

MOPAN
2017-18 ASSESSMENTS

**World Health Organization
(WHO)**

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MOPAN Assessments

World Health Organization (WHO)

2017-18 Performance Assessment

Preface

ABOUT MOPAN

The Multilateral Organisation Performance Assessment Network (MOPAN) comprises 18 countries¹ that share a common interest in assessing the effectiveness of the major multilateral organisations they fund. These include United Nations agencies, international financial institutions and global funds. The Network generates, collects, analyses and presents relevant and credible information on their organisational and development effectiveness. This knowledge base is intended to contribute to organisational learning within and among the organisations, their direct clients and partners, and other stakeholders. Network members use the reports for their own accountability needs and as a source of input for strategic decision-making.

MOPAN 3.0, first applied in 2015-16, is the latest operational and methodological iteration of how the Network assesses organisations. It builds on the former version, the *Common Approach*, which the Network implemented from 2009 through 2014.

In 2017-18, MOPAN assessed 14 organisations, including the World Health Organization (WHO). The other 13 are:

- Asian Development Bank (ADB)
- Food and Agriculture Organization (FAO)
- Global Environment Facility (GEF)
- Global Partnership for Education (GPE)
- International Fund for Agricultural Development (IFAD)
- International Organization for Migration (IOM)
- Office of the United Nations High Commissioner for Human Rights (OHCHR)
- Office of the United Nations High Commissioner for Refugees (UNHCR)
- United Nations Entity for Gender Equality and the Empowerment of Women (UN Women)
- United Nations Educational, Scientific and Cultural Organization (UNESCO)
- United Nations Population Fund (UNFPA)
- United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA)
- World Food Programme (WFP).

Operating principles

MOPAN generates assessments that are credible, fair and accurate. Credibility is ensured through an impartial, systematic and rigorous approach. MOPAN seeks an appropriate balance between coverage and depth of information from a variety of sources and through multiple streams of evidence. The Network gives priority to quality of information over quantity and uses structured tools for enquiry and analysis. An audit trail of findings ensures transparency. MOPAN applies efficient measures of assessment practice through building layers of data, with a view to limiting the burden on organisations assessed. A focus on organisational learning aims to ensure utility of the findings by multiple stakeholders.

Objectives of the MOPAN methodology

MOPAN seeks to provide a diagnostic assessment, or snapshot, of an organisation. It tells the story of an organisation's current performance. MOPAN is guided by framing questions which serve to understand the relevance, efficiency and effectiveness of multilateral organisations, while also garnering a sense of the sustainability of their results. The empirical design of MOPAN is based on a theory of change.

1. Australia, Belgium, Canada, Denmark, Finland, France, Germany, Ireland, Italy, Japan, Korea, Luxembourg, the Netherlands, Norway, Sweden, Switzerland, the United Kingdom and the United States. MOPAN also has two observers, New Zealand and the United Arab Emirates.

The methodology's key elements include a set of five performance areas against which the assessment takes place. The first four cover strategic, operational, relationship and performance management. The fifth area englobes the organisation's contribution to development, humanitarian and normative results. These areas are captured in the MOPAN indicator framework against which performance is measured using three evidence streams – a document review, surveys, and interviews and consultations – brought together in a combined approach.

A MOPAN assessment is not an external audit of an organisation, nor is it an institutional evaluation. MOPAN does not comprehensively assess all operations or all processes of an organisation, nor can it provide a definitive picture of all the organisation's achievements and performance during the time period of the assessment. Neither does MOPAN offer comprehensive documentation or analysis of ongoing organisational reform processes.

Acknowledgements

The MOPAN assessment was finalised under the overall strategic guidance of Suzanne Steensen, Head of the MOPAN Secretariat. It was prepared under the responsibility of Samer Hachem, Senior Advisor. We are very grateful to Natacha Gomes, institutional lead from Luxembourg, and Elisa Adelman, institutional lead from the United States, for championing this assessment of WHO on behalf of the MOPAN membership

The assessment was conducted with support from IOD PARC, an independent consultancy specialised in assessing performance and managing change in the field of international development. Matthew Crump served as Team Lead for the assessment of WHO with support from Nick York and Steven Lally, under the overall leadership of Julian Gayfer. Ipsos MORI administered the partner survey.

The report benefited from a peer review conducted within the MOPAN Secretariat and from the comments of a senior independent advisor, Deborah Rugg, former chair of the UN Evaluation Group and former director of the Inspection and Evaluation Division at the UN Secretariat. Jill Gaston edited the report, and Andrew Esson provided layout and graphic design.

MOPAN is grateful to its Steering Committee representatives for supporting the assessment of WHO. Finally, MOPAN would like to convey appreciation to WHO management and staff for their input and comments at various stages, in particular those staff members who internally co-ordinated the process and provided substantive feedback on the final draft report.

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Acronyms and abbreviations

3MDGF	Three Millennium Development Goal Fund	LNB	Leave no one behind
AAAQ	Availability, accessibility, acceptability and quality	M&E	Monitoring and evaluation
AFR	African Region	MDG	Millennium Development Goal
AFRO	African Regional Office (WHO)	MENA	Middle East and North Africa
AMR	American Region	MI	Micro-indicator
AMRO	American Regional Office	MNCH	Maternal, newborn and child health
APSED	Asia Pacific strategy for emerging diseases and public health emergencies	MoFA	Ministry of Foreign Affairs
CC	Collaborating Center	MoH	Ministry of Health
CCS	Country Cooperation Strategy	MoPH	Ministry of Public Health
CEE	Central and Eastern Europe	NCD	Non-communicable disease
CoIA	Commission on Information and Accountability	NESDP	National Economic and Social Development Plan
COSO	Committee of Sponsoring Organizations of the Treadway Commission	NGO	Non-governmental organisation
CRE	Compliance, risk management and ethics	NHP	National Health Plan
EMR	Eastern Mediterranean Region	NHPSP	National Health Policies, Strategies and Plans
EMRO	Eastern Mediterranean Regional Office (WHO)	OECD	Organisation for Economic Co-operation and Development
ePMDS+	Performance Management and Development System	OpenSRP	Open Smart Register Platform
ERGS	Equity, human rights, gender and social determinants	PAHO	Pan American Health Organization
EUR	European Region	PB	Programme Budget
EURO	European Regional Office (WHO)	PBAC	Programme, Budget and Administration Committee of the Executive Board
FAO	Food and Agriculture Organization	PIP	Performance Improvement Plan
FENSA	Framework of Engagement with Non-State Actors	PMD	Performance Management Department
GER	Gender, Equity and Rights	PMDS	Performance Management Development System
GPW	General Programme of Work	QCPR	Quadrennial comprehensive policy review
HGF	Health Systems Governance and Financing	RBM	Results-based management
HIV/AIDS	Human immunodeficiency virus and acquired immune deficiency syndrome	RMNCH	Reproductive, maternal, newborn and child health
HQ	Headquarters	RO	Regional office
HR	Human resources	SBSA	Strategic Budget Space of Allocation
HRD	Human Resources Management Department	SDG	Sustainable Development Goal
HRH	Human Resources for Health	SDH	Social determinants of health
HWO	Hindu Women's Organisation	SEARO	Regional Office for South-East Asia
IASC	Inter-Agency Standing Committee	UHC	Universal health coverage
IATI	International Aid Transparency Initiative	UN	United Nations
IAWG	Inter-agency Working Group	UNAIDS	Joint United Nations Programme on HIV/AIDS
IEOAC	Independent Expert Oversight Advisory Committee	UNCC	United Nations Compensation Commission
IER	Information, evidence and research	UNDAF	United Nations Development Assistance Framework
IFRS	International Financial Reporting Standards	UNDG	United Nations Development Group
IHM	Infectious hazards management	UNDP	United Nations Development Programme
IHP+	International Health Partnership	UNEG	United Nations Evaluation Group
IHPP	International Health Policy Programme	UNHCR	United Nations High Commissioner for Refugees
IHR	International health regulations	UNICEF	United Nations Children's Fund
IOS	Internal Oversight Services	UNITAR	United Nations Institute for Training and Research
IPSAS	International Public Sector Accounting Standards	UNSWAP	United Nations System-wide Action Plan
ISAs	International Standards on Auditing	USD	United States dollars
JEE	Joint External Evaluation	WER	Weekly Epidemiological Record
JIU	Joint Inspection Unit of the United Nations System	WHA	World Health Assembly
KPI	Key performance indicator	WHE	WHO Health Emergencies Programme
		WHO	World Health Organization
		WPR	Western Pacific Region
		WPRO	WHO Regional Office for the Western Pacific

Executive summary

In 2017-18, MOPAN, the Multilateral Organisation Performance Assessment Network, assessed the performance of the World Health Organization (WHO). The assessment looked at WHO's organisational effectiveness (strategic, operational, relationship and performance aspects) and the results it achieved against its objectives. This was the third MOPAN assessment of WHO; the previous assessments were conducted in 2010 and 2013.

CONTEXT

Over the 70 years since its founding, WHO seeks to remain fit for purpose in the increasingly complex global health environment. The pace and scale of reform and change for WHO over the past 15 years have accelerated significantly. In 2011, WHO started a far-reaching reform agenda to improve the organisation's overall performance and accountability. This reform aims to address the changing public health needs of the world's population going forward in the 21st century. Since 2018, WHO has continued this drive for improvement through an ambitious transformation agenda that is linked to its 13th General Programme of Work (GPW13).

During the time frame of this MOPAN assessment and following the election of a new Director-General in July 2017, a transitional period commenced. A new senior leadership team was appointed and began extensive strategic work on GPW13. The programme of work is now complete and received approval at the World Health Assembly in May 2018, following a highly consultative and participatory process of stakeholder engagement.

MOPAN seeks to examine how the organisation translates strategic intent into evidence of implementation. The assessment takes into account evidence from GPW13 and from the previous General Programme of Work, GPW12. It focuses primarily places on the achievements of targets in GPW12. Where the development and strategic trajectory of GPW13 enriches the illustration of WHO's performance journey, this has been brought into view.

KEY FINDINGS

WHO presents itself as an increasingly reflective organisation. It is mindful of its global role in a rapidly changing world; aware of its organisational responsibility to meet evolving demands on its normative, technical and emergencies work; and capable of organisational change to ensure that previous experience and learning allow it to maintain its relevance. Through successive strategic periods, WHO has deliberately aligned its work to global development goals, including the Millennium Development Goals and the 2030 Agenda for Sustainable Development. The foundation of WHO's work is Sustainable Development Goal (SDG) 3: ensuring healthy lives and promoting well-being for all at all ages. Through its commitment to SDG 3, WHO has embarked on a transformative agenda aimed at supporting countries in reaching all health-related SDG targets.

WHO has made significant progress in several areas since the last MOPAN assessment in 2013. There has been a substantial evolution in WHO's results-based management approach, with a well-developed system created for GPW12. Good progress has been made in tracking outputs and some aspects of outcomes across its 37 programme areas. Evaluation has likewise moved forward, and the organisation is well placed to make further improvements in key areas, provided resourcing is realistically allocated.

WHO has demonstrated how lessons learned and good practices are transforming the organisation's programming. A reshaped operating model of its emergency preparedness and response programme enables much greater levels of responsiveness and relevance. An embedded Country Cooperation Strategy process is in place, resulting in higher levels of alignment with national priorities (e.g. national health strategies and plans) and with United Nations Development Assistance Frameworks. This process has enhanced and integrated planning and prioritising activities

based on country need by applying a coherent, bottom-up process. WHO's increasing ability to act on lessons learned – sometimes learned publicly – has allowed it to re-establish its role in directing and co-ordinating international health within the United Nations System. WHO has explicitly used learning from its evaluations and successive MOPAN assessments.

This assessment identified four **strengths** of WHO:

1. WHO has a clear long-term vision which informs and drives its strategy and results framework. GPW12 provided WHO with a long-term vision, more results-orientated strategic priorities and direction. GPW12 outlined key reform initiatives and organised the programmatic work of WHO. The ambitious new strategy (GPW13) and the allied transformation agenda continue the necessary reforms of the organisation. They step up the pace of change on WHO's performance journey and focus on results at country level.

The transition from GPW12, through an effective strategy development process for GPW13, has involved an inclusive, participatory and consultative procedure that has resulted in high levels of understanding and buy-in. WHO has increasingly and more deliberately applied its comparative advantage to its vision. The organisation's recognised strengths include its convening role, expert knowledge, data, ability to be seen as an honest broker/adviser, close relationships and trust with health ministries and governments, and presence across the full range of member states (i.e. both developed and developing countries). GPW13 now sets new ambitious "triple billion goals" in line with the SDGs.

2. WHO has implemented extensive organisational change initiatives while delivering core business. Reform efforts have provided a strong foundation for continued institutional development and transformation to support the implementation of GPW13. This programme of work integrates and builds on the previous reform agenda initiated by the previous leadership. That reform agenda brought WHO forward on an integrated approach to management; developed more robust internal controls; effectively organised category and programme areas; implemented an in-country, bottom-up prioritisation and planning process; strengthened results-based management and evaluation; achieved significant human resources reform; and reconfigured WHO's emergency preparedness and response programme with a sense of urgency, discipline and focus. These efforts, among others, illustrate WHO's ability to learn from and respond to lessons and performance information to achieve greater levels of responsiveness, relevance and effectiveness.

3. WHO plays a unique role among global health organisations in its mandate to provide independent, normative guidance. WHO often carries out less visible work which lays the foundation for the work of other partners, guiding them and providing effective strategies to address health issues by building sustainable institutional capacity. Although WHO's contributions to strengthening, building the capacity of and co-ordinating health systems and its wider normative work are often less noticeable, they are no less important.

4. WHO has brought decision making closer to country needs. WHO's schemes of delegation across the levels of the organisation provide clarity on accountability and authority, and promote increased responsiveness to local conditions by placing decision-making with those closer to the work to be done. At the same time, WHO has made significant strides in its planning and prioritising activities based on country needs by applying a coherent, bottom-up process. Finally, the embedded Country Cooperation Strategy process has resulted in higher levels of alignment with national priorities and UNDAFs.

The assessment also identified four major **areas for improvement**:

1. Despite considerable efforts to shift its financing model, WHO remains reliant on a small number of major contributors. Securing sufficient funding to cover all priority programming areas remains problematic, and the proportion of earmarked funds increases year on year, thus compounding the challenge. Efforts to diversify the funding base of WHO have yielded limited success to date. High levels of earmarked funds remain a challenge to organisational adaptability, flexibility and agility.

2. Capacity and capability vary across the levels of the organisation and are not always adequate to meet needs and expectations. To be effective in its intensified focus on results at country level, WHO will need to align the staffing levels of headquarters and regional and country offices. It will also need to actively address the distribution and development of staff skills and expertise to support the ambitions of GPW13.

3. Further progress is needed towards a more integrated approach to external engagement. While WHO has made incremental adjustments to working with partners and mobilising resources, a more fundamental shift in approach and intensified, interconnected efforts are needed to capitalise on WHO's comprehensive portfolio of partners. Evidence highlights that WHO is in the process of resetting and repositioning its role within key partnerships; this should provide the context for more robust relationships with partners based on comparative advantage and more routine monitoring of the partnership effectiveness.

