing mechanisms to respond to the needs of its partners during the COVID-19 pandemic.

6.1.3 WHO and Member States have recognised that increased delegation is required to country offices. During 2023 a new global DOA was signed by the DG and five regional directors, in recognition that change was required from the conditions that had been in place for the period here under review. This was put in place specifically to give greater authority to WRs and to enable country offices to be more agile, make timely decisions and respond more quickly to the changing situations on the ground. Other measures put in place included WHO's work and policy on flexible working arrangements (during COVID-19, new approaches to Business Continuity management and other innovations regarding KPIs and dashboards in Regional Offices. There remain challenges in the application of the new global DOA; collaborating with key staff in the regional offices, work is underway in the regions to ensure the DOA is fully implemented to achieve its intended objectives. This was not in place during the period of our review, hence the lower score.

MI 6.1 Evidence confidence	High confidence

MI 6.2: Partnerships are based on an explicit statement of comparative or collaborative advantage e.g. technical knowledge, convening power/partnerships, policy dialogue/advocacy	Score
Overall MI rating	Satisfactory
Overall MI score	3.2
Element 1: Corporate documentation contains clear and explicit statement on the collaborative advantage that the organisation is intending to realise through a given partnership	4
Element 2: Statement of comparative advantage is linked to clear evidence of organisational capacities and competencies as it relates to partnership	3
Element 3: Resources/competencies needed for intervention area(s) are aligned to the perceived comparative or collaborative advantage	3
Element 4: Comparative or collaborative advantage is reflected in the resources (people, information, knowledge, physical resources, networks) that each partner commits (and is willing) to bring to the partnership	3
Element 5: [UN] Guidance on implementing the Management and Accountability Framework exist and is being applied	3
MI 6.2 Analysis	**Evidence documents**
6.2.1 WHO's comparative advantage is set out in its corporate documentation. WHO's engagement with non-State actors is guided by documented overarching principles that include the roles of each partner, consistent with the WHO's constitutional mandate. A new policy for work with non-state actors has been drawn up, and the associated FENSA sets out how WHO's partnerships range from lighter engagements such as participation in each other meetings, to more meaningful technical collaboration such as collaboration in emergencies, operations and also field visits to some country officers with the support from non-state actors. Partnerships have to "add value" to the work of WHO. Each partnership is governed by a MOU that must comply with FENSA guidelines. At the same time, WHO is putting in place broader partnership agreements with key institutions, including with organisations such as the African Union, the Commonwealth Secretariat or the Organisation Internationale de la Francophonie. For country level, the Working for Health 2022-30 Action Plan set out how WHO, together with Member States and stakeholders, support countries to build and strengthen their health and care workforces. WHO has also put in place the WHO Collaborating Centres. **6.2.2. WHO has a mandate to lead in the UN system on health issues, a role strengthened during the COVID-19 pandemic.** WHO led the response to the COVID-19 pandemic and its role was of global significance and impact. WHO's leadership role for health emergencies strengthened as result of the COVID-19 pandemic. FENSA guidance is that they have to "add value" to the work of WHO in the context of organisation's capabilities. Documents reviewed show the comparative advantage of WHO across specific thematic areas, e.g. the Partnership for Maternal, Newborn and Child Health supports WHO's delivering the GPW13 or WHO's coordination role in the Refugee Health Extension, an initiative with European Centre for Disease Prevention and Control, International Organisation of Migration (IOM), UNFPA, United Nations High Commissioner for Refugees (UNHCR) and UNICEF, the framework for strengthening health emergency preparedness in cities and urban settings. **6.2.3. While some resources available to deliver WHO's mandate are realigned to facilitate partnerships, the primary function of many partnerships is to add value to WHO's programme of work and resources.** WHO Partnership Policy (WHA66) sets out expectations. We heard of many variations how WHO's collaboration and exercising of its comparative advantage differs from team to team, thematically and in country. Overall, WHO's convening and delivery roles have been strengthened over the period under review, and capacity built e.g. FENSA training. This has been driven both by the transformation process linked to GPW13 and Member States and enabled by the response to COVID-19 (for instance COVAX, ACT-A). Annual reports are provided to EB/WHA on specific reviews of partnerships. WHO has significantly reconsidered the capacity and resources required for it to function, not least in-country, as part of its Transformation Agenda. There is agreement to increase resources available in-country. A Core Predictable Country Presence (CPCP) has been identified to deliver against WHO's mandate; the CPCP is calibrated against the capabilities of the	16 34 36 67 76 96 168 169 196 219 232 234 343 352 375 419 469 498 666 684 685

host country to deliver and oversee health delivery in their contexts and what therefore WHO is likely to have to do to respond. WHO is also seeking to make more explicit what partners bring to its partnerships, at country level and with non-state actors. Partners support these organisational changes and seek their acceleration. **6.2.4 WHO seeks to ensure that value added (rather than specifically stating comparative or collaborative advantage) is reflected in the resources it brings to partnerships.** Partnerships are intended to demonstrate alignment with GPW13 Member States and WHO support the aims of the GPW13 Transformation Agenda so that human and financial resources, structures and operational changes are better aligned to deliver WHO's comparative advantage. MOU's underlying FENSA agreements set out the resource expectations of WHO's non state partners. As the global health architecture evolves, there is evidence from documents that WHO has been optimising international partnerships for country-level impact, as reflected in the level of technical collaboration with bilateral partners (beyond their financial roles). Over two thirds of WHO's country offices reported that they worked with bilateral partners, within their technical capacity, on health emergencies; 59% on UHC and 49% on healthier populations. In 2021-22, nearly all WHO country offices engaged with non-State actors to advance towards improved health outcomes. Most country offices worked with academic institutions (84%), local NGOs (78%), the media (76%), professional bodies/associations (72%), CSOs (68%), international NGOs (61%). These collaborations enable more effective delivery against country priorities, suggesting that these partnerships and collaborations were strategically identified. At the same time, WHO's engagement with inherently political forums, such as the G20, has also increased, with WHO being an official participant in the Sherpa, leader-level and health tracks. **6.2.5 WHO operates to apply the UN Management and Accountability Framework in practice.** We found no general WHO guidance adding further information. WHO informed us that the WHO Office in NY (WUN) is the lead for managing this area of work. WRs communicate directly with WUN on problem solving. Guidance of Engagement with the UNCT in the context of the UN Management Accountability Framework was developed and shared with Regional and Country levels in 2022.	
MI 6.2 Evidence confidence	**High confidence**

MI 6.3 Demonstrated commitment to furthering development partnerships for countries (e.g. support for South-South collaboration, triangular arrangements, and use of country systems)	**Score**
Overall MI rating	**Satisfactory**
Overall MI score	**3**
Element 1: Clear statement on how the organisation will support principles of collaboration with countries on their development agenda (Nairobi Principles, 2030 Sustainable Development Agenda)	3
Element 2: Clear statement/guidelines for how the organisation will support development partnerships between countries	4
Element 3: Clear statement/guidelines for how the organisation will use country systems	3
Element 4: Internal structures and incentives supportive of collaboration/cooperation with countries, and use of country systems where appropriate	2
MI 6.3 Analysis	**Evidence documents**
6.3.1 WHO focuses much of its work on strengthening the response to health challenges in the countries where it works; this is codified in WHO policy and CCS guidance which makes specific reference to the need to support countries' achievement of the health-related Sustainable Development Goals. The CCS process is intended to support inclusive and evidence-based national development planning, and according to the 2020 CCS Strategy Guide "*responds to that country's National Health and Development Agenda and identifies a set of agreed joint priorities for WHO collaboration, covering those areas where the organisation has a comparative advantage in order to assure public health impact*." WHO's process explicitly looks to express national priorities in its planning and engages with country governments and civil society and the private sector in policy dialogue and in its country programmes of work to achieve the SDGs. WHO also references other global commitments, such as the Nairobi Principles, in its wider guidance. We note that in 2020 WHO assessed not all country plans were fully updated in a timely way. **6.3.2 WHO supports the South-South and triangular cooperation (SSTC) to achieve SDGs as mandated by**	15 34 36 58 72 73 134 150 160 193 196 204 224 308

Member States. Many examples exist around particular key themes of WHO supporting partnerships to achieve specific objectives, e.g., Action on Social Determinants of Health, NCDs, Emergencies, and COVID-19. The CCS Guide 2020 (a further revision of the CCS guide was ongoing in 2023) sets out, as part of the processes of analysing and then building effective partnerships in support of the achievement of the SDGS, that the WHO in each country should look for the opportunity to enable South-South and Triangular Cooperation. Each WHO regional office has a key role in linking health expertise and organisations between the countries in their region, developing common approaches and cross learning to specific challenges. Multiple activities are reported on annually by regional offices showing how they seek to build cooperation on issues from Polio to HIV to UHC. For EMRO, a Communications, Resource Mobilisation and Partnership department, was established in 2019 to galvanise and coordinate action across the region. However, from our review of documentation SSTC could be more explicitly set out in some of the regional strategies, and survey respondents noted co-ordination around specific issues could be improved e.g., on the zoonotic outbreaks like anthrax, rabies to avoid duplication. **6.3.3 WHO's country planning guidance does not explicitly set out how it will use country systems, though that should where possible work to support and strengthen them**. The WHO's country planning process begins (as recommended in the Country Co-operation Agreement) with an analysis of the health and development agenda that should be both vertical (alignment with national priorities and SDG action plan) and horizontal (interconnectedness of targets, indicators and 2030 agenda and GPW13 data). It does not, explicitly, assess country capacity, however it says analysis should make every effort to identify gaps relating to the country context which could be addressed and bridged by the CCS, as a source of added value and support. In response to MOPAN's survey, 88% of respondents "Strongly Agree", "Agree", or "Somewhat Agree" that WHO helps develop the capacity of country systems where it works. **6.3.4 While our survey indicates that WHO does use them, it is not clear how WHO incentivises the use of country systems for its work.** WHO's new Common Predictable Country Platform (CPCP) sets out the conditions for different levels of resourcing based on an assessment of the capability of the country, though it is not fully codified in all guidance what strong or weak capacity is. We did not find evidence of clear criteria governing the conditions when WHO should and should not provide assistance through host government institutions. The WHO Emergency Response Framework (2017) stated that the health sector coordination mechanism is ideally to be established and managed by Ministry of Health, with technical and operational support provided by WHO; IHR and emergency preparedness/response use country systems.	419 469 566 567
MI 6.3 Evidence confidence *Evidence was rated as "Medium" because evidence related to furthering development partnerships for countries is fragmented across multiple guidance documents. For a full assessment, analysis would require more evaluations on the extent in which country systems were used, as highlighted in element 4 above.*	**Medium confidence**

MI 6.4: Strategies or designs identify synergies with development partners, to encourage leverage/catalytic use of resources and avoid fragmentation in relation to 2030 Sustainable Development Agenda implementation	**Score**
Overall MI rating	**Satisfactory**
Overall MI score	**3.25**
Element 1: Strategies or designs clearly identify possible synergies with development partners and leverage of resources/catalytic use of resources and results	3
Element 2: Strategies or designs clearly articulate responsibilities and scope of the partnership	3
Element 3: Strategies or designs are based on a clear assessment of external coherence	4
Element 4: Strategies or designs contain a clear statement of how leverage will be ensured	3
MI 6.4 Analysis	**Evidence documents**
6.4.1 There are multiple examples where WHO seeks to include the consultation and coordination with international, country and non-state actor partners to ensure coherence and complementarity, but fragmentation of financing needs to be reduced. An example where synergies are clearly set out include the three-year Global Action Plan for Healthy Lives and Well-being for all (SDG3 GAP) by the UNGA - with WHO	20 34 67 76 106

as one of the 13 signatory agencies. The Working for Health 2022 - 2030 Action Plan is an example of a partnership with International Labour Organisation (ILO) and Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee; it is delivered via pooled funding through a Multi-Partner Trust Fund and catalytic technical support. At the country level, the CCS should set out the complementarity and synergies of WHO with others' activities. One respondent to our survey noted that "*COVID-19 saw the best and worst of all agencies in terms of competition for financing and there needed to be better coherence to ensure that all financing and efforts from all partners were more pooled together and rallied around country needs and priorities rather than driven using a more top-down approach*." Some respondents to MOPAN are concerned that not enough is being done to ensure coherence in the use of resources across all WHO's partnerships; 58% "Strongly Agree", "Agree", "Somewhat Agree" that WHO coordinates its financial contributions with partners to ensure coherence and avoid fragmentation / duplication at country level. Over 20% of (global) peer organisations disagree that it does (close to 10% strongly disagree). We also note that, uniquely among multilateral organisations, one of the largest contributors (almost 10%) to WHO's budget is the Bill and Melinda Gates Foundation, which contributes more than 88% of all philanthropic funding to WHO. **6.4.2 Many strategies and designs clearly articulate responsibilities and scope of the partnerships. These are set out in the MOUs with partners and with WHO's agreements on joint working with other UN agencies, for example.** Much work over the period of the review has specifically gone into how WHO engages with non-state actors to achieve more effective collaboration, set out FENSA guidelines and governed by a handbook published in 2019. The Secretariat also assesses whether such actors are mandated to have (the more substantial) "official relations", which are then articulated clearly in bilateral agreements and submitted to the Board for approval. Across the UN, the Strategic Preparedness, Readiness and Response Plan to end the global COVID-19 emergencies established in 2022 between WHO, UNICEF and Gavi is a good example of how the WHO sets out roles and responsibilities in delivering the global response to COVID-19. It also set out how national government-led "One Country Teams" (which comprises UN country teams led by WHO, public and private stakeholders, etc.) should be put in place to concentrate on planning and budgeting, etc. Other examples included COVAX and ACT-A. **6.4.3 Many if not all WHO strategies and activities seek to promote external coherence in response to global health challenges, though it is not clear how much formal assessment of coherence has been undertaken**. Mechanisms such as the CCS and FENSA seek to structure external coherence, as do specific initiatives; the Global Action Plan for Healthy Lives and Well-being for all (SDG3 GAP) and the SPRP in the face of COVID-19 are examples. WHO actively seeks coherence, for instance to promote Universal Health Coverage, WHO supported ministerial-level events on universal health coverage and mobilised permanent representatives of United Nations Member States to participate in the International Universal Health Coverage Day campaign. For other issues, such as developing a Global Strategy on Digital Health 2020-25: "*The [WHO] Secretariat will promote collaboration among stakeholders to ensure progress by building synergies, facilitating technical collaboration, and developing digital global public goods that can be shared and used globally. The collaboration will include building on synergies, facilitating technical collaboration, and developing quality assured and evidence based global digital health public goods that can be shared and used globally*." **6.4.4. WHO sets out how to engage with non-state actors through its FENSA process, including how to leverage benefits and finance in response to global health challenges, which it does explicitly to leverage external resources to support its targets.** This takes place from global to programmatic scales. Notably we heard examples where WHO is leveraging value from non-state partners whose significant contribution is not made public. WHO and its staff are extremely sensitive to both the benefits, and the risks, of entering into partnerships with private institutions and companies.	107 134 183 224 241 308 325 343 567
MI 6.4 Evidence confidence	**High confidence**

MI 6.5: Key business practices (planning, design, implementation, monitoring and reporting) co-ordinated with relevant partners	**Score**
Overall MI rating	**Satisfactory**
Overall MI score	**3**
Element 1: Active engagement in joint exercises/mechanisms (planning, coordination, monitoring,	3

evaluation) to support external coherence	
Element 2: Participating in joint monitoring and reporting processes with key development partners	3
Element 3: Identifying shared information or efficiency gaps with development partners and developing strategies to address them	3
MI 6.5 Analysis	**Evidence documents**
6.5.1 WHO participates in multiple joint planning, coordination, monitoring and evaluation exercises at global, regional and country levels to coordinate around shared issues, not least COVID-19. The UNSDCF is the primary co-ordinating mechanism in country. At global (and country) scale, joint programming is increasingly important. For instance, internal assessments show that most *WHO country offices increasingly participated in joint UN programming over the period; p*articipation rose from 62% to 76% between 2019-20 to 2021-22. There were regional variations; 94% of country offices in the African region, 91% in SEARO, and 81% in the Americas participated in joint UN programmes. Donor partner co-ordination mechanisms are in place in some countries where WHO works. In emergency contexts, WHO participates in mechanism such as the cluster system. Responding to our survey, 81% of respondents "strongly agreed", "agreed" or "somewhat agreed" that WHO is actively engaged in inter-agency coordination mechanisms for planning, implementation, monitoring, and context analysis in countries where it works. However, it was noted in a survey that in emergency situations, WHO does not always coordinate with humanitarian actors, instead launching its own appeals for funds. Notably, survey respondents indicate the variations between different contexts, with some praising WHO for its coordination efforts, and others saying they have seen little or no evidence of it. At the country level WHO is actively engaged and contributing into the UN Common Country Analysis, which is an integrated, forward-looking, and evidence-based analysis of the country context for sustainable development.	17 72 95 105 150 158 172 310 314 357 421 422 610 653 657 658
6.5.2 WHO participates in joint monitoring and evaluations of programming, particularly at the country level, though this process could be further improved. In 2022, the Agile Member States task group recommended that WHO improve its joint monitoring with member States, alongside strengthening the WHO results framework and the monitoring of its performance. By the end of 2020, 113 joint external evaluations had been completed and 67 State Parties had prepared national action plans for health security. WHO's EVL partners with external evaluation counterparts e.g., and the UNAIDS-commissioned mid-term evaluation of its 2016-21 Strategy and Unified Budget, Results and Accountability Framework (along with United Nations Development Programme [UNDP], UNFPA and UNICEF) in 2022-23. 78% of MOPAN survey respondents "strongly agreed", "agreed" or "somewhat agreed" that WHO participates in joint evaluations at the country/regional level; 18% responded "don't know/no opinion". Joint monitoring forms part of the UNDF system. Since 1990, WHO and UNICEF have served as joint custodians of global data on WASH and have jointly monitored and published country, regional and global-level reports on WASH trends. The 2022 Inter-Agency Humanitarian Evaluation on the COVID-19 Global Humanitarian Response Plan (GHRP) also made several references to WHO's collaborative reporting with key development partners. For example, in 2020, WHO co-led the Global Information Management, Assessment and Analysis Cell (GIMAC), a multi-stakeholder initiative that sought to provide technical support to GHRP countries with processing, reporting on and analysing secondary data and support with global decision-making on COVID-19. 76% of MOPAN survey respondents "strongly agreed", "agreed" or "somewhat agreed". WHO jointly monitors progress on shared goals in-country with local and regional partners. A higher proportion of donors indicated "don't know/no opinion" (35%).	
6.5.3 WHO uses shared information to improve the efficiency of its operations. WHO's Health Security Preparedness department utilises joint external evaluations to work with countries to identify what capacities exist; there are 120 reports from Member States and 12 upcoming reports and evaluations. For SDG3 GAP: "*The findings of the monitoring framework identify concrete actions to strengthen collaboration among multilateral agencies. The findings allow agencies to identify and prioritise contexts where agency alignment with local priorities and coordination with each other may need improvement….*" The *WHO led the UN Crisis Management Team during the pandemic, coordinated the inter-agency action for UN staff protection, scaled up supply chain systems and provided regular crisis updates to members Regional Offices took leading roles engaging with national governments and partners through consultation to strengthen operational partnerships.* The European Health Report 2021 flagged that COVID-19 has highlighted the gaps in health information systems (HIS) and the need for implementing digital solutions to improve efficiency. It stated that the WHO Regional Office for Europe would "help Member States with the further digitalisation of their HISs and with effective measures to leverage the potential of the volume and types of information that will become available in order to support health policy-making". In the COVID-19 pandemic, WHO also worked with partners to establish a global surveillance system to gather standardised data.	

MI 6.5 Evidence confidence	**High confidence**

MI 6.6: Key information (analysis, budgeting, management, results etc.) shared with strategic/implementation partners on an ongoing basis *Implementation partners definition: national government entities, including agencies or institutions; non-governmental organisations (NGOs) and civil society organisations (CSOs); United Nations system entities acting as implementing partners; non-United Nations multilateral and intergovernmental entities; and other entities, such as research and academic institutions, with which United Nations system organisations enter into agreements and to which they allocate resources to execute or implement programmes, projects and activities for the organisation's beneficiaries*	**Score**
Overall MI rating	**Satisfactory**
Overall MI score	**3**
Element 1: Clear corporate statement on transparency of information is aligned to the International Aid Transparency Initiative	4
Element 2: Information is available on analysis, budgeting, management in line with the guidance provided by the International Aid Transparency Initiative	3
Element 3: Responses to partner queries on analysis, budgeting, management and results are of good quality and responded to in a timely fashion	2
MI 6.6 Analysis	**Evidence documents**
6.6.1 WHO joined the IATI as of 1 November 2016 and maintains clear corporate statements on their commitment to increased transparency. WHO has implemented the IATI standard and put in place country pages with relevant information such as budgets and expenditures on strategic priorities, as well as the outcomes and outputs that make up WHO's results planning and funding up to the output level. WHO annually submits financial data to the United Nations System Chief Executives Board for Coordination. However, internal and external respondents to our review note that allocation of financial resources for the implementation of strategies should be made known in more detail and could be more transparently presented. **6.6.2 WHO implements the IATI standard by publishing country pages with all the relevant information such as budget, expenditures and funding up to the output level.** Data is published under an open licence and downloads of country data in the IATI standard (XML) files are available. Under WHO's IATI publication model, WHO adopts the "open licence principle" in which data is published under an open licence and strictly refers to the implementation of WHO's biennial programme budgets (PB). Hosted Partnerships are excluded from WHO's publications. WHO publishes data at the output level, which is the organisation-wide standardised expected result. It represents WHO's country offices' planned contributions to each output, for a given biennium. Beyond IATI, WHO made its first appearance in the Aid Transparency Index in 2022 and scored "good" in its assessment, detailed on the Publish What You Fund website which also sets out it ranks 5th across the UN agencies scored. WHO also notes it publishes budgets on its Member States Portal. However, several MOPAN survey respondents from partner governments commented on a perceived lack of transparency around funding allocations and financial management, noting in particular that the criteria for making financial allocations, and the broader guidelines, are not sufficiently clear. We saw no independent evaluation of transparency or the how key partners are using WHO systems when they exist. **6.6.3 WHO has an Information Disclosure Policy (2017) that sets out the categories of information that are publicly available, which information is available on request and what it classifies as confidential information.** The information policy appears to be written with the presumption that all information should be publicly available unless it falls under a list of clear exceptions (this being personal information, that which relates to security and safety, and where the disclosure may adversely affect WHO's relations with a Member State or other intergovernmental organisation). We saw no systematic assessments of how well WHO responds to partner queries for information so are unable to make a clear judgement on WHO's performance. We note, however, that several respondents to our survey from donors and national governments provided evidence of slow or poor responses at global, regional and national levels to requests for information. WHO told us that the Secretariat had, during 2022-23, "significantly increased the number	38 46 67 156 212 221

of Member States information sessions (in response to their requests)".	
MI 6.6 Evidence confidence	**High confidence**

MI 6.7: Clear standards and procedures for accountability to beneficiaries implemented	**Score**
Overall MI rating	**Unsatisfactory**
Overall MI score	**2**
Element 1: Explicit statement available on standards and procedures for accountability to beneficiary populations e.g. Accountability to Affected Populations	2
Element 2: Guidance for staff is available on the implementation of the procedures for accountability to beneficiaries	2
Element 3: Training has been conducted on the implementation of procedures for accountability to beneficiaries	2
Element 4: Programming tools explicitly contain the requirement to implement procedures for accountability to beneficiaries	2
Element 5: Approval mechanisms explicitly include the requirement to assess the extent to which procedures for accountability to beneficiaries will be addressed within the intervention	2
MI 6.7 Analysis	**Evidence documents**
6.7.1, 6.7.2, 6.7.3, 6.7.4: There is a recognition across many parts of WHO that accountability to beneficiary populations needs to be strengthened. WHO policies set out how Member States, non-state actors and country partners are to be consulted in the design and implementation of its operations. For the UN's Health Cluster Coordination Teams, Operational Guidance on Accountability to Affected Populations has not been updated since 2017. The CCS guidance also sets out how to consult with partners in-country. WHO is strengthening and codifying its engagement with civil society partners. There are broad commitments on accountability covering particular areas of WHO's work; for instance, the Multisectoral Accountability Framework to accelerate progress to end tuberculosis by 2030. For global health sector strategies on, respectively, HIV, viral hepatitis and STI there is also a recognition that accountability to affected populations needs to be strengthened. New policies on PRSEAH also strengthen accountability. AFRO's Regional Strategy for health security and emergencies 2022-30 acknowledges this saying "*Accountability: As a principle, accountability needs to be institutionalised at all levels. Accountability should be based on a people-centred and rights-oriented framework that is concerned with respecting the rights, dignity and safety of people affected by health emergencies''*. Other areas have also sought to set out Accountability is emphasised in the HRP Annual Report 2020. The "HRP has published a paper to examine evidence on existing accountability strategies for sexual and reproductive health in humanitarian settings". WHO documents also set out TB-affected communities and patient groups play key roles in accountability related to TB, as acknowledged in SDGs, the End TB Strategy, the Moscow Declaration and the political declaration of the GA high-level meeting on TB in 2018. We can find no evidence of a comprehensive requirement for training on accountability, though this has been delivered in particular parts of WHO. The CCS does not set out how accountability to beneficiaries will be addressed. 70% of respondents said, "Strongly Agreed", "Agreed" or "Somewhat Agreed" that WHO has effective standards and procedures for accountability to its partners.	18 91 169 187 193 214 285 471 566
MI 6.7 Evidence confidence *Evidence confidence was rated as "Medium" since no evidence of a comprehensive requirement for training on accountability could be found, nor systematic evidence of country or regional processes or guidance on accountability.*	**Medium confidence**

MI 6.8: Participation with national and other partners in mutual assessments of progress in implementing agreed commitments	**Score**
Overall MI rating	**Satisfactory**
Overall MI score	**3**
Element 1: Participation in joint performance reviews of interventions e.g. joint assessments	3
Element 2: Participation in multi-stakeholder dialogue around joint sectoral or normative commitments	3
Element 3: Use of surveys or other methods to understand how partners are experiencing working together	3

on implementing mutually agreed commitments.	
MI 6.8 Analysis	**Evidence documents**
6.8.1 WHO participates in joint performance assessments at national level and with regional partners. CCS guidance outlines the use of Joint External Evaluations to assess country-level performance. Examples of joint evaluations include WHO Thailand's collaboration with the Ministry of Public Health of the Royal Thai Government, where they conducted an independent mid-term evaluation of the CCS to identify achievements, challenges and gaps. It is not clear this approach, however, is universally applied. In 2022, the Secretariat acknowledged that there was the ambition to introduce joint assessment of the output scorecard with national counterparts, and that this was not yet universal practice. At the country level, WHO also contributes annually into the UN Country Results Reports, which report on the status of system-wide implementation of the Cooperation Framework as well as other planning documents between the UN and the Government. Other examples of joint assessments include the UN Joint External Evaluation and Universal Health and Preparedness Review, the UN Sustainable Development Cooperation Framework, joint evaluations with the Inter-agency Humanitarian Evaluation, UN as well as the PAHO approach to joint monitoring of results with country officials. 76% of survey participants "strongly agree", "agree", or "somewhat agree" that WHO jointly monitors progress on shared goals in-country with local and regional partners, though a higher proportion of donors indicated that they didn't know or did not have an opinion (35%). **6.8.2. WHO participates in many types of multi-stakeholder dialogue.** Dialogue is also seen as a key input to formulating new CCSs and determining country priorities. A key objective of the CCS is to "*To engage key stakeholders and foster consensus on strategic priorities for WHO's collaboration with the country in the medium term, with input from the Secretariat on how to implement these priorities and the framework and mechanisms for measuring impact*." Such dialogue helps build global standards, policy, guidance, enables joint programming and provides a space to share knowledge. Above the country level, examples of dialogue and partnership include The Partnership for Maternal, Newborn and Child Health, The European Observatory on Health Systems and Policies (where WHO EURO hosts the Observatory and is an active member of its Steering Committee), regional consultations in southeast Asia RO in considering the Global Strategy on Health, Environment and Climate Change. The Global Action Plan (SDG3 GAP) provides strong evidence on the power of WHO's participation in multi-stakeholder dialogue, particularly towards achieving SDG3. While it is recognised that WHO continues to engage in joint programming, survey respondents to MOPAN noted that joint approaches could be further improved by, for example, combining other areas with health (e.g., livelihoods), and leveraging innovative processes when working with countries and avoiding repeating the same process over and over again. In selected countries WHO supports the development of National Health Policies, Strategies and Plans (NHPSPs), which play an essential role in defining a country's vision, policy directions and strategies for ensuring the health of its population. NHPSPs provide a framework in countries for dealing with the complex range of issues needed to improve health outcomes, including those related to the Sustainable Development Goals and to other national priority health problems. **6.8.3 WHO uses surveys and other feedback mechanisms to consult with stakeholders when devising strategies.** We found a range of evidence; for instance, the global health sector strategies on HIV, viral hepatitis and sexually transmitted infections for the period 2022-30 Strategy were developed with the input from various stakeholders during virtual consultations in 2021 in all WHO regions. To assess the implementation of the SDG3 GAP, national governments and relevant authorities were asked to provide responses to a questionnaire on their health coordination environment. For some departments, like the mental health and substance abuse department, there are regular forums (started in 2018) where WHO partners may discuss WHO plans and provide feedback. Further to this, country surveys are conducted every three years as part of the Action Plan on Mental Health to collect data and monitor progress. Similar surveys are conducted for dementia and alcohol use.	73 105 120 156 187 310 468 498 499
MI 6.8 Evidence confidence	**High confidence**

MI 6.9: Use of knowledge base to support policy dialogue and/or advocacy	**Score**
Overall MI rating	**Satisfactory**

Overall MI score	**2.83**
Element 1: Statement in corporate documentation explicitly recognises the organisation's role in knowledge production	4
Element 2: Knowledge products produced and utilised by partners to inform action	3
Element 3: Knowledge products generated and applied to inform advocacy, where relevant, at country, regional, or global level	3
Element 4: Knowledge products generated are timely/perceived as timely by partners	2
Element 5: Knowledge products are perceived as high quality by partners	3
Element 6: Knowledge products are produced in a format that supports their utility to partners	2
MI 6.9 Analysis	**Evidence documents**
6.9.1 WHO explicitly recognises its global role in knowledge production (as defined by MOPAN). GPW13 clearly states a core role of WHO to be "*shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge; setting norms and standards and promoting and monitoring their implementation; articulating ethical and evidence-based policy options*". Clear statements in other documentation set out WHO's role in producing normative guidance, research, awareness raising and knowledge dissemination. The 'Investment case for sustainably financing WHO' recognises the WHO's role in knowledge production and it played a critical role during COVID-19 to produce norms and standards from research to policy and recommendations and vaccines production. The total resources allocated for knowledge production have not been quantified. **6.9.2 WHO's products are utilised by partners to inform action across the globe.** During the period under review, country responses to COVID-19 document show how a wide range of WHO products had an impact on global action across all continents ranging from how to monitor the outbreak to treatment and vaccines. Knowledge products were updated regularly and helped shaped the largest and most co-ordinated response to a pandemic in modern history. WHO's clinical practice guidelines got the highest overall scores in methodological (72.8%) and reporting qualities (83.8%), according to an external study: ""Analysis of COVID-19 Guideline Quality and Change of Recommendations: A Systematic Review" WHO regularly provides knowledge products to inform action in response, for instance, to emergency events; in 2022-23, 74 Disease Outbreak News articles were produced on 27 events in 37 countries, disseminated publicly through the WHO's website. This included knowledge around 16 multi-country events, such as the outbreak of severe acute hepatitis of unknown aetiology in children; yellow fever in eastern, western and central Africa; and the global monkeypox/mpox outbreak. **6.9.3 WHO's knowledge products seek to inform policy changes at country, regional and global level**. For instance, on polio there is a strategic communications framework, which aims to foster country ownership by highlighting the benefits, risks and opportunities polio transition presents to national health systems and by emphasising the value of essential polio functions and networks set up to eradicate polio for broader public health. In June 2021, WHO set up Product Design and Impact (PDI) unit in the Science Division to focus on the policy changes at countries and regions. The European Observatory on Health Systems and Policies was founded to bridge the gap between academic research and policy in practice. Its country monitoring, analysis and health systems performance assessment functions generate evidence to meet policy needs. Its evidence products are open-access, public goods and it works with Member States and WHO to tailor evidence packages to respond to specific challenges at the country level and enable policymakers to make informed decisions. **6.9.4 We have seen no independent evaluation of the coherence of WHO's knowledge products with partners' needs.** WHO has comprehensive guidance on for its production of Technical Products (TPs) 2022 that it says ensures that the knowledge products of WHO are meeting the needs of Member States. During COVID-19, the Independent Oversight Advisory Committee for Health Emergencies (IOAC) noted that there is a tension between rapid communication and timely provision of guidance, particularly the delay between messaging at press briefings and putting out corresponding guidance on key response elements (e.g., testing strategy, mask usage, managing personal protective equipment shortages, and long-term virus suppression strategy), which resulted in uncertainty around Covid-19 measures. We are also aware from interviews that WHO sometimes struggles to meet its six-week KPI for translation of guidance. This can inhibit the uptake of knowledge products. **6.9.5 Partners assess that the WHO is able to produce high quality knowledge products.** Almost 90% of	17 36 53 59 73 80 81 93 169 224 235 338 426 457 470 512 512 667 669 675 677 679 680

respondents to our survey agree that WHO provides high-quality inputs to the global policy dialogue. Respondents were less complimentary about the timeliness and quality of documents for governing body meetings, however. "*Documents are late – sometimes extremely late – and are often not very informative or well written"* was one Board Member's view, echoing others. This, said survey respondents, makes it difficult for Member States to properly consult so they can express fully formed views in time to guide the work of WHO. It also was seen to contribute to a lack of trust between the Secretariat and Member States. **6.9.6. WHO is improving how it communicates to users to enable better dissemination.** WHO is increasingly seeking to use knowledge products that are visually engaging and well-presented (e.g., COVID-19 dashboard). Manuals are now provided to staff on effective data visualisation. WHO publications have a wide reach, e.g., statistics show published papers on COVID-19 in AFRO region show that publications reached on average 500 people each week, with an average page view of about 1300 per week. The high level of views is an indication of their utility. The WHO COVID-19 Research Database collated more than 900,000 citations. The WHO Institutional Repository for Information Sharing (IRIS) was moved to a cloud-based infrastructure with the aim of increasing accessibility and delivery of 250,000 WHO publications worldwide. IRIS usage remains high with projected number of downloads for 2023 reaching 80,000,000 (similar to 2022). WHO is further diversifying its platforms to reach a broader audience. For 2018-19 WHO reported its presence on social media – Twitter, Facebook and LinkedIn grew significantly, and the WHO website received more than 600 million visitors. A WHO Academy mobile application on COVID-19, was launched in May 2020. A dedicated department promotes a new standard of practice to monitor dissemination and uptake and evaluate the impact of WHO guidelines at country level.	
MI 6.9 Evidence confidence	**High confidence**

Performance management

Systems geared to managing and accounting for development and humanitarian results and the use of performance information, including evaluation and lesson-learning

KPI 7: The focus on results is strong, transparent and explicitly geared towards function	**KPI score**
Unsatisfactory	**2.43**
MI 7.1: Leadership ensures application of an organisation wide RBM approach	**Score**
Overall MI rating	**Unsatisfactory**
Overall MI score	**2.33**
Element 1: Corporate commitment to a result culture is made clear in strategic planning documents	3
Element 2: Clear requirements/incentives in place for the use of an RBM approach in planning and programming	2
Element 3: Guidance for setting results targets and developing indicators is clear and accessible to all staff	3
Element 4: Tools and methods for measuring and managing results are available	2
Element 5: Adequate resources are allocated to the RBM system	2
Element 6: All relevant staff are trained in RBM approaches and method	2
MI 7.1 Analysis	**Evidence documents**
7.1.1. While WHO has made clear that it is committed to implementing a results culture, and while this has yet to fully emerge, progress has been significant. One of the five organisational shifts in GPW13 was to increase the focus on results, particularly at the country level. WHO's current results framework is used annually to report to the World Health Assembly on the Triple Billion Targets. A tool, jointly developed by Member States and the Secretariat, consists of an impact measurement system with 46 outcome indicators; an output scorecard to ensure that the work of the Secretariat is oriented towards achieving the GPW 13 targets; and qualitative country case studies. It is available online. 12 outcome areas are also set out in support of the Triple Billion Targets online, and leading indicators seek to bridge the gap between outputs	14 17 18 37 52 73 81 193

and outcomes. WHO collects considerable volumes of health data presented at global, regional and national level, also available online. While reporting its framework is coherent, in practice WHO does not have a single RBM framework, however, rather many management and reporting frameworks at corporate, regional, country and project/programme level. All may be considered to demonstrate RBM to some extent, but they have to date focussed on accountability rather than management, and as the evaluation of GPW13 identifies, with limited success. There is**, in addition,** a WHO wide Output Scorecard, which measures performance across six dimensions: (1) effective delivery of leadership in health; (2) effective delivery of global public health goods; (3) effective delivery of technical support to countries; (4) integration of gender, equity and human rights; (5) delivering value for money; and (6) achieving results in ways leading to impact. WHO's corporate commitment to a results culture is also reflected in its Programme Budgets, via the Transformation Agenda, and more recently as part of the AMSTG reforms. An independent evaluation of WHO's approach to RBM reported in Jan 2023 that the Secretariat had not yet established a culture of RBM, that there was no common understanding of what RBM is across WHO, nor whether results are restricted to outcomes or outputs, or include both. WHO responded to this report positively and has put into place transparently available corporate and country scorecards to cover its operations, although these are subject to further development and on current progress will take some time to roll out fully (fewer than 30 country offices are currently using a scorecard to measure impact). Attempts have been made to simplify reporting. We found staff were aware of the importance of RBM and WHO's commitment to developing an RBM culture, but it is not yet fully reflected across all WHO's planning documents, hence a score of 3 for this element.

216
281
283
313

7.1.2. WHO integrates its results into planning and programming through the budgeting process. WHO sees its entire budget process built around setting out results. The Output scorecard and mid-year, end of year results reporting are significant parts of WHO's budget and operational planning system, it reports, with these being increasingly used to hold staff to account for delivery. The 2023 evaluation of RBM found that WHO had focused on using results targets in planning, with less emphasis on their use in implementation. Staff were not routinely held to account to demonstrate the use of results data in their performance management, it found, though this is changing, for instance as from mid-2023 WRs now have standardised KPIS. The handbook for the induction of heads of offices says that "In WHO's Results-based Management Framework, work plans are the expression of collective and individual accountabilities for results; indicate the agreed manner by which results are to be achieved within authorised resources; and provide a basis for monitoring and assessing the performance of teams and individual staff members." The RBM evaluation noted this was not sufficiently common practice. We saw insufficient evidence of the use of results in informing theories of change in planning and programming across the organisation, which could identify a results chain and enable the plausible contribution of WHO's actions to eventual outcomes to be tracked; WHO acknowledges this is an issue and we heard that Theories of Change may be implemented for the next GPW; that they are is notably a recommendation of the January 2024 evaluation of GPW 13 which calls for WHO to develop "*an explicit, comprehensive and coherent theory of change that articulates the challenge at stake, enablers and barriers, key actions and changes required, intermediate and final outcomes, as well as the respective roles of key stakeholder*s." The RBM evaluation reported as a "very weak point" the link between WHO using reported results to inform the next planning cycle. The January 2024 evaluation of GPW13 confirmed this view, and "*found that the GPW 13 results framework, while ambitious and welcomed by internal and external stakeholders, faces significant design issues, data currency problems and limitations to its utility. While useful for communication purposes, the effectiveness of reporting in supporting accountability, decision-making and learning is currently limited*."

7.1.3. While staff report they are not yet fully clear on how to develop indicators or set results targets, WHO reports that guidance is available and linked both to budgeting and operational planning (for instance at country level). The RBM evaluation noted in early 2023 that roles and responsibilities for RBM in WHO were unclear, although some guidance on priority setting did exist. As a result of various restructuring processes, there are a number of departments and divisions with responsibility for particular parts of RBM, the evaluation reported. This was particularly an issue in headquarters. In addition to the impact framework reporting system, a new system of reporting for corporate decision-making had been introduced; it is unclear how this is integrated with other elements of monitoring and reporting. WHO sees results management embedded within the mechanism for budget allocation, and guidance is available online to ensure results (for instance in operational plans) link to outcomes. We saw there was much effort underway to build a stronger results culture, however the 2024 Evaluation of GPW 13 notes that "challenges in data availability and reliability need to be addressed for effective, evidence-driven decision-making at all levels. Overall leadership has been provided by respective Directors-General and their office, as a whole, or units within it, such as the Transformation team. Others who have some involvement in guiding different elements of RBM include the Deputy Director-General's Office, the Assistant Director-General for Business Operations

(previously General Management), Planning, Resource Coordination and Performance Monitoring (PRP), CSS, the WHO Office at the United Nations in New York, Division of Data, Analytics and Delivery for Impact (DDI), the Strategic Planning Department of WHE, the EVL, IOS, the External Auditor and CRE. Arrangements for RBM vary by regional office. In some cases, this function is led by the DAF and, in others, by DPM although WHO reported to us that the function is fully led by DPMs. Respondents commented that there had been confusion over different roles and responsibilities for RBM and its different elements and fragmentation of RBM elements across the organisation. We heard commentary that WHO does not always work from the outcomes it wishes to achieve back to the necessary outputs needed; rather it focuses its effort on outputs. The RBM evaluation called WHO's output framework too complex. Staff acknowledge that within units and sets of priorities theories of change would enable results management to be more coherent and more clearly linked to outcomes.

7.1.4. Tools for measuring results are available, supported by an online data hub. WHO's focus on global health data is comprehensive and links to the SDGs, coming together in the World Health Data Hub, which links to other data such as the World Health Statistics Report and COVID-19 data. There are multiple dashboards and indicator sets that report on global targets, available online (including the Output Score Card that WHO reports was a direct result of the 2018 MOPAN assessment). However, the 2023 RBM evaluation noted that "*The OSC and other reporting systems are seen as complex, subjective, time consuming and of limited utility. There are calls for this to be simplified in order to improve the OSC process and to leverage this mechanism to promote better decision-making."* The annual World Health Statistics Report sets out progress against the SDGs. While this data reporting is comprehensive, sufficient guidance for how these global results link to WHO's own RMB is not yet in place. There is no guidance that allows the entire WHO to explain how it plausibly contributes to these global results, which leads funders to be unclear at times on the contribution that WHO makes to their achievement. The 2024 evaluation of GPW 13 noted that "*Data availability, currency and result reporting practices have been inconsistent throughout the GPW period and stakeholder feedback is that they are burdensome.*" However, capacity building around results management is underway alongside, for instance, the roll out of the use of country scorecards. WHO is also rolling out its new Business Management System platform, which is intended to assist capture performance data and support a results-based culture.

7.1.5. WHO has yet to allocate sufficient resources to its management of RBM. While WHO allocates funding for the offices and processes that contribute to implementing an RBM approach (including ADG Business Operations, PRP, DDI, Evaluation, management officers for HQ Divisions and counterparts in Regions and Countries), the RBM evaluation report noted that WHO's funding model, system of human resource management, and issues revolving around its regionalised structure and country offices have made applying RBM difficult. Among several factors that the evaluation said hindered the application of RBM, the report notes that skills/capacity are limited among staff and Member State representatives. The RBM report also notes that insufficient resources have been allocated to managing RBM. While training is provided on RBM, WHO recognises the need to

7.1.6. There is no mandatory requirement for WHO staff to be trained in RBM. We saw no evidence of plans in place to implement an organisational wide training programme, although some capacity building is underway particularly linked to the country scorecards.

MI 7.1 Evidence confidence	**High confidence**

MI 7.2: Corporate strategies, including country strategies, based on a sound RBM focus and logic	**Score**
Overall MI rating	**Unsatisfactory**
Overall MI score	**2.40**
Element 1: Organisation-wide plans and strategies include results frameworks	2
Element 2: Clear linkages exist between the different layers of the results framework, from project through to country and corporate level	2
Element 3: An annual report on performance is discussed with the governing bodies	3
Element 4: Corporate strategies are updated regularly	3
Element 5: The annual corporate reports show progress over time and notes areas of strong performance as	2

well as deviations between planned and actual results	
MI 7.2 Analysis	**Evidence documents**
7.2.1. Organisation-wide plans, such as the GPW13 and Programme Budget, link to high level organisational results. The Programme Budget (PB) for 2022-23 for instance, uses the same integrated results framework as the GPW13. Results are reviewed as part of the biennial budgeting process and reported annually to the WHA through the budget report. Guidance for drafting Country Cooperation Strategies (updated in 2020) includes that they should align with the WHO's Impact Framework (the Triple Billion targets and 46 programmatic indicators), however this is in the process of being applied and was not the WHO's practice during the period under review. Operational Plans at country level more clearly link to results; country offices have to report on indicators set out in the operational plans each year. Thematic, headquarters-based departments report that they are sometimes unable to see their expected results reflected in the corporate targets. There was positive progress over the period under review; for instance, the Transformation Progress Report provides an example of how alignment between different layers of the organisation improved SEARO's alignment with the new WHO Impact Measurement Framework. The GPW 13 dashboards seek to show which outputs and budget areas relate to high level outcomes (the Triple Billion). The 2023 RBM report noted, however, that there is no common results and indicators framework that aggregates outputs and outcome information at the three levels of the organisation (country, regional, global) into a single corporate framework. WHO reports it is now "partially true" it has an integrated framework. Respondents noted that the results management system remains fragmented, and that while outputs are arranged under outcomes, how outputs contribute to the outcome achievements is not fully clear. While WHO reports it has made strides since the previous MOPAN review, WHO is not yet meeting the criteria and key issues highlighted in by the independent RBM evaluation remain. As noted in MOPAN's previous 2017-18 assessment, this remains a work in progress (particularly the overall theories of change) hence this is scored a 2. The January 2024 evaluation of GPW13 concluded "*The GPW 13 theory of change is implicit and at best incomplete or potentially misleading"* and that "*monitoring and evaluation activities occur, but they lack a comprehensive and integrated strategy, leading to misalignment and gaps. Data availability, currency and result reporting practices have been inconsistent throughout the GPW period*".	18 28 37 81 143 185 196 200 283 285 355 356 357 425
7.2.2. There is still more effort needed to ensure that results at global, regional and country level are fully linked. All new and updated Regional Strategies should clearly align to the vision and targets laid out in GPW13. At the country level, CCS are developed jointly with the partner government to determine specific actions towards WHO's strategic targets aligned to national priorities and needs. A CCS guide was issued in 2020 and is currently being updated in 2023. As of late 2022, 68% of country offices had a CCS that was valid or an advanced stage of development (only two CCSs in public domain, hence the others not available for review by the MOPAN team). WHO notes that the country operational plans, linked to the budget, more clearly articulate the results for WHO country offices; these are reported on annually and updated as part of the biennial budgeting process. It is clear from interviews that WHO's high level vision and targets (the Triple Billions) are well understood by its personnel, and that managers make every attempt to link their respective work area to the overall directions and targets, even though they sometimes lament that a required degree of specificity and visibility is compromised at the outcome level. We note that the Triple Billion Targets are outcomes that WHO's activities and outputs are intended to contribute to. The Evaluation of GPW13 concluded that "*Impact is measured in terms of the Sustainable Development Goals using indicators approved by Member States and Health Assembly resolutions. The design of outcomes, outputs and indicators is, on balance, acceptable. However, there are issues concerning the coherence and consistency between them, the manner in which countries and regions relate to them, as well as the methodology for the Output Scorecard*".	
7.2.3. WHO's DG formally presents a results Progress Report against SDG, GPW13 and other high-level targets to the World Health Assembly annually, and results are also reported separately to the WHA as part of the programme budget reporting system. Both the Progress Report and Programme Budget (PB) report are discussed at the WHA and available online. The annual reporting to the WHA draws on the WHO's scorecards and results measurement framework structuring outputs by outcomes. Reporting is also available to governing bodies and online using the Output Scorecard and country dashboards online at aggregate and for country offices. There is no programmatic reporting annually against expected achievements set out in Country Cooperation Strategies, though country dashboards partially perform this function, and are linked to the country operational plans. Individual activities supported by the WHO also report on impact from time to time, notably in response to the COVID-19 pandemic (e.g., the "ACT now, ACT together 2020-21" impact report).	

7.2.4. WHO's current overall corporate strategy, the Global Programme of Work, was planned for a four-year duration. GPW13 was due to end in 2023 but has been extended by two years as a result of disruption caused by COVID-19. From evidence available it does not appear all Country Cooperation Strategies are systematically updated, for instance, every two years linked to the current biennial funding cycle. There was more evidence of thematic strategies being updated, linked to budgeting. In the period WHO responded to C0vid 19 with a series of new programmes of work in response.

7.2.5. Annual reporting shows progress against high level targets overall but does not cover all scales of the organisation. The Triple Billion dashboard shows overall progress made, and where targets are off track. The mid-term review of WHO's results based on the GPW13 results framework presents progress towards the Triple Billion targets and outcomes. The online output scorecard tracks outputs. The Programme Budget (PB) Portal shows variance between planned and actual inputs at global regional and country scale but does not clearly set out how outputs make plausible contribution to Triple Billion outcomes for all activities of the WHO. While reporting draws from "impact stories" related to outcomes, there is no requirement for annual reporting against expected achievements against country strategies. However, operational reporting now takes place through mid-term and end-of biennium results reports, now a new PB Digital Platform WHO sees this, along with the Output Scorecard (since 2019) providing the reporting that reflect Organization -wide efforts. Variances are indicated on the portals (including for budget performance). Individual activities supported by the WHO also report on impact from time to time, notably in response to the COVID-19 pandemic (e.g., the "ACT now, ACT together 2020-21" impact report).

MI 7.2 Evidence confidence	**High confidence**

MI 7.3: Results targets set based on a sound evidence base and logic	**Score**
Overall MI rating	**Unsatisfactory**
Overall MI score	**2.40**
Element 1: Targets and indicators are adequate to capture causal pathways between interventions and the outcomes that contribute to higher order objectives	2
Element 2: Indicators are relevant to the expected result to enable measurement of the degree of goal achievement	2
Element 3: Development of baselines are mandatory for new Interventions	2
Element 4: Results targets are regularly reviewed and adjusted when needed	3
Element 5: Results targets are set through a process that includes consultation with beneficiaries	3
MI 7.3 Analysis	**Evidence documents**
7.3.1. Targets and indicators are not yet fully adequate to capture causal pathways between what WHO does and the outcomes it is seeking to contribute to, specifically the GPW13 targets. While each of the Triple Billion outcomes is given a proposed budget, and the actions WHO intends to take to apply to measure these outcome indicators are usually captured, WHO does not systematically set out or report on the chain of causality how WHO might plausibly be seen to contribute to achieving each outcome. New interventions and programmes are not consistently required to demonstrate an evidence-based theory of change, nor a logical framework. However, such approaches are used across WHO; for instance, the SDG3 GAP monitoring framework provides a theory of change to achieve impact and a way to analyse results at the country level. Likewise, PAHO has a theory of change for its strategic plan 2020-25 setting out a results chain containing impact indicators, outcomes and outcome indicators, and outlining how the results respond to PAHO mandates. The independent 2023 evaluation of WHO's RBM reported the use of theories of change was not yet comprehensive, resulting in WHO, especially country offices, being unable to capture contributions to organisational results. It also said, "*it is difficult to get a clear picture of what WHO is doing, e.g., in particular countries, and how that is contributing to outputs and outcomes in those countries."* WHO notes that while it may have control over the technical outputs it produces and provides, the extent to which these are used to deliver outcomes depends largely on others, in particular national governments. Whilst this is true, we assess that more can be done to systematically and comprehensively capture and report the plausible contributions of WHO to the outcomes it seeks to achieve and note that WHO's Triple Billion Targets are themselves outcomes. The evaluation of GPW13 published in January 2024 noted varied practices in the	18 35 70 73 100 121 143 172 187 193 196 283 309 313 436

"positioning GPW as a corporate strategy for the Secretariat, an institutional strategy for Member States and the Secretariat, a global health strategy for the global health ecosystem or a combination of these". It went on to say "The GPW 13 theory of change is implicit and at best incomplete or potentially misleading, as it focuses essentially on the Secretariat to achieve triple billion objectives."

7.3.2. We did not find WHO consistently applying quality standards for results indicators. The programme budget (PB) lists indicators for each outcome and the proposed budget by the major office. It also provides details on actions to take to measure the outcome indicators. For specific elements of WHO's activities clear expectations have been established regarding the quality of indicators (e.g., in response to COVID-19 in the SPRPS). The 2019 regional plan of action also gives an example of how indicators were set for WHO's Global Strategy on Health, environment and climate change, showing the link between indicators and strategic actions. However, we did not find quality expectations to be consistently applied by WHO across all its activities, nor evidence that the selected indicators of new interventions and strategies were reviewed systematically by relevant experts. The 2023 RBM evaluation report also notes concerns over consistency; "*Changes may also occur within a GPW period in some cases. Such changes are considered to hinder long-term tracking of WHO's contribution to health outcomes and they also have implications for retraining of staff in new systems and indicator frameworks. Where such changes are made, it is essential to give thought to how trend analysis may be maintained wherever possible*." The 2024 GPW13 evaluation noted varying country level capabilities and inconsistent data availability, currency and reporting practices mean substantial challenges remain for the results information, in spite of "commendable efforts" by the Secretariat to improve reporting.

7.3.3. New interventions and programmes are often required to identify baseline measurements, but this is not universal. There is much evidence of baselines being available for specific activities and programmes ranging from communication strategies to impact indicators and targets for HIV, viral hepatitis and STIs, to PAHO providing baseline measurements for impact indicators within their strategic plan. The CCS, which defines the WHO's country's strategic priorities and indicators for each outcome to measure progress and impact, should include a baseline report according to WHO's guidance; each country should work with the WHO Country Office to decide which specific targets and indicators will be chosen to track and evaluate a milestone. However, we heard evidence that baseline data was not always available at country level. Tracking methods are set out and linked to the WHO Impact Framework. For some indicators in the monitoring framework, setting a global baseline is a challenge and the framework does not include any new targets beyond those already expressed in the SDG targets. We note, however, that baseline measurements are included for output indicators in the proposed Programme Budget (PB) for 2024-25.