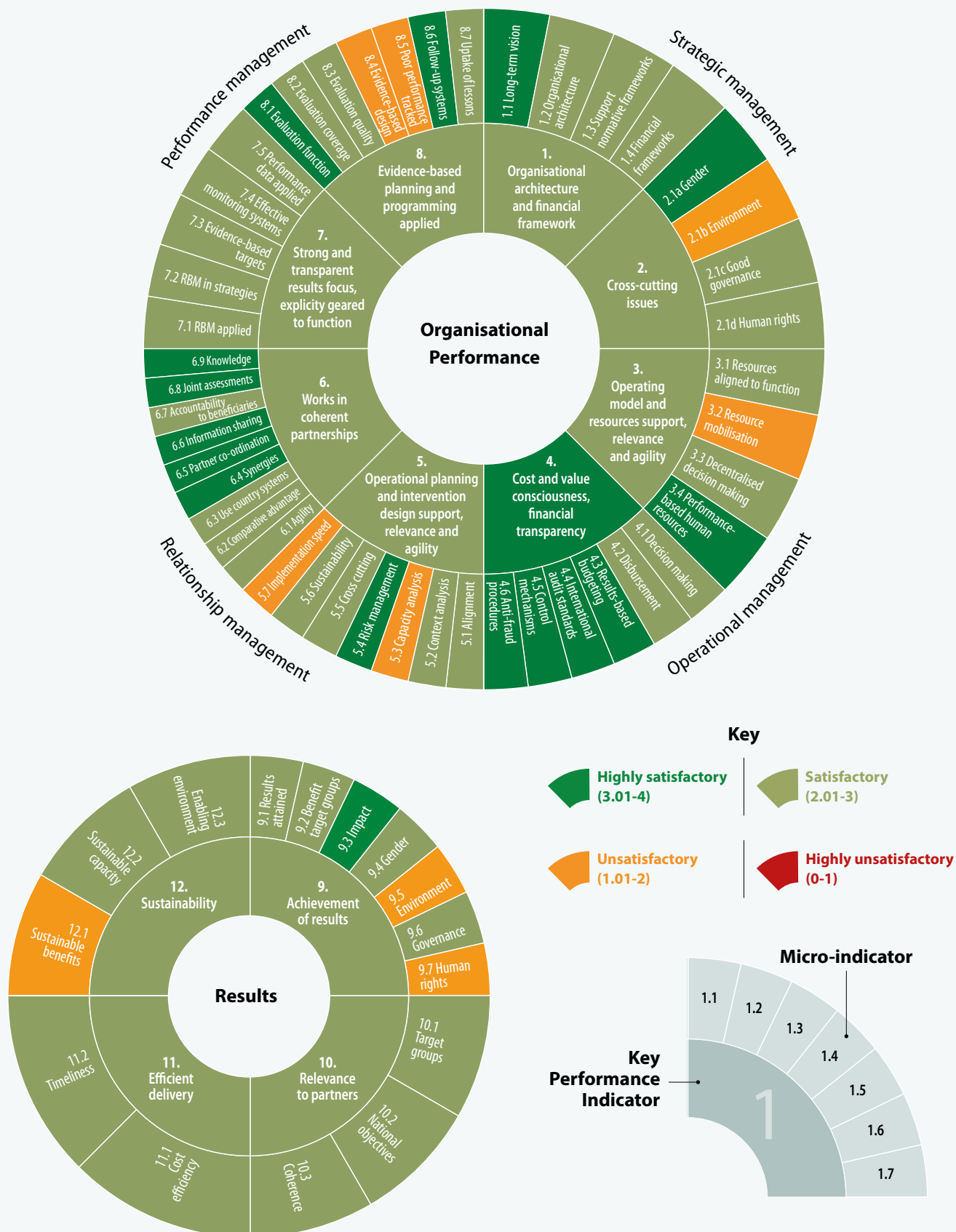
4. The ambitions of GPW13 present significant technical challenges around measuring and reporting on results. These include the fundamental difficulty of defining WHO's results in what is a shared endeavour with member states. The organisation has begun developing an impact framework linked to GPW13, but has not yet fully designed or implemented it. Involving an expert group is a useful and serious way of ensuring technical quality and credibility, but many challenges in definition, measurement and application remain to be addressed.

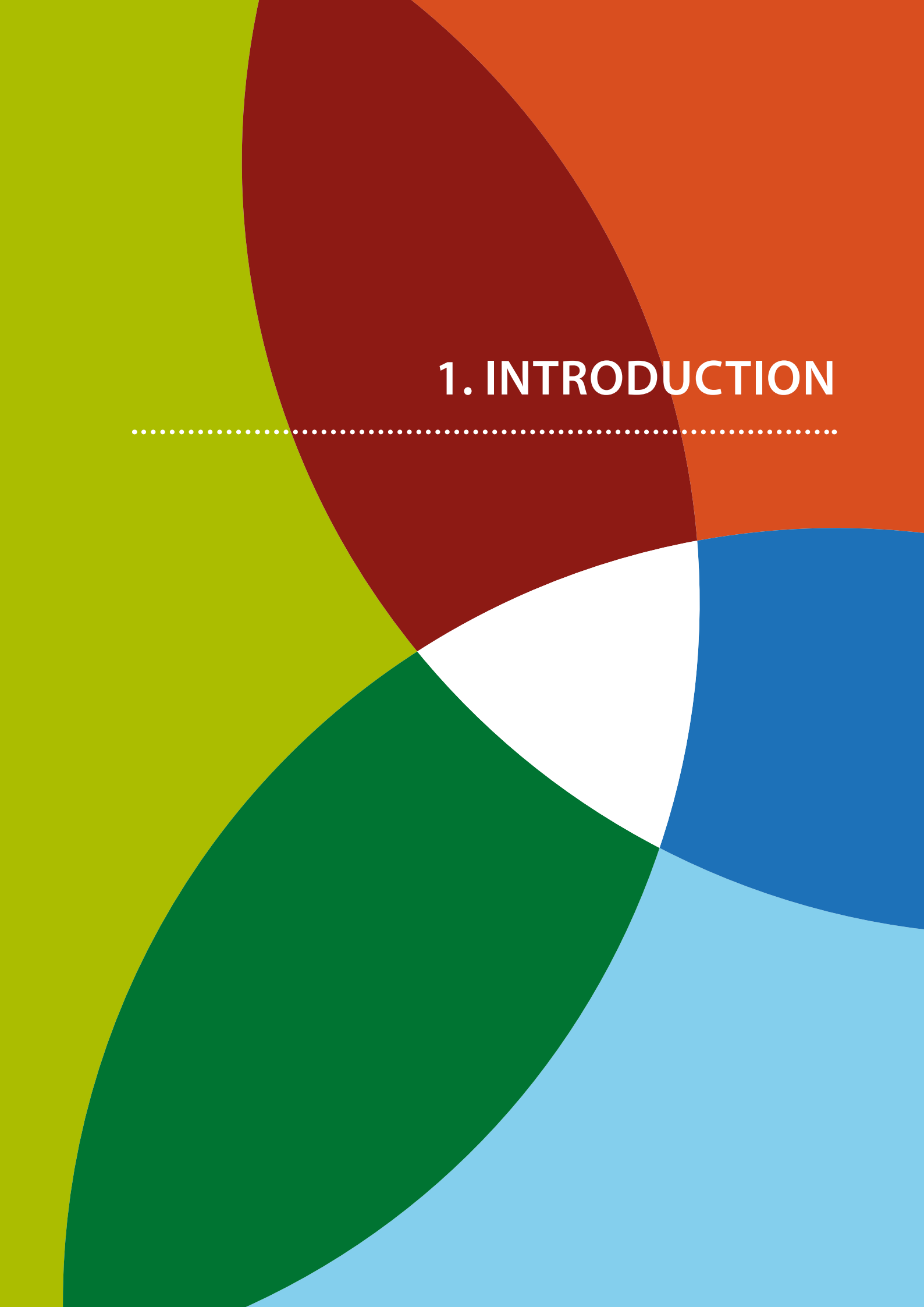
METHODS OF ANALYSIS

The assessment of performance covers WHO's headquarters and regional and country field presence. It addresses organisational systems, practices and behaviours, as well as results achieved during the period 2016 to mid-2018. It relies on three lines of evidence: a review of 181 documents, interviews with 75 staff members individually and in small groups, and an online survey conducted among partners in 13 countries.

The MOPAN 3.0 methodology entails a framework of 12 key performance indicators and associated micro-indicators. It comprises standards that characterise an effective multilateral organisation. MOPAN conducted the assessment with support from IOD PARC, a consulting company located in the United Kingdom that specialises in results-based performance assessment in international development. Luxembourg and the United States acted as the institutional lead countries, representing MOPAN members in this assessment process.

WHO PERFORMANCE RATING SUMMARY (2017-18)





1. INTRODUCTION

Chapter 1. Introduction

1.1. STRUCTURE OF THE REPORT

This report has three chapters and three annexes. Chapter 1 introduces the World Health Organization (WHO) and the MOPAN 3.0 assessment process. Chapter 2 presents the main findings of the assessment in relation to each performance area. Chapter 3 provides the conclusions of the assessment. Annex 1 summarises the evidence gathered against each indicator with the detailed scores. Annex 2 lists the documents used for the analysis. Finally, Annex 3 provides an overview of the results of MOPAN's partner survey.

1.2. WHO AT A GLANCE

Mission and mandate: WHO was created in 1948 as a specialised agency of the United Nations (UN) within the terms of Article 57 of the Charter of the United Nations. The organisation is guided by the principles within its constitution that all people should enjoy the highest standard of health, regardless of race, religion, political belief, and economic or social condition. WHO is responsible for being the directing and co-ordinating authority on international health within the UN System. It also provides leadership on global health matters and engages in partnerships; promotes and develops the health research agenda; sets norms and standards; articulates evidence-based policy options; provides technical support to countries; and monitors and assesses health trends.

Governance: The World Health Assembly (WHA) is the overarching decision-making body for WHO and is attended annually by all 194 member states. The WHA is supported by the Executive Board, comprised of representatives of 34 Member States for a term of 3 years. The Executive Board advises the WHA, facilitates its work, and gives effect to the WHA's decisions and policies. The Executive Board meets, in January, to agree on the agenda for the annual World Health Assembly and resolutions to be considered by the WHA. The WHO is administered by the Director-General, who is elected by a vote of member states at the WHA for a five-year term. The Director-General is the chief technical and administrative officer and is responsible for oversight of WHO's policy on international health work.

Organisational structure: The WHO Secretariat is headquartered in Geneva, Switzerland, and is responsible for overall management and administration of the organisation. WHO is divided into six regions, each of which has a regional office. The regional offices play an important role in WHO's organisational and management structure; they are the link between headquarters and the country offices for all the policy-setting, planning, results and data-related functions.

WHO currently employs approximately 7 000 people and has offices in 150 countries, territories and areas. Through a renewed country focus, WHO seeks to improve performance at the country level according to the country's needs. Each country office develops a Country Cooperation Strategy (CCS) to guide its work and which is overseen by WHO's regional offices, and technical assistance is provided to country offices as required. WHO works closely with other UN agencies and a multitude of partners to mobilise political will and material resources.

Strategy: The MOPAN assessment took place during a time of strategic transitions, in terms of periods of the General Programmes of Work (GPWs) (from 2014-19 for GPW12 to 2018-23 for GPW13) as well as the election of the Director-General in May 2017, and the formation of the senior leadership team in July 2017. The General Programme of Work provides the high-level, strategic vision for WHO and the organisation's key priorities that inform and drive results. Each GPW is aligned with three biennial Programme Budgets which together form the basis of WHO's results-based management framework.

GPW12 (2014-19) and Programme Budgets set out work across six categories of work: communicable diseases; non-communicable diseases; promoting health through the life course; health systems; preparedness, surveillance and

response; and corporate services. GPW12 outlines a results chain and sets out how WHO's work is organised over the period of the strategy; how the work of the organisation contributes to the achievement of a defined set of outcomes and impacts; and the means by which WHO can be held accountable for the way resources are used to achieve specified results. The results chain links the work of the Secretariat (outputs) to the health and development

GPW12 reflects WHO's mission and is presented through six leadership priorities:

- Advancing universal health coverage by enabling countries to sustain or expand access to all needed health services and financial protection and by promoting universal health coverage as a unifying concept in global health.
- Addressing unfinished and future challenges of health-related Millennium Development Goals by accelerating the achievement of the current health-related goals up to and beyond 2015.
- Addressing the challenge of non-communicable diseases and mental health, violence, and injuries and disabilities.
- Implementing the provisions of the International Health Regulations (2005) by ensuring that all countries can meet the capacity requirements specified in the Regulations.
- Increasing access to quality, safe, efficacious and affordable medical products (medicines, vaccines, diagnostics and other health technologies).
- Addressing the social, economic and environmental determinants of health as a means to promote health outcomes and reduce health inequities within and among countries.

The results framework establishes the basis for WHO's operational planning and reflects country priorities, as outlined in the CCSs. For a total of 30 programme areas within the Programme Budget, there are defined outputs and relevant monitoring indicators. Each programme area within the Programme Budget contributes to the achievement of a specific outcome. There are eight overall impact goals: reduce under-five mortality; reduce maternal mortality; reduce the number of people dying from AIDS, tuberculosis and malaria; reduce premature mortality from non-communicable diseases; eradicate polio; eradicate guinea worm; prevent death, illness and disability arising from emergencies; and reduce rural-urban differences in under-five mortality.

GPW13 (2019-23) was approved by the WHA in May 2018, and aligns with the Sustainable Development Goal (SDG) targets and indicators structured across the three strategic priorities. Each strategic priority comprises a 1-billion people goal, and together they are coined the "triple billion goals". These include:

- Advancing universal health coverage: 1 billion more people benefitting from universal health coverage
- Addressing health emergencies: 1 billion more people better protected from health emergencies
- Promoting healthier populations: 1 billion more people enjoying better health and well-being.

GPW13 provides for achieving these goals through three strategic shifts as a part of the transformation agenda:

- Set up global leadership, based on WHO's core functions of providing leadership on matters critical to the health of all people and engaging in strategic partnerships.
- Drive impact in every country, based on WHO's core functions of articulating ethical and evidence-based policy options and of providing technical support, catalysing change and building sustainable institutional capacity.
- Focus global public goods on impact, based on WHO's core functions of setting, promoting and monitoring implementation of norms and standards; monitoring the health situation and assessing health trends; and shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge.

In order to achieve these strategic shifts, WHO has committed to a wider transformation agenda involving major organisational shifts in its accountabilities and management; organisational design and operating model; processes and tools; culture; and relationships. These five organisational shifts aim to increase WHO's impact at country level to ensure alignment with the SDGs. The transformation is taking place across the three levels of the WHO. A roadmap for transformation has been developed, building on lessons learned in previous reforms, ongoing change efforts, principles used to design the transformation, and timelines and architecture.

Finances: WHO is funded by voluntary contributions from both state and non-state actors, as well as through flexible funds provided by member states on a biennial basis. Under the approved Programme Budget 2016-17, the WHO's annual income from voluntary funds (USD 3.618 million) and flexible funds (USD 1.441 million) amounted to USD 5.059 million. The largest portion (74% or USD 3.354 million) of the Programme Budget is allocated to the base budget (core programmatic work), with the remaining portion (26% or USD 1.191 million) allocated to polio, disease outbreaks and crisis response, and special programmes. The largest source of voluntary contributions was member states (51% or USD 1.845 million) followed by philanthropic foundations (17% or USD 615 million), UN and intergovernmental organisations (15% or USD 543 million), partnerships (7% or USD 253 million), non-governmental organisations (7% or USD 253 million), the private sector (3% or USD 109 million), and academia (less than 1% or USD 30 million). A public Programme Budget web portal was established in 2016, and is updated every quarter; it provides member states and other partners details on both programme performance and financing, in line with WHO's membership in the International Aid Transparency Initiative.

Organisational change initiatives: The WHO has undergone an accelerated reform process in the recent past as it seeks to remain fit for purpose. The reform agenda that began in 2011, and continued during GPW12, aimed to improve the overall performance and accountability of the organisation. Under GPW12, WHO's ambitious reform process was member state-driven, with objectives defined at the 64th World Health Assembly (2011) and the Executive Board's 129th session for WHO "to be an organisation that pursues excellence". Since 2018, the new transformation agenda has sought to continue the reform process explicitly linked to GPW13 as highlighted above.

The reform process included three areas of focus: programmes and priority setting, governance reform, and managerial reform. The reforms to programmes and priority setting included agreement among member states as to the criteria used to identify priorities, set high-level goals, and use WHO's core functions and comparative advantage to highlight its work. The governance reform aimed to strengthen the co-ordinating and directing role and improve coherence in global health. WHO underwent reform of its governing bodies, its hosted partnerships, its role in promoting health concerns in intergovernmental forums and health governance, and its governance capacity. The reform of management policies and systems was intended to promote WHO as an organisation that is effective, efficient, responsive, objective, transparent and accountable. The managerial reform included aligning WHO's three levels of organisation, enhancing performance in countries, and improving strategic communications and knowledge management, accountability, risk management and transparency.

Under GPW12, WHO has experienced an ongoing governance reform under the previous and newly-elected Director-General. The reform has involved various processes to improve, among other things, WHO's governance structures and the demands they place on its operational efficiency. These have included the development of a more credible, transparent and legitimate process for electing the Director-General. There is the desire to reduce variation and improve harmonisation in how WHO's regional governing bodies operate with the WHA. To manage the large amounts of information presented in WHA agendas the Bureau, which is made up on the WHA Chair, Vice Chair and representatives from each region, has been strengthened with the addition of officers of the Executive Board. The Director-General has instituted face-to-face meetings with the Bureau creating greater accountability and responsibility. Better information management systems and processes have been developed for the WHA. A traffic light system has also been put in place to reduce the amount of time that representatives are permitted to address the WHA.