7.3.4. Results are generally updated. At the highest level, the WHO's results framework is updated alongside the GPW with the results framework remaining intact for the period of each GPW. The current GPW13 period has been extended as a result of COVID -19; Member States have recognised the need to improve its indicators e.g., to monitor universal health coverage indicators 3.8.1 (coverage of essential health services) and 3.8.2 (financial hardship) and to track emerging areas of public health importance such as primary health care, climate and health, mental health, physical inactivity and disability, and timely detection and response to health emergencies. The Secretariat is preparing a proposal on new indicators for its universal health coverage index. Across WHO, there is not yet a fully consistent approach to the periodicity of reviewing and updating targets, although progress has been made by more clearly articulating results in the budgeting process. This ensure that results are updated every biennium, and for country offices and other units, progress is reported annually. PRP and DDI coordinate and lead on this work with business owners across the organization. The use of the Output Scorecard (and the underlying indicators and targets) have improved over the past few years, WHO reports. The use of these dashboards has increased transparency and access by Member States since the last assessment.

7.3.5. For interventions and country frameworks, partners are often consulted on the WHO's results. At the highest level, the WHO's GPW is subject to scrutiny and approval by Member States. An overview of the programme budget (PB) monitoring and assessment mechanisms shows that during the end-of-biennium performance assessment, the WHO output scorecard was used to assess the Secretariat's performance in delivering outputs which were previously agreed with Member States. For CCS, results targets are intended to be aligned to targets set out in national development plans and frameworks, and country governments are consulted during CCS drafting. 77% of stakeholders responding to MOPAN's survey agreed that WHO consults with stakeholders on the setting of results targets at a country level.

MI 7.3 Evidence confidence	High confidence

MI 7.4: Monitoring systems generate high quality, useful performance data in response to strategic priorities	Score
Overall MI rating	**Unsatisfactory**
Overall MI score	**2.50**
Element 1: The corporate monitoring system is adequately resourced	2
Element 2: Monitoring systems generate data at output and outcome levels of the results chain	2
Element 3: Reporting processes ensure data is available for key corporate reporting and planning, including for internal change processes	3
Element 4: A system for ensuring data quality exists	3

MI 7.4 Analysis	Evidence documents
7.4.1. Corporate monitoring functions in WHO are not yet fully resourced. The 2023 independent evaluation of the RBM framework found that there is a lack of focus and resources dedicated to the capacity to implement an RBM approach, particularly at country level. The evaluation found a lack of support for implementation and guidance on how the global, regional and country plans can be translated into implementation in countries. It specifically identified that "*Management skills and competencies of WHO managers, in general, and in relation to RBM specifically, require strengthening*." We note that there has been growing emphasis recently on corporate monitoring and reporting; but systems are relatively new and as set out above not consistent. Documents suggest that at the country level, resources are insufficient to support data, delivery and innovation capacity. We also heard how some of the key WHO indicators do not have enough data e.g., road safety (Lack of road traffic injuries in LMIC) and prevention of violence. The deficit is not universal; some technical departments (e.g., addressing TB) have good statistical capacity. The CPCP model of resourcing that came into being in 2023 includes provision for M&E needs, though this had not yet been implemented. **7.4.2. WHO generates much data at output level, less at outcome level and stakeholders have commented that it remains difficult to identify from the data provided WHO's contribution to development outcomes.** The 2023 internal audit report to the WHA found that "*there was limited data on output leading indicators, which restricted the ability to objectively monitor progress and measure the extent to which the work of the WHO Secretariat influenced the outcomes and impact, thereby undermining the organisation's accountability for results*." There was also "*incomplete reporting at the budget centre level for output scorecards and there were lengthy quality assurance and editorial processes'*; the output scorecard is meant to measure the Secretariat's outputs. Internal reporting noted that the team piloting the output scorecard for GPW13 felt the tool was very ambitious, given the expectation that it be applied to each GPW13 output. The 2023 independent evaluation of RBM noted that "*It is of concern that there does not appear to be an overarching indicator framework which captures the WHO Secretariat's contribution based on (a) theory(ies) of change explicitly describing causal pathways. WHO has made progress on monitoring public health outcomes, with a framework linking to SDGs. DDI has worked to support data quality improvement from countries. Some WHO outputs are also described. However, it is difficult to get a clear picture of what WHO is doing, e.g., in particular countries, and how that is contributing to outputs and outcomes in those countries.*" It went on to comment that it was unclear, for example, if *"WHO country offices have output and outcome indicators and targets which they use to track progress. It is currently not possible to get a clear picture of progress towards expected outcomes and WHO's contribution to these from the reporting against the results framework. This is particularly an issue at country level although there are different pieces of the picture reported in some regions and by HEADQUARTERS*." Again, some parts of WHO's work is more clearly monitored and reported on; the UHCP Annual Report includes examples of outcomes achieved, progress monitoring report for NCDs presents information for each country related to their achievement against monitoring indicators, data insights are provide for polio cases in different countries and provinces with vaccination rates and campaign performance. Measurement of the inputs, outputs, outcomes and impact of the Working for Health 2022-30 Action Plan is also done through a monitoring framework, which includes indicators, which are mapped to specific health dimensions, and means of verification; and the SDG3 GAP also has a monitoring framework which tracks inputs, outputs, outcomes and impact. WHO also has a range of tools to support all countries in monitoring and accelerating progress towards universal health coverage. These include the Global Health	16 18 34 81 86 183 184 283 304 333 425 436 440 443 469 470

Expenditure Database, which monitors financial inputs to national health systems, and tracks time trends of country health spending and health financing progress matrices, which helps to identify country-specific recommendations on the policy shifts required to accelerate progress to universal health coverage. In spite of these systems, the 2023 RBM evaluation points there is concern that "*WHO may excessively highlight the positives which can have the perverse effect of undermining credibility and hence trust."* Some funders we spoke to share this view.

7.4.3. Processes are in place to update indicators. Core sector indicators are updated periodically to reflect new strategic directions and changes in context, including the specific identification of a suite of indicators related to COVID-19. For instance, the WHO Strategic Partnership for Health Security and Emergency Preparedness portal was expanded during the reporting period in order to better include the tracking and monitoring of national preparedness investments and to include links to the COVID-19 Partners Platform. Progress on the Polio transition planning is regularly tracked through a monitoring and evaluation dashboard; in response to recommendations made in the mid-term evaluation of the Strategic Action Plan for Polio, the monitoring and evaluation framework is being revised through a consultative process to introduce gender- and equity-disaggregated indicators and set targets to further strengthen monitoring of the implementation of national polio transition plans by the end of 2023. The Proposed Programme Budget (PB) for 2024-25 maintains the same results framework used for reporting on the GPW13 but is being updated in response to learning (See 7.4.2 above). It serves as an organising frame for programmatic work and budgeting.

7.4.4. Standards and oversight of data quality are being strengthened. The WHO reports its data oversight model to be a federated governance structure designed to streamline and strengthen end to end processes and systems for collecting, storing, analysing, disseminating and using data. WHO reports it utilises collaborative engagement to drive cross-cutting technical excellence and promote a strategic and coherent approach to data in order to reduce fragmentation, eliminate redundancies and enhance efficiency. Coordination and leadership occur at two levels, it reports: at the Data Governance Committee and the Data Hub and Spoke Collaborative. We note comments from partners and funders that WHO's data quality has been called into question due to concerns over the lack of independent validation or evaluation. The need for improved quality management of reported information was also reflected in the RBM evaluation. WHO is aware and responding to these criticisms. The DDI department has shifted its focus from strategy and delivery to intensify support to countries by working with partners to ensure countries have improved capacity in robust data systems. WHO also report ongoing key efforts to review, strengthen output and outcome data across the Organization that are part of the PB and results reporting (PRP has been guiding this work, notably for the OSC and results reporting, it reports).

MI 7.4 Evidence confidence	**High confidence**

MI 7.5: Performance data transparently applied in planning and decision-making	**Score**
Overall MI rating	**Unsatisfactory**
Overall MI score	**2.5**
Element 1: Planning documents are clearly based on performance data	2
Element 2: Proposed adjustments to interventions are clearly informed by performance data	2
Element 3: At corporate level, management regularly reviews corporate performance data and makes adjustments as appropriate	3
Element 4: Performance data support dialogue in partnerships at global, regional and country levels	3
MI 7.5 Analysis	**Evidence documents**
7.5.1. While much information is available to staff, independent assessments report that not all programming sufficiently uses performance data for planning. The 2023 evaluation of WHO's results-based management concluded that while WHO increasingly recognises that RBM needs to be an end-to-end process covering planning, budgeting, implementation, monitoring, the use of monitoring data decision-making was not yet comprehensive. The evaluation identified that "a very weak point" in the [results] chain is the link between the reported results and the next planning cycle. They also concluded this was, in part, the lack of an institutional organisational learning system to guide decision-making processes. WHO reports that this picture has evolved, and that the planning cycle is now more clearly using data derived from results reporting and the Output Scorecard, prioritization exercises with countries and regional offices, operational	16 65 75 204 283 333 336 353 340

planning, as well as financial data. This data is contained in the PB portals and dashboards. 425

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7.5.2. WHO's activities are monitored through their implementation, though evaluations indicate simplification is required, not least to assist with decision-making. At the highest level WHO's practice in recent years has been to issue mid-term reviews halfway through biennial budget cycles, reporting on programmatic performance. A mid-term review of the implementation of the Programme Budget (PB) for 2022–23 reported progress on deliverables planned for the biennium with the main results that have emerged in the first year, as reported by the output delivery teams, leaving the more extensive programmatic assessment using the output scorecard for the end of biennium. The 2023 RBM evaluation concluded that "*It is unclear how much the results reporting process informs decision-making regionally and corporately. It appears that any such role is relatively minimal currently and there are concerns that current monitoring and reporting does not provide adequate information for this purpose*. "During the period of reporting we heard that a new system of reporting for corporate decision-making was introduced based on 'high impact strategic deliverables' that reported quarterly using a RAG rating system. This is intended to help identify corrective measures to accelerate progress against the Triple Billion targets. However, it's not clear how this is integrated with other elements of monitoring and reporting and what the link is to corrective action. WHO also informs us that "*An iterative approach has been implemented, starting at the country/territory/area office level to ensure maximum alignment with local context and priorities"* for 24/25 though it is not clear how this will lead to adjustments in interventions. 488 576 578 579

7.5.3. WHO's use of corporate results information has been and is further being strengthened in order to manage performance, but building an approach and capacity that synthesises lessons from that needs further work. During the period under review, WHO put in place multiple performance dashboards and has strengthened its approach to RBM (not least as a response to the evaluation published in 2023). This now provides senior managers with key information it previously lacked and is to be commended. AFRO (and other RO) now has KPIs and use dashboards to report on progress to management. The use of HQ Business Intelligence suites and dashboards has also increased. This element remains, as it was for MOPAN's 2017-18 review, a work in progress. On a regular basis, the Executive Board and Member States review performance information, and Regional Offices also review dashboards of country performance (a process respondents told us was valued and impactful). For instance, AFRO performance results are reported to the Regional Compliance and Risk Management Committee on a quarterly basis and shared with budget centres to take note of past performance results and implement recommended actions as needed. Weaknesses in the evaluation function (see KPI 8) and the lack of a truly systematic approach to learning across WHO mean that the potential provided by such data is not yet being fully realised into making positive changes across WHO's operations.

7.5.4. Multiple channels are used to report to Member States and other stakeholders on progress against global health targets which together provide the platform for active discussions around the collective achievement of targets. The Data, Analytics and Delivery for impact Report (2022) provides numerous snapshots of how performance data has been used at a regional and corporate level to identify policy commitments and support coordination efforts of global health issues. Key WHO resources include the WHO's Data Sharing Policies, the UN Joint Statement on Data Protection and Privacy in the COVID-19 Response and GATHER (Guidelines for Accurate and Transparent Health Estimates Reporting). A 2021 Health Data Governance Summit brought together experts to review best practices in data governance, sharing and use. The World Health Data Hub is explicitly designed to overcome issues like data fragmentation and inequalities in data access, and seeks to provide tools for data visualisation, analysis and sharing that are accessible to academics, the public and policymakers around the world. Other resources exist, for instance the WHO serves as the secretariat to the Health Data Collaborative that brings together a network of over 60 partner organisations with 183 members from the private and public sectors, civil society, academia, philanthropic groups, multilateral organisations and countries to support countries' priority data needs. WHO serves as the secretariat to the HDC. The SDG Global Action Plan's "Data and Digital Health Accelerator" is another example; this includes a focus on strengthening data for primary health care and CRVS.

MI 7.5 Evidence confidence	**High confidence**

KPI 8: The organisation applies evidence-based planning and programming	KPI score
Unsatisfactory	2.14
MI 8.1: A corporate independent evaluation function exists	**Score**
Overall MI rating	**Unsatisfactory**
Overall MI score	**2.50**
Element 1: The evaluation function is independent from other management functions (operational and financial independence)	2
Element 2: The head of evaluation reports directly to the Governing Body of the organisation (structural independence)	3
Element 3: The evaluation office has full discretion in deciding the evaluation programme	2
Element 4: The central evaluation programme is fully funded by core funds	2
Element 5: Evaluations are submitted directly for consideration at the appropriate level of decision-making pertaining to the subject of evaluation	3
Element 6: Evaluators are able to conduct their work throughout the evaluation without undue interference by those involved in implementing the unit of analysis being evaluated (behavioural independence)	3
MI 8.1 Analysis	**Evidence documents**
8.1.1. The mandate of WHO's central Evaluation Office is set out in policy to be clearly independent, but we found that its operation had been constrained by a lack of funding and the commitment of (non evaluation department) senior staff; this constraint now appears to be lifting. The evaluation policy (2018) and "Framework for strengthening evaluations and organisational learning in WHO" clearly outlines the mandate, independence and scope of responsibilities of the central/independent evaluation function. This policy does not offer the same clarity on its role in overseeing the scope or quality of decentralised/joint evaluations, however (with WHO seeing its federated structure resulting in regional offices tending to operate independently from HQ). The central evaluation department told us it works consistently with UNEG guidelines, and thus while it manages corporate evaluation, required it provides quality assurance and backstopping for the decentralized evaluations. The policy along with the Financial Regulations and Financial Rules sets out that the EVL is the custodian of the evaluation function and reports directly to the DG and should (and does) report annually to the Executive Board. A responsibility also been given to the Independent Expert Oversight Advisory Committee (IEOAC) to review the evaluation function. The EVL is formally responsible for: (a) leading the development of a biennial organisation-wide evaluation work plan; (b) informing senior management on evaluation-related issues of organisation-wide importance; (c) facilitating the input of evaluation findings and lessons learned for programme planning; (d) coordinating the implementation of the framework for evaluation across the three levels of the organisation. Country and regional-level evaluations are commissioned and managed by the EVL, and the regional office concerned, in collaboration with the relevant country office, although the central function may also commission country and regional evaluations as it wishes. The EVL was moved in 2014, from being within the Office of Internal Oversight Services to become an independent entity in the office of the Director-General. The UN sets guidance for the functioning of evaluation in the UN Evaluation Group's Norms and Standards, highlighting the need for both behavioural and managerial independence. We heard evidence of the operation of the function being constrained through its reporting line, and a lack of understanding by some at very senior levels in WHO of the role or mandate of evaluation in the organisation. Our view is that more managerial independence is required than has been evident in recent years. A new workplan for 2024-25, was developed in consultation with senior management across the Organization and reviewed by the Independent Expert Oversight Advisory Committee in October 2023 **8.1.2. While the head of evaluation presents reports to the Executive Board, stakeholders note the oversight of the evaluation function has not been sufficiently strong in the past, is now improving.** We note that formally the head of Evaluation should report directly to the DG on administrative matters, and report annually on evaluation matters to the Executive Board, and that the Director should have the same degree of reporting independence to the EB as the Director of IOS. In recent years, however, the practice was that the head of evaluation has day to day reported to the DG's Chef de Cabinet on administrative matters, including for resourcing issues. An independent review of the implementation of WHO's evaluation policy conducted in 2017 recommended (among other things) a clearer process for appointing and managing	1 23 25 98 105 132 174 283 323 471 562 585 673

the head of evaluation so that the reporting is direct to the DG with Board input, and that the IEOAC's role "could be deepened to match what happens on compliance functions - or perhaps better still it could be supplemented by an Evaluation Advisory Group with members who have specific expertise in evaluation". We heard evidence that the time provided by the governing bodies to scrutinise the operation and reports of the evaluation function may have not been enough to provide anything more than superficial oversight, and that insufficient resources had been committed to ensuring the transparency and accountability mechanism of evaluations. The Independent Expert Oversight Advisory Committee (IEOAC) formally serves in an expert advisory capacity, providing the DG with advice on the staffing, resources and performance of the evaluation function, including now providing advice on the selection and performance of the Head of the Evaluation Unit, and on the biennial workplan for evaluation activities; and monitoring the timely, effective and appropriate implementation of all evaluation recommendations. We note that the most recent hiring the EVL Director took place consistent with the 2017 review recommendations. The first time Governing Bodies were involved in selecting the Dir, EVL was in 2022. The time provided by the IEOAC for oversight and guidance to consider evaluations may still remain limited.

8.1.3. While the Evaluation Office's mandate gives it the autonomy to commission evaluations independently (which it does through consultations with relevant offices and on request), in practice the programme of work is constrained by resources. The Director of Evaluation currently undertakes a consultative process to identify and prioritise evaluations, e.g., of WHO's contributions at country level. Five to six months prior to the beginning of each new biennium, the Director holds consultations with Regional Directors and Directors of Programme Management in each region to select countries for such evaluations, to be included in the biennial organisation-wide evaluation work plan. The EB review and approve the biennial evaluation workplan (and Member States can add additional topics and comment on those presented). Between 2017 and 2021, the EVL has commissioned and managed seven evaluations of WHO's contribution at country level, as well as a synthesis of the evaluations of WHO's contribution at country level. The EVL responds also to specific requests, for instance a formative evaluation of WHO's work with collaborating centres was initiated at the request of the Chief Scientist. The process of identification of a programme of work for in evaluation was variously described by stakeholders as 'passive' and 'piecemeal', however; not sufficiently driven by a strategic approach that seeks to comprehensively support WHO's overall priorities, strategy and development. The 2017 independent review of the WHO's Evaluation Policy specifically recommended that the WHO's policy should be updated to include (among other things) coverage of evaluations, resourcing and budgeting settings (looking to Member States to provide clear expectations). The peer review panel for the same review also noted that "While the preparation of the corporate evaluation plan should be consultative, the final decision on content and approach should rest with the head of evaluation, who should present the plan at the EB for approval. Overall, the evaluation plan should address the WHO mandate not only across the various technical areas but also the organisation's core functions and its management across the three levels of the organisation." Between July and August 2023, EVL developed the evaluation workplan for 2024–2025 in consultation with senior management across the Organization and reviewed by the Independent Expert Oversight Advisory Committee in October 2023. One of the key considerations when developing the evaluation workplan for 2024–2025 was to improve the balance in coverage of the triple billion targets so that Member States and stakeholders are better informed of the achievements under GPW13. Evidence from these evaluations will feed into the developmental evaluation of GPW14. For the first time, a costed evaluation plan was produced. We were told that the IEOAC recommended additional ideas for developing the workplan (REF) which the EVL Office have implemented for the 2024-25. The Evaluation Director and the Chief Evaluation Officer consulted with most of the organisations directors and developed a WP against the overall organisational outcomes of GPW13. Member states also make suggestions for evaluations.

8.1.4. WHO's Evaluation Office does not have its own formal evaluation budget and is not sufficiently funded by core nor voluntary contributions. The budget for the EVL, based on the organisation-wide evaluation work plan for 2020–21 (for example) approved by the Executive Board, was USD 3.8 million for staff and USD 2.35 million to implement corporate evaluations and the work of the EVL. When compared with other UN organisations, it would appear insufficient resources for the evaluation function have been incorporated into programme budgeting. The United Nations Joint Inspection Unit has, according to the WHO's own 2018 Evaluation Policy, noted that "organisations should consider a range of funding that is between 0.5% and 3.0% of organisational expenditure"; however, we note (for instance) WHO's resourcing of evaluation in 2017 was at around 0.1% of budget with only 6 staff in EVL. The peer review panel commenting for the 2017 independent review of the WHO's Evaluation Policy noted that "The budget allocations are also below the evaluation budgets of other UN agencies of comparable size. What is more, the actual resources made available for evaluation fall considerably short of budget allocations. As a result,

the number of evaluations carried out has been less than programmed. If WHO's evaluation function is expected to deliver the results expected, adequate, stable and predictable human and financial resources need to be made available at all levels." Their conclusion remains valid. While outside the central EVL, funding is available for regional evaluation specialist positions at the P4 level, fully dedicated evaluation capacity only exists in 2 out of 6 regional offices (EMRO and PAHO), while another 2 regions (AFRO and SEARO) have evaluation focal points with more limited capacity. Although EURO and WPRO are recruiting evaluation specialists in 2024, total resourcing still appears at a level far below that of other comparable entities of the United Nations system, which typically fund such functions through pooling of resources from voluntary contributions. The insufficient amount of financial and human resources available for budgeting does not enhance an organisation-wide culture and understanding of evaluations in WHO. **8.1.5. Evaluations are submitted to the appropriate customers, but not all are readily available.** Many, although not all, evaluation reports are available for internal and external stakeholders through the WHO's evaluation websites. Findings, recommendations and responses to completed corporate and many decentralised evaluations are now being tracked through a consolidated digital platform, and routine dissemination of evaluation reports is done via email to all Missions in Geneva, and internally to senior management. Specific evaluations, requested by governing bodies, are transmitted to customers as required. However, according to the 2023 Evaluation annual report, "neither the organisation-wide evaluation work plan nor the organisation-wide repository of evaluation plans and reports systematically capture all decentralised evaluations that are conducted across the organisation, thus preventing effective tracking of management responses and implementation of recommendations of completed evaluations." WHO's disclosure policy and Evaluation policy clearly stipulate that evaluation plans, reports, management responses and follow-up reports should be published on the WHO evaluation website, including country and regional offices where possible. WHO reports that in addition to publication on the websites, routine dissemination of evaluation reports is done via email to all Missions in Geneva, and internally to senior management. **8.1.6. WHO recognises the need for independent evaluation; we found no evidence of undue influence over the conduct of reports.** The Evaluation policy (2018) set out the independence of evaluation is necessary for credibility, influences the ways in which an evaluation is used and allows evaluators to be impartial and free from undue pressure throughout the evaluation process. Delivery of central evaluations appears to be consistent with this good practice. We were not able to confirm if this was also the case for decentralised evaluations, though we saw no evidence reporting concerns of interference. We note that in their comments on the 2017 independent review of WHO's evaluation policy, the panel of peer experts noted the complexity of reporting lines in WHO and said specifically that "Given the federated structure of the organisation, it may be difficult to put in place dual reporting lines such that specialists report both to the Regional Director as well as the head of Evaluation. A feasible solution (building on positive experience elsewhere in the UN) would be for the regional evaluation specialists to be appointed to the central EVL but outposted to the respective regions."	
MI 8.1 Evidence confidence	**High confidence**

MI 8.2: Consistent, independent evaluation of results (coverage)	**Score**
Overall MI rating	**Unsatisfactory**
Overall MI score	**1.80**
Element 1: An evaluation policy describes the principles to ensure coverage, quality and use of findings, including in decentralised evaluations	2
Element 2: The policy/an evaluation manual guides the implementation of the different categories of evaluations, such as strategic, thematic, corporate level evaluations, as well as decentralised evaluations	3
Element 3: A prioritised and funded evaluation plan covering the organisation's planning and budgeting cycle is available	1
Element 4: The annual evaluation plan presents a systematic and periodic coverage of the organisation's interventions, reflecting key priorities	1
Element 5: Evidence demonstrates that the evaluation policy is being implemented at country-level	2
MI 8.2 Analysis	**Evidence documents**

8.2.1. WHO's 2018 evaluation policy sets out principles that define how evaluation in WHO should be conducted, but the policy does not ensure the coverage of WHO's operations. The principles appropriately set out guidance at the highest level for how evaluation is to be conducted, covering the impartiality, independence, utility, quality, transparency, credibility, ethics, and how human rights and gender equality should be considered. The policy references, and is based on, the United Nations Evaluation Group's Norms and standards for evaluation. It includes how the reports are to be used, and how recommendations are to be followed-up under the oversight of the Executive Board as well as the appropriate senior management at headquarters, regional and country levels. While corporate and decentralized evaluation frameworks (SEARO, PAHO) and guidance refer to the development and use of evaluations, there is no policy to ensure sufficient coverage over time by evaluations of WHO's headquarters, regional, or country operations to sufficiently maintain accountability and learning. One of the key considerations when developing the evaluation workplan for 2024–2025 was to improve the balance in coverage of the triple billion targets. However, decentralised evaluations lack clear guidance; the WHO's 2023 Evaluation: Annual Report notes: "*Without a system whereby managers of WHO projects/programmes/initiatives are given clear institutional responsibility to commission decentralized evaluations, and in the absence of an appropriate planning and reporting mechanism for this purpose, progress in this area will be slow.*"

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8.2.2. WHO's policy distinguishes between different types of evaluations (e.g., thematic, programmatic, office specific and discretionary) and external and joint evaluations. It outlines the types of evaluation, using the definitions set out by the UNEG. It also sets out that the Executive Board can commission an evaluation of 'any aspects of WHO' at its discretion, and that, other stakeholders, such as Member States, donors or partners, may also commission external evaluations of the work of WHO "for the purpose of assessing performance and accountability or prior to placing reliance on the work of the organisation". WHO has recently put in place a new decentralised evaluation policy and manual.

8.2.3. WHO's published work plan has, in recent years, been a summary of some of its evaluation activities rather than a strategically oriented programme linked to WHO's priorities. The evaluation workplan for 2024–2025, developed in consultation with senior management across the Organization and reviewed by the Independent Expert Oversight Advisory Committee in October 2023, sought to overcome this deficit and to improve the balance in coverage of the triple billion targets so that Member States and stakeholders are better informed of the achievements under the Thirteenth General Programme of Work, 2019–2023. There is no single document capturing all evaluations planned or underway across WHO, however, Respondents informed us they do not yet have sight of all evaluations that are conducted across WHO in any one year as not all decentralised functions report these to WHO centrally. Similarly, the EVL is not able to report on how much is spent on evaluation across WHO in any one year.

8.2.4. The annual evaluation work plan has not sought to systematically cover all WHO's operations or priorities, though the 2024-25 plan aims to improve the balance in coverage of the triple billion targets. There is no structural link between evaluation and WHO's programme of work (noting that the GPW13 evaluation undertaken as part of the preparations for GPW14). Evaluation is not yet seen sufficiently as a strategic function that can systematically support the decision-making needs of management and the Board or foster the learning culture that elements of GPW13 were intended to build. In interviews, some key senior (not EVL) staff saw evaluation primarily as an external accountability function, rather than a means to assist with promoting learning and organisational improvement. It is thus seen by some key decision-makers as an external burden, rather than a function that seeks to achieve improvement. We did see; however, some clear evidence of evaluation being used to support specific issues and decisions (e.g. improving results-based management (2023) or learning about the progress of transformation (2021)). Coverage across WHO's federated structure remains an issue.

8.2.5. Evaluations are being conducted at country level, though there is no mandatory coverage for evaluations, and progress is slow. We note progress was slowed by COVID-19 causing Country Programme Evaluations to be suspended. A new Framework for evaluations of WHO's contribution at country level was issued in 2022. The Global Network for Evaluation (GNE) has been revitalized since 2022, with routine meetings, provides a foundation for greater rollout of country programme evaluations, managed by Regional Office evaluation offices/officers. In addition, for the past few years, the CSS department has a requirement for evaluation of Country strategies -- which will be further aligned with EVL. WHO reported that, as of November 2022, the EVL has commissioned and managed seven evaluations of WHO's contribution at country level in the period of MOPAN's review: Thailand (2017), Rwanda (2018), Romania (2018), India (2019), Senegal (2019), Kyrgyzstan (2020) and Myanmar (2021). Evaluations of Djibouti, Iraq and Tunisia are underway and will be finalised in Q1 2024. In addition, a synthesis of the evaluations of WHO's contribution

at country level was also conducted in 2021. Each region is planning to conduct at least one country evaluation per year. Individual country offices also conduct evaluations, although to date there is no central repository of these and not all evaluations commissioned at country level appear to be captured and reported on centrally. The WHO's April 2023 Evaluation: Annual Report notes "*neither the Organization-wide evaluation workplan nor the Organization-wide* repository of evaluation plans and reports systematically capture all decentralized evaluations that are conducted across the Organization." It also noted the lack of resourcing for the the function, saying "Outside the central Evaluation Office, dedicated evaluation capacity exists in most regional offices but this is at a level far below that of other comparable entities of the United Nations system." WHO's evaluation of GPW 13 published in January 2024 noted "some monitoring and evaluation activities occur, but they lack a comprehensive and integrated strategy, leading to misalignment and gaps".	
MI 8.2 Evidence confidence	**High confidence**

MI 8.3: Systems applied to ensure the quality of evaluations	**Score**
Overall MI rating	**Satisfactory**
Overall MI score	**2.6**
Element 1: Evaluations are based on design, planning and implementation processes that are inherently quality oriented	2
Element 2: Evaluations use appropriate methodologies for data collection, analysis and interpretation	3
Element 3: Evaluation reports present in a complete and balanced way the evidence, findings, conclusions, and where relevant, recommendations	3
Element 4: The methodology presented includes the methodological limitations and concerns	3
Element 5: A process exists to ensure the quality of all evaluations, including decentralised evaluations	2
MI 8.3 Analysis	**Evidence documents**
8.3.1. WHO's policy sets out how the quality of evaluations will be ensured, and assessments made indicate quality standards are followed, but this policy also requires operationalisation. The policy sets out that the quality will be maintained through (i) the continuous adherence to WHO evaluation methodology as elaborated in the WHO evaluation practice handbook, the applicable guidelines and the norms and standards for evaluation of the United Nations Evaluation Group; (b) an independent quality assurance mechanism for all decentralised evaluations; and (c) independent quality assessment of corporate and decentralised final evaluation reports. The WHO Evaluation Practice Handbook sets out the steps and processes to be used to assure quality, including that the Global Network on Evaluation should perform quality checks on individual evaluations to ensure standards are complied with. We note that the WHO's evaluation handbook was in place for ten years from 2013 until updated after our review had concluded evidence gathering. The EVL oversees the quality of evaluations (whether conducted internally or by contracted evaluation firms), including through the routine use of Evaluation Reference Groups. The EVL told us it was introducing hiring of quality assurance experts who will separately provide additional support for decentralised evaluations. The Evaluation Practice Handbook was updated in May 2023. The 2017 review of WHO's evaluation policy assessed the quality of evaluations and reported that "all the corporate evaluations produced in the last 3 years were reviewed against UNEG norms and standards and without exception were found to be of a good standard, noting this was 'an impressive achievement'". We can find no more recent assessment of quality.	23 25 51 100 104 105 106 107 132 174 244 283 323 357 562 585 592 593 674
8.3.2. WHO's guidance on evaluation sets out how quality can be supported, and sets out that appropriate methodologies for data collection, analysis and interpretation should be used (consistent with wider UNEG guidance). It specifically identifies that evaluation designs should be tailored to their purpose, and that data should be triangulated, with judgements made against transparent criteria. From the evidence provided, we are not able to assess to what extent this guidance is systematically applied across all evaluations conducted within WHO, hence this is only scored a 3. We note however, for instance that the Independent Evaluation of WHO's RBM Framework (2023) has a methodological section that discusses the evaluation's design, planning and implementation process.	702 703
8.3.3. Evaluation reports seen by the MOPAN team appear to be consistent with standard UN practice in their presentation of evidence and findings. Findings are fact checked and externally delivered evaluations	

are supervised by technically capable internal WHO staff. The 2017 review found that all WHO's evaluations it looked at demonstrated sufficient quality of their evidence, findings, conclusions, in line with UNEG guidelines. WHO has also developed and use internal checklists for each evaluation (based on UNEG guidelines). **8.3.4. Evaluations set out the limitations and any methodological concerns.** A sample of evaluations seen by the review team indicates limitations to evaluations' methodologies are noted. In addition, although not public, each evaluation implementor must develop an inception report that lays out the methodology and QA internal and external approaches – which are reviewed/approved by the evaluation manager and, where used, the Evaluation Reference Group and Evaluation Management Group. **8.3.5. Quality assurance and ensuring methodological rigour primarily falls on evaluation team leaders to ensure that all evaluation processes and products are of high quality**. External quality assurance for headquarters commissioned evaluations is provided by staff in the EVL. While an independent review of the evaluation function took place in 2017, we saw no evidence of a more recent systematic process whereby a representative sample of self-evaluations was reviewed annually and validated by the independent evaluation function against clear criteria to assess quality. We heard no comments from stakeholders questioning the quality of WHO evaluations.	
MI 8.3 Evidence confidence	**High confidence**

MI 8.4: Mandatory demonstration of the evidence base to design new interventions	**Score**
Overall MI rating	**Unsatisfactory**
Overall MI score	**1.60**
Element 1: A formal requirement exists to demonstrate how lessons from past interventions have been taken into account in the design of new interventions	2
Element 2: Clear feedback loops exist to feed lessons into new interventions design	2
Element 3: Lessons from past interventions inform new interventions	2
Element 4: Incentives exist to apply lessons learnt to new interventions	1
Element 5: The number/share of new operations designs that draw on lessons from evaluative approaches is made public	1
MI 8.4 Analysis	**Evidence documents**
8.4.1. New financial commitments made by WHO are required to consider and demonstrate how lessons from past interventions have been taken into account as part of WHO's business planning processes. The 2023 RBM review noted, however, that the links between reported results and the prioritisation of activities for new planning cycles were often weak. It said that "in part, this reflects the lack of an institutional organisational learning system to guide this decision-making process." The 2017 review of the evaluation policy also noted that the culture of evaluation in WHO was still developing and that more should be done to clarify how evaluations contribute to organisational learning and results-based management. A platform has been developed since then to identify, collect and collate recommendations from past reports. This "Consolidated Platform" for managing and tracking recommendations is unique across the UN in its breadth and scope. Since 2015, 5000 recommendations from various sources (governing bodies: Independent Expert Oversight Advisory Committee (IEOAC), Programme, Budget and Administration Committee of the Executive Board (PBAC), Executive Board, World Health Assembly; external and internal audit; Independent Oversight Advisory Committee for Health Emergencies (IOAC**)** and the Independent Commission on SEA; evaluation; JIU) have been coded and entered into the data base. The Platform, which the public and Member States can access though a dashboard, is currently primarily an internal tracking tool, but could be further developed to support institutional learning more systematically. It also seeks to identify and group findings covering similar issues; in 2018, the Secretariat developed an approach to identify root causes for key cross-cutting recurrent systemic issues, identifying 5 and following implementation of solutions and impact. The 2017 review of evaluation pointed out that since a large number of somewhat similar recommendations may be received from the various oversight functions, WHO management could "experiment with grouping sets of recommendations (even if from different sources) into 'actionable agendas' which could reduce duplication and allow greater coherence and effectiveness in addressing the issues raised in evaluations and other processes." Notably, the annual internal audit reports presented to the WHA extracts and summarises cross WHO institutional learning thematically in a similar way to the 2017 review's suggestion.	132 164 283 312 471 472 478 481 608 670 671

8.4.2. Evidence on the learning and adapting through feedback loops is mixed. The 2023 RBM evaluation reported internal and external respondents noting that there were major bottlenecks that limit the ability of WHO to be a learning organisation, in particular, an excessive focus on the accountability aspects of reporting (both for results and evaluations). This, it noted, hinders the ability of WHO to learn if accountability is geared to demonstrating the value of WHO to donors rather than allowing understanding areas of good and poor performance, including root causes, in order to improve programming. The 2017 review of WHO's evaluation policy took a slightly different view, noting that evaluation was not the same as learning, and the need for evaluation to serve accountability needs within the context of (an as yet undeveloped) learning culture within WHO. While WHO generates much information, it does not yet have a structured approach that builds and disseminates lesson learning or communicates relevant lessons from evaluations in a sufficiently systematic way. The 2017 review noted that the structure of WHO and multiplicity of activities makes tracking, collating and disseminating lessons difficult. Dissemination primarily relies, it appears, on downloading reports from the website. The central EVL does informal briefings and lesson learning sessions with Member States from time to time, however.

8.4.3. New interventions are required to take into account previous learning, though it has not been systematically assessed how much they do so in practice. WHO requires lessons to be taken into account, although this is not formally a criterion for the approval of new activity. Management responses to evaluations are required, as are responses to internal and external audit reports, which WHO report may lead to formal presentations to Member States on actions. We note that the DG introduced the Delivery for Impact Department, who conduct regular global stocktakes, bringing together senior leaders to discuss progress and correct the course where necessary. Between 2020 and 2021, 5 stocktakes were run, each indicating overall progress, highlighting countries in greatest need and charting a path based on success stories. This, however, is not linked to formal planning or design processes.

8.4.4. Formal incentives do not exist to apply past lessons to future activities (for instance integrating the application of prior lessons into the processes of financial approval). The 2017 review of evaluation policy noted that "The level of ownership and follow up of the evaluations to ensure actions are taken (and that behaviour actually changes) is quite limited." The 2023 RBM evaluation also confirmed that there are no formal incentives linking past lessons to planning future activities.

8.4.5. There is no explicit number or share of new operations designs that drew on lessons from evaluative approaches publicly available. WHO is in the process of making public the tracking of its response to recommendations, showing which, it has responded to. The Management Responses of Evaluations that specifically outline the follow-on work to integrate findings and lessons are published on the EVL website adjacent to the respective evaluation. We could find no evidence of what proportion of approved projects that incorporate relevant lessons from past operations being meaningfully reported publicly annually.

MI 8.4 Evidence confidence	**High confidence**

MI 8.5: Poorly performing interventions proactively identified, tracked and addressed	**Score**
Overall MI rating	**Unsatisfactory**
Overall MI score	**2**
Element 1: A system exists to identify poorly performing interventions	2
Element 2: Regular reporting tracks the status and evolution of poorly performing interventions	2
Element 3: A process for addressing the poor performance exists, with evidence of its use	2
Element 4: The process clearly delineates the responsibility to take action	2
MI 8.5 Analysis	**Evidence documents**
8.5.1. Some systems exist to identify and report on poor performing WHO activities. WHO is increasingly using dashboards to report on its strategic and country targets, but these do not yet fully capture the performance of its own activities (albeit financial disbursements are reported). Performance tracking is being put in place linked to the new business process system but was not yet evident for the period under review. A new Member States Portal became operational early in 2023; WHO reports that this was the first time that	21 204 313 339 443

all of the different dashboards (Programme Budget, including HR data, financial reporting and results reporting) were brought together. In answer to our survey 65% respondents noted that WHO consistently identifies and responds effectively to interventions that are under-performing. There was, however, an interesting variation in perceptions between the classes of respondents; 72% of national government respondents and 80% of implementing organisation respondents were positive about WHO's identification and responses to poor performance, whereas only 45% of donors and 52% of peer organisations were. 37% of donors and 31% (global) peer organisations responded, "don't know/no opinion". WHO reports it systematically addresses recommendations from audits, evaluations and other reviews reflecting recurrent, systemic, cross-cutting issues & their root causes. Since 2017, WHO has had a web-based system for recording all JIU reports and recommendations directed to WHO, identifying follow-up actions and tracking their implementation.	547 658 686 687 688 689 690 691 692 693
8.5.2. We found mixed evidence that WHO identifies and reports on problematic, potentially problematic or interventions that are otherwise underperforming for regular follow-up. WHO tracks achievements against strategic objectives and increasingly uses reporting dashboards to highlight country level and organisational performance. At the highest level, in support of the GPW13, the delivery dashboard highlights areas and interventions that are complete, in progress, not started and that need attention. There is a similar chart that tracks the progress of the Triple Billion strategy, with various categories considered (e.g., acceleration scenario, budget and finances, tracking and problem-solving). This is a stock-take report that provides of WHO addressing poor performing areas by tracking progress of the Triple Billion strategy. Through the budgeting process, operational plans are reviewed annually. he Office of Compliance, Risk Management and Ethics (CRE) manages an organisation-wide risk register and internal control framework exercise where all business owners must identify risks and mitigation action. Other tools are used, for example in the EURO region, a risk management dashboard now allows all WHO budget centres in the Region to monitor their risks proactively, 'limiting the scope for overdue response actions and enabling exchange of best practices, while an audit dashboard supports senior managers oversight of implementation of audit recommendations.' AFRO (REF) has a similar system, as does the Global Service Centre. WHO reports that many technical programmes have their individual tracking systems. In early 2023, WHO (GPG) approved a new risk management strategy that includes a risk appetite statement that also identifies potential issues. The Risk Management tool was updated in 2023. However, at the moment there is limited adaptation and agility, and uneven evidence of targeting resources and time on improving poor performance.	
8.5.3. There is no centrally mandated process whereby projects flagged as problematic or underperforming are required to be subject to more frequent supervision, although this approach may be used across WHO's federated structure. WHO reports it is ensuring that evaluation and other recommendations are being more carefully followed up, however, and the response to, for instance audit recommendations is being tracked. However, no evidence was provided of programmes being put in performance improvement plans if they are identified from routing monitoring as requiring improvement. Special supervision reports are not formally used to identify issues and challenges for follow-up with progress in addressing these issues reported over time, although again this approach may be used in different parts of WHO's structure.	
8.5.4. Responding to issues of poor performance relies on the management chain, and the pressure exerted by (for instance) Member States. We found no formal process of placing potentially problematic activities or projects that are otherwise underperforming in a centrally defined or monitored process for performance improvement or regular follow-up, based on their lack of achievement of key performance targets.	
MI 8.5 Evidence confidence	**High confidence**

MI 8.6: Clear accountability system ensures responses and follow-up to and use of evaluation recommendations	**Score**
Overall MI rating	**Unsatisfactory**
Overall MI score	**2.5**
Element 1: Evaluation reports include a management response (or has one attached or associated with it)	2

Element 2: Management responses include an action plan and/ or agreement clearly stating responsibilities and accountabilities	3
Element 3: A timeline for implementation of key recommendations is proposed	3
Element 4: An annual report on the status of use and implementation of evaluation recommendations is made public	2
MI 8.6 Analysis	**Evidence documents**
8.6.1. Many (but not all) evaluation reports published on WHO's website is accompanied by a management response. We have seen that management responses to completed evaluations and their implementation are now tracked in a consolidated digital platform, which provides a single point of entry for business owners to enter updated progress status for relevant recommendations and identifies key organisational learning lessons and recurrent issues; this is a relatively new tool and was not in place throughout the period of our review. WHO reports these management responses are also uploaded to the evaluation webpage alongside the evaluation report; as noted, however, not all evaluations on the website from the last three years have a management response visible on WHO's website. WHO's 2023 Evaluation; Annual Report notes specifically the lack of systematic publication or tracking of management responses for decentralised evaluations. **8.6.2. The management response should, according to WHO's guidelines, set out how recommendations will be responded by management, and who is responsible for doing so**. This information (where a management response has been given) is summarised in a standard format, with the status of the response to all recommendations now being captured in a consolidated digital platform. Our review of management responses loaded on the WHO's evaluation website shows this procedure is followed in most cases (where the response has been uploaded) and the standard format is readily understandable. However, not all evaluations are yet accompanied by a management response. **8.6.3. The management response sets out when action should be taken, for the evaluations that have them.** For all evaluations, the management response format identifies whether a recommendation is accepted, comments on the findings and sets out the status of the response (in progress, planned etc). Management responses seen by the team provide a clear response to evaluation reports indicating agreement with findings and proposed actions for follow-up by when and identify disagreements with findings. The Peer Review panel for the 2017 independent review of WHO's evaluation policy suggested that a practical way of improving the quality and engagement of staff with recommendations would be to enhance the engagement with stakeholders at the point where recommendations are being developed, with a view to making them more relevant and meaningful to users. The 2023 evaluation office report presented to the WHA noted that "management responses are not always prepared in a timely fashion, the EVL encourages the drafting of the management response at the time of the stakeholder workshop where the main findings of the evaluation are presented. This maximises the utility of evaluation findings, recommendations and management response by creating an opportunity to discuss and promote ownership" It is not clear that recommendations are yet being developed in this way. **8.6.4. For some but not all, evaluations, the status of WHO's responses to evaluation recommendations are made public**. Management responses to the evaluations loaded on the EVL are available on the WHO evaluation webpage. While the annual evaluation report submitted to the World Health Assembly does not summarise the status of responses to recommendations, a separate document setting out management responses to evaluations is provided prior to every May session of the governing bodies. This summarises the management response to "Selected Corporate and Decentralised Evaluations". This reporting was put in place during the period covered by our review in response to a request from Member States to be kept informed about how evaluations are taken forward. Currently, WHO does not yet systematically capture all decentralised evaluations that are conducted across the organisation; this prevents effective tracking of management responses and implementation of recommendations of all completed evaluations. The consolidated digital platform aims to capture all responses to historical evaluations and is available on the WHO's intranet and to Member States; we understand it is planned that a version of this will be made public in the near future in dashboard format, although this was not the case, however, during the period of our review.	21 23 98 99 100 105 132 156 164 283 316 313 336 426 585
MI 8.6 Evidence confidence	**High confidence**

MI 8.7: Uptake of lessons learned and best practices from evaluations	Score
Overall MI rating	**Unsatisfactory**
Overall MI score	**2.00**
Element 1: A complete and current repository of evaluations and their recommendations is available for use	2
Element 2: A mechanism for distilling and disseminating lessons learned internally exists	2
Element 3: A dissemination mechanism to partners, peers and other stakeholders is available and employed	2
Element 4: Evidence is available that lessons learned and best practices are being applied	2
MI 8.7 Analysis	**Evidence documents**
8.7.1. Not all evaluations conducted by WHO are available in a single repository, although many corporate and some decentralised evaluations are available through the evaluation office website. The consolidated digital platform is a repository compiling 4,000+ recommendations made to the management in recent years from a variety of sources. The evaluation of RBM in WHO notes that it incorporates a taxonomy of categories and themes to identify patterns and overlapping and recurring themes. These have been integrated into the searchable consolidated digital platform that enables synthesis of recommendations, input and tracking of follow-up actions and implementation, and facilitating root cause analysis to identify main common and recurring issues affecting organisational performance. In 2023 this is being put into the form of a dashboard, that is intended to allow users (in particular Member States) to: a) review the implementation status and progress of recommendations; b) identify any duplication/repetition across recommendations from all sources, trends, issues and further analysis of root causes; c) keep track of follow-up reporting to and/or calls for consultation with Member States as stated in recommendations. It should be noted that the Office of Internal Audit also maintains a web-based portal to facilitate the monitoring and follow-up of audit recommendations – by both management and audit staff members, and its annual report to governing bodies includes cross cutting learning. This information is being integrated into the consolidated digital platform. Our survey shows 71% of respondents "agree" WHO learns lessons from previous experience, rather than repeating the same mistakes. 19% responded "don't know/no opinion". **8.7.2. The consolidated digital platform is seen as a key tool to enable distillation of findings, but there is not yet a fully developed system used across WHO that captures and disseminates lessons in support of continuous learning.** Evaluations are primarily communicated as formal reports; there is not a great deal of variation of communication mechanisms used by WHO to disseminate evaluation findings, although technical departments do communicate some findings in summary form. The EVL reports that as well as occasionally (approximately once a year) producing a brief "Evaluation matters" newsletter it provides regular briefings on ongoing and completed evaluations to Member States and internal stakeholders. It also organises webinars for the regional and cluster focal points of the Global Network on Evaluation to share findings of corporate evaluations. We heard evidence of some parts of WHO seeking to improve learning, for instance PAHO is seeking to improve how it captures lessons from evaluations. Notably, during the COVID-19 pandemic there was demand for a strong WHO to provide advice based on evidence and data and focused on results and impact and the DG and WHO technical experts provided evidence-based messages and answered questions based on lessons emerging from across WHO's response, and lessons were regularly captured and disseminated at country, regional and global scales.	15 59 73 81 100 105 131 283 304 387 443 559 560 565 585

8.7.3. Communication of findings and lessons from evaluation is not yet a fully mature function in WHO. WHO's Evaluation Policy (2018) explicitly outlines the expectations for disclosure and dissemination of evaluation reports. WHO shall make evaluation reports available in accordance with the organisation's disclosure policy, it says. Lessons learned from evaluations shall be distilled, reported and disseminated as appropriate. The 2017 independent review of the evaluation policy noted that "engagement by the EVL and the evaluation function is rather limited overall and needs to expand as the function matures and develops"; in spite of the activity set out above, this finding fundamentally remains true. At the same time, parts of WHO do capture and disseminate lessons; for instance, according to the AFRO Annual Report (2022): "The strategic actions to mitigate disruptions and revive the delivery of essential health services, as well as guide system recovery and improve resilience, were informed by data from evaluations including pulse surveys." We heard of other examples, e.g., in PAHO. The 'Driving impact in Every Country: Programme Budget (PB) for 2018-19 Results Report acknowledged that: "While WHO continues to be challenged, it also has mechanisms in place to learn lessons. WHO is changing, but it needs to do so even more boldly". SEARO and PAHO have website pages summarising evaluations, though in the case of SEARO the latest available evaluation was from 2020. WHO reports that at headquarters level and in regions there are few resources to communicate to internal and external stakeholders the findings of evaluations. Four brief online "newsletters" summarising WHO evaluations have been published since 2019 and a summary of findings, actions, recommendations and learning from corporate and decentralised evaluations was published in 2023. Neither demonstrate systematised processes of dissemination. Platforms for communication are limited, and we could find little or no use of (for instance) social media platforms to communicate evaluation findings. Evaluation reports themselves tend to be written for a specialist audience.

8.7.4. There is insufficient evidence that lesson learning is systematic or that lessons are being applied. The evaluation function was subject to an independent external review in 2017; the EVL would benefit from a more external regular reviewing cycle. The 2017 review included an element of peer review. It did not include a review of how to strengthen the uptake of evaluation lessons through knowledge management and dissemination. The findings were made public and communicated to the governing bodies. We heard from EVL staff that they are undertaking a review of the function internally.