In April 2017, six years into the reform, a comprehensive, independent evaluation, entitled *Evaluation of WHO Reform (2011-2017)*, was published. It noted significant achievements across all three focus areas: Improved programmes and priority setting through increased alignment of Country Cooperation Strategies with national health strategies and plans; better co-ordination across the organisation using programme and category networks; and greater transparency of resource allocation and financing. Governance reform successfully increased the level of member

states' engagement; continued WHO's role in shaping the global health agenda; optimised, harmonised, and aligned regional and global governing bodies; and improved WHO's engagement with other actors through the WHO Framework of Engagement with Non-State Actors. Managerial reforms improved oversight and accountability through the establishment of the Office of Compliance, Risk Management and Ethics and the Evaluation Office; implemented a risk management framework; defined a whistleblowing policy and a disclosure and management of conflicts framework; provided a culture of evaluation within the organisation; and enhanced human resources and related policies.

However, several issues within WHO arose from the evaluation. These include lack of improvements in decision-making, the shift in focus to WHO's response to the Ebola outbreak since 2014, and a mechanistic approach to reform and change management.

Box 1: Preventing sexual exploitation, abuse and harassment²

- Addressing the World Health Assembly in May 2018, the Director-General reinforced his commitment against sexual violence. He stated, "WHO has zero tolerance for sexual harassment and sexual exploitation and abuse. That applies everywhere, from headquarters to the smallest country office."
- WHO senior management has established a Working Group composed of a Deputy Director-General for Corporate Services; a Chef de Cabinet; directors of the Human Resources Management Department, the Office of Compliance, Risk Management and Ethics, the Office Internal Oversight Services and Department of Communications at the Office of the Director-General; and Legal Counsel. They meet regularly to review progress on policies and procedures related to sexual exploitation and abuse (SEA).
- WHO has several policies regarding safeguarding ethics, including preventing SEA and sexual harassment. Examples include its Code of Ethics and Professional Conduct (2017); the WHO Sexual Exploitation and Abuse Prevention and Response Policy and Procedures (2017); and its Code of Conduct for responsible research (2017). Several mechanisms are also available for reporting misconduct, including whistleblower policies, the WHO Integrity Hotline and investigation through the Office of Internal Oversight Services.
- Regular updates and communications inform staff of changes and development of new policies and procedures regarding safeguarding ethics, including preventing SEA and sexual harassment. WHO instituted a policy in April 2018, which requires all staff to undertake training on SEA and general harassment. WHO policy and procedures are also outlined within the staff E-Manual available on the intranet. All staff contracts reinforce WHO's zero tolerance for SEA and now include a clause requiring adherence to the WHO Sexual Exploitation and Abuse Prevention and Response policy and procedures.

2. The 2017-18 MOPAN assessment does not cover the organisation's performance with regard to preventing sexual exploitation and abuse and sexual harassment (SEAH). This topic may become an area of assessment in future cycles. In the meantime, the assessment team simply collected key facts related to safeguarding against SEAH as self-reported by the organisation but did not verify the actual implementation of the instruments outlined by the organisation

1.3. THE ASSESSMENT PROCESS

Assessment framework

This MOPAN 3.0 assessment covers the period from 2016 to mid-2018 in line with the MOPAN 3.0 methodology, which can be found on MOPAN's website.^{3, 4} The assessment addresses organisational systems, practices and behaviours, as well as results achieved. It focuses on the five performance areas presented in Box 2. The first four relate to organisational effectiveness, and each has two key performance indicators (KPIs). The fifth performance area relates to effectiveness of development, humanitarian and normative work, and comprises four KPIs.

The MOPAN 3.0 indicator framework was developed by MOPAN's Technical Working Group, drawing on international standards and reference points, as described in Annex C of the Methodology Manual.

Box 2: Performance areas and key performance indicators

Aspect	Performance area	KPI
Organisational effectiveness	Strategic management	KPI 1: The organisational architecture and the financial framework enable mandate implementation and achievement of expected results
		KPI 2: Structures and mechanisms support the implementation of global frameworks for cross-cutting issues at all levels
	Operational management	KPI 3: The operating model and human and financial resources support relevance and agility
		KPI 4: Organisational systems are cost and value-conscious and enable financial transparency and accountability
	Relationship management	KPI 5: Operational planning and intervention design tools support relevance and agility within partnerships
		KPI 6: Partnership working is coherent and directed at ensuring relevance and the catalytic use of resources
	Performance management	KPI 7: The focus on results is strong, transparent and explicitly geared towards function
		KPI 8: The organisation applies evidence-based planning and programming
Development effectiveness	Results	KPI 9: Development and humanitarian objectives are achieved, and results contribute to normative and cross-cutting goals
		KPI 10: Interventions are relevant to the needs and priorities of partner countries and beneficiaries, and the organisation works towards results in areas within its mandate
		KPI 11: Results are delivered efficiently
		KPI 12: Results are sustainable

3. In addition, the assessment team has also taken account of earlier developments from mid-2014 which were agreed at inception phase to be relevant in consultation with WHO.

4. MOPAN 3.0 Methodology Manual, 2017-18 Assessment Cycle, <http://www.mopanonline.org/ourwork/ourapproachmopan30/>

Applying the MOPAN methodology to WHO

The assessment of performance covers the WHO Secretariat (headquarters, regional offices and field offices). Since the MOPAN assessment time frame (2016 to mid-2018) falls within the period of GPW12 (2014-19), the modified strategic priorities and results chain which are noted in GPW13 have not been the focus of the document review ratings. However, the revised targets and indicators which are now aligned with the SDGs have informed the Programme Budget 2018-19 and its resource allocation and are expected to bridge the period between GPW12 and GPW13. While taking into account documentation from both GPWs, the assessment places its focus on GPW12, as it examines strategic intent and implementation. Where the development and strategic trajectory of GPW13 enriches the illustration of WHO's performance journey, this is brought into view.

For KPIs 9-12 on development effectiveness, this assessment specifically focused on results achieved as of the 2016-17 period. A key reference was the latest WHO Results Report and the underpinning data for that report, as published by WHO on its Programme Budget portal. The dataset shows programme performance indicators for the latest available biennium, which is 2016-17. For each performance indicator agreed by the WHA, the portal shows the baseline, target and progress up to either 2016 or 2017 depending on data availability. These data were mapped to the MOPAN indicators and then used together with other lines of evidence (e.g. evaluations, headquarters interviews document reviews) to reach an assessment.

The MOPAN methodology 3.0 was applied with some minor adjustments in indicator application or interpretation to reflect the realities of WHO's mandate and operating systems. These included KPI 2.1c on good governance (see also Annex 1). As agreed with WHO, this indicator was interpreted and orientated to WHO's work to promote the principles of good governance by strengthening the governance of health systems.

Lines of evidence

This assessment relies on three lines of evidence: a document review, a partner survey, and staff interviews and consultations. The assessment team collected and analysed these in a sequenced approach, whereby each layer of evidence was informed by, and built on, the previous one, wherever possible.

- The assessment team collected and reviewed a significant body of evidence. Annex 2 presents a list of the 181 documents utilised, although many more than this were screened for inclusion. Results documentation included 10 independent evaluations and reports of the external auditor as well as the final published version of WHO's most recent internally-produced Results Report for 2016-17 shared with the WHA (May 2018). A draft of the document review also was shared with WHO; the organisation provided feedback and additional documentation to update the review and address gaps before the review fed into the overall analysis.
- There were 264 responses to the online partner survey, which was conducted between March and April 2018, and which was drawn from respondents in 13 countries (Bangladesh, Bolivia, the Democratic Republic of the Congo, Ethiopia, Guinea, Jordan, Lebanon, Mexico, Myanmar, Pakistan, Papua New Guinea, Tunisia and Turkey). This was a relatively high response rate (28%), and was helped by the proactive engagement of WHO country offices in encouraging partner participation. The survey was designed to gather both perception data and an understanding of practice from a diverse set of well-informed partners of WHO. Survey responses came from donor and national government representatives, UN agencies, and international non-governmental organisations and other non-governmental organisations (see Annex 3).
- The team interviewed 75 staff members at WHO's Geneva headquarters in April 2018. These were primarily face-to-face interviews, but there were also several video conferences. These provided coverage of all WHO's divisions and operational regions.

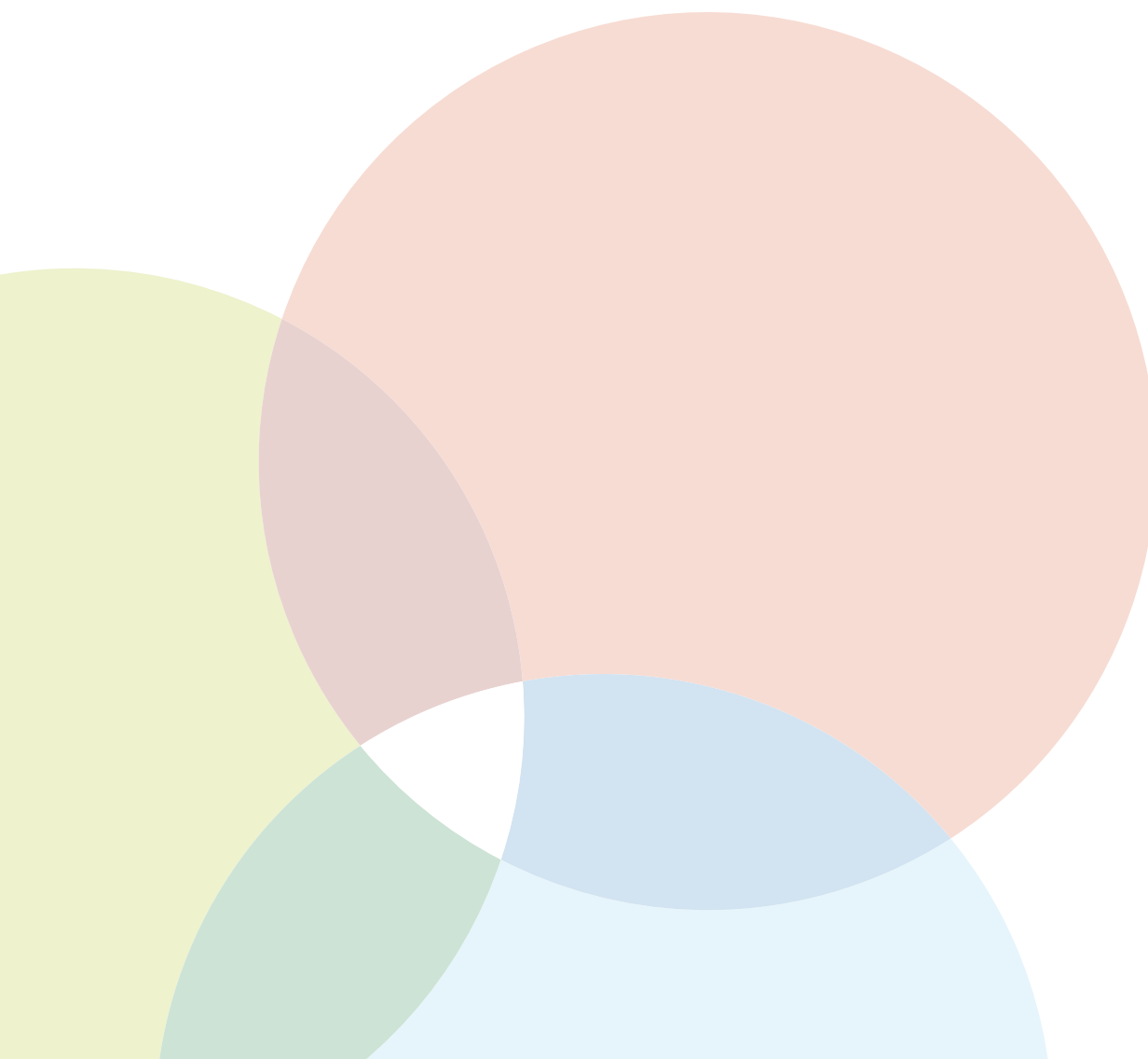
Discussions were held with Institutional Lead representatives from the United States, as part of the analytical process, to gather insights on current priorities for the organisation from the perspective of MOPAN member countries.

Limitations

The assessment was undertaken during a period of considerable strategic transition, following a sustained period of organisational change and reform across WHO. The relative newness of the senior leadership team and the advent of GPW13 during the assessment time frame prevented a full reflection on the translation of strategic intent into implementation for WHO's new strategy as embodied in GPW13. Likewise, it has not been possible for this MOPAN assessment to identify or reflect the extent and influence of these most recent institutional developments comprehensively. Instead, the assessment should be understood as a snapshot of WHO at a specific point in time (2018), mindful of the ongoing process of organisational transformation.

This report refers to quantitative and qualitative results from the MOPAN partner survey where they provide detail to strengthen or challenge other evidence. Although the survey response rate was reasonable, the assessment treated its results with caution.

Given WHO's status as a specialised agency, the assessment team worked in concert with WHO to take suitable account of the fact that the organisation's work includes a substantial normative function. Due to this function, WHO's project implementation role is correspondingly small, which affected how the team used some of the MOPAN elements and indicators, although in MOPAN 3.0, this usage is already well incorporated. Together, the assessment team and WHO discussed and agreed the interpretation of key performance indicators and micro-indicators.





2. DETAILED ASSESSMENT OF WHO PERFORMANCE

Chapter 2. Detailed assessment of WHO performance

The performance is assessed on four dimensions of organisational effectiveness – strategic, operational, relationship and performance management – and on the results achieved by the organisation. These findings are constructed against the organisation’s own strategic plan and performance indicators.

In this way, organisational effectiveness relates to a blended assessment of intent, effort and response. Organisational intent is expressed through commitments, strategies, policies and guidance. The organisational effort is that which the organisation puts behind a particular agenda for performance and improvement. The organisational response is its reaction to the effects of this effort in relation to changing organisational direction, practice and behaviour.

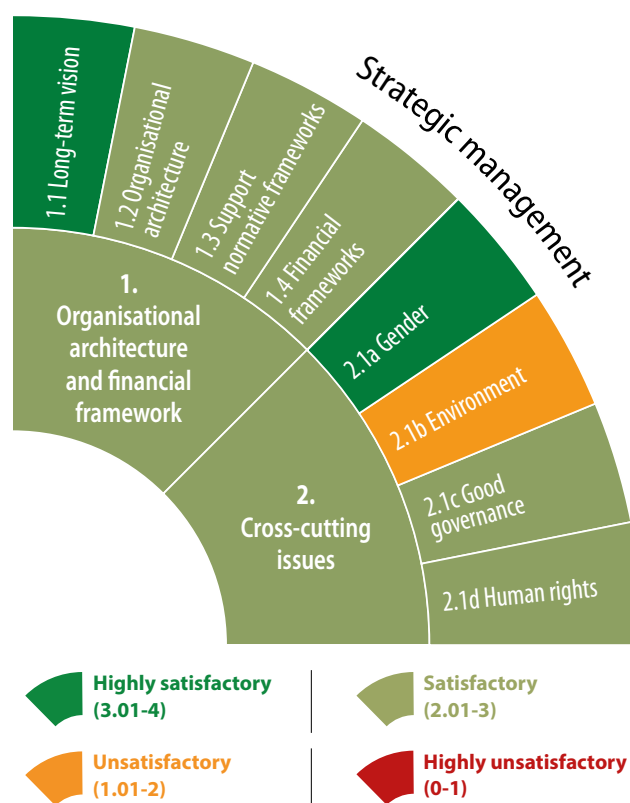
Organisational effectiveness is juxtaposed alongside development effectiveness. The latter refers to the extent to which the organisation is making a difference in ways that reflect its strategic objectives and mandate.

2.1. ORGANISATIONAL EFFECTIVENESS

PERFORMANCE AREA: STRATEGIC MANAGEMENT

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

The World Health Organization (WHO) has a succession of increasingly clear, publicly available strategies (general programmes of work) which provide high-level strategic vision and key priorities to inform and drive results. Key reform initiatives are also detailed. WHO plays a unique role among global health organisations in its mandate to provide independent normative guidance. It demonstrates high levels of alignment with global development goals. WHO clearly articulates its comparative advantages; it gears its programming to these while necessarily responding to emerging member states’ demands and sudden-onset crises. Considerable effort and significant progress have been made on articulating and reporting against WHO’s results chain, though challenges remain. While WHO’s organisational architecture has some congruence with strategic plans, WHO has undergone extensive reform aimed at improving programmes and priorities, governance, and management within the organisation. Due to the operating model, strategic alignment across the organisational levels remains a constraining factor and challenge.