MI 8.7 Evidence confidence	**High confidence**

Results

Achievement of relevant, inclusive and sustainable contributions to humanitarian and development results are achieved in an efficient manner

KPI 9: Development and humanitarian objectives are achieved, and results contribute to normative and cross-cutting goals	**KPI score**
Satisfactory	**2.83**
MI 9.1: Interventions assessed as having achieved their objectives, and results (analysing differential results across target groups, and changes in national development policies and programs or system reforms)	**Score**
MI rating	**Satisfactory**
MI score	**3**
4. Highly satisfactory: The organisation achieves all or almost all intended significant development, normative and/or humanitarian objectives at the output and outcome level. Results are differentiated across target groups.	
3. Satisfactory: The organisation either achieves at least a majority of stated output and outcome objectives (more than 50% if stated) or the most important of stated output and outcome objectives is achieved	
2. Unsatisfactory: Half or less than half of stated output and outcome level objectives is achieved	
1. Highly unsatisfactory: Less than half of stated output and outcome objectives has been achieved, including one or more very important output and/or outcome level objectives	
MI 9.1 Analysis	**Evidence documents**
"Interventions" in WHO refer to projects, programmes, initiatives, and other activities, including technical support and the development of guidelines and guidance documents. WHO is directly accountable to deliver its outputs, while achieving outcomes will in general require several inputs and contributions from a range of stakeholders and particularly also by Member States. Hence, while WHOs outputs should be critical to contributing to successfully progress towards health outcomes, accountability is shared and direct contributions in that regard by a single stakeholder (WHO in that instance) cannot be easily quantified. For example, policy dialogue is an essential activity at the country level on public health priorities, and it informs government policy, implementation recommendations and legislation. However, it is the shared responsibility of stakeholders to drive this forward. Likewise, achieving impact targets will require a collective effort by a range of stakeholders, with the expectation that WHO´s interventions should be significantly contributing to achieve these impact targets. However, WHO should be able to demonstrate (and account for) to what extent its outputs plausibly contribute to the desired outcomes. **When it comes to impact, the world is off track to achieve the impact targets; at outcome level many targets are not being met, and/or more than 50% do not have recent data.** At output level, 55% of output indicators have been achieved or were on track at the end of biennium 2020-21. The Programme Budget (PB) for 2022-23 includes a results framework, intended to serve as a tool to demonstrate impact and accountability. The same framework is included in the Proposed Programme Budget (PB) for 2024-25 which will facilitate observing trends over time. The PB includes 12 outcomes, 46 outcome indicators (including 39 SDG goal indicators) and about three to five outputs per outcome. Outputs are WHO's contributions towards health outcomes. The impact and outcome level are reported through a Results Report at the end of each biennium, and a Midterm Report (MTR) half-way through the Biennium. These reports feature stories and country reports. The Results Report for 2020-21 and the MTR published in 2023 were reviewed to determine progress for KPI 9. The Results Report summarises the end-of-biennium performance assessment for all three levels of WHO. There is also a WHO Output scorecard (OSC) that is used to assess performance in delivering outputs at each budget centre level and agreed with Member States. In addition, reports to governing bodies on the status of PB implementation and financing are regularly prepared and submitted. The World Health Statistics Report, the latest edition from 2023, summarises status on progress towards health-related SDGs, and also on impact towards the Triple Billions. The multitude of documents and tools makes it challenging to find a full	15 16 17 18 19 20 51 53 59 71 76 77 172 218 283

description of the baseline, all the outcome and output targets and progress towards them in one place and to get the full picture easily, without having to navigate across various sources and documents, and particularly to understand the situation systematically and comprehensively at country level. Findings for the OSC are presented for countries of most regions, excluding AMRO/PAHO. These country reports exclude assessment of public health goods. Broadly, DDI has responsibility for data at outcome and impact level while PRP has responsibility at the output level, including for the OSC. Various evaluations pointed to the need to simplify the output monitoring process, and the MTR only presents main results and feature stories emerging from the work during the first year of the biennium. At the impact level (using data from the end of 2022 from MTR) it is reported that the "world is off track to reaching most of the Triple Billion targets and health-related SDGs. For healthier populations, where progress towards targets requires multisectoral action and shared responsibility to address determinants of health, progress has been made and the tractors suggest that the target will likely be met by 2025". For Universal Health Coverage (UHC) major gaps exist, and disruptions due to the COVID-19 pandemic had a major negative impact on progress. Overall measures of progress are largely driven by increased access to HIV services, while most other indicators, including on coverage for routine childhood immunisation, malaria, TB, NCDs and other preventable diseases continue lagging, with some indicators, specifically on financial hardships being worsened. Likewise for protection from health emergencies, progress is not on track to reach the billion targets by 2025. Improvements in preparedness have been made and measured (Prepare indicator). There is still work underway to determine optimal ways to measure health emergencies protection. In the area of Healthier Populations, there is also insufficient progress to reach the SDG; air pollution has not been tackled, adult obesity is on the rise, and prevalence of tobacco use remains high. WHO reported 14.9 million excess deaths globally as a result of the COVID-19 pandemic, which led to a reversal of years of progress in many countries. At the outcome level, using the latest available data, a fairly large proportion of the outcome indicators (53%) do not have recent data. Concerns have been raised that results monitoring at country level is limited, with obviously no analysis of attribution of WHOs to achieving health outcomes. To address this, DDI has been working with countries to compile and validate data to be incorporated into dashboards, including regional workbooks, which provide MFI 3B data by country for each billion, as well as the prototype Global Delivery Dashboard, which soft launched in May 2023 and informed two member state consultations on WHO milestones. However, there are significant data gaps with regards to measuring health outcomes. At the output level (with 2021 being the last year where indicator results are being presented, the next reporting cycle is anticipated for end 2023), overall, for 78 indicators the targets have been reached (of 142 indicators overall), amounting to 55%. There is a slight difference across the impact/outcome areas, with 24/33 indicator targets being met (73%) for the UHC Billion, 8/19 for the Better Health and Well-being Billion (42%), and 11/26 for the Emergency Protection Billion (42%). For the "more effective and efficient WHO providing better support to countries" 27/45 of the indicator targets at output level have been achieved in 2021 (60%).	
MI 9.1 Evidence confidence *Evidence confidence was rated "Low" because there was limited evidence available in relation to interventions assessed as having achieved their objectives or impact. Most data was available at output level only.*	**Low confidence**

MI 9.2: Interventions assessed as having helped improve gender equality and the empowerment of women	**Score**
MI rating	**Satisfactory**
MI score	**3**
4. Highly satisfactory: Interventions achieve all or nearly all of their stated gender equality objectives	
3. Satisfactory: Interventions achieve a majority (more than 50%) of their stated gender objectives	
2. Unsatisfactory: Interventions either lack gender equality objectives or achieve less than half of their stated gender equality objectives. (Note: where a programme or activity is clearly gender-focused (maternal health programming for example) achievement of more than half its stated objectives warrants a rating of satisfactory	

1. Highly unsatisfactory: Interventions are unlikely to contribute to gender equality or may in fact lead to increases in gender inequalities	
MI 9.2 Analysis	**Evidence documents**
It is challenging to determine across the board whether and to extent WHO interventions have helped to improve gender equality and the empowerment of women. WHO scores its interventions and outputs as satisfactory towards gender equality. WHO identifies that collecting, analysing, and using good quality, disaggregated data is necessary to improve people's health and well-being. WHO's Global Health Statistics were disaggregated by sex for the first time in 2019, after the COVID-19 pandemic had revealed the fragility of the integration of gender and equity considerations in surveillance data; WHO was not able to report sex-disaggregated data for COVID-19 cases consistently. Of WHO's 46 outcome indicators, 31 now can be disaggregated, and 13 actually do have sex-disaggregated data, 18 do not. WHO has a Health Inequality Data Repository with multiple indicators and data set out, but it was hard to identify meaningful information from this repository on progress and impact. WHO guideline development routinely includes a process to ensure gender considerations. The WHO guidelines handbook (2014) explicitly requests the incorporation of equity, human rights, gender and social determinant in all new guidelines, and considers this a requirement of approval for any guideline; guideline developers are advised to use tools like the Gender Analysis Matrix to examine the extent to which interventions covered in the guideline address gender issues. In the results reporting, WHO assesses for every output certain scores, ranging from technical support, to leadership, value for money, Global Public goods, and Gender, Equity, human rights and disability. In the latter, a sub-score on gender equality and empowerment is assigned. The mean score for each outcome is graded at 3 (on a 1-4 scale), considered satisfactory. Only for outcome 3 "improved access to medicines, vaccines, diagnostics…", the gender score is below 3 and rated as "developing". This output scores for gender issues appears to be the most relevant piece of information for MI 9.2 and has been used to derive the score. However, it is worth noting that the Output Scorecard dimension on Gender, Equity, Human Rights and Disability was reported for the first time in this results report, having been newly implemented. As such, it did not yet capture all the work demonstrating WHO's commitment to incorporating GER into their work. In 2021, an evaluation of the Integration of Gender, Equity and Human Rights (GEHR) in the work of WHO found the lack of strategic guidance on gender, equity and human rights in the previous ten years had hindered the meaningful integration of gender, equity and human rights in the work of WHO to date. That evaluation found that WHO needed to "make a step change in driving and investing in gender, equity and human rights throughout the Organization" if it was to fulfil its role as the custodian of the right to health and achieve the objectives set out in the GPW13. Internal integration of gender, equity and human rights in the organizational culture and capacity is directly linked to performance in external facing work, it said, going on to report that "Country-level work on gender, equity and human rights has not been supported effectively, resulting in variable degrees of integration and represents a missed opportunity for WHO to have an impact on health inequities." It is noteworthy that in WHO's work force, women remain underrepresented in senior positions at D1 and D2 level, with only small changes in reality from 2017 (as at 31 July 2023, 36.8% of heads of country offices were women only marginally higher 35% recorded in 2017 – WHO currently has an aim of increasing this figure by at least 3% per year). While gender equality underpins many strategic documents in WHO, and the organisation has adopted a gender parity policy with concrete targets towards achieving gender parity among its own workforce there has been only slow of progress to increase the proportion of female staff in cadre and leadership positions (at D1 and D2 levels), with men still being overrepresented (details under KPI2). In the partners' survey, over 80% "strongly agree", "agree" or "somewhat agree" that WHO's strategies and operations sufficiently promote gender equality.	15 16 17 18 19 20 50 51 53 59 71 76 77 100 145 172 228 283 472 655 714
MI 9.2 Evidence confidence *As noted above, evidence is fragmented across the board to determine whether, and to what extent, WHO interventions had helped improve gender equality and the empowerment of women. Most data gathered were at output level. For a full analysis, data captured against outcome level would be required. Therefore, evidence was rated as "Low".*	**Low confidence**

MI 9.3: Interventions assessed as having helped improve environmental sustainability/helped tackle the effects of climate change	**Score**
MI rating	**Unsatisfactory**
MI score	**2**
4. Highly satisfactory: Interventions include substantial planned activities and project design criteria to achieve environmental sustainability and contribute to tackle the effects of climate change. These plans are implemented successfully and the results are environmentally sustainable and contribute to tackling the effects of climate change	
3. Satisfactory: Interventions include some planned activities and project design criteria to ensure environmental sustainability and help tackle climate change. Activities are implemented successfully and the results are environmentally sustainable and contribute to tackling the effects of climate change	
2. Unsatisfactory: EITHER Interventions do not include planned activities or project design criteria intended to promote environmental sustainability and help tackle the effects of climate change. There is, however, no direct indication that project or programme results are not environmentally sustainable. AND/OR The intervention includes planned activities or project	
1. Highly unsatisfactory: Interventions do not include planned activities or project design criteria intended to promote environmental sustainability and help tackle climate change. In addition, changes resulting from interventions are not environmentally sustainable/do not contribute to tackling climate change.	
MI 9.3 Analysis	**Evidence documents**
While it is challenging to determine across the board whether and to extent WHO interventions have helped to improve environmental sustainability and have helped to tackle climate change, there are several relevant aspects related to this MI. Interventions do not appear to routinely include planned activities and project design criteria to ensure environmental sustainability and tackling climate change. A broad range of activities is being implemented leading to a range of positive results in these areas. As described under KPI 2, WHO has demonstrated leadership and expressed commitment to addressing environmental sustainability and to help tackle the effects of climate change. The organisation has produced cutting-edge strategies and evidence-based guidance documents. WHO itself has committed to becoming carbon neutral by 2030. In 2023, in a report to the WHA, 86% of WHO country offices reported having worked with the environment, water and sanitation, and climate change sector. Many examples of initiatives and interventions exist that show the clear linkages between human health outcomes and environmental issues (mentioned below), and where countries have taken up the guidance, used WHO tools, carried out vulnerability assessments, and/or made plans to make their health system climate resilient. It is unclear whether project design criteria for all interventions exist; for normative guidelines, the WHO guideline handbook does not stipulate the routine consideration and incorporation of environment and climate change aspects in the development of all of WHO's new guidelines. Overall, results monitoring and reporting does not include clear and transparent information to what extent WHO's interventions across the board have helped to achieve improvements of environmental sustainability or tackle the effects of climate change, hence this aspect could not be easily and comprehensively captured by the review team. Additionally, at the output level, WHO did not attribute a score for this cross-cutting area of work (unlike for gender, equity and human rights, where a gender score was applied). There is, at the same time, a wide array of documented focused activities and initiatives, together with country case studies, in the WHO results report contributing to achieve relevant outcomes (specifically outcome 3.3 – healthy environments to promote health and sustainable societies.). In the partners' survey, 68% "strongly agree", "agree", or "somewhat agree" that WHO's strategies and operations promote environmental sustainability and address climate change. Some areas of progress/achievements should be noted: ● Strong presence and visibility of WHO at relevant international fora, such as at COP27 in Egypt, with 50 events. ● Publication of a WHO Manifesto for a healthy and green recovery from COVID-19, with six policy prescriptions and 80 specific actions for healthy societies that cover protecting nature, water and sanitation, clean energy, sustainable food systems, polluting activities and healthier cities. WHO was approved as a Green Climate Fund Readiness Delivery Partner in 2020. ● Development of WHO guidance on climate-resilient and environmentally sustainable health care	15 16 17 18 19 59 60 120 145 172 218 361 440 443 469 555

facilities, and some evidence of its application at country level. ● Production of updated WHO Air Quality Guidelines 2021 recommending new air quality levels to protect the health of populations by reducing levels of key air pollutants, some of which contribute to climate change. Technical support to several countries initiating action on air quality. ● WHO leadership of the Alliance on Transformative Action on Climate and Health initiative that aims to support countries in building climate resilient and sustainable health systems. ● Development of scorecards on health and environment for over 80 countries providing snapshots on six environmental threats towards finding solutions to addressing them. ● Establishment of the Alliance for Transformative Action on Climate Change (ATACH), garnering the commitment of over 75 countries to date to build climate-resilient and low carbon health systems. Several countries (including Iran, Jordan, Morocco, the UEA, Grenada and St Lucia, with WHO technical support, completed Health Vulnerability Assessments to Climate Change. ● Implementation of Water safety plans (WSP) in at least 93 countries, following an approach promoted by WHO. In SEARO, 700 WSP plans were implanted. ● As regional examples: The 2020-21 Results in Africa report states that "Climate change and health projects are underway in countries to improve early warning and surveillance of climate-sensitive diseases and develop climate-resilient water safety plans". ● The PAHO Quinquennial Report 2018-22 states, "the PAHO Bureau fostered progress on climate change and health, strengthening health and climate change governance and partnerships in the Region, and facilitating integrated planning, enhanced capacities, and increased investments." The Caribbean Action Plan on Health and Climate Change, the Andean Plan on Health and Climate Change 2020-25, and the 2018 Declaration of Ministers of Health of the Southern Common Market (MERCOSUR) and Associated States on Health and Climate Change, are examples of concerted intersectoral actions.	
MI 9.3 Evidence confidence *Evidence confidence was rated "Low" because there was little or no evidence available to determine across the board whether, and to what extent, WHO interventions had helped improve environmental sustainability and tackling climate change. Most data gathered were at output level. For a full analysis, data captured against outcome level would be required.*	**Low confidence**

MI 9.4: Interventions assessed as having helped improve human rights including the protection of vulnerable people (those at risk of being "left behind")	**Score**
MI rating	**Satisfactory**
MI score	**3**
4. Highly satisfactory: Interventions include substantial planned activities and project design criteria to promote or ensure human rights and reach those most at risk of being left behind. These plans are implemented successfully and the results have helped promote or ensure human rights demonstrating results for the most vulnerable groups.	
3. Satisfactory: Interventions include some planned activities and project design criteria to promote or ensure human rights. These activities are implemented successfully and the results have promoted or ensured human rights.	
2. Unsatisfactory: EITHER Interventions do not include planned activities or project design criteria intended to promote or ensure human rights or demonstrate their reach to vulnerable groups. There is, however, no direct indication that project or programme results will not promote or ensure human rights, AND/OR The intervention includes planned activities or project design criteria intended to promote or ensure human rights but these have not been implemented and/or have not been successful	
1. Highly unsatisfactory: Interventions do not include planned activities or project design criteria intended to promote or ensure human rights. In addition, changes resulting from interventions do not promote or ensure human rights. Interventions do not focus on reaching vulnerable groups.	
MI 9.4 Analysis	**Evidence documents**
While it is challenging to determine across the board whether and to extent WHO interventions have helped to improve human rights including the protection of vulnerable people (those at risk of being "left behind") there are several relevant aspects related to this MI: **Interventions appear to frequently include activities towards ensuring human rights, addressing inequities,**	14 15 17 18 19

and elevating the concept of 'leave no one behind'. WHO's guideline development routinely includes a design criterion to address human rights. In the results reporting, WHO assesses its output performance largely as satisfactory. WHO is exerting strong leader- and partnership, including within the UN group and vis-à-vis Member States, promoting and addressing human rights, health inequality and 'leave no one behind' in most aspects of its work. The health inequality monitoring efforts will likely bear fruit to address these increasingly, despite challenging geo-political, economic, and social dynamics in many settings.

In the results reporting, WHO assesses for every output certain scores, ranging from technical support, to leadership, value for money, Global Public goods, and Gender, Equity, human rights and disability. For the latter, sub-scores on reducing inequities, meaningful participation and inclusion of persons with disabilities are assigned. In general, the first two elements, reducing inequities and meaningful participation, are graded as satisfactory, while for inclusion of persons with disabilities the scores are consistently lower, graded as "developing". These output scores for GER appear to be the only systematic appraisal in the results report (of 2020-21) to inform grading of MI 9.4.

As already mentioned under MI 9.2, the WHO guidelines handbook (2014) explicitly requests the incorporation of equity, human rights, gender and social determinants in all new guidelines, and considers this a requirement of approval for any guideline.

WHO in its GPW13 is explicit about its focus on reducing health inequalities, clearly underpinning each of the three Billion Targets. WHO highlights and promotes Universal Health Coverage (UHC) as an essential contributor towards the improvement of Human Rights and protection of vulnerable groups.

Since 2022, a strategy for Inequality Monitoring and Analysis was adopted, with goals and targets, and a system put in place to routinely monitor inequalities, and progress towards targets. Tools have been made available, including, among others, Health Inequality Monitoring eLearning tools, Capacity building on-line workshops, a Health Equity Assessment tool Kit (HEAT), a Health Inequality Data Repository as the largest database of disaggregated data globally (containing 50 data sets, more than 2000 indicators, and more than 25 dimensions of inequality globally), and a Health Inequality Report Series.

From an evaluation perspective, the 2021 evaluation of integration of GER, noted that "*while there is an output in the biennial programme budget (PB) relating to corporate aspects of gender, equity and human rights, there is no corresponding outcome that Member States and the Secretariat have a shared responsibility for achieving. There is a gap in terms of a specific strategy outlining how WHO intends to operationalise the integration of gender, equity and human rights (GER) into its work*." The area of disability has not been formally assessed - A formative evaluation of the implementation of the WHO policy on disability will, reportedly, be conducted in 2023.

There are good examples of leadership by WHO as headquarters and regional initiatives to support human rights, the rights of vulnerable groups or "leave no one behind", informing and promoting and, quite often, leading to country action in this area:

- Globally, WHO takes the lead among all UN agencies for the "leave no one behind' working group.
- Support to the partnership between OHCHR and WHO on the UN inter-agency Task Force on NCD and on the INB (Intergovernmental Negotiating Body on Pandemic Treaty) to ensure pandemic instrument have a human rights focus.
- A special initiative to ensure that SIDS become a global health priority and convened the SIDS Summit for Health (June 2021).
- Establishment of a global network on accountability-transparency in health systems with participation of UN agencies and civil society and coordinated development of a chapter on gender and equity in the "2019 UHC Monitoring Report".
- In the African Region, 28 out of 47 countries are addressing equity, gender equality, human rights and social determinants in their health policies and programmes.
- In the Americas Region, nearly two-thirds of countries are using human rights norms and standards to formulate and/or implement policies and plans that address health equity / ethnicity (although this seems low – surely all countries should be using human rights norms and standards).
- According to the PAHO Quinquennial Report 2018-22 states, PAHO "promoted human rights and health at the highest policy making levels at regional, subregional, and multi-country levels, emphasising the importance of legislation as a framework for the realisation of the

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right to health and other human rights. The Bureau provided technical comments on legislative proposals and policies developed by Member States, as requested, in order to strengthen national legal frameworks for rights-based approaches to health issues, and in December 2021, published a series of technical notes on human rights and health". - In the European Region, The WHO Health Equity policy tool has been developed to support WHO Member States and partners to strengthen implementation of high-level commitments and strategies to reduce barriers to health equity and health gaps. - In SEARO, Member States were supported to develop/update national strategies on RMNCAH focused on equity, especially on those living in hard-to-reach areas and vulnerable groups. - Voices of target population were included, e.g., adolescents, people living with HIV. - A resolution on the Health of Indigenous Peoples approved in the 76th World Health Assembly.	
MI 9.4 Evidence confidence *There is no comprehensive analysis to determine whether WHO interventions as having helped improve human rights including the protection of vulnerable people. Most data gathered were at output level. For a full analysis, data captured against outcome level would be required. Hence, evidence confidence was assessed as "Low".*	**Low confidence**

KPI 10: Interventions are relevant to the needs and priorities of partner countries and beneficiaries, as the organisation works towards results in areas within its mandate	**KPI score**
Satisfactory	**3**
MI 10.0: Normative products and functions are effective at influencing global, regional and partner country policy and programmatic improvements	**Score**
MI rating	**Satisfactory**
MI score	**3**
MI 10.0 Analysis	**Evidence documents**
WHO applies systematic methods for guideline development to identify the need for a guideline, the needs of the target groups and includes consultations with the end-users to establish their needs, values, attitudes and preferences, and to tailor and package recommendations accordingly. Evaluative evidence would be required to determine how normative products influence country policy and programme improvements however this has to not been done. The Handbook for guideline development (2014) describes the process through which a normative guideline in WHO has to be developed. The process is systematically applied, and, for a guideline to be approved, it requires the review and approval of the Guideline Review Committee (GRC). The guideline development includes initial assessment of the need for that guideline, as well as the needs of the ultimate users and those individuals and populations that will be affected by a guideline. A Value-Attitudes-Preferences (VAP) study is usually conducted to inform and help shape the guideline recommendations. The GRC Secretariat itself, housed in WHO headquarters, provides WHO staff with technical advice on the guideline development process, sets benchmarks, and reviews for quality, relevance, expected impact, feasibility, economic considerations including cost of product development and its application. The process is thorough, well-structured and systematic and increasingly well understood and followed by WHO staff with normative development responsibilities. One criticism particularly by external stakeholders and partners is on the time it may take to finalise and publish a guideline – while the average guideline development process is eight months to two years (with six months for scoping and planning including data gathering). In some instances, shortness of resources, both technical and financial, have delayed the process. Another important critique stemming from an evaluation of WHO's normative functions, commissioned by WHO in 2017, was that there was no "master plan" for normative products in WHO, that prioritisation of normative products should occur for a given time period, and that dissemination of information and normative products also was requiring improvements.	106 190 205 335 336 499 525 576 705

When COVID-19 emerged, the need for rapid advice and guidance was obvious – under the leadership of the Chief Scientist a fast-track mechanism to ensure the timeliness, coherence and quality for all WHO guidance specifically relevant for addressing aspects of COVID-19 to provide approval or critique within 48 hours. Emergency interim guidelines were developed within weeks, and rapid advice guidance within 1-3 months. An impressive array of COVID-19 related guidance was issued and made available publicly very quickly, and where needed, technical support for their understanding and use was provided to partners at all levels. It has been increasingly recognised that a certain level of training/technical support in the use of new guidelines would increase the likelihood that the guideline is applied and is used well and to a maximum effect. Hence, some technical departments organise virtual platforms (e.g., webinars) for their own staff at country level and partners to disseminate and explain newly available guidelines. WHO Country staff is then expected to ensure dissemination, adaptation where needed, and application where relevant through proactive engagement with country counterparts. There is evidence from the interviews that this may be hampered by the lack of technically competent country staff in certain areas and countries. Some departments also track and monitor the uptake of guidelines at end-user level (often policymakers or health care providers in countries), yet this is not consistently done across the technical areas within WHO. Data, in the broadest sense, should be considered a normative public good. In that regard, data collected, analysed and published in the World Health Statistics Report which include parameters like excess mortality due to COVID-19, progress towards the health-related SDGs and the Triple Billion targets (including universal healthcare access) undoubtedly will affect policy and programmatic decisions at all levels. Another positive example of normative leadership is WHO's role as custodian of global health data, which involves the development and oversight of global health data governance, the World Health Data Hub, as well as impact optimization tools and guidance. The WHO Global Health Observatory (a WHO-hosted partnership) which develops tools and templates to focus on policy relevance. All evidence products are open-access public goods. The Observatory works with Member States and the WHO Secretariat at the points in the policy cycle when decision makers need evidence inputs.	
MI 10.0 Evidence confidence *As noted above, there is no comprehensive analysis currently available to determine whether WHO normative products across the board were effective in influencing policy and programmatic improvements. We found insufficient evaluations conducted that assessed the impact of WHO's products influencing global, regional and partner country policy and programmatic improvements, although anecdotal evidence was positive. Hence, evidence confidence was assessed as "Low".*	**Low confidence**

MI 10.1: Interventions objectives and design assessed as responding to beneficiaries global, country, and partner/institution needs, policies, and priorities (inclusiveness, equality and Leave No One Behind), and continuing to do so where circumstances change	**Score**
MI rating	**Satisfactory**
MI score	**3**
MI 10.1 Analysis	**Evidence documents**
Systematic needs assessment of target groups including consultation of target groups is a required step in the development of normative products and intervention design of WHO. Equity and 'Leave No One Behind' are deeply and visibly engrained in the GPW13, as well as in thematic strategy documents in WHO. Interviewees were aware of the pursued Leave No One Behind agenda and noted WHO's leadership in the Leave No One Behind working group among UN agencies. For normative products, often informing the design of interventions, clinic practice, and policy at various levels - according to the GRC guideline development process - one criterion to be assessed to obtain approval is considerations of equity, inclusiveness and 'leave no one behind'. Routinely, this data gathering with target groups to better document their Attitudes, Values and Preferences is done through individual interviews, surveys, or, very commonly by conducting focus group discussions with the target groups. There is insufficient evidence to estimate the extent to which this is being done in all instances, however, given the stringent GRC approval process, it can be safely speculated that it happens regularly. The CCS process should, through structured consultation, respond to the needs of partners at country level.	106 190 205 335 336 419 436 499 525 576

Considerations of equity, human rights, and inclusiveness are also included in the CCS handbook as a required step to inform the development of country cooperation strategies and interventions. We note that as of late 2022, 68% of country offices had a CCS that was valid or an advanced stage of development, but that it was not possible from these to assess how much, in reality, partners consider WHO's approach and plans effectively respond to their needs. In the global Results report of 2020-21, all outputs are reviewed and graded to assess to what extent the priorities of the most vulnerable are assessed, whether action taken (hence interventions) to maximise sustainable results are in line with priorities of Member States and partners, and thirdly, whether the best delivery approaches have been chosen to implement the work of WHO: for all three parameters the grading in the WHO report is consistently between 3-4 (satisfactory to strong). In the partners' survey, over 85% "strongly agree", "agree" or "somewhat agree" that WHO's work has responded appropriately to the needs of beneficiaries, including the most vulnerable populations. 85% of survey respondents "strongly agree", "agree" or "somewhat agree" that WHO appropriate adapted its work as the context changed. 85% of survey respondents " We have seen no systematic evaluation whether WHO's interventions objectives and designs assessed as responding to beneficiaries global, country, and partner/institution needs, policies, and priorities	
MI 10.1 Evidence confidence *As noted above, there was no comprehensive analysis currently available to determine whether WHO interventions objectives and designs assessed as responding to needs, policies, and priorities. Most data collected was at output level only. Hence, evidence confidence was assessed as "Low".*	**Low confidence**

KPI 11: Results are delivered efficiently	**KPI score**
Satisfactory	**3**
MI 11.1: Interventions/activities assessed as resource/cost-efficient	**Score**
MI rating	**Satisfactory**
MI score	**3**
MI 11.1 Analysis	**Evidence documents**
The overarching question of what value for money is, is not easily judged, however there are a number of examples to indicate that the "Value for Money" concept is gradually being embedded in the organisation. i. The sixth progress report on the implementation of the Transformation Agenda of the WHO Secretariat in the Africa Region: "Delivering quality results and value for money: Value for money has become an integral element of WHO's work at all levels. In 2020, the Secretariat introduced value-for-money performance indicators for all technical units to assess application and achievement of the value-for-money approach in maximising the impact of every dollar spent. An innovative capacity building initiative has also been designed to embed value-for-money principles in planning, implementation, monitoring and resource mobilisation processes across the Secretariat. Short, animated videos that use WCO examples to communicate the meaning of value for money, how it is applied, and the efficiencies gained as a result have been produced to build the capacities of programme management officers, PMOs, now present in, and supporting 26 WCOs". ii. Although the world is off-track to achieve WHO's global normative objectives, there are multiple examples of WHO accomplishing normative results in a timely, resource & cost-effective way: "More than 133 countries increased or introduced a new health tax between 2017 and 2022, showing that Member States are increasingly equipped to use fiscal measures to improve health, reduce health care costs and generate a revenue stream for development - owing in part to increased technical support and updated guidance from the Secretariat. Now, 146 countries are protected by at least one measure of the MPOWER technical package; 60 countries are on track to achieving the global targets for reducing tobacco use; and health taxes are part of a comprehensive strategy for preventing noncommunicable diseases, which kill 41 million people every year." Mid-term review	15 17 62 63 64 425 481 555

of the Programme Budget for 2022-23. iii. "The WHO Contingency Fund for Emergencies was used for rapid responses and for the continuity of essential response in 14 emergencies, for a total of USD 43.7 million allocated during 2020; 90% of initial releases were made within 24 hours of a request for funds." Executive summary Results Report Programme Budget 2020-21 (Mid-term). iv. Further highlights in support of WHO programmes include: "the processing of a record number of over 60,000 goods and services POs with 97% of the transactions processed within target turnaround times. WHO procurement report 2022. **v.** The improvement of systems can help, ultimately, to deliver results efficiently, such as the BMS. Although not yet implemented, interviewees commented. "The BMS can pull out more data, do a lot of linkages especially to the results area. It's more transparent too - this can help improve efficiency."	
MI 11.1 Evidence confidence *Evidence confidence was rated "Low" as there was no comprehensive analysis to determine whether interventions/activities assessed as resource/cost-efficient. There were insufficient evaluations being conducted in this area. Hence, evidence confidence was assessed as "Low".*	**Low confidence**