Restructuring finances was a key component of the reform. WHO has successfully secured sufficient overall funding for the organisation as a whole, but financial alignment with priority areas remains a challenge, mostly due to highly-earmarked nature of the funds. In addition, despite considerable efforts to broaden its funding base, WHO still relies on a small number of major contributors.

The new senior leadership team has brought renewed vigour to the organisation's existing cross-cutting initiatives. Human rights are at the core of WHO's values, going back to WHO's Constitution (1946) which declares the highest attainable standard of health as a fundamental human right. WHO enacts a rights-based approach to its programming in line with international standards and the Sustainable Development Goal (SDG) imperative to "leave no one behind". In its work, WHO addresses aspects of climate change and health, including environmental health, and the new strategy (GPW13) extends the ambitions of GPW12. WHO's aim to promote the principles of good governance, which is central to the organisation's mandate, is interpreted through its work on strengthening the governance of health systems.

KPI 1: The organisational architecture and the financial framework enable mandate implementation and achievement of expected results.

This KPI focuses on the extent to which WHO has articulated a coherent and strategic vision of how and for what purpose it has organised its human activity and capital assets to deliver both long- and short-term results.

WHO has a clear long-term vision which informs and drives its strategy and results framework. The publicly available strategy (General Programme of Work) provides such a vision, including priorities and direction; it outlines key reform initiatives and the work of WHO. This high-level, strategic document gears WHO's operations. The 12th and 13th General Programmes of Work (GPW12 and GPW13) build on lessons learned, member states' feedback and demands from previous strategic periods.

During the time frame of the assessment and following the election of a new Director-General in July 2017, a transitional period commenced during which a new senior leadership team was appointed and these new team members took up their positions and began extensive strategic work on GPW13. GPW13 formulation is now complete and received approval at the World Health Assembly (WHA) in May 2018, following a highly consultative and participatory process of stakeholder engagement. This current strategy contributes to the high-level, ambitious vision and clearly demonstrates intent based around the "triple billion goals". The intent is framed around outcomes and impact, i.e. that 1 billion people in each of three key areas – universal health access, healthier lives and health emergencies – should benefit directly from what WHO contributes to the global health system alongside its member states.

While WHO was described by some during the assessment as "the organisation of last resort"⁵ for health-related global issues, it has nonetheless endeavoured to clearly articulate its comparative advantages. Responding to member states' requests to more explicitly set out its comparative advantage in a complex global health environment, WHO acts as a convenor and facilitator to apply the following criteria in setting priorities: capacity to develop evidence in response to current and emerging health issues; ability to contribute to capacity building; capacity to respond to changing needs based on an ongoing assessment of performance; and potential to work with other sectors, organisations and stakeholders to have a significant impact on health.

While considerable effort and significant progress have been made on articulating and reporting against WHO's results chain, challenges remain. WHO General Programmes of Work present how WHO's work is organised over a given strategic period, how the work of WHO contributes to the achievement of a defined set of targets and how WHO can be held accountable for the way resources are used. In practice, many of WHO's recent results reporting have not met its ambition of outcome and impact-level reporting. The newly revised WHO Results Report seeks to summarise the organisation's key programmatic achievements and financial highlights during the biennium. In bringing these two areas together and effectively pairing achievement of specific results with the resources allocated, WHO is seeking to hold itself more accountable for investments made by member states and donors.

5. "Organisation of last resort" is interpreted to mean that WHO is the last (and first) line of defence on critical risks in the global health system and therefore takes the lead on issues such as antibiotic resistance, avian flu, Zika virus and Ebola.

WHO has a complex operating model that is globally distributed and has multiple points of strategic oversight, management and operational intricacy across the three levels of the organisation. While WHO's organisational architecture has some congruence with strategic plans, it has been necessary for the organisation to undergo extensive reform aimed at improving programmes and priorities, governance, and management. While WHO has prioritised and actively encouraged multisectoral collaboration internally and with partners, the complex operating model does not always allow for strong co-operation within the organisation and with partners in all cases. The extensive reform of the WHE presents a programmatic example of a reform that seeks to enable much greater responsiveness and relevance. However, while the WHO Health Emergencies Programme (WHE) has significantly improved vertical co-ordination and communication among all three levels of the organisation, horizontal co-ordination and communication between the WHE and other parts of WHO presents room for improvement.

The interplay between the different levels of the organisation is, paradoxically, both a significant strength and weakness. Global reach and coverage, regional co-ordination, and technical inputs combined with on-the-ground representation and access are key strengths. However, due to the complex operating model, issues of strategic alignment with the strategic plan across the levels are a constraining factor and challenge, as is the organisation's ability to be financially flexible and sufficiently adaptable to the changing context within which it operates. Despite steady improvements over successive strategic biennium in the definition and reporting of results, organisationally, WHO is both the Secretariat and member states. Separating the results for which WHO is solely accountable from those for which it has joint responsibility, remains an intractable challenge for the organisation to address.

WHO has a unique role among global health organisations in its mandate to provide independent normative guidance. Following an independent evaluation of WHO's normative function, WHO aims to strengthen its normative work as set out in GPW13. It is building on flagship examples of global health governance instruments including the Framework Convention on Tobacco Control, the International Health Regulations and the Pandemic Influenza Preparedness Framework.

WHO has sought to find greater alignment at the nexus of its mandate, its programming, member states' priorities and global normative frameworks. WHO recognises the drawbacks of using internationally agreed goals with organisational strategic planning; it acknowledges that the time frame for the achievement of health-related global development goals does not coincide exactly with the time frame of organisational strategic periods. However, WHO demonstrates high levels of alignment with the Millennium Development Goals (MDGs), as evidenced in GPW12, and with the SDGs in GPW13. WHO is actively involved in carrying out the quadrennial comprehensive policy review (QCPR). It shares progress annually through the United Nations (UN) Department of Economic and Social Affairs Survey of UN Agency Headquarters for the UN Secretary-General's report on the implementation of the QCPR resolution.

Financial accountability has seen incremental improvements. WHO has made continuous refinements to its primary tool for ensuring accountability and transparency. The entire Programme Budget (PB) – both assessed and voluntary contributions – is approved by member states. Additionally, the Programmatic and Financial Report presents the Executive Board with more accurate, timely and robust reporting. Documentary, interview and consultation evidence all note how reform efforts have led to substantial improvements in the way priorities are set for the PB; further, a structured process is now in place for the development of the PB. At the time of introduction, only half of countries were setting their priorities through this process. For PB 2020-21, evidence notes that nearly all countries went through the structured process of bottom-up prioritisation and identified a focused set of priorities.

Despite considerable efforts to shift the funding environment, WHO remains reliant on a small number of major contributors. The level of predictability in financing has improved, with 83% of funding assured at the start of the 2016-17 biennium versus 62% in 2012. However, the level of flexibility has not significantly improved, with an

over-reliance on specified voluntary contributions. The share of these contributions is reported to have increased to 71% of total funding in 2014-15 from 68% in 2012-13, according to the 2016-17 mid-term programmatic and financial report. WHO notes that this trend is continuing into 2016-17.

Financial alignment with priority areas remains a challenge. Financing does not always match programme areas' priorities identified by the WHA. Certain targeted areas receive a large amount of funding while others are chronically underfunded. Evidence for example shows persistent financing gaps for some programme areas categorised as high priority on the bottom-up prioritisation by member states. The programme area with the largest funding gap is non-communicable diseases, followed by emergency operations.

Reforms have yet to translate into lower levels of tightly earmarked funds by donors, which present a challenge to adaptability, flexibility and agility. WHO is funded by voluntary contributions from both state and non-state actors, as well as by assessed contributions from member states. Increasing flexible funding remains a key strategic issue for WHO. While the restructuring of finances was a key component of the reform, all evidence streams signal that securing sufficient funding remains problematic, as the proportion of earmarked funds increases yearly, compounding the challenge. Programme Budgets have been highly earmarked by disease areas, but at country level, there may be other priority demands for resources as well, for example supporting other needs in the health system, or strengthening health system capacity. Notwithstanding improvements in financial transparency and accountability, areas of reform conceived to address funding demands have not been effective, in part due to the management of the reform and change.

KPI 2: Structures and mechanisms support the implementation of global frameworks for cross-cutting issues at all levels.

This KPI looks at the articulation and positioning within WHO structures and mechanisms of the cross-cutting priorities to which the organisation is committed, in pursuit of its strategic objectives.

The new senior leadership team has brought renewed vigour to existing, ongoing initiatives on gender equality to the organisation. All evidence streams note the concrete action that WHO is taking in implementing the existing policies on gender balance. For example, the Human Resources Management Department produces a six-monthly report with metrics on gender equality in staffing, by clusters and departments in the headquarters and regional and country offices, to determine progress and challenges. Following the appointment of the new Director-General, a more gender-balanced team has been built at the level of Deputy Director-General/Assistant Director-General to ensure that WHO's gender policy is actively applied and addresses barriers to gender equality at all staff levels.

Some progress on improving gender equality is noted for the period covered by the assessment, and particularly recently, but gaps remain. Globally, women represented 42.8% of staff in the professional and higher category in 2016, although the percentage was much lower in some regions. Between July 2017 and July 2018, the share of female staff in the professional and higher category holding long-term appointments increased from 43.7% to 44.7% at the global level. As a result of the Director-General's commitment to gender parity, particularly at the senior level, women made up 35% of staff at D1 and D2 senior executive grades, an increase of 5 percentage points since July 2017.

Moving forward into GPW13, WHO intends to increase its focus on cross-cutting issues, but this has not yet been fully operationalised. The measurement of progress on cross-cutting issues within GPW13 and the accompanying impact framework takes a greater equity focus, including an indicator on equity. At this stage, the extent to which other impact indicators consider cross-cutting issues is not clear. Documentary and interview evidence notes that cross-cutting issues are integrated more at a strategic level than operationalised, but this is improving.

There is a dedicated Gender, Equity and Rights (GER) team, providing a source of both internal and external technical advice and guidance. The core team based at WHO's headquarters is complemented by regional Gender Focal Points in the organisation. Resource constraints limit the scope and reach of activities the GER team can address, with the result that the headquarters and regional offices take up the country-level shortfall wherever possible. The GER team, in conjunction with other WHO departments (e.g. the Department of Information, Evidence and Research, the Department of Health Systems Governance and Financing, and the Unit of Social Determinants of Health) provides a Country Support Package for Equity, Gender and Human Rights (to "leave no one behind" on the path to universal health coverage).

Effective capacity development opportunities for staff on gender equality are in place. WHO's iLearn online platform for staff training is available to all WHO country office staff and offers a comprehensive e-learning series on equity, gender and human rights (3 hours, 30 mins), alongside a virtual course on gender and health awareness, analysis and action. Complementing these, the GER team offers face-to-face training workshops where resources allow for more in-depth and hands-on capacity building of WHO country office staff. Evidence from staff interviews and consultations notes good uptake of this capacity development.

WHO addresses aspects of climate change and health in its work. Strategic and operational documentary evidence, including GPW12 and the Workplan on Climate Change and Health, offers a framework for countries to follow to mitigate climate risks. As such, this framework provides an internal policy position on environmental sustainability and climate change. However, while the Workplan suggests the need for an agreed set of indicators for countries, this is only on a voluntary basis. Additional documentary evidence of implementation was noted, including a number of regional strategies on health and the environment which are endorsed at a regional level. Corporate reporting evidence notes that WHO monitors progress across all its regions towards the SDGs that have relevance for health and the environment.

WHO seeks to support national health authorities to better understand and address determinants of health and the effects of climate and environmental change on health. GPW13 extends the ambitions of GPW12 and makes clear WHO's commitment to tracking progress against particular environment-related SDG targets. Focus areas include providing green health facilities; substantially reducing the number of deaths and illnesses from hazardous chemicals and from air, water and soil pollution and contamination; and improving water, sanitation and energy.

WHO has internal environmental screening and review procedures and guidance which are presently being revised. Existing guidance, including the Environmental Management Procedure (2010), is presently under review and revision; interview and consultation evidence notes that procedures and guidance are not consistently applied in all cases. WHO has a dedicated Environmental Services Team to support implementation and oversight of WHO's internal environmental safeguard activities. There has been an increasing budget for staffing and activities to be carried out in support of environmental sustainability and climate change issues to address health and the environment; in 2016-17, this budget was USD 110 million, an increase over the USD 102 million in 2014-15. Evidence from staff interviews and consultations illustrates that human and financial resources are not always available to address environmental sustainability and climate change issues. Technical training and capacity-building support are available, particularly related to climate change, and include an online module on climate change and health. This has been jointly developed with the UN Institute for Training and Research, as part of the United Nations Compensation Commission Learn initiative. Evidence shows good uptake of this capacity development.

WHO's work on health governance, including national health systems strengthening and health policy, is extensive. While no standalone dedicated policy document exists, health governance runs throughout much of WHO's work and is central to the mandate of WHO. This has been a key part of its work for many years, as detailed in successive strategic and operational plans. Examples include helping to implement the International Health Partnership programme and country compacts, the European Union-Luxembourg programme supporting governance health, and UHC. WHO's work with health systems on voice and accountability, as well as global governance of health, is significant. Examples include the development of appropriate national policies for medicines and health technologies that are based on principles of

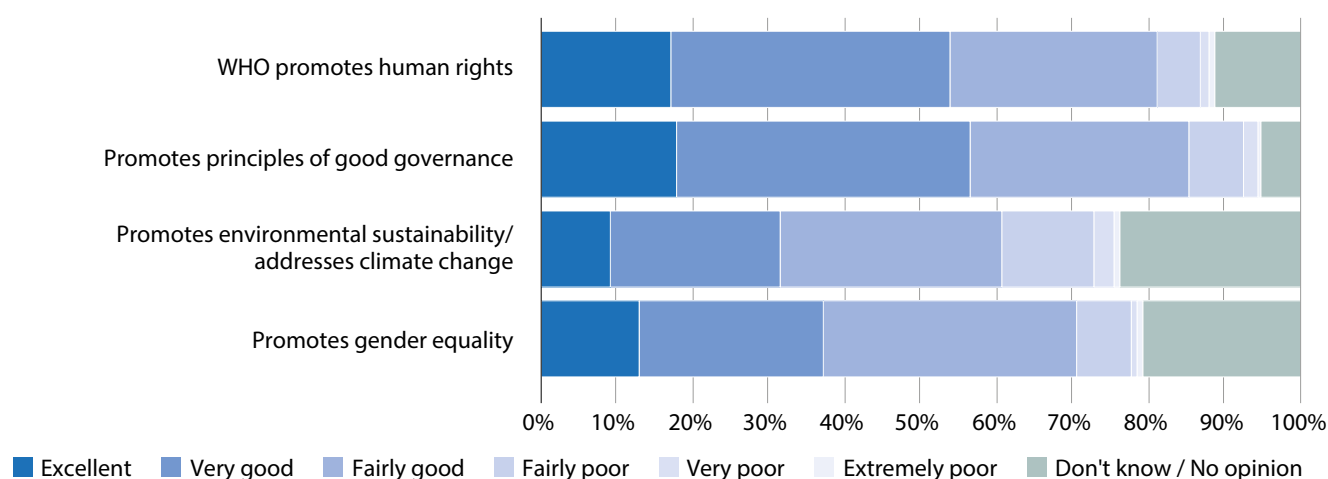
good governance, rational procurement and the management of prices. WHO recognises that a key part of the health governance approach consists of giving citizens a voice in decision-making processes and in implementing, monitoring and evaluating activities to increase accountability, participation, coherence and transparency.

Human rights are at the core of WHO's values, and are addressed across the different levels of the organisation and different areas of its work. WHO is committed to a rights-based approach to programming in line with international standards and leaving no one behind. A joint WHO- UN statement on ending discrimination in health care settings sets out the context and commitments, and recognises that such discrimination presents a major barrier to the achievement of the SDGs. This statement also publicly commits WHO and UN entities to work together to support member states in taking co-ordinated, multisectoral action to eliminate discrimination in health care settings.

Concrete examples of using and integrating human rights in core work are visible. These include WHO Quality Rights guidance as well as tools for training staff on human rights and mental health; integrating human rights into WHO's core normative function; and expanding WHO's understanding of and approach to issues such as discrimination against lesbian, gay, bisexual, transgender, queer and intersex individuals (LGBTQI). The WHO Programme Budget web portal provides quarterly updates on programmes, outputs and deliverables in relation to gender, equity and human rights mainstreaming.

WHO's ongoing and cross-cutting activities, especially efforts in respect of equity, are interwoven with the Sustainable Development Goals. To strengthen this orientation, the programme areas of gender equality, equity and human rights and the social determinants of health have been merged into a single, new programme area: equity, social determinants, gender and human rights. Much of WHO's work is predicated on sustainability. For example, WHO's normative work creates a foundation for other partners – guiding their work, encouraging innovation and providing effective strategies to address health issues by building sustainable institutional capacity.

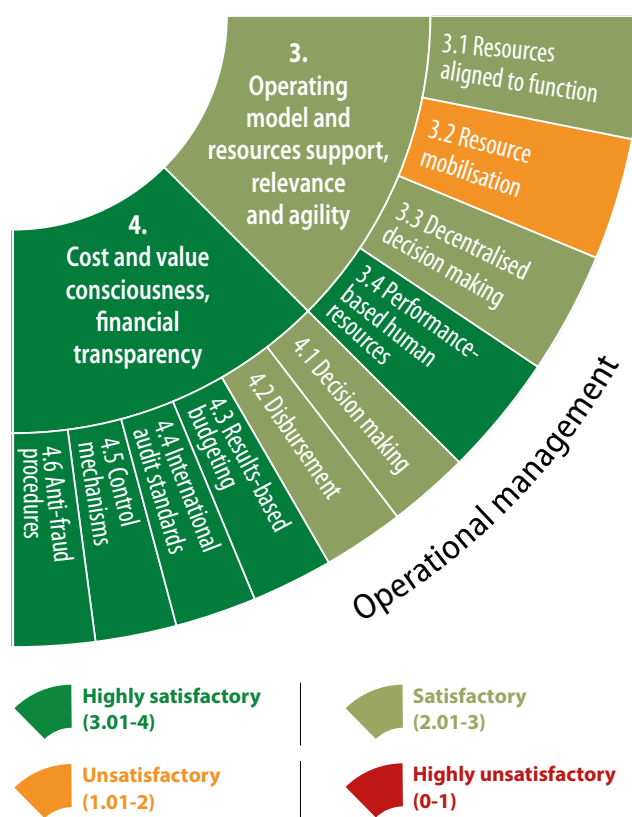
Figure 1: Survey response – CROSS-CUTTING ISSUES



PERFORMANCE AREA: OPERATIONAL MANAGEMENT

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

WHO is undergoing significant reforms to organisational structures and staffing. Human resources systems and policies are increasingly performance-based and geared to results. Considerable effort has been exerted to allocating resources across the levels of the organisation to more explicitly align with organisational priorities and goals. However, challenges remain in matching resources to requirements. Financial and human resources will need to continue to shift from headquarters to country level, as GPW13 encourages more impact focus at country level. Using the Strategic Budget Space Allocation has promoted predictability and transparency in providing more flexible resources at country level. Delegated decision-making authorities are in place and effectively applied. WHO has made significant strides in its planning and prioritisation process; it more clearly aligns resources with the focus of work and priorities at country level and thus with strategic objectives. In addition, WHO has significantly improved its operational agility on emergency response.

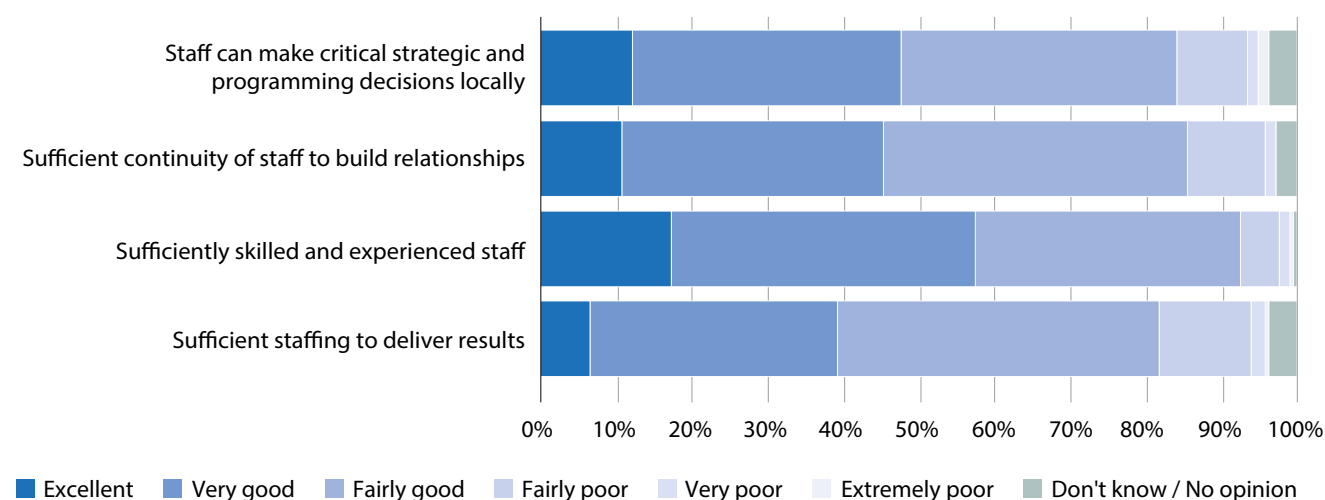


KPI 3: The operating model and human and financial resources support relevance and agility.

This KPI focuses on how key operational functions (e.g. human resources, resource generation and programming) are continuously geared to support strategic direction and deliver results.

Significant reforms, clearly linked to the strategic direction, have been undertaken; these include adjustments to organisational structures and staffing. As part of the reform, a comprehensive and coherent range of initiatives has been implemented. Human resources systems and policies are increasingly performance-based and geared to results. Notably, WHO has implemented a geographical mobility policy; a harmonised selection process for longer-term positions in the professional and higher-level categories; a new internal assessment process for candidates for positions as heads of WHO offices; a Performance Management and Development Framework; an enhanced WHO global competency model; and a Corporate Framework for Learning and Development. An independent evaluation notes that the reform “sought to delineate clear roles and responsibilities for the three main levels of WHO, seeking synergy and alignment around common organisation-wide policy and strategic issues, at the same time as striving for a clear division of labour with accountability for resources and results”.

Such reforms however take time to become effective. Given that human resources policies have inherent rigidities within them when applied to a complex, global, tri-layered organisation, fully implementing new policies and procedures, and translating these into effective ways of working is work in progress. Evidence from interviews notes that whilst policy level changes have been effectively implemented, the necessary changes in working practices is more mixed; with historic practice often remaining the predominant way of working with meaningful change taking time to embed. An independent evaluation of the Implementation of the Geographical Mobility Policy conducted in 2017 found that as the mobility compendium exercise is a new modality for WHO, its effectiveness needs to be assessed over time, with trust needing to be built.

Figure 2: Survey response – STAFF PERFORMANCE

Overall, reform and organisational transformation are ongoing. The advent of GPW13, and the significant transformational realities behind it, will necessitate further changes to the architecture and operating model of WHO. The reshaping of the operating model detailed in GPW13, to increase emphasis on country impact, will necessitate further organisational transformation and greater levels of partner collaboration to achieve the “triple billion goals”. The anticipated scale of change, along with the requirement for transformative change in staffing and mindset, will require considerable resolve and time to design, roll out and embed. While some strategic consideration to this was underway during the assessment, this is predominantly at the concept stage related to the strategic intent. There is evidence from regional and country offices that, while not organisation-wide, a structured assessment of workforce composition is presently being pursued.

WHO has exerted considerable effort to allocate resources across the levels of the organisation in order to more explicitly align with organisational priorities and goals; however, challenges remain in matching resources to requirements. Country offices use a systematic approach for setting priorities, allocating resources and making choices in the development of Country Cooperation Strategies (CCSs). These offices identify up to ten priority areas and put 80% of resources against these, applying an 80/20 rule of thumb (i.e. 80% investment on core targets and 20% flexibility). A country office thus retains some flexibility to respond to the unique context of its operating environment. This context-specific priority setting is a significant achievement since the MOPAN 2013 assessment, resulting in gains in strategic alignment. The use of results-based management (RBM) in priority setting and resource allocation is a sensitive process, both internally and with donors, given that WHO has excess demands and disease-specific funding by donors.

Resources will continue to need to shift from headquarters to some country offices, with GPW13 in principle allowing greater focus at country level through a more bottom-up approach. Under GPW13 and “triple billion goals”, the list of choices will be tighter still and more integrated across WHO. Planning includes fewer options, with all offices mapping their outcomes, and there will likely be a need for greater arbitration. A planning framework is in place to support selection (from a limited menu), mapping against country priorities. The implications of the current polio programme and realities of implementing the strategic transition action plan present resourcing risks related to redeploying staff towards different areas of work.

The utilisation of the Strategic Budget Space Allocation has promoted predictability and transparency in providing flexible resources at country level. This approach has added a needs-based element to resource distribution, and decisions on resource amounts are clearly set out. Evidence from staff interviews and consultations notes this is implemented in all regions. The methodology for the Programmatic Priorities Stratification Framework of the Pan American Health Organization (PAHO) strategic plan highlights an innovative method of resource allocation within the PAHO programme.⁶

WHO has exerted significant effort to strengthen resource mobilisation in line with its strategic objectives, and has improved predictability of funding. WHO had a weak resource mobilisation capacity at all levels of the organisation at the start of the reform. Financing and resource mobilisation was part of the reform agenda under the previous Director-General; it included active outreach as part of earlier financing dialogue to fund the Programme Budget. Resource mobilisation now no longer focuses on a specific Programme Budget, but rather on broad priorities. As of January 2019, resource mobilisation will focus on the “triple billion goals” and on enabling functions rather than category and programme areas. The financing dialogue has evolved into continuous communication with WHO’s partners. The transformation of WHO’s approach to resource mobilisation includes internal reorganisation to ensure a coherent approach to deliver a clear engagement strategy for each donor across the WHO staff working on resource mobilisation. A dedicated team brings together people working on resource mobilisation with regional and country-level and programme area leads.

There is clear recognition of the need to diversify the funding base of WHO. All evidence streams, including the *Evaluation of WHO Reform (2011-2017), Third Stage*, note too great a reliance on a small base of donors, with this evaluation noting, “Despite 30 new contributors joining the contributor base since 2011, 76% of voluntary contributions are paid by 20 contributors in 2016-2017. This is a sign that the dependency on key donors is not reducing in material ways”. At the same time, the high number of donor agreements (about 3000) presents a significant administrative and reporting burden on the organisation in addition to placing constraints on addressing priority issues, implying diversification and shifting funding towards programmatic priorities need to go hand-in-hand.

Delegated decision-making authorities, including annual accountability compacts between the Director-General and Assistant Directors-General, are in place and effectively applied. Delegations of authority and Letters of Representation of regional directors exist and are publicly available. These describe delegation of decision-making authorities for programme, administration, finance, resource mobilisation and donor agreements; for staffing; and for re-delegation. Similar mechanisms have been introduced between regional directors and heads of country offices; for example, the regional offices in Southeast Asia, Africa and the Western Pacific promote responsiveness to local conditions by placing decision-making with those closest to the work to be done.

The WHO Health Emergencies Programme represents a fundamental development for the organisation. This programme complements WHO’s traditional technical and normative roles with new operational capacities and capabilities for its work in outbreaks and humanitarian emergencies. WHE brings improvements in speed and predictability to WHO’s emergency work (Box 3). It uses an all-hazards approach, promoting collective action and encompassing preparedness, readiness, response and early recovery activities. The new WHE aligns with the principles of a single programme: one clear line of authority, one workforce, one budget, one set of rules and processes, and one set of standard performance metrics. It has allowed achieving significant improvements to operational agility in emergency response. World Health Assembly resolutions give the Director-General authority to make budget transfers of up to 5%, with additional spending where necessary for disease outbreaks and crisis response. Furthermore, ongoing transformation processes at regional and country levels are seeking to better match capacity to needs and priorities. Specific mechanisms such as the regional hubs and the global alert network within the WHE allow staff and experts to respond quickly in crisis situations.

6. PAHO is the Regional Office for the Americas for WHO.

Box 3: WHO Health Emergencies Programme in practice

- Within 24 hours following the announcement on 5 May 2018, of an Ebola virus disease (EVD) outbreak in the Democratic Republic of the Congo (DRC), the WHO Health Emergencies Programme activated a full Incident Management System at global and regional levels. WHO deployed more than 50 experts (including a senior vaccination facilitation team from Guinea) within days. WHO released contingency funds, contacted key partners, notified the UN Secretary-General and sent a team to the field site immediately after the confirmation of two cases in the country's Equateur Province. The first meeting of the Emergency Committee, convened by the WHO Director-General under the International Health Regulations, took place on 18 May.
- WHO conducted a formal, rapid risk assessment that determined that the public risk was high at the regional level. On the basis of the assessment, the WHO Regional Office for Africa identified nine countries neighbouring the DRC to support them with preparedness and readiness activities. During June 2018, WHO deployed teams of experts, known as Preparation Support Teams, to eight of these countries. The aim of these missions was to assess countries' readiness, using the WHO standardised checklist, and to provide technical support to countries to develop and initiate national contingency plans in co-operation with partners.
- WHO, in collaboration with the countries, developed a nine-month WHO Regional Strategic Plan for EVD Operational Readiness and Preparedness in Countries Neighbouring the Democratic Republic of the Congo (June 2018-February 2019). The strategic plan aims to ensure alignment of preparedness and readiness actions in the nine countries, focusing on eight technical areas: strengthening multisectoral co-ordination; surveillance for early detection; laboratory diagnostic capacity; points of entry; rapid response teams; risk communication, social mobilisation and community engagement; case management and infection prevention and control capacities; and operations support and logistics. The purpose of the WHO Regional Strategic Plan is to ensure that the countries bordering the DRC are prepared and ready to implement timely and effective risk mitigation, detection and response measures should there be any importation of EVD cases.
- On 27 June, all the people who were exposed to the last confirmed EVD case-patient completed their mandatory 21-day follow-up without developing symptoms – an important milestone. The last confirmed EVD case-patient in Equateur Province was cured and discharged from the Ebola treatment centre. The end of the ninth outbreak of Ebola in the country was marked on 24 July.
- The Independent Oversight and Advisory Committee (IOAC) was briefed that the timeline of the WHO response was swift, that an operational research component was included in the response, that the ring vaccination was well received by communities and that more than 2 700 individuals were vaccinated from 20 May to 16 June. The Deputy Director-General of Emergency Preparedness and Response highlighted the excellent collaboration with key partners; the UN World Food Programme and United Nations Organization Stabilization Mission in the Democratic Republic of the Congo, MONUSCO, provided logistical support, which is critical to field responses in hard-to-reach areas. In terms of funding, the IOAC noted that the joint response plan was launched with a total of USD 56 million and that all requested funds have been received. The IOAC recommended a comparative analysis of the Ebola response in West Africa in 2014 and in the DRC in 2018, which could be shared with member states.

During the significant reform efforts, clearly linked to the strategic direction (GPW12), a number of initiatives were launched that have strengthened performance and career management. Since the last MOPAN assessment in 2013, WHO has significantly reformed human resources, including by defining a human resources strategy, endorsing a mobility policy, making important updates to staff rules and regulations, and implementing a new performance management system. A Performance Management and Development Framework, supported by two policies (Recognizing and Rewarding Excellence and Managing Underperformance) and by a performance management tool (the Performance Management and Development System, or ePMDS+), has significantly strengthened performance and career management.

With the introduction of the ePMDS+, performance assessments have been systematically organised. Documentary evidence notes, “All performance management evaluations (100%) were completed. ... Key performance indicators have been institutionalised and monitored for all professional and general service category staff [and] 100% of staff workplans and performance reviews (including personal development plans) were completed on time”. The 2017 evaluation of WHO reform provides evidence of an improved compliance rate with ePMDS that it notes “has consistently increased and is now above 90% globally”. Individual, departmental, programmatic and global programmes of work are now aligned to corporate objectives; the Performance Management and Development Framework ensures that staff are able to perform at their highest level and are accountable for their work. This is clearly linked to organisational improvement.