MI 11.2: Implementation and results assessed as having been achieved on time (given the context, in the case of humanitarian programming)	**Score**
MI rating	**Satisfactory**
MI score	**3**
MI 11.2 Analysis	**Evidence documents**
The massive impact of the COVID-19 pandemic has resulted in further delay to achievement of the health-related Sustainable Development Goals (SDG) targets. The Programme Budget for 2022 Results Report noted: "The world was off track to reach most of the Triple Billion targets and the health-related SDGs before the coronavirus disease (COVID-19) pandemic, and it is even further off track now. However, in noting the time frame of results, it is important to consider the external constraints under which the organisation functions (as elucidated in the sections on financing and human resources), and the full breadth and extent of the work of the organisation. The bullet points below highlight progress in various areas: ● **Healthier populations:** The indicators for healthier populations are influenced by multi-sectoral policy actions to address determinants of health. Substantial progress has been made, and the current trajectory indicates that this target will likely be met by 2025; however, this will be insufficient progress to be on track to reach the related targets of the SDGs by 2030. For example, the global age-standardised prevalence of tobacco use remains high. The prevalence of adult obesity continues to be on the rise in all WHO regions, with no immediate sign of reversal. Air pollution has not been tackled in many areas of the world. Data from the pandemic period continue to be sparse, so the full extent of the impact of the coronavirus disease (COVID-19) pandemic on various health determinants and policies is not yet quantified. ● **Universal health coverage:** The world is off-track to meet the universal health coverage billion target by 2025 and related SDGs by 2030. The disruptions caused by the COVID-19 pandemic have had a significant impact on many indicators, only some of which are recovering. Overall measures of progress are largely driven by increased HIV service coverage. Service coverage for routine childhood vaccination, malaria, tuberculosis, noncommunicable and other diseases and preventive services all continue to lag, while indicators for financial hardship have worsened. ● **Health emergencies protection:** Progress in health emergencies protection is not on track to reach the billion targets by 2025. Improvement in preparedness, measured through core capacities related to the International Health Regulations (2005) and reflected by the Prepare indicator, contributed positively in 2022. However, pandemic-related disruptions to high-priority pathogen vaccination programmes, measured under the Prevent indicator, need to be resolved. Efforts are continuing in order to assess the best way to measure health emergencies protection, including the integration of timeliness targets for detection, notification and response to health emergencies – 2023 Mid-term Review of the Programme Budget for 2022-23. ● However, there are also a number of positive results, e.g. "Some crises never made the headlines due to successful prevention efforts. Case numbers fell in major cholera hotspots such as Somalia, South Sudan and Yemen. Globally, cholera cases declined by 60% in 2018 thanks to the delivery of 18 million doses of the vaccine. Mass vaccination against yellow fever protected more than 100 million people	17 51 71 232 425 461

from the disease in 2018-19. Some 500 million people were also vaccinated for seasonal influenza in 2019." Driving Impact in every country - WHO Results Report, Programme Budget for 2018-19. ● Successive reports of the Independent Oversight Advisory Committee for Health Emergencies (IOAC) programme note in 2022 - Since 2021 cholera cases have increased globally. Many affected countries reported higher case numbers and case fatality rates than previously. In 2022 at least 30 countries reported a cholera outbreak with 1.1 billion people at risk. WHO graded the global cholera outbreak as a Grade-3 event under the Emergency Response Framework and activated a full incident management system at headquarters, regional offices and affected countries. This unlocked financial resources and mobilised WHO-wide surge capacity. ● During the period May 2022 to April 2023 WHO's timely response to emergencies included multi-country outbreaks of M-Pox, global cholera outbreaks, floods in Pakistan, Sudan virus disease, Uganda Marberg virus, drought and flood emergency in the Greater Horn of Africa, humanitarian crisis in Sahel region of Africa, The Ukraine Emergency, the earthquake in the Syrian Arab Republic and Turkey and other protracted emergencies and humanitarian crises.	
MI 11.2 Evidence confidence *At the time of our assessment there was insufficient evidence from evaluations of the WHO's results to report confidently on this indicator. Confidence was rated as "Low" as a result, although as set out above evidence exists of some timely delivery and achievement, alongside other results that are delayed.*	**Low confidence**

KPI 12: Results are sustainable	**KPI score**
Satisfactory	**3**
MI 12.1: Benefits assessed as continuing, or likely to continue after intervention completion (Where applicable, reference to building institutional or community capacity; and/or strengthening enabling environment for development, in support of 2030 Sustainable Development Agenda)	**Score**
MI rating	**Satisfactory**
MI score	**3**
MI 12.1 Analysis	**Evidence documents**
WHO's highest-level targets look to achieve enduring results in support of the UN's Sustainable Development Goals (SDG). The Thirteenth General Programme of Work's (GPW13) Triple Billion targets of achieving one billion more people benefitting from universal health coverage, one billion more people better protected from health emergencies, and one billion living with better health and well-being, are supported by 12 key health outcomes that together look to achieve sustainable benefits. The 12 outcomes seek to focus the work of WHO to strengthen global, regional and country health systems and capacities, and address the determinants of health, as well as, reducing risk factors. The lack of systematic coverage of evaluations (see KPI 8 above) that assess whether expected benefits are achieved means **we are unable to report clearly on the sustainability of a representative sample of WHO interventions, nor whether the capacity built sustains. Some examples of where corporate and decentralised evaluations have provided insights on efforts to achieve sustainable results include the midterm evaluation of the implementation of the Strategic Action Plan on Polio Transition, which reported that the polio surveillance infrastructure set up during the programme has the potential for sustained results, should the infrastructure be maintained. The evaluation of the implementation of the WHO global action plan for the prevention and control of noncommunicable diseases (2013-2020) assess WHO and Member State progress made in implementing the NCD-GAP and barriers to sustained results. The evaluation of WHO's Neglected Tropical Diseases Programme also assesses to what extent programme results are durable over time at the country, regional and global levels. Examples of decentralised evaluations addressing sustainability of results include the evaluation of WASH across the Asia Pacific, while evaluations of WHO's response to COVID-19 in EMRO and Ukraine outlines opportunities to build momentum and sustain COVID-19 initiatives.** At the highest level, WHO currently reports that the world is on track to meet only one of the three Triple	15 16 17 53 158 656 779 780 781 782 783 784

Billion targets. The disruptions caused by the COVID-19 pandemic have yet to be fully quantified but have had a significant impact on many indicators, only some of which are recovering. For the target of achieving one billion more people living with better health, substantial progress has been made, and the current trajectory indicates that this target is likely to be met by 2025 (albeit this will be insufficient progress to be on track to reach the related targets of the SDG by 2030). The world is also off track to meet the universal health coverage billion target by 2025 and related Sustainable Development Goals by 2030 and progress in health emergencies protection is also not on track to reach the billion target by 2025 although progress has been significant; 920 million more people are projected to be better protected from health emergencies by the end of 2023 due to improvements in preparedness, prevention, detection and response to events.

While the billion targets are not all going to be met, it is clear that sustainable change is being achieved. Many global health indicators continue to show improving health for people; at its basic level, a higher proportion of the global population continues to live longer and live more years in good health. Between 2000 and 2019 (the last reporting period and prior to the pandemic), global life expectancy (LE) at birth increased from 66.8 years in 2000 to 73.3 years in 2019, and healthy life expectancy (HALE) increased from 58.3 years to 63.7 years, with longevity and health among females consistently higher than males. During this time the global population rose by over 1.3 billion people. The share of deaths caused by communicable, maternal, perinatal and nutritional conditions (communicable diseases) continues to decline (especially those that tend to kill children under 5 years of age). There have been advances in reducing some of the world's leading infectious diseases; HIV/AIDS and tuberculosis both dropped out of the top 10 global causes of death by 2019. At the global level, seven of the top 10 causes of death in 2019 were non-communicable diseases, and the share of deaths resulting from non-communicable diseases has increased from 60.8% in 2000 to 73.6% in 2019. Like for HIV, global efforts had resulted in an 18% reduction in malaria mortality rates by 2019 compared to 2015. This was far from the milestone of a 40% reduction by 2020, however, and progress is off track to meet the target of at least 90% reduction by 2030. Incidence rates of Tuberculosis have similarly rapidly declined. Trends see a consistent reduction in deaths due to the four major non-communicable diseases (NCDs) (like, cancer, cardiovascular diseases, diabetes and chronic respiratory diseases) in all ages. Globally, the greatest reduction was in the mortality rate for chronic respiratory diseases, a 37% decline between 2000 and 2019. However, diabetes has shown an unfavourable trend with a 3% increase. There is more attention now being paid to NCDs, with 36 countries incorporating them into the delivery of primary health care during the period under review. Other significant milestones have also been reached in the period under review, such as the SDG targets of reducing hepatitis-B prevalence to less than 1% among children under five years, eliminating malaria in 10 countries and at least one neglected tropical disease in 42 countries, more than three million people in 18 countries improving control of hypertension with the WHO HEARTS technical package, and 26 million people received antiretroviral medicines.

At the same time, during the period under review the WHO provided institutional leadership in the global response to COVID-19. Between 2020 to September 2023, the WHO records that there were 6.96 million deaths directly caused by COVID-19, with more than 770 million cases recorded globally. Also, as of September 2023, WHO records that more than 13.5 billion doses of vaccine have been administered across the world. While it is not possible to say so definitively, one estimate has said that more than 20 million lives were saved by the vaccine in its first year alone, and that if WHO global vaccine targets had been met, one in five of deaths as a result of COVID-19 may also have been prevented. Independent assessments have commended the WHO for its response, but COVID-19 showed how WHO's capacity to influence the global response to a global challenge such as the pandemic is limited. While being the lead health organisation in the international system, WHO could not do everything and ultimately the response to global health challenges, such as, COVID-19 relies on global, regional, and country actors and coordination within a global system where different actors' comparative advantages are maximised.

The COVID-19 pandemic also highlighted the importance of the social and environmental determinants of health in achieving sustainability, better health and well-being. The pandemic drew specific attention to air pollution, the most important environmental determinant of health, which caused an estimated seven million premature deaths in 2020; fine particulate matter is a risk factor for severe COVID-19. COVID-19 has also highlighted the importance of safe water, sanitation and hygiene (WASH) to protect humans from infectious diseases. The worldwide COVID-19 pandemic also highlighted and sometimes exacerbated social, gender and health inequities.

The quantifiable return on investment in WHO has been identified as "very substantial". In its investment case for a more sustainably financed WHO presented to the World Health Assembly, the cost of the WHO in net present value terms over the coming 10-year period, 2022–31, is seen as USD 33 billion The public value

created as a result of this investment (conservatively estimated) was assessed to be between USD1.155 trillion and USD 1.46 trillion. The resulting return on investment is USD 35 for every USD1 invested in WHO, it says. The same report from 2022 also notes that: *"there are many areas of WHO's work where the value of the health benefits created has not been calculated and there are uncertainties in any calculation of the benefits generated by WHO that accrue from the totality of the organisation's efforts and accumulate over a long period. Also, the public value created by WHO is itself dynamic as both health needs and benefits vary across regions and over time."* It also notes that the lack of resources currently available at country level in terms of expertise and finance remains an obstacle to enhancing Member States' capacity in data collection, analysis, monitoring and reporting on the Triple Billion targets and the Sustainable Development Goals. Global action, substantially influenced and led by WHO, is having a sustained impact on health indicators, but much more remains to be done and can be done. Regional inequalities exist globally, with progress in Africa lagging behind other parts of the world. WHO's interventions at the global, regional and country level are taking place alongside and to achieve continuous and sustained improvement in most global health indicators. The rate of achievement is not fully at the pace to achieve SDG targets, nor is the rate of change consistent across the globe. Challenges are increasing, not least as a result of the number of people who are identified as vulnerable to emergencies also increases. More information is needed to enable clear assessments to be made of the sustainability of specific activities and interventions undertaken by WHO.	
MI 12.1 Evidence confidence *As noted above, little evidence was available. For a full assessment, analysis would require more evaluations to determine the sustainability of specific activities and interventions undertaken by WHO. Hence, evidence confidence was assessed as "Low".*	**Low confidence**

2 Annex B – List of Documents

Code	Document Title
1	WHO (2013), WHO evaluation practice handbook, World Health Organization, https://apps.who.int/iris/handle/10665/96311, [accessed on: 1 September 2023].
2	WHO (2021), *Human resources: annual report by the Director-General (A74/25)*, World Health Organization, https://apps.who.int/iris/bitstream/handle/10665/358458/A74_25-en.pdf?sequence=1&isAllowed=y, [accessed on: 14 September 2023].
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3 Annex C – Results of the MOPAN external partner survey

Key Information on the Partner Survey	
Sample countries	Niger, South Africa, Uganda (AFRO), Colombia, Honduras (AMRO/PAHO), Egypt, Afghanisatn (EMRO), Tajikistan, Moldova (EURO), Nepal, Indonesia (SEARO), Cambodia, Mongolia (WPRO)
Effective sample size	1153
Survey responses (response rate)	375 (33%)
Survey time frame	12 June – 27 July 2023

The online survey was administered by MOPAN and was conducted over a period of 7 weeks, starting on 12 June and closing on 27 July 2023. The survey was sent to an initial contact list of 1135 individuals provided by WHO and MOPAN members. The individuals were drawn from the 13 sampled countries; in addition to a category described as 'global' and another one labelled 'regional or multi-country'. A total of 373 partners responded, yielding a response rate of 33%.

Respondent Profile

Figure 1: Role of partners surveyed

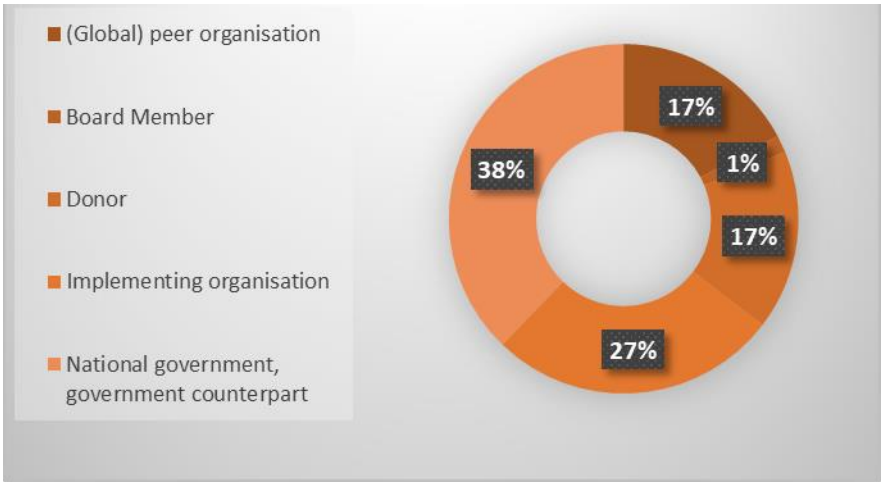
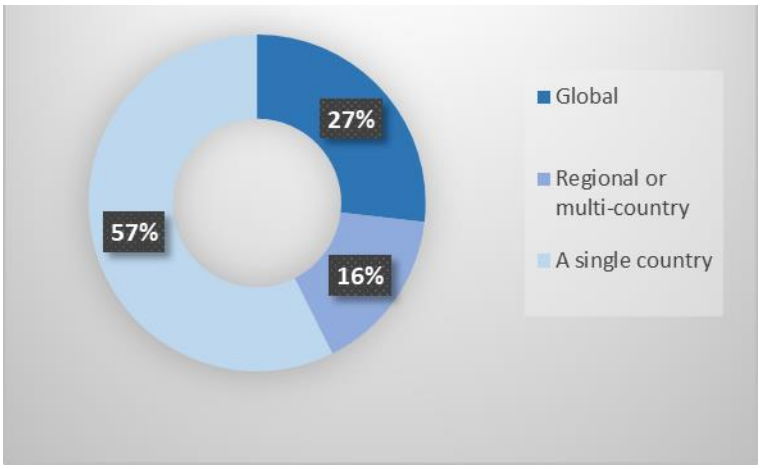


Figure 2: Geographic focus of partners surveyed



Survey Results

Strategic management

Figure 3: WHO's strategic priorities are clear

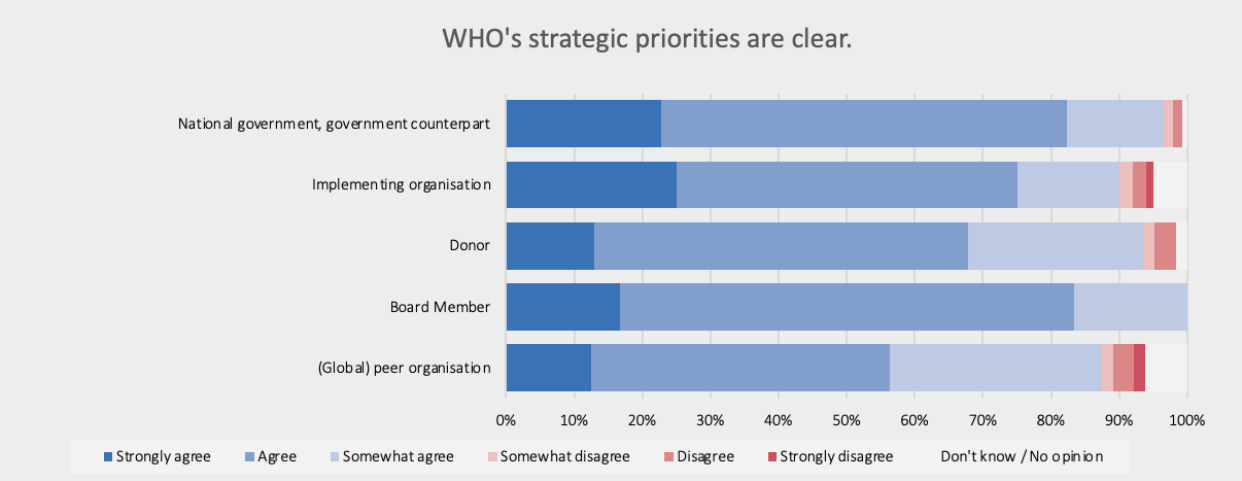


Figure 4: WHO's strategic priorities align with its comparative advantage

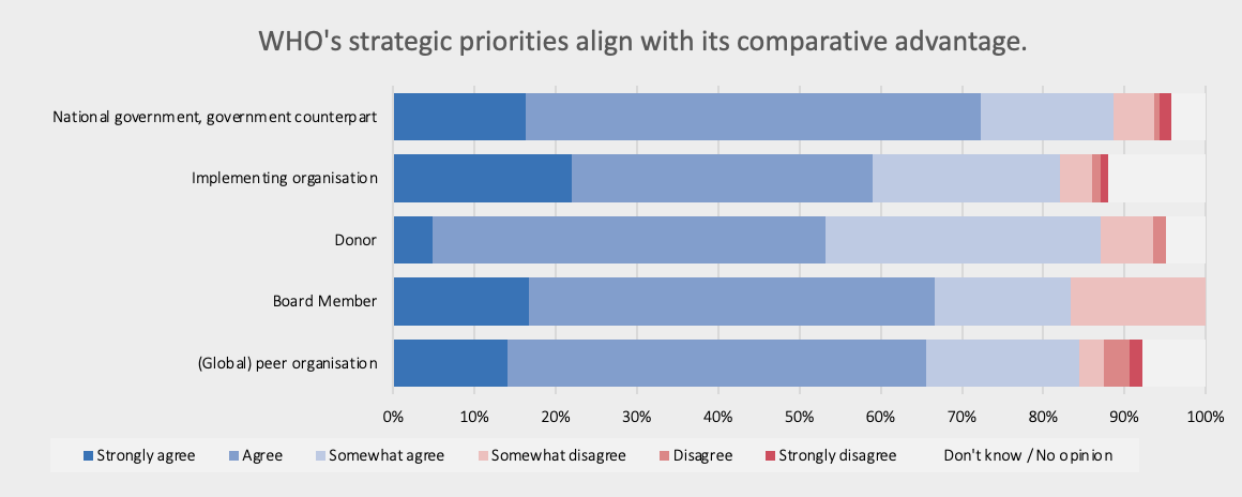


Figure 5: WHO's budgeting and financing mechanisms enable the achievement of its strategic priorities

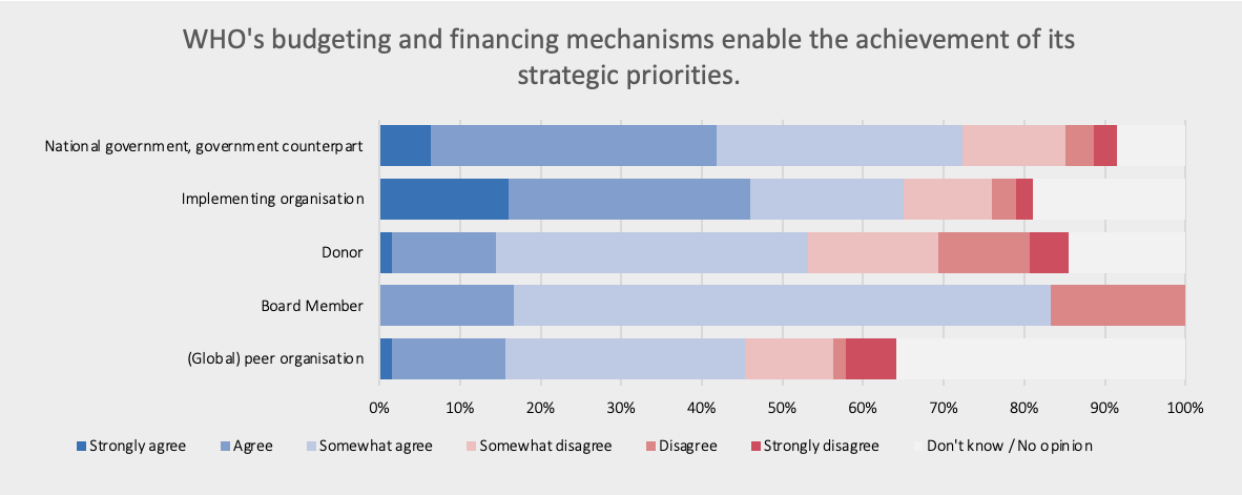
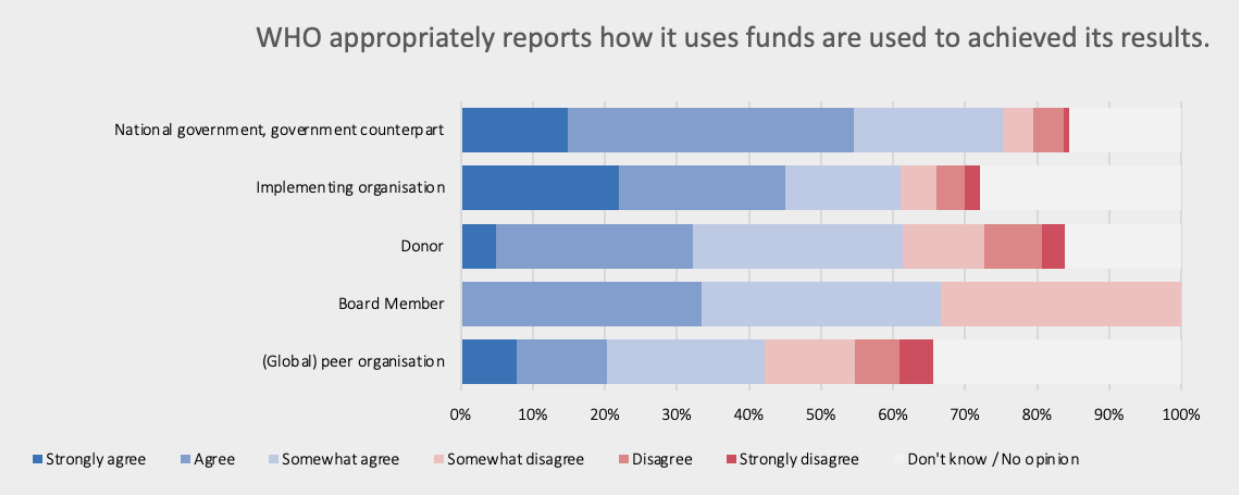


Figure 6: WHO appropriately reports how it uses funds are used to achieved its results



Staffing

Figure 7: WHO has sufficient staff deliver its intended results, within or available to the countries where it operates

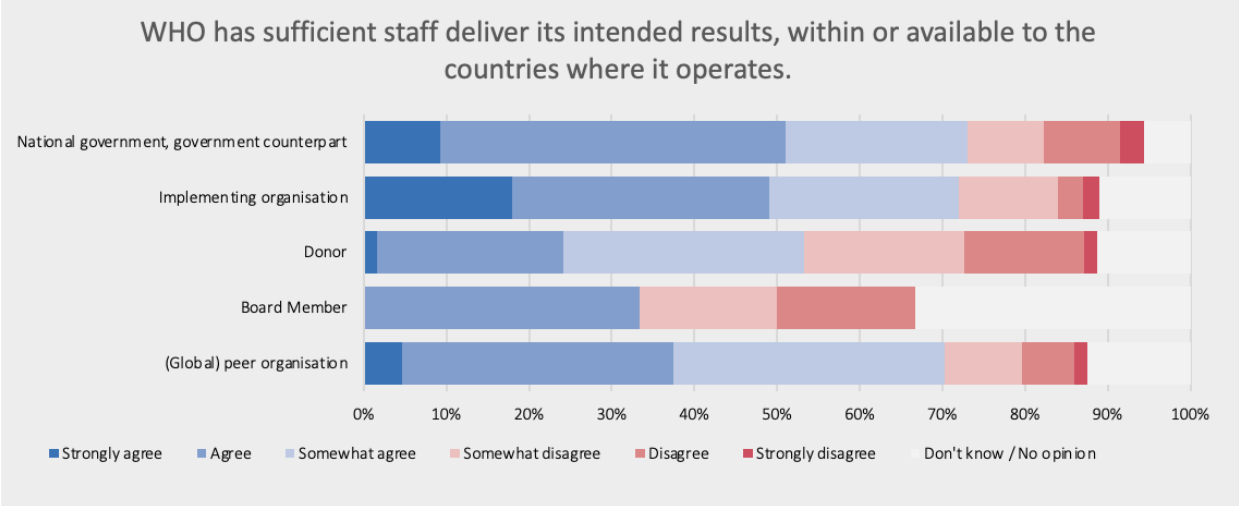


Figure 8: Staff are sufficiently experienced and skilled to work successfully in all the contexts where WHO works

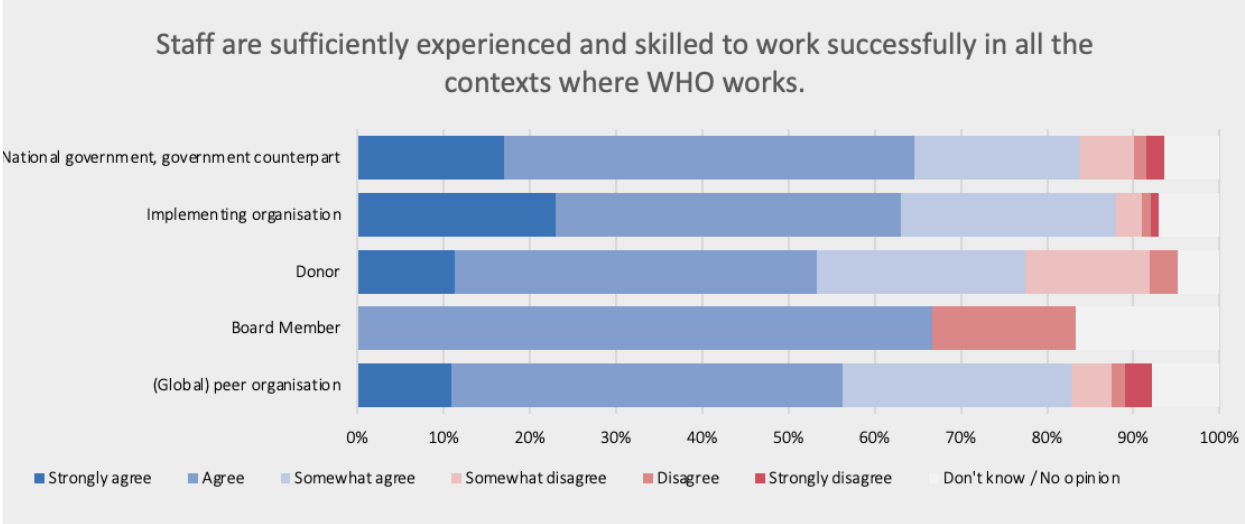
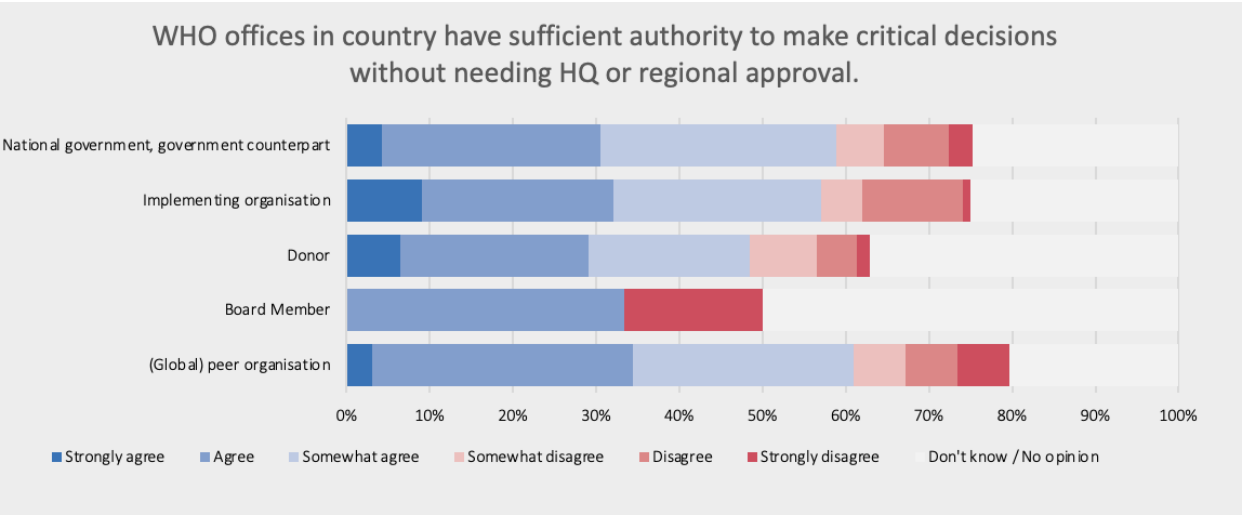


Figure 9: WHO offices in country have sufficient authority to make critical decisions without needing HQ or regional approval



Cross-cutting issues

Figure 10: WHO strategies and operations sufficiently promote gender equality

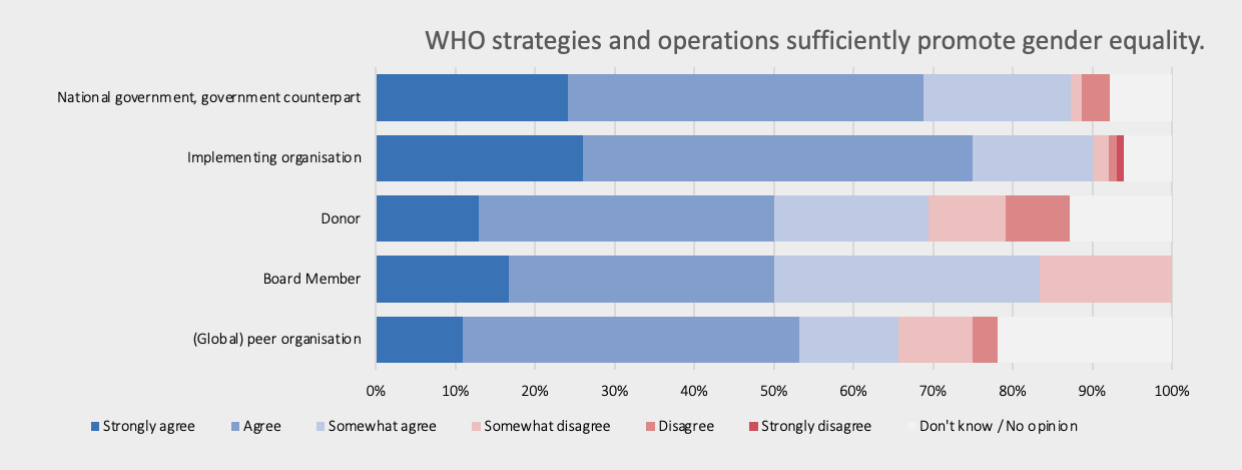
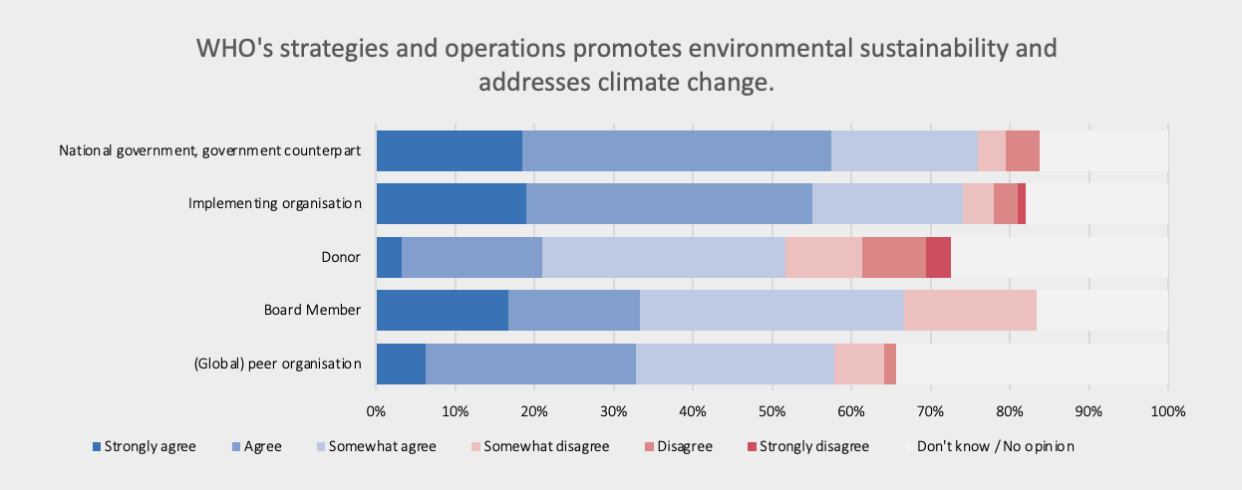


Figure 11: WHO's strategies and operations promotes environmental sustainability and addresses climate change



Interventions

Figure 12: WHO's work responds appropriately to the needs of beneficiaries, including the most vulnerable populations

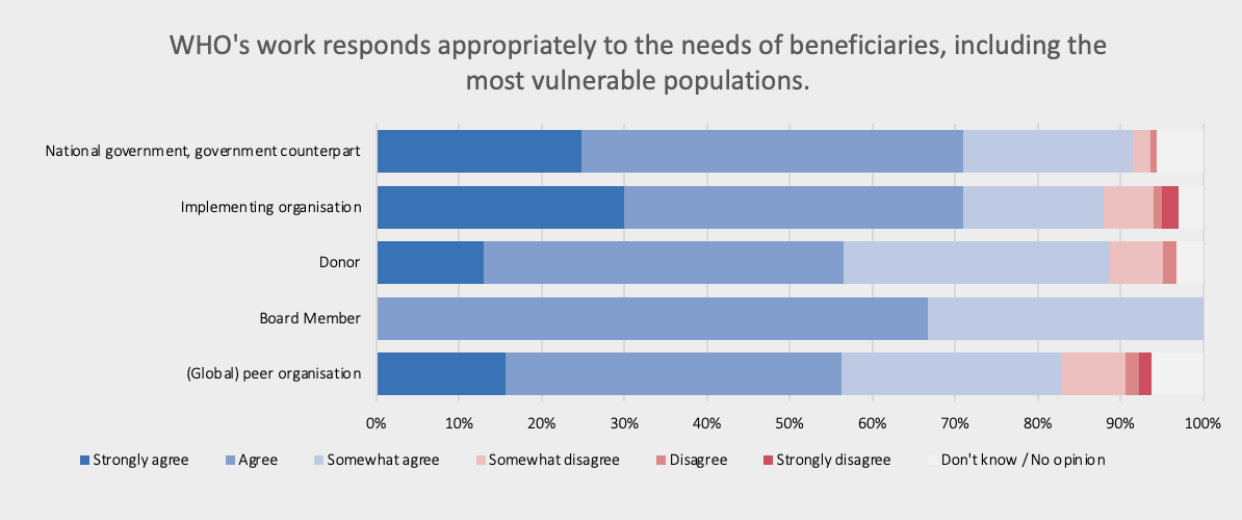


Figure 13: WHO appropriately adapts its work as the context changes

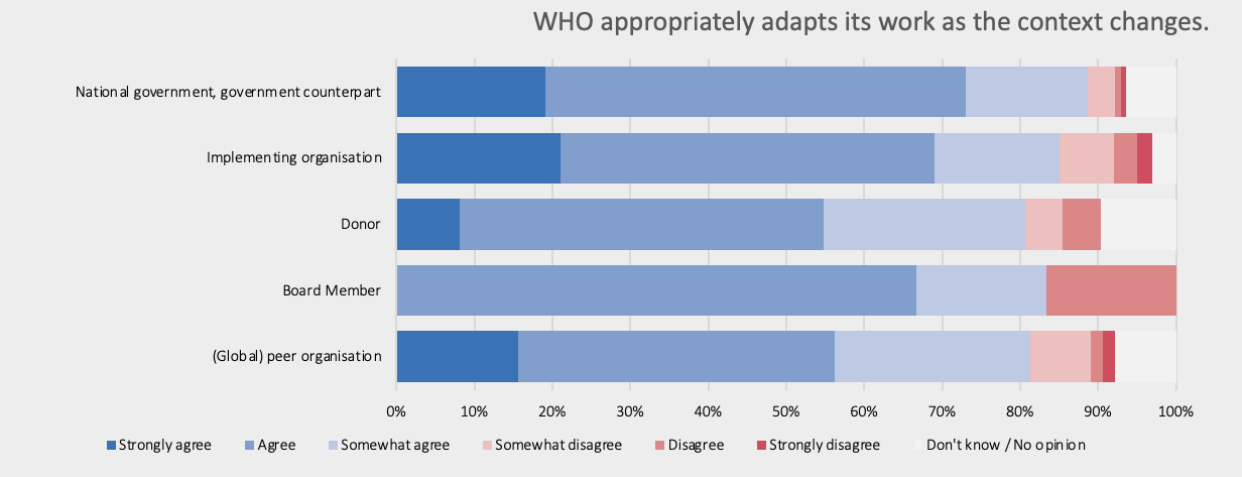


Figure 14: WHO's work aligns with the national programmes and intended results of countries it works in

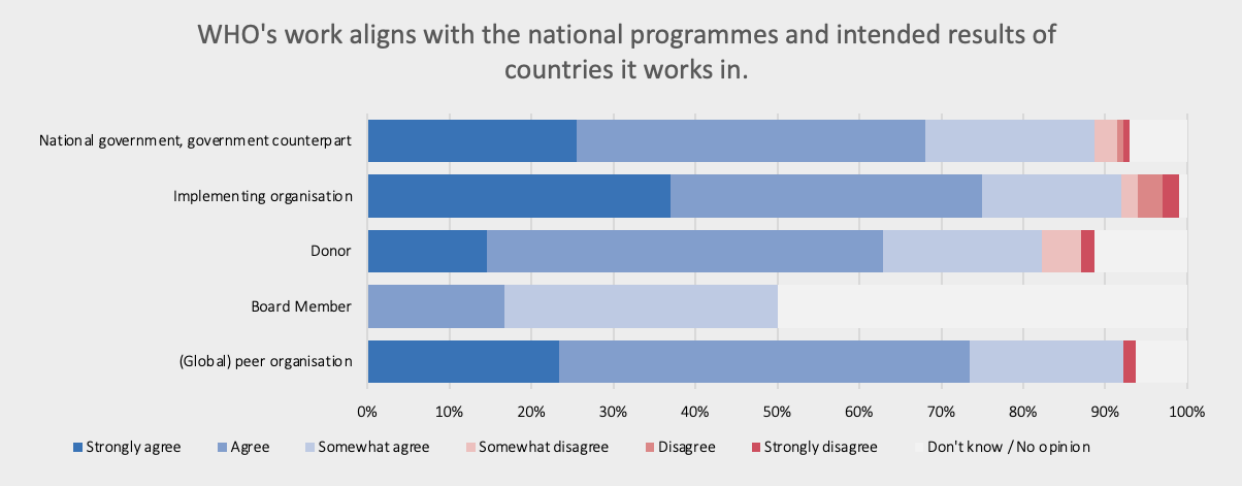
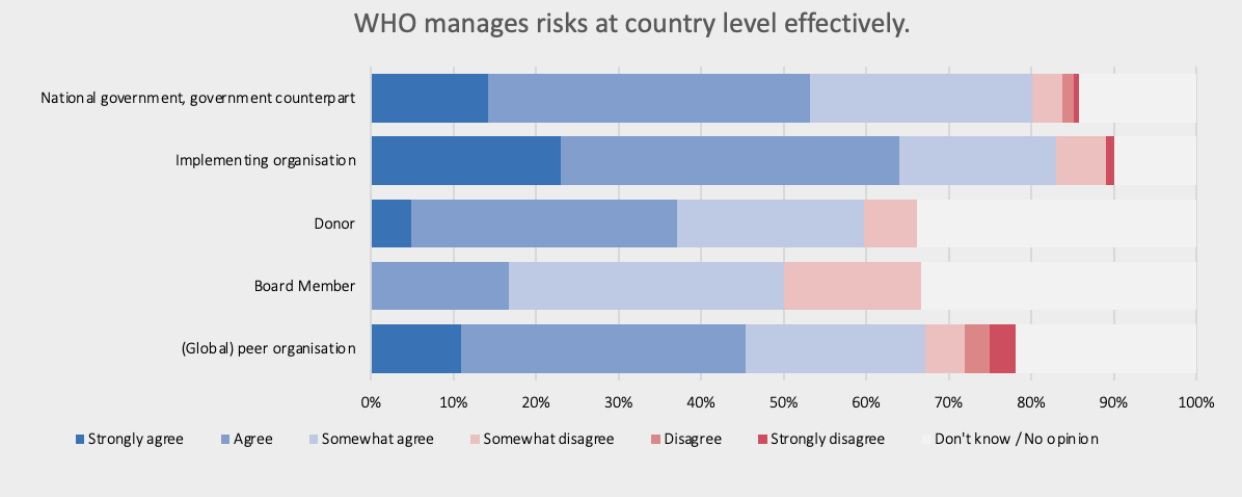


Figure 15: WHO manages risks at country level effectively



Managing financial resources

Figure 16: The criteria that WHO uses to allocate its financial resources are clear

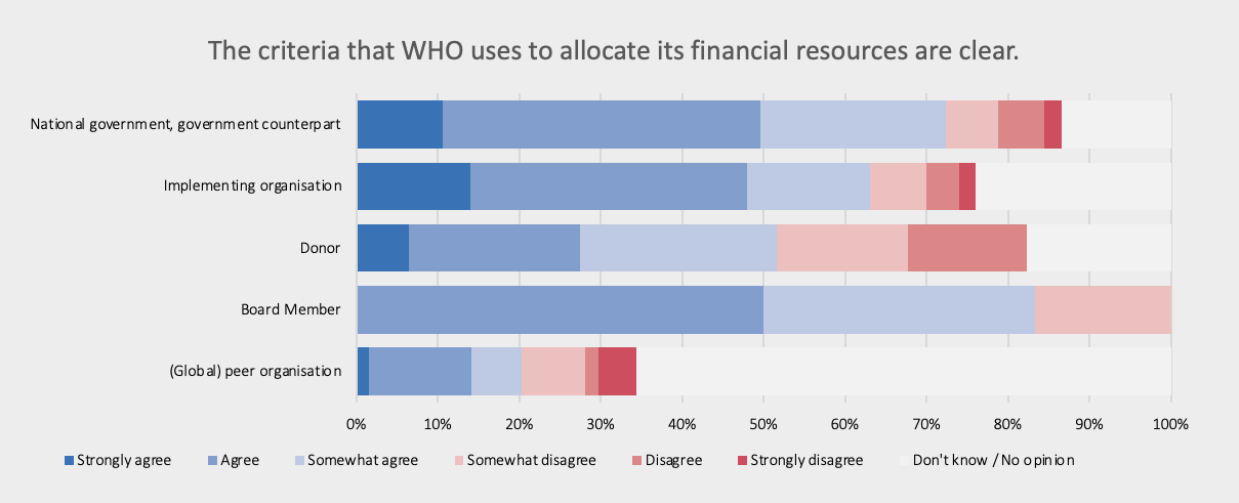


Figure 17: WHO communicates clearly on payment timeframe and any variations associated with payments

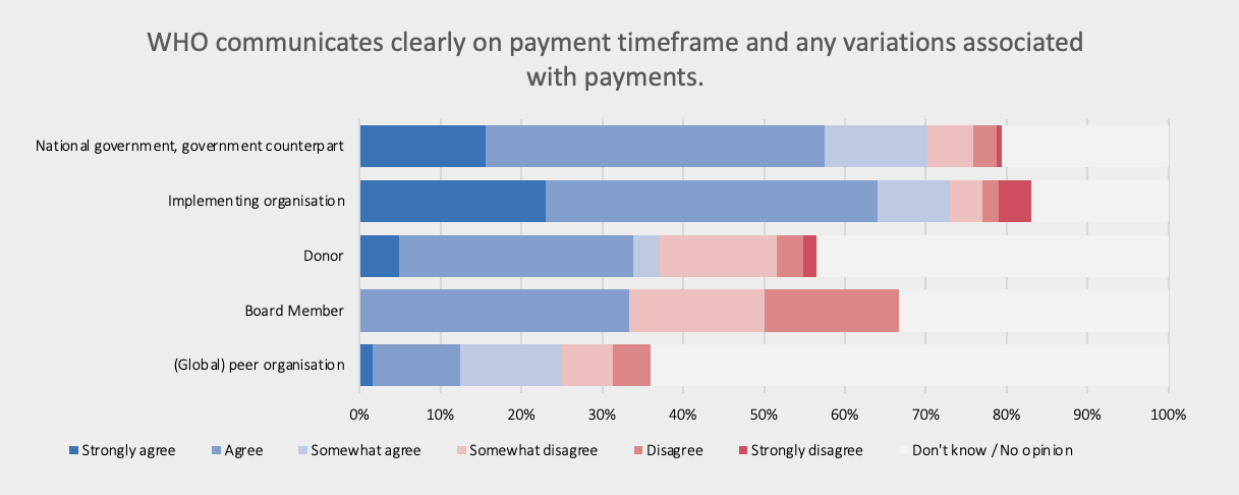
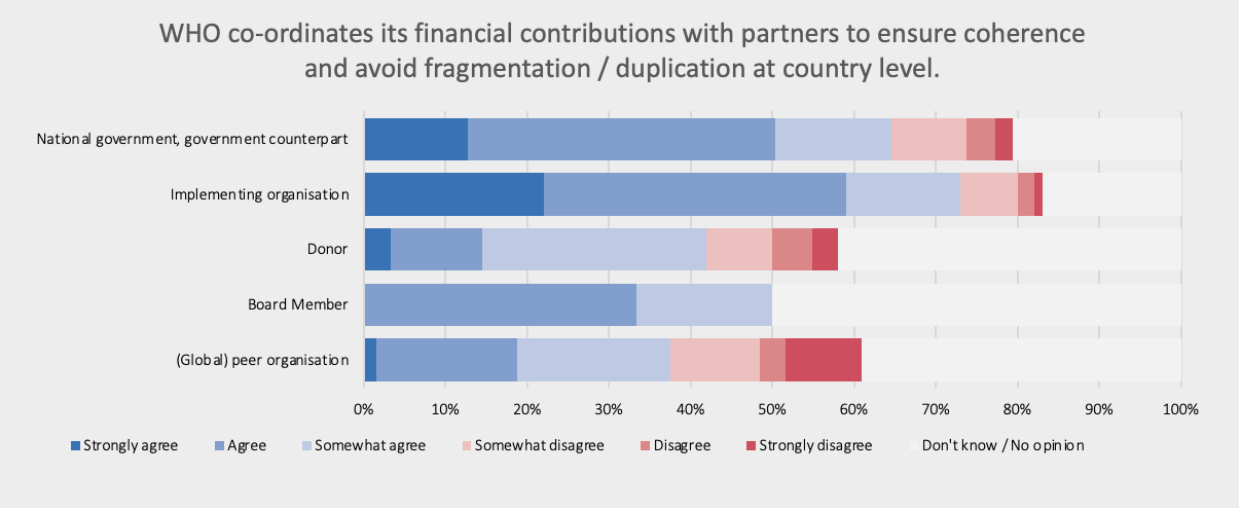


Figure 18: WHO co-ordinates its financial contributions with partners to ensure coherence and avoid fragmentation / duplication at country level



Managing relationships

Figure 19: WHO provides high-quality inputs to the global policy dialogue

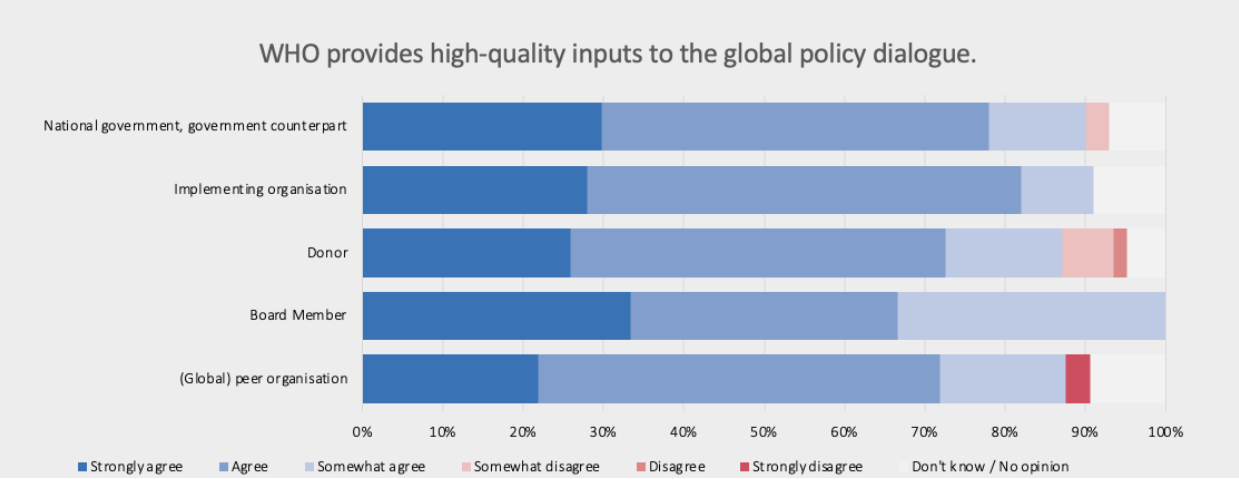


Figure 20: WHO shares key information (e.g. General Programme of Work and results framework, budget, results reporting, Standard Operating Practices that involve partners) with partners on an ongoing basis