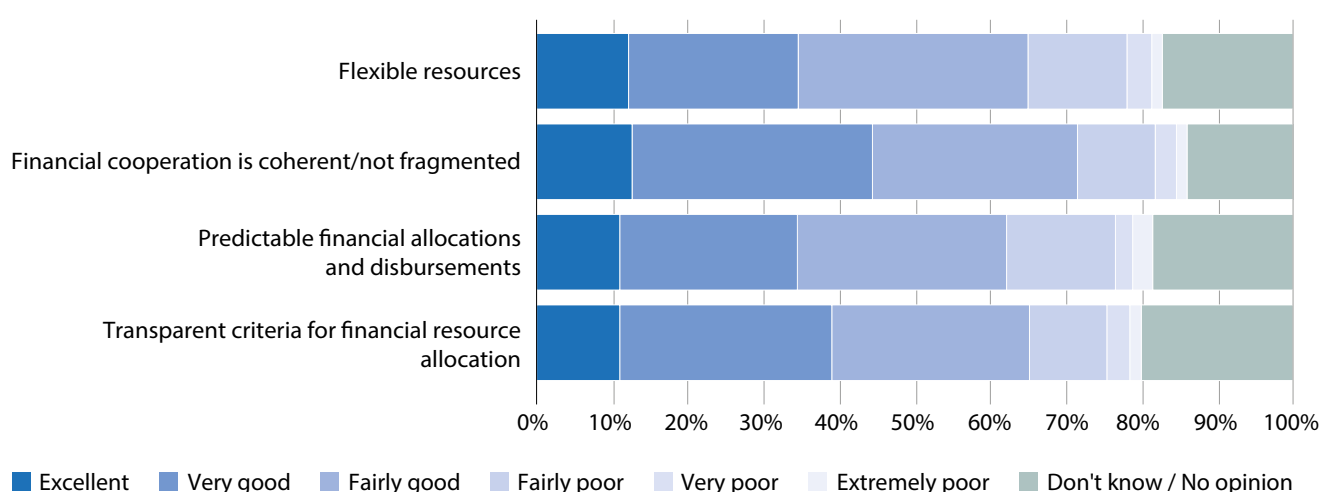
KPI 4: Organisational systems are cost- and value-conscious and enable financial transparency and accountability.

This KPI examines how WHO uses its external and internal control mechanisms to meet the standards it sets on financial management and transparency.

WHO’s key financial information is published regularly, promoting transparency Intended resource allocation is explicitly set out within each biennial Programme Budget, and aligned with the strategic priorities defined in the General Programme of Work, which shows where resources are allocated against priority categories and programmes of work. WHO Programme Budgets establish regular review points to assess progress towards financial and programmatic targets. WHO monitors and reports on the progress through the mid-term review that is issued at the mid-point of the biennium.

Established policies, guidelines and tools are in place to govern the allocation of resources to partners. For example, the Framework of Engagement with Non-State Actors (FENSA) sets out parameters and regulates the receipt and allocation of resources to non-governmental and private organisations for implementation of work in accordance with the Programme Budget and with the Financial Regulations and Financial Rules. Financial information is publicly available via the Programme Budget web portal. WHO is a member of the International Aid Transparency Initiative.

Figure 3: Survey response – FINANCIAL RESOURCE MANAGEMENT



The financial situation of WHO remains challenging, with persistent gaps in the base programme component.

WHO sets out planned spending through each of its biennial Programme Budgets (disaggregated by major office, level, category and programme area). Financial information indicates that there are often shortfalls in funding across programme areas, with expenditure recently exceeding total revenue, while other areas are overfunded. The Programmatic and Financial Reports explain variations in spending. While driving factors are partly external, including

earmarking constraining shifting of resources between overfunded and underfunded areas, WHO is also aware of and seeking to address internal procedural blockages that have affected country office capacity, such as the appointment of staff and organisational delays in deploying staff rapidly in response to emergencies.

WHO has made significant strides in its planning and prioritisation process. This process, now driven from the bottom up, more clearly aligns resources with the focus of work and identification of priorities at country level and is resulting in greater alignment of financial resources with strategic objectives. Instructions, support and guidance issued to country offices help to prioritise work and budgets to ensure that 80% of resources are in line with (up to ten) country priorities. The Programme Budget follows this bottom-up prioritisation process, which includes consultations with member states during regional committees and at the Executive Board. The bottom-up approach is complemented by a top-down process to identify global priorities expressed through resolutions of the governing bodies.

WHO is shifting to a more results-based model, applying a costing of results approach. Most recently, in May 2017, the costing of results (outputs) was presented to the WHA for the Programme Budget 2018-19. This provided an overview of the iterative process for costing the outputs, with full costing by programme area and by category, and with a breakdown by staff and activities.

WHO continues to become more cost-conscious. Recognising the continued risk of rising costs and the adverse financial consequences of exchange rate fluctuations, WHO has made various efficiency savings and improved budgetary discipline. As mentioned in the Programme budget 2016-17 document, savings in staff costs have been made (to a share of 41% from 47% of expenditure over a three-year period). Other savings have been made by offshoring administrative work to countries where staff costs are lower and by better managing travel, with greater use of video conferencing instead of face-to-face meetings. Consideration of potential cost savings is becoming a more systematic aspect of future Programme Budgets. A comprehensive value-for-money plan has recently been developed and submitted to the governing bodies.

WHO has robust internal and external audit functions, meeting international standards. WHO has comprehensive and robust internal control mechanisms. They comprise a set of operational and financial safeguards using an organisation-wide common framework and harmonisation of risk management practices. The organisation's dedicated Office of Compliance, Risk Management and Ethics (CRE) promotes transparency and management of corporate-level risk, within the framework of WHO's ethical principles. The WHO Internal Control Framework and the WHO Accountability Framework set out the organisation's overall approach to internal control. WHO's Corporate Risk Policy and risk register provide the structure and tools for risk management and analysis. External audits are conducted to specified international standards and in conformity with common auditing standards. Financial statements are audited in accordance with the Financial Regulations and in conformity with the International Standards on Auditing issued by the International Auditing and Assurance Standards Board, as noted in The Report of the External Auditor (2017).

Progress of audit work is routinely tracked and monitored. Internal audit reports and progress of audit work operate within the Committee of Sponsoring Organizations of the Treadway Commission (COSO) framework for internal control and an internal dashboard is shared with Director-General. Internal control effectiveness increased to 75% in 2017. Implementation of audit recommendations has improved to 4-6 months in 2017 from 15 months in 2015, with the Director-General and Global Policy Group encouraging increased implementation. Progress on the implementation of external and internal audit recommendations is readily available over successive years (2015, 2016 and 2017); updates of actions taken by the Secretariat ensure full implementation. The Office of Internal Oversight Services and the WHO external auditor issue reports and recommend improvements to the Office of the Director-General.

The Independent Expert Oversight Advisory Committee (IEOAC) reviews all audit reports, risk reports, financial reports and other information relevant to the overall control framework. The committee's reports are provided to the Director-General and to the Executive Board. The reports advise on risk management and on financial and internal control matters. They also identify any potential areas for improvement and provide advice on how to address weaknesses.

WHO has made continued efforts to strengthen risk awareness and improve risk management skills. Routine induction for all staff on internal audit mechanisms is regularly undertaken to achieve greater risk awareness and training on risk management; regional counterparts support the wider CRE process. The IEOAC and the Executive Board provide additional guidance following the risk evaluation process (risk registers).

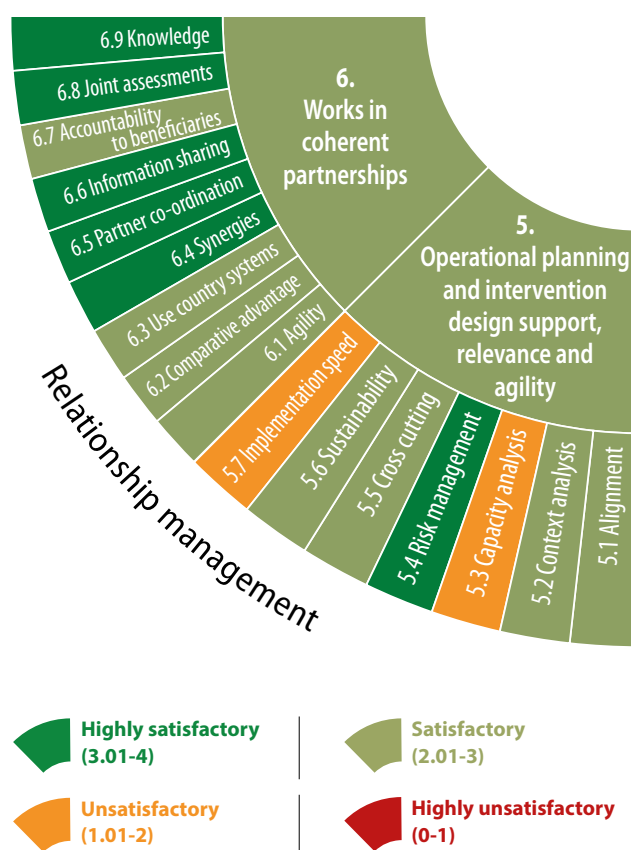
A clear fraud prevention policy, guidelines and tools are in place and actively applied. WHO carries out a fraud prevention policy supported by fraud awareness guidelines; these are reinforced by a Code of Ethics and Professional Conduct. WHO also has dedicated Whistleblowing and Protection against Retaliation policy and procedures and guidance on contacting the Office of CRE. An integrity hotline, managed by an independent company, has been established to provide a safe and independent mechanism to report any concerns about issues involving WHO.

All existing staff have undertaken ethics and professional conduct training, and briefings are provided to all new WHO staff during induction/orientation sessions. Annual training is conducted for newly-appointed heads of offices in countries, territories and areas. All staff members in headquarters receive information on ethical behaviour, whistleblowing, protection from retaliation and the risk of fraud. Advice and guidance on specific issues are provided through the Office of CRE, the ombudsperson, the Human Resources Management Department, or the Division of Administration and Finance as applicable. WHO requires all staff members in designated employment categories to complete an annual declaration of interests.

PERFORMANCE AREA: RELATIONSHIP MANAGEMENT

Engaging in inclusive partnerships to support relevance, to leverage effective solutions and to maximise results (in line with Busan Partnerships commitments).

WHO has made major headway in its operational planning, using national health goals to identify priorities and develop Country Cooperation Strategies (CCSs). WHO has well-established access and strong relationships with key in-country stakeholders. WHO is diligent and active in protecting its reputational asset and is very serious about not compromising or negatively influencing its normative function. Built within its mandate and core function, WHO's technical support seeks to enable and empower countries to implement the health-related interventions. While joint planning, programming, monitoring and information sharing is a strength, joint evaluation work by WHO of the type that other members of the United Nations Evaluation Group engage in is less common. Generating knowledge is a main and reputable part of WHO's role in the global health system. WHO's work with member states on health statistics and standards is central to building the infrastructure for monitoring health of beneficiaries.



A key instrument in most areas of WHO's work is the organisation's sophisticated, transparent approach to partnerships and collaborations. WHO carefully considers its comparative advantage and role in partnerships. As part of its new external engagement strategy, WHO is in the process of resetting and repositioning its role within major partnerships. WHO seems to align its human resources and expertise with its comparative advantage more effectively than it does its financial resources.

KPI 5: Operational planning and intervention design tools support relevance and agility within partnerships.

This KPI focuses on the scope and robustness of WHO's processes and practice to support timely, flexible and responsive planning and intervention design for partnerships.

WHO's operational planning aligns with national health priorities, and is the starting point for health situation analyses to identify priorities and develop Country Cooperation Strategies. External evaluation notes that "significant headway has been made in the approach to planning and prioritising activities based on country needs. This includes notably increased alignment of Country Cooperation Strategies with national health strategies and plans".

External stakeholder consultations are actively undertaken early and throughout the CCS development process to strengthen relevance. Agreed roadmaps for the consultation process are developed that involve the stakeholders (e.g. ministry of health, ministry of planning, parliamentarians and state governors) meeting near the outset.

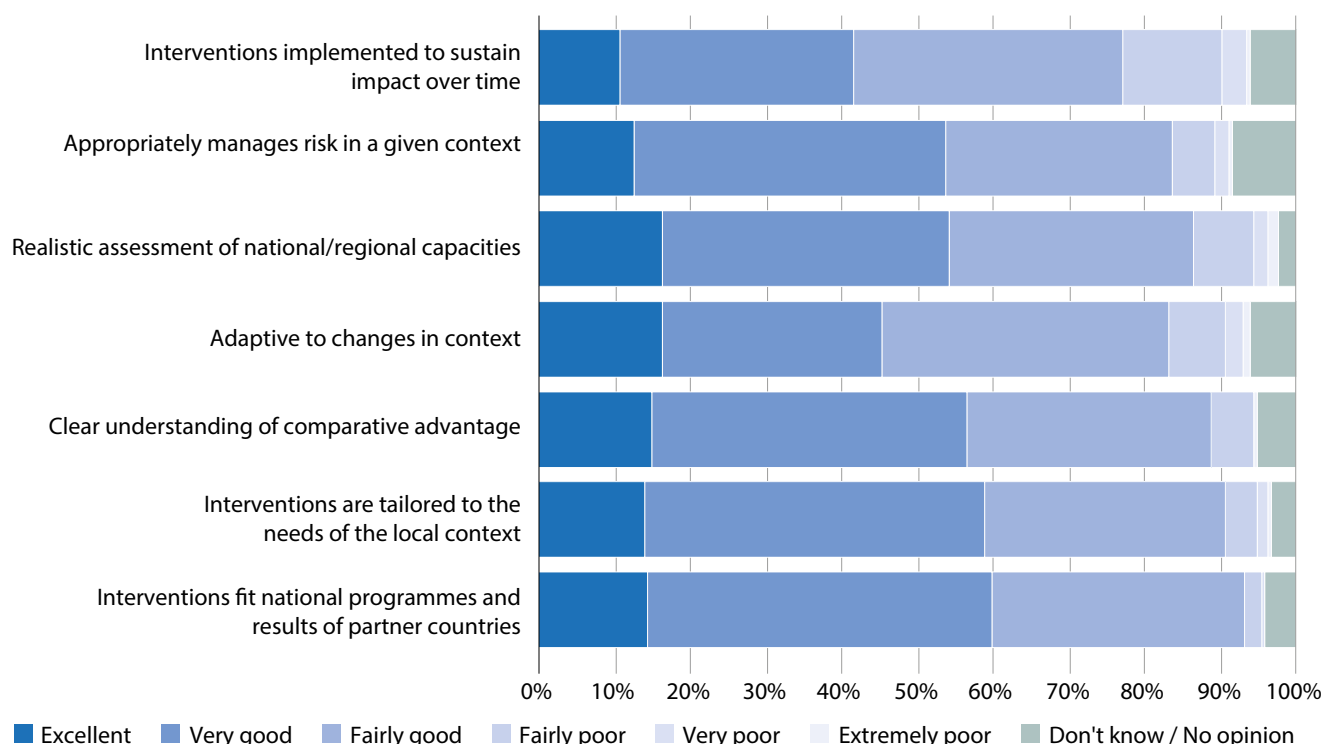
WHO has well-established access and strong relationships with in-country ministries of health and other ministries and partners, given its prominent convening and chair and co-chairing roles. WHO offices have high levels of leadership and participation in co-ordinating mechanisms for health sector partners at the country level, with WHO staff members taking up chairing or co-chairing roles. This level of access and engagement allows WHO to develop its CCSs based on joint understanding and close working with partners, ensuring strong emphasis on participation, contextual analysis and country ownership.

WHO's capacity analysis of national partners is inconsistent. While corporate guidance on the formulation and development of CCSs notes that a capacity analysis should be conducted, limited evidence of this in practice was noted.

Country Cooperation Strategies contain some focus on cross-cutting issues in most cases, though as yet they neither are universally applied nor do they address all such issues consistently. CCSs do not consistently refer and draw on detailed analysis of gender issues; environmental sustainability and climate-related contextual factors (including vulnerability to natural disasters and climate change); and governance and accountability issues related to improving health status. Monitoring targets for cross-cutting issues are integrated into each CCS reviewed and are tracked at country, regional and global levels, although this is not yet universally applied in all cases.

Significant progress has been made to the management and mitigation of risk since the 2013 MOPAN assessment. With the adoption of the comprehensive Risk Management Policy in late 2015, risk management is now firmly embedded into operational planning and is more consistently built into work plans, ensuring that risks and risk mitigation measures have been identified, documented and incorporated. This has resulted in better risk analysis and mitigation planning in the regular implementation of work plans. An online risk management tool has also been developed with built-in validation and feedback loops.

At a corporate level, WHO's Risk Management Policy sets out the high-level objectives of WHO's risk management process. The policy informs effective decision-making to improve delivery of results. Further, it embeds risk management in operational processes and in the RBM cycle (planning, performance assessment, budgeting). In addition, this policy increases accountability and internal control.

Figure 4: Survey response – OPERATIONAL PLANNING AND INTERVENTION DESIGN

Although its effective implementation remains to be assessed, FENSA provides a clear framework and mechanism for managing risks, including conflict of interest and reputational risk. FENSA defines and guides WHO's engagement with non-state actors. A clear process exists related to engagements with non-state actors as well as "official relations" with WHO, and a committee reviews proposals of engagement. The Director-General, working with the regional directors, ensures coherence and consistency in implementation and interpretation of FENSA across all levels of the organisation. However, as FENSA is still relatively new, it is too early to assess how well the framework is being implemented.