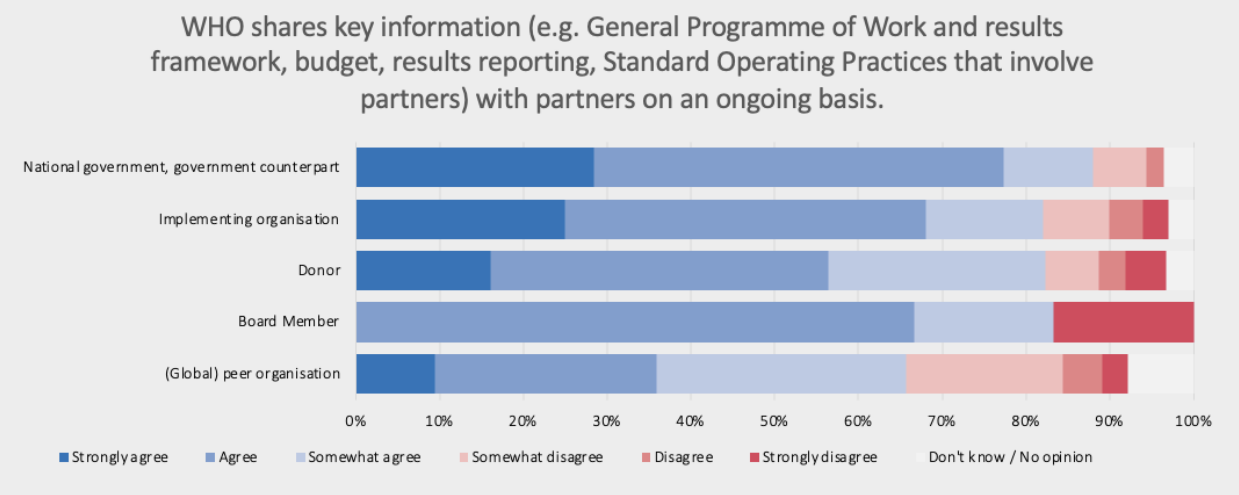


Figure 21: WHO helps develop the capacity of country systems where it works

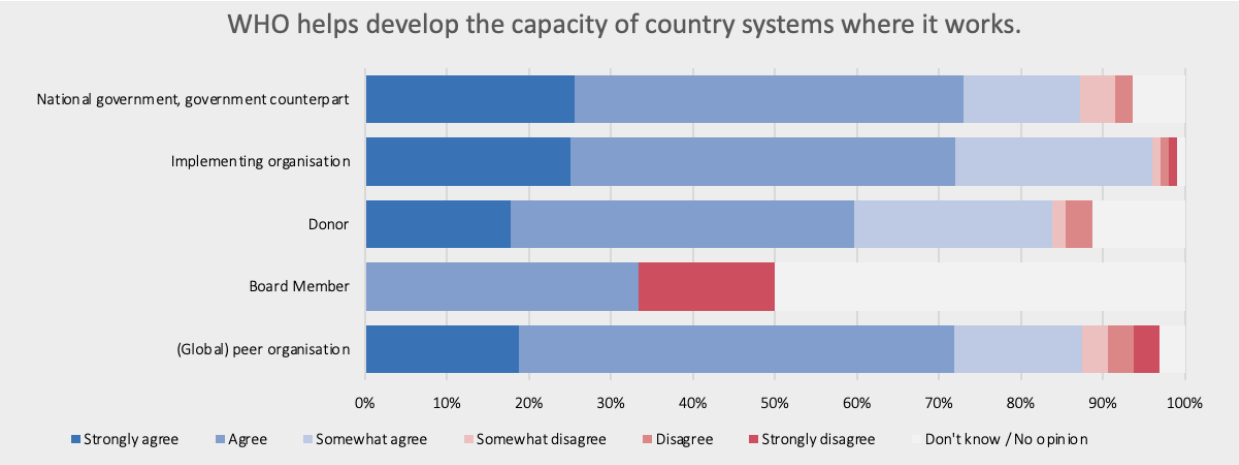


Figure 22: WHO's partners are involved in decisions throughout the programme cycle, as appropriate (planning, coordination, monitoring and evaluation)

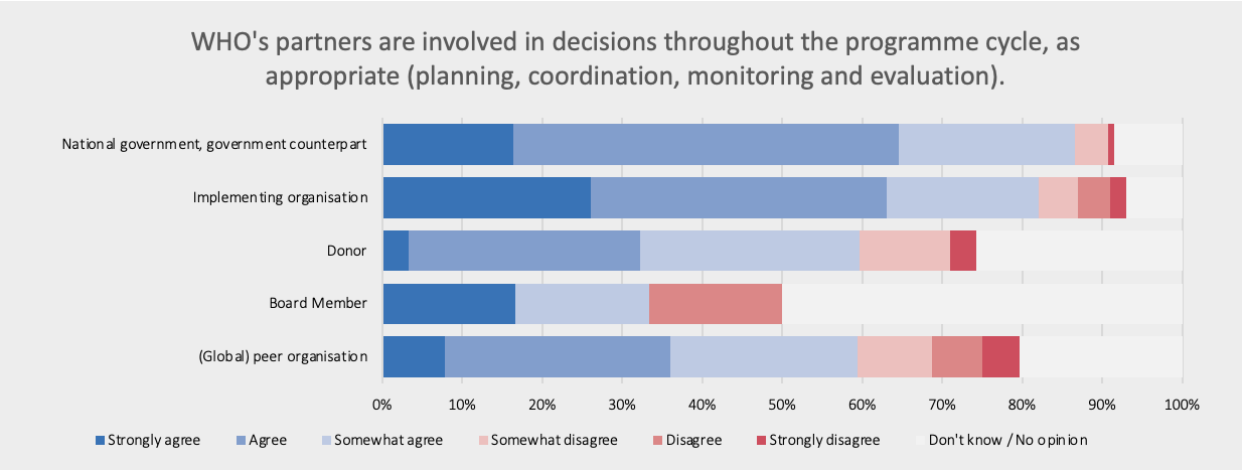


Figure 23: WHO is actively engaged in inter-agency co-ordination mechanisms for planning, implementation, monitoring, and context analysis in countries where it works

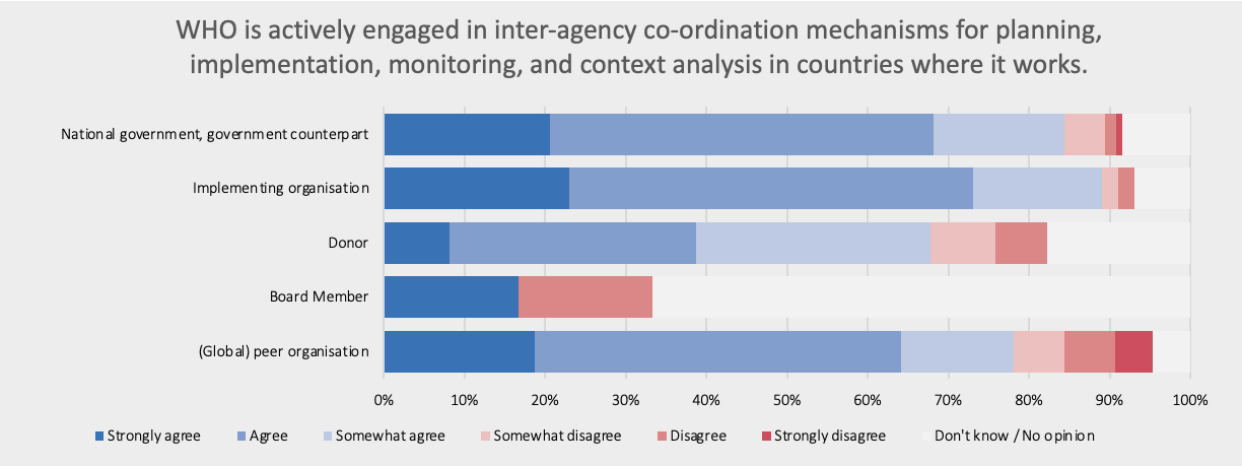


Figure 24: WHO jointly monitors progress on shared goals in-country with local and regional partners

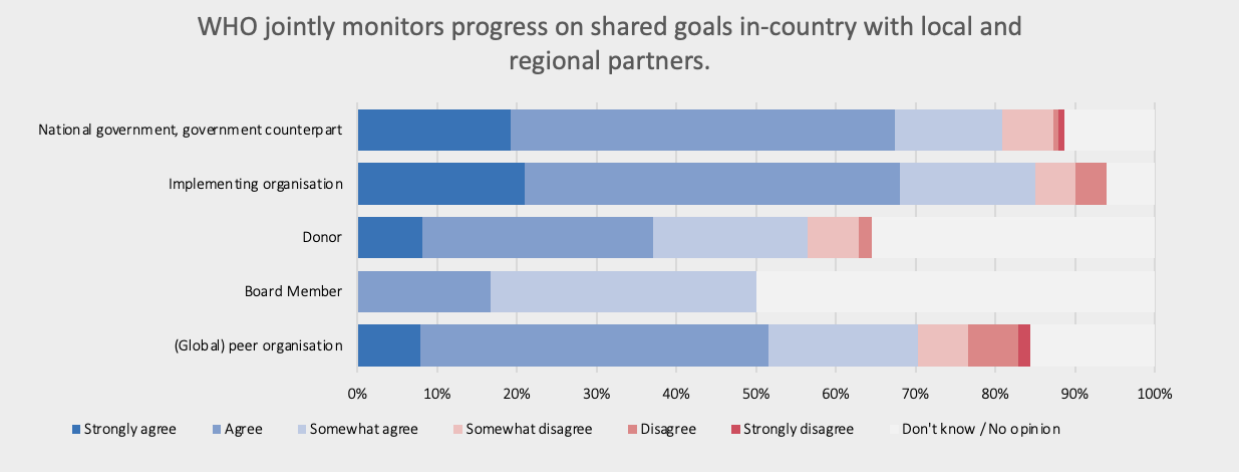


Figure 25: WHO requires its partners to apply clear standards for preventing and responding to sexual misconduct in relation to host populations

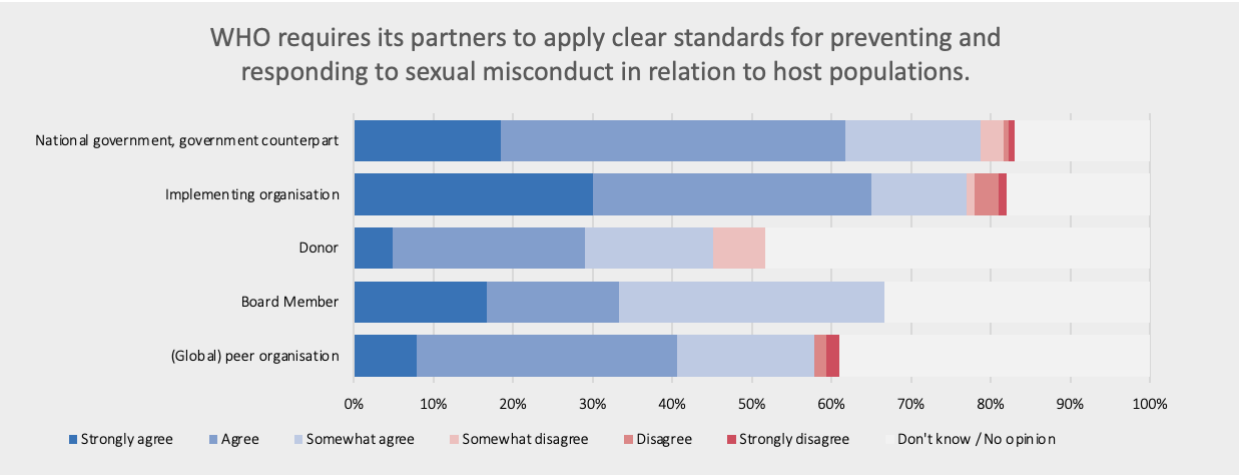
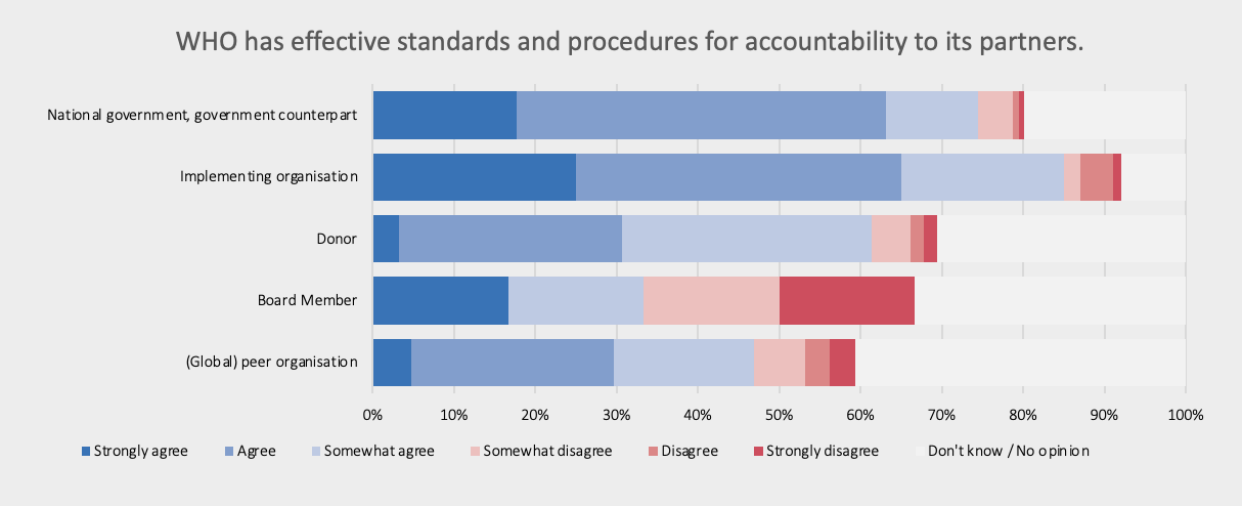


Figure 26: WHO has effective standards and procedures for accountability to its partners



Organisation's response to COVID-19

Figure 27: WHO has been able to adapt its programming and activities to respond to COVID-19 in an agile and responsive way

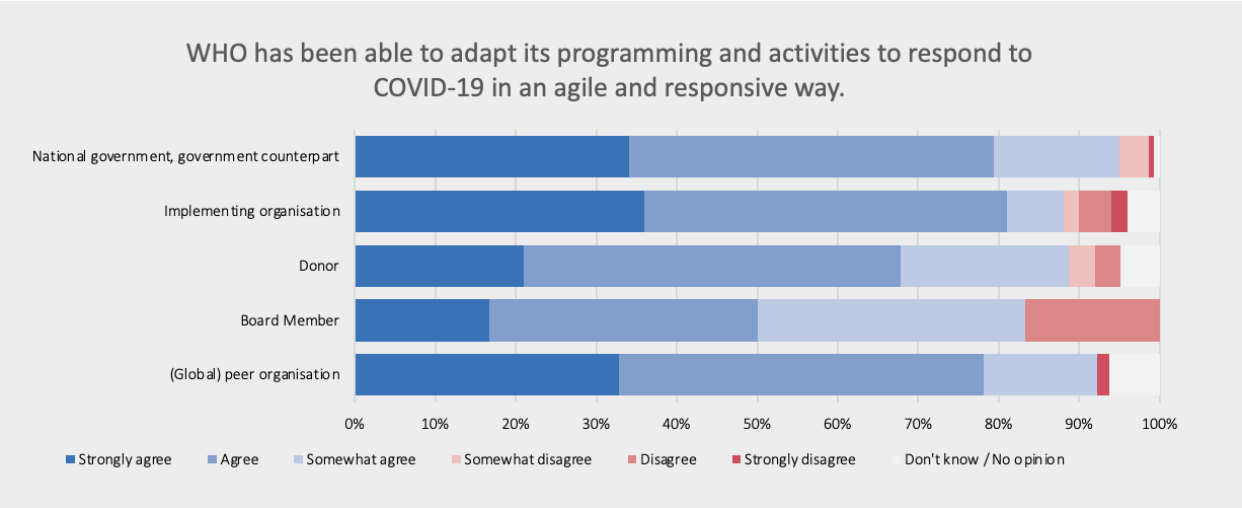
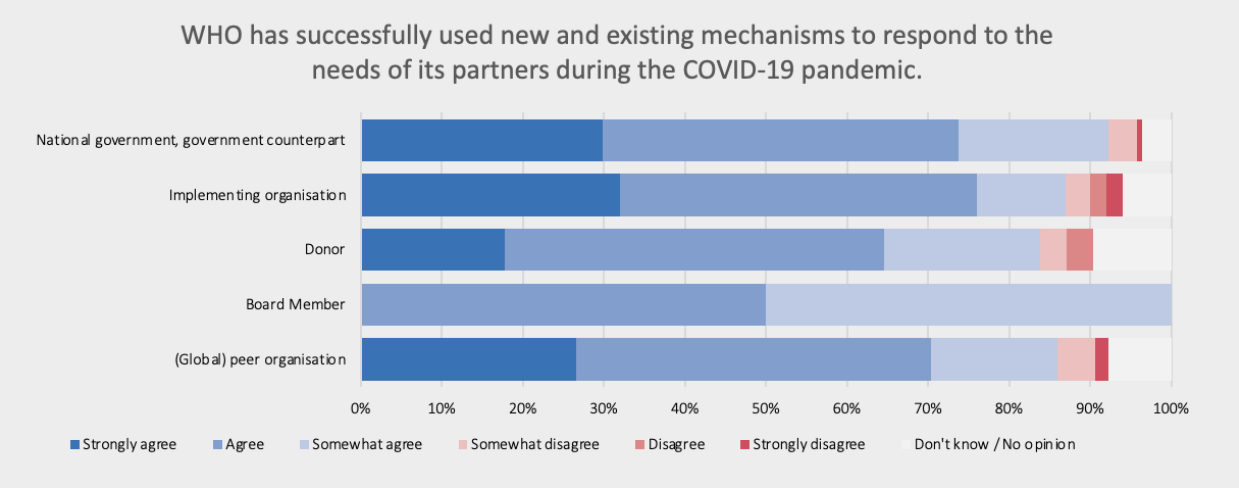


Figure 28: WHO has successfully used new and existing mechanisms to respond to the needs of its partners during the COVID-19 pandemic



Performance management

Figure 29: WHO prioritises a results-based approach – for example when engaging in policy dialogue, or planning and implementing interventions

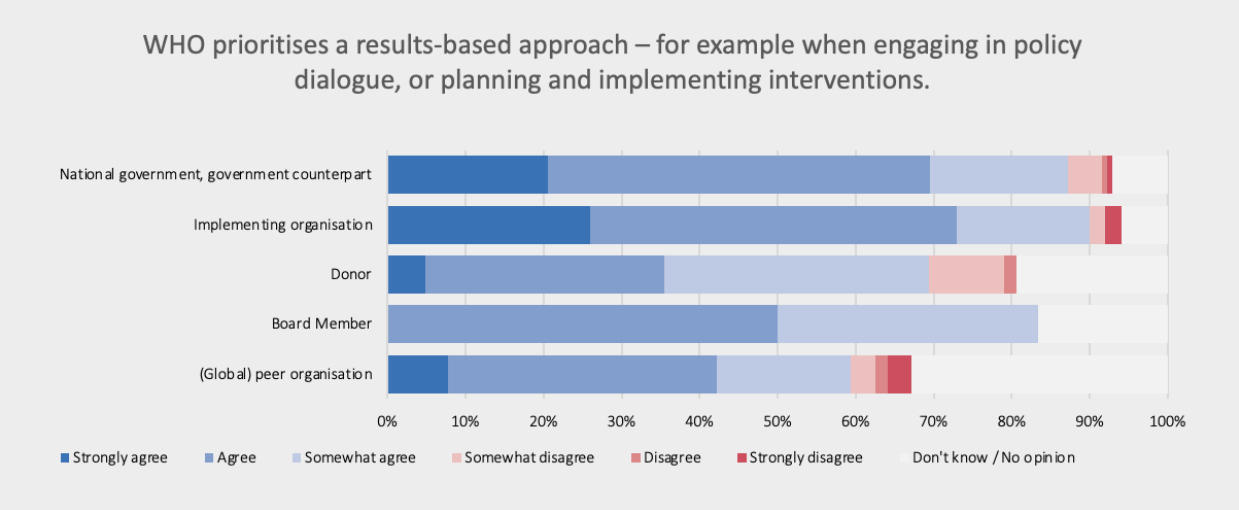


Figure 30: WHO consistently identifies and responds effectively to interventions that are under-performing

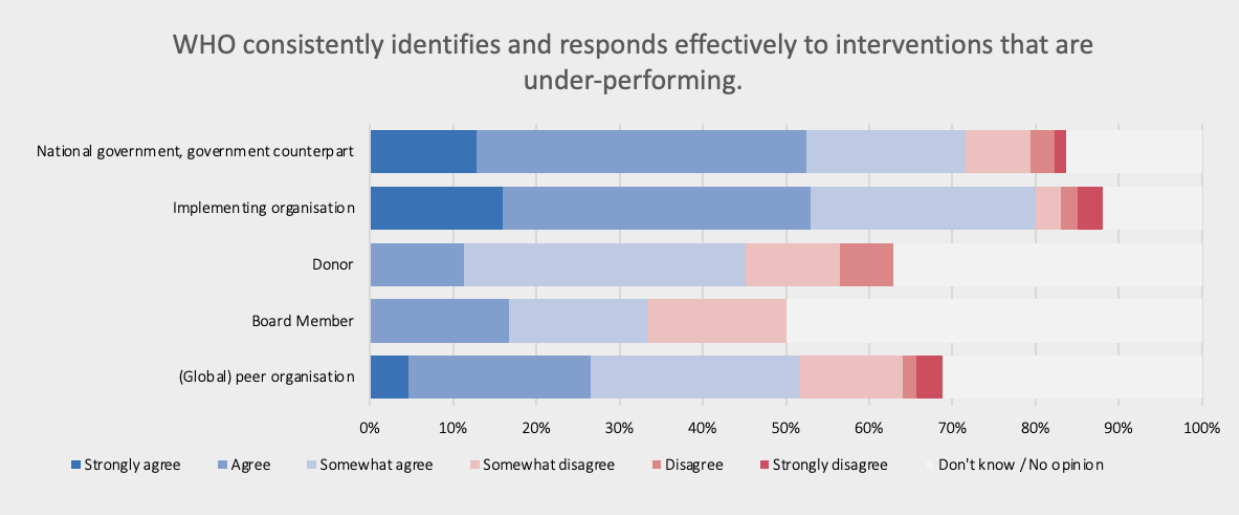


Figure 31: WHO consults with stakeholders on the setting of results targets at a country level

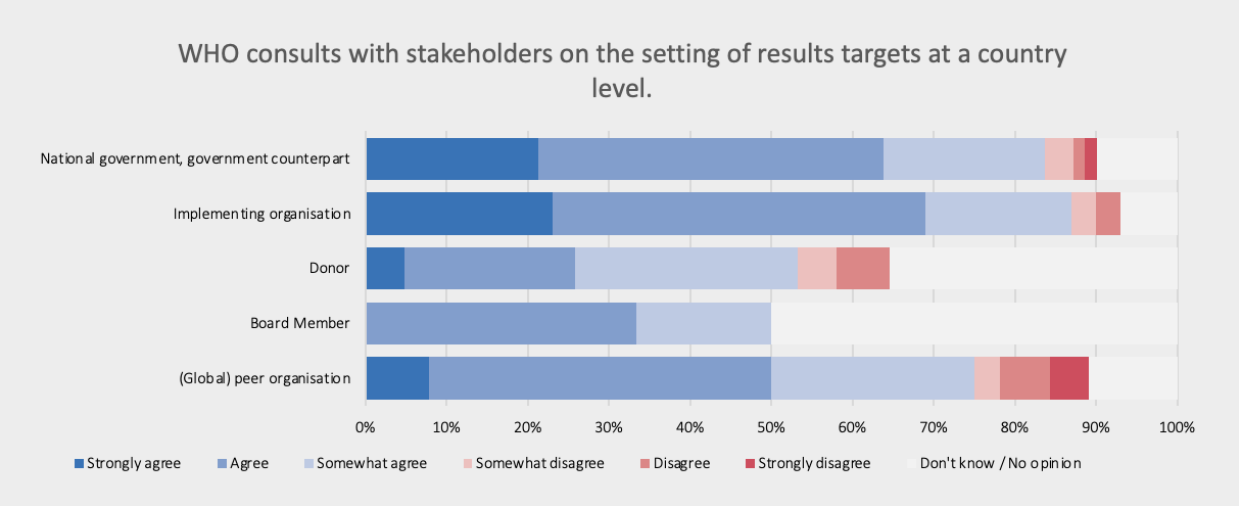


Figure 32: WHO participates in joint / inter-agency efforts to prevent, investigate and report on any sexual misconduct by personnel in relation to the host population (Sexual Exploitation and Abuse)

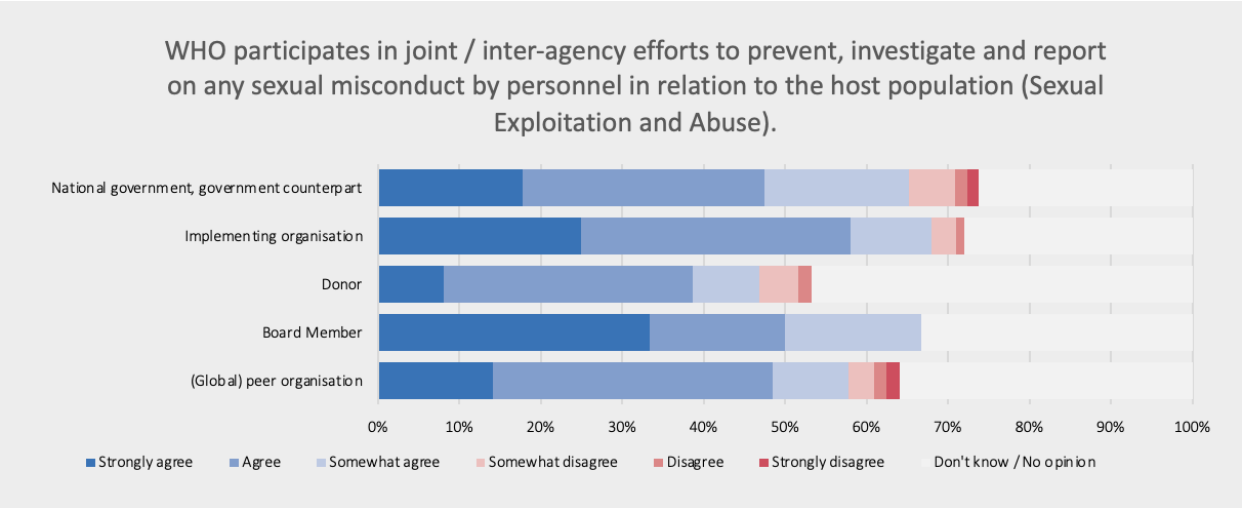


Figure 33: WHO participates in joint evaluations at the country / regional level

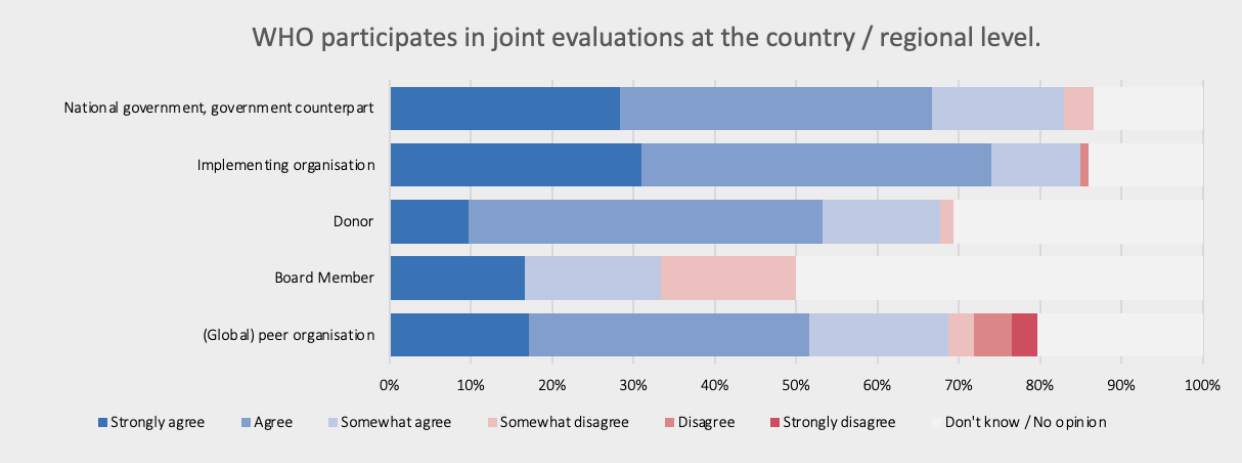


Figure 34: WHO learns lessons from previous experience, rather than repeating the same mistakes