Much of WHO's work focuses on building strength and sustainability into the governance of health systems. WHO's normative work, for example, provides a foundation for that of other partners, guiding their work, innovation and effective strategies to address health issues sustainably (through institutional development and capacity building). WHO's technical support, which is built within its mandate and core function, seeks to enable and empower countries to implement the health-related interventions rather than having WHO do it for them.

WHO actively considers and is engaged in strengthening the enabling policy and legal environment required to sustain expected benefits of its intervention. For example, WHO's work programme on law and universal health coverage supports countries to ensure that their existing (or proposed) legal, administrative and institutional settings enable and do not hinder the path towards UHC. Creating an enabling legal environment for UHC means taking steps to remove legal barriers as well as developing and maintaining laws that support its different dimensions.

The CCSs and regional frameworks provide detailed monitoring for interventions; however, they do not explicitly note speed of implementation universally and consistently. The WHO Health Emergencies Programme actively tracks the percentage of requests for initial emergency funds (of up to USD 500 000) disbursed within 24 hours of request. WHE also tracks how effectively the programme is managed and sustainably staffed and financed.

KPI 6: Partnership working is coherent and directed at leveraging and/or ensuring relevance and the catalytic use of resources.

This KPI looks at how WHO engages in partnerships to maximise the effect of its investment resources and its wider engagement.

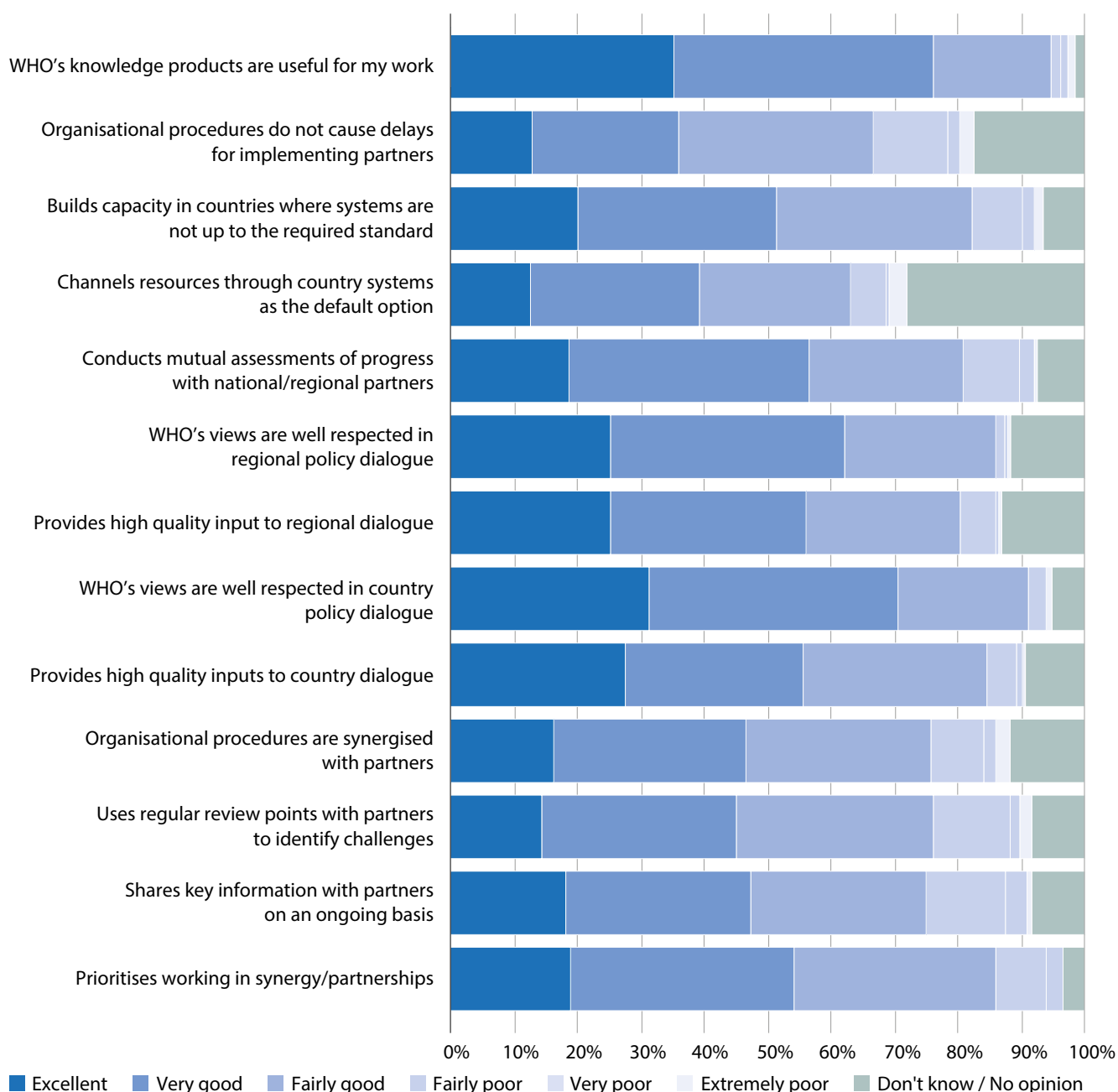
Across all levels of the organisation, much of WHO's delivery approach is actively based around partnerships, synergies and leverage. GPW13 sets out clearly the importance of synergies and leverage, in recognising that the “triple billion goals” will not be achieved by WHO alone; it will involve close working with member states and a wide range of other partners. In some areas such as immunisation and malaria, the agreements with partners (for example, the global funds) have evolved over time. In certain areas, they are stronger and more mature than in others. Sometimes WHO is constrained by the fact that it has limited direct leverage over resources and that other multilateral partners come with deeper pockets and are pursuing change agendas in their own right. This is even the case of several of the key partnerships that WHO originally hosted, and where it continues to have a role on the boards of these partners.

WHO has a flexible and increasingly transparent approach to partnerships and collaborations focused on comparative advantage. Within its partnership approach, WHO carefully considers its comparative advantage and role. Its recognised strengths include its convening role, expert knowledge, data, ability to be seen as an honest broker and/or adviser, close relationships and trust with health ministries and governments, and its presence across the full range of member states (i.e. both developed and developing countries).

In particular, WHO's knowledge generation is a central part of its role in the global health system and has a strong reputation. WHO's work with member states on health statistics and standards is key in building the infrastructure for monitoring the health of beneficiaries. This is a major contribution. WHO's knowledge work has also been central to, for example, access to medicines and quality standards for essential medicines across the globe. It has led many international policy developments such as improving health equity and performance, universal health coverage, the Framework Convention on Tobacco Control and international agreements on air pollution. GPW13 attaches relatively greater importance to generating knowledge with impact, focusing the normative and technical work where it can make the most difference for health impact in countries and for beneficiaries.

On the other hand, some of the normative work of WHO often has much less visibility, and thus funding resources are in short supply relative to potential value added. The real impact of areas of work such as non-communicable diseases and health promotion, as well as normative work (e.g. International Classification of Diseases [ICD], access to medicines) and strengthening health systems is often less visible. An example of how global public goods in knowledge can be undervalued is the recently released ICD 11; it is a vital part of how every health system in the world functions, but its impact is hard to measure and is not typically listed by donors as a funding priority. WHO aims to be bolder in taking reasonable credit for what it is achieving, although how to capture a “reasonable” level of contribution is yet to be defined.

Overall and while improvements have been made, the approach to partnerships still lacks consistency in engagement. WHO is engaging in a wide range of partnerships, with various partners, various levels of formalisation, and various levels of monitoring. FENSA now defines and guides WHO's engagement with non-state actors but evidence from interviews across layers of the organisation points to inconsistency in engagement with different partners. WHO is in the process of reviewing the effectiveness of its partnerships across its portfolio and seeking to exert appropriate influence within their parameters in relation to its comparative advantage. This may necessitate WHO withdrawing from partnerships that no longer facilitate effective working. In particular, as part of its new external engagement strategy, WHO is in the process of resetting and repositioning its role within key global partnerships.

Figure 5: Survey response – PARTNERSHIPS

Given WHO's financial constraints relative to key multilateral partners, it is, by default, better able to bring expertise, leadership, data, knowledge and networks to the table than the financial resources that others can provide.

Working jointly with national governments, aligning with country objectives and building national capacity are central to how WHO functions at country level. Its work with UN partners is extensive, but there is limited joint evaluation activity. Its role on the health-related SDGs, its technical assistance, its advice/leadership role on universal health coverage, health data, health systems and policy, and its monitoring and responding in specific disease areas are building ownership with countries. This is through effective partnering at country level, including the use of joint planning instruments such as the United Nations Development Assistance Frameworks (UNDAFs). Independent external evaluation found that WHO had participated in UNDAF in 99% of cases where an UNDAF

Box 4: The Global Polio Eradication Initiative (GPEI)

- GPEI was launched in 1988 following a WHA resolution to eradicate polio. Polio eradication is one of the more important areas of WHO's work, in terms of its significance for global health, the level of scrutiny from the international community and in terms of resource mobilized and deployed. GPEI is one of the earliest examples of public private partnerships, made up of WHO, Rotary International, CDC, UNICEF and the Bill and Melinda Gates Foundation.
- The Independent Monitoring Board (IMB) provides an independent assessment of the progress being made by the GPEI in the detection and interruption of polio transmission globally. Towards the end of 2017 it was flagging problems with the final stage of polio eradication
- Specifically, in its 2017 15th report, the IMB noted that GPEI had been promulgating an 'almost there' narrative based on the fact that the number of wild poliovirus cases was at its lowest in history eg. "We expect to be within months of polio elimination in Pakistan". However, the interruption of transmission did not in fact materialize. The message from the IMB was that the link between the number of cases reported and the underlying transmission of the virus needed to be scrutinised more closely to deal with the possibility that the virus was circulating undetected in what might be called blind spots in the last 3 polio endemic countries or indeed in other hard to reach areas in other countries.
- At that stage in 2017 the IMB noted that there had been improvements in programmatic performance but some of the areas of weakness were getting better only slowly; noting that where transformative change was needed to deal with unyielding problems it was not happening. The IMB also commented that some observers have remarked that the Polio Programme "has run out of ideas and is at risk of coming to a stalemate in its battle with the poliovirus." Many had reported to the IMB that a pervasive sense of fatigue and low spirit seemed to be permeating the GPEI. A small number of leaders reflected privately on whether eradication is even possible and whether, even if it does seem to have been achieved, the Polio Programme will know that it has been done. At that stage the IMB's view was that it firmly believed that polio eradication can and will be achieved but it also called on the leadership to re-energise the Polio Programme.
- In 2018, the Polio Oversight Board (POB) (the GPEI governance mechanism, made up of the heads of the five GPEI partners), requested the IMB to commission an external review of polio endemic countries. Also in 2018, the POB agreed to develop a new strategy for polio eradication 2019-2023.
- The external review (independent Review Team) that included extensive field visits to Pakistan, Afghanistan, and Nigeria, was completed in time for the IMB to draw on the findings for the October 2018 16th report. The Review Team concluded that "Access limitations due to insecurity continue to represent the biggest threat to polio eradication and progress towards interrupting transmission has stalled". On the basis of this and other evidence, the IMB concluded that "progress towards interrupting polio transmission has stalled and may well have reversed". It noted that the "total number of wild poliovirus cases globally has increased: 25 compared to 13 for the same period (30 October) in 2017. The case count so far this year [2018] exceeds the total for the whole of 2017."

existed in the countries where it operates. The engagement on the Inter-agency Standing Committee is just one key example of joint planning, monitoring and implementation. Joint monitoring on health is often led by WHO in country, and this is a key area of its expertise and value added. Its role in the SDGs in health is very important, and in universal health coverage, it is crucial (with other partners such as the World Bank). However, while joint planning, programming, monitoring and information sharing clearly constitute a strength, joint evaluation work by WHO of the type in which other members of the United Nations Evaluation Group (UNEG) engage is less common.

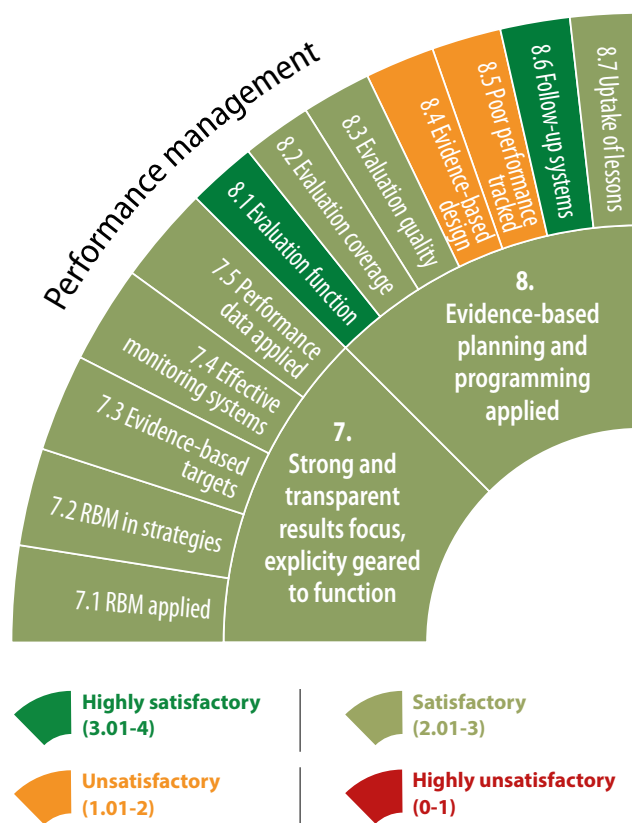
WHO actively participates in dialogue and is the lead for the health cluster. It participates and often leads multi-stakeholder dialogue on joint sectoral and normative commitments. It does so in support of the health elements of UNDAF, country-level monitoring of health systems and goals, emergency response (the Joint External Evaluation), and in specific disease areas such as polio (Box 4), malaria and non-communicable diseases.

WHO has mechanisms in place to review the changing context and identify the programmatic changes that would be required but agility is constrained by resources. Planning processes, including country cooperation strategies, allow identifying required changes in programmes as conditions change. Feedback from country partners also suggests that WHO works well with partners to review and identify changes in conditions regularly, to understand how the programmes should evolve. However, WHO's agility in making changes and adjustments to programmes is constrained by the earmarking of resources. Important exceptions in terms of agility include emergency response, but also recent changes at regional and country level. For example the PAHO Program and Budget 2018-19 includes the flexibility to shift PB allocation among the six categories in order to accommodate emerging priorities and changes in funding availability during the biennium.

PERFORMANCE AREA: PERFORMANCE MANAGEMENT

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

WHO has shown strong commitment to building its approach to results-based management and has implemented an integrated system to track what it achieves. The new WHO leadership has set out an ambitious vision to improve RBM, focusing on outcomes at country level and the new "triple billion goals". This fits well with the SDGs and WHO's strategy to "be bolder" in showing its achievements, but there are significant technical challenges to overcome. WHO has made good progress on its evaluation work, and the latest step in this evolution is the revised evaluation policy recently agreed by the Executive Board. The organisation responds constructively to the peer review – for example, in specific provisions on independence and management responses. Further clarity would be useful on where organisational learning sits within WHO.



KPI 7: The focus on results is strong, transparent and explicitly geared towards function.

This KPI looks at how WHO transparently interprets and delivers an organisation-wide focus on results.

WHO leadership has shown strong commitment to an organisation-wide approach to results-based management over several years. During the biennium covered by the 12th General Programme of Work, WHO sought to build an integrated approach centred around a Programme Budget with a single system for tracking resources, outputs and – where possible – outcomes. The system is integrated across all three levels of WHO's work: corporate, regional and country. It was rolled out with detailed guidance on results frameworks and indicators, including baselines and validation of data, with appropriate training and managerial support. Consequently, in 2018, WHO was

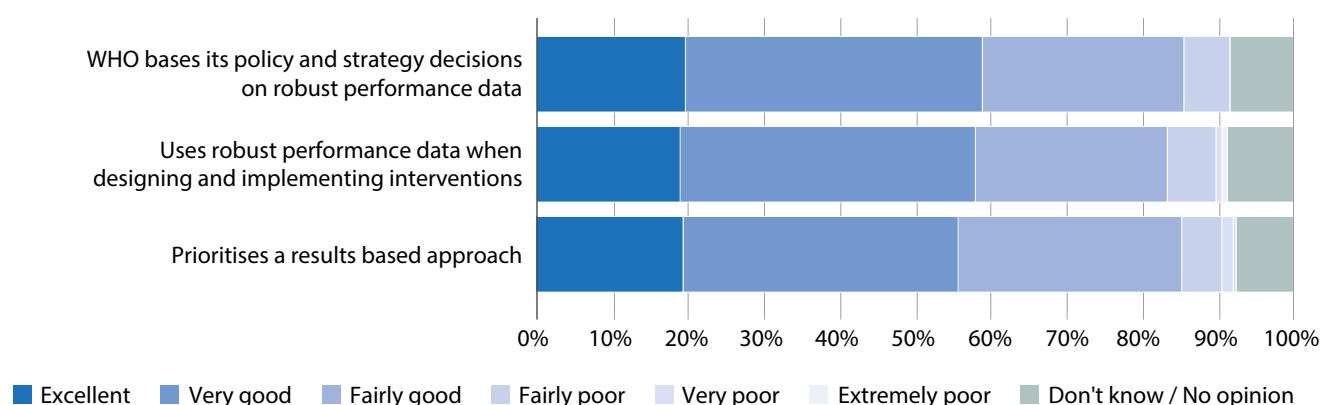
able to present a new Results Report to the WHA showing the principal achievements and the key information on how resources are used in each main category and programme area, backed up by a detailed set of indicators on results which were used for this MOPAN assessment.

Demonstrating the WHO Secretariat's contribution to results remains challenging due to issues of reasonable measurement of contribution and attribution of work in partnerships. The overall effort by WHO to build RBM into its work represents important progress and provides an impressively comprehensive picture of a rather wide range of complex roles. But, much more remains to be done in order to link contribution to the achievement of national and global health goals. Measuring results in the global health system is very difficult, and WHO achieves its results in partnership with member states and many other players. Independent evaluations highlight the inherent challenges of demonstrating a full results chain for WHO's work in practice, given its role within a complex global health system. For example, the evaluation of WHO's contribution on the MDGs found that it was possible to document achievements but not to show the Secretariat's contribution or to frame expected outcomes so that they could be monitored in a credible way. Management's own assessment of WHO systems recognised that existing tools and that approaches already in place provide "a good basis" for assessing results, but that stronger integration is also required.

The Director-General and leadership team are clearly aware of the challenges and importance for WHO of showing results in a credible way and building on the progress made. They are now seeking to take RBM to the next level. The WHO Results Report states their ambition to "move from a focus on outputs to a much sharper focus on outcomes and impact". In interviews, senior officials described how WHO needs to be bolder in reporting the contributions it achieves. The new programme of work agreed by the World Health Assembly in May 2018, GPW13, therefore has a strong theme of impact and seeks to articulate how the organisation will further develop its approach to results. It is very clearly about focusing WHO on the impact it achieves at country level, with the ambitious and clear set of "triple billion goals".

The impact approach raises further challenges around data and measurement. The RBM system is therefore in a transition phase and work is underway to develop it further. While this is still at a relatively early stage, and much too early to assess, it is already clear that successful implementation will place considerable demands on the data and methods WHO has available to measure its results. Currently the programme areas generate data in a timely way in a single integrated system, but this is organised around category and programme areas and many of the indicators are outputs at programme level. Shifting to presenting results as outcomes for beneficiaries at country level, as required for the new approach set out in GPW13, is aligned to global good practice but will be technically and practically difficult. As already noted, WHO does not achieve results on its own, but it does so in partnership with the member states who actually drive most of the relevant work themselves.

Figure 6: Survey response – RESULTS-BASED MANAGEMENT



Challenges around the quality of data and measurement are being met with a co-ordinated response and positive engagement by staff. WHO is fully aware of these challenges and is taking them seriously with an organisation-wide effort to build new approaches and overcome the technical hurdles, for example through its work on the new impact framework; WHO is also commissioning an Expert Working Group to provide high-level technical advice on how to measure impact and results. The level of ambition and focus coming from the top on this is quite evident, and interviews conducted for this assessment suggest that staff are engaging positively at different levels including in country offices. However as technical experts, many are also well aware of the challenges involved in attributing impact of changes in health outcomes to one organisation within a complex global system.

KPI 8: The organisation applies evidence-based planning and programming.

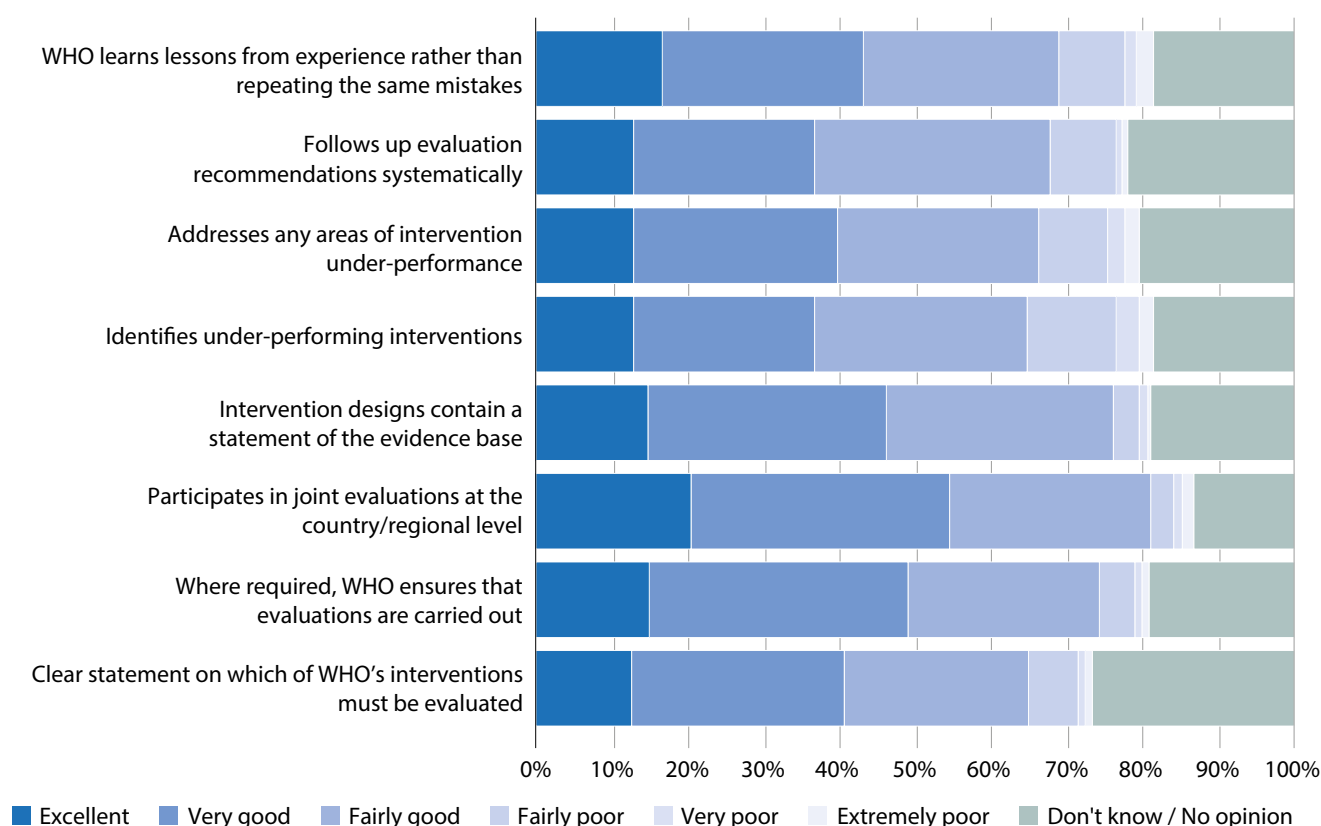
This KPI focuses on the evaluation function, its positioning within WHO's structures, attention to quality, accountability and putting learning into practice.

WHO has taken a series of important steps to strengthen its evaluation function. The first WHO evaluation policy was instituted in 2012; then, as the evaluation of WHO reform noted, significant progress was made with the creation of an independent evaluation office in 2014 and a direct reporting line to the Office of the Director-General, though not to the Executive Board. The policy and the subsequent Framework for Strengthening Organisational Learning and Evaluation were instrumental in guiding evaluative work in WHO, including regular reporting to the Executive Board on the work programme and on completed evaluations. More recently, an independent review in 2017 made recommendations on critical areas to strengthen evaluation further, and there has been active follow-up. The new updated evaluation policy, agreed in May 2018, directly addresses issues raised in the review and adds provisions to reinforce independence, including term limits and the process for engaging when the head of evaluation is appointed.

The central evaluation unit is doing commendable work but is stretched. The new policy provides clarity on budgetary independence and refers to UNEG benchmarks for adequate resourcing for evaluation. This is still a challenge. Although core funds are provided to cover priority corporate evaluations, there are important gaps in resourcing. The evaluation office is much smaller than in other large UN agencies and has to prioritise tightly, so it is not always able to cover its full range of intended functions in depth.

The culture of evaluation is still developing. The process of building a culture of evaluation takes time and starts at the top – in WHO there is indeed clarity at central level. For example, WHO has a clear evaluation plan which is agreed by the Executive Board and discussed with them and the Independent Expert Oversight Committee. On the other hand, awareness of WHO's evaluation policy has not yet permeated fully throughout the organisation; in that sense a culture of evaluation is still emerging and would need a strong further push to reach the country level, led by the evaluation office and senior management. It appears that coverage of evaluation is significantly stronger at corporate level than at the decentralised level, which is not untypical for large development organisations but is a key issue for WHO given how it works. There is a long-standing tradition of evaluation in some WHO regions such as the Americas, but the staff in country offices interviewed as part of the MOPAN assessment did not show a high level of awareness of evaluation and some confused it with audit. WHO has developed a number of tools to support evaluation, including a handbook and guidance, a learning strategy and online learning modules.

Quality is better for centralised evaluations but not yet tracked at every level. Centralised/corporate evaluations, presented to the Executive Board, are high quality, relevant and credible and have fed into decision-making. On the other hand, systems for checking the quality of evaluations across the organisation including at regional and country level are still developing.

Figure 7: Survey response – IMPLEMENTATION AND USE OF EVALUATIONS

Feedback loops have been strengthened in some areas. For major policies and strategies, a feedback loop for evaluation exists, and findings are fed back to the Executive Board annually. There have been in-depth, influential and relevant evaluations of the WHO reforms and of health emergencies and many other key strategic areas (e.g. staff mobility). In health emergencies, change in response to learning lessons has been fundamental and highly visible and has been followed up with external scrutiny by the Independent Expert Oversight Advisory Committee. Limited evidence was found on systems intended to identify and track poorly performing interventions at the aggregate level. On the other hand, the arrangements for follow-up on evaluation recommendations in WHO are fairly clear and, as noted above, the accountability has recently been strengthened in the new evaluation policy (2018).

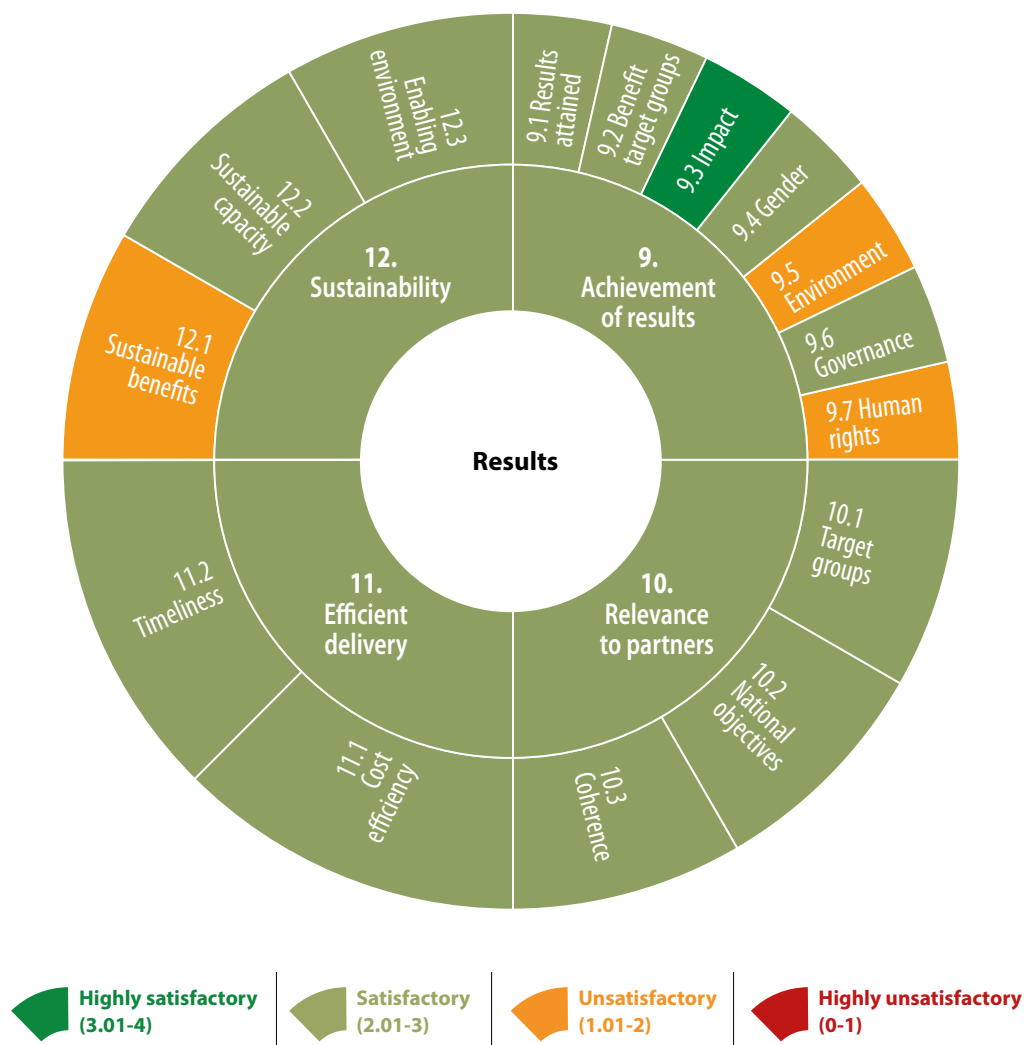
No clear requirement for checking how evidence is used in design. It is not clear what requirement is in place in WHO to demonstrate how lessons have been taken into account when new interventions are being designed, or if this is being tracked. WHO has recently provided additional clarity on responsibility for follow-up on evaluation recommendations – this rests with the management and is led by the Director-General's office.

There was no specific evidence of incentives to apply lessons in designing new interventions, nor was it clear where organisational learning sits within WHO. Indeed, in the past, organisational learning has been mixed with evaluation to some degree. While previous reform efforts have resulted in the development of a learning framework, WHO has not been able to implement this within a clearly articulated overall strategy. Meetings with Assistant Directors-General in the follow-up to the headquarters visit confirmed that this issue is now on the radar of senior management.

2.2. DEVELOPMENT EFFECTIVENESS

PERFORMANCE AREA: RESULTS

Achievement of relevant, inclusive and sustainable contributions to humanitarian and development results in an efficient way.



As shown in its 2018 Results Report to the World Health Assembly, WHO has delivered important results in a wide range of targeted areas which are relevant and inclusive. Its own comprehensive system of performance indicators shows satisfactory progress on most targeted objectives, such as tackling diseases, supporting health at key stages of the life cycle and addressing the determinants of ill health. Health emergencies is a highly scrutinised area. The progress made since the Ebola crisis is clear both in the indicators and the independent assessment by the expert committee on health emergencies. One of the large areas of WHO's work, with many indicators, is health systems. Its expertise on policy and on system and capacity building means that sustainability and long-term results are inherently a strong focus. Cross-cutting work is also generally strong, particularly on gender equality. The results indicators are harder to relate to the specific cross-cutting areas of human rights and environmental sustainability. It is also less clear how WHO ensures that results are delivered in an efficient way, except for example in the clear improvements in timely response on emergencies. The new WHO leadership is giving attention to the efficient delivery of results, and a new value-for-money strategy is currently being developed.

KPI 9: Development and humanitarian objectives are achieved, and results contribute to normative and cross-cutting goals.

This KPI examines the nature and scale of the results WHO is achieving against the targets it sets and its expectations on making a difference.

Overall, WHO has a comprehensive system to assess results which shows that with the majority of indicators the organisation has a satisfactory level of achievement or is on track. As already noted, WHO has put in place a comprehensive system to provide a detailed measurement its results, while at the same time working towards being able to measure impact. In its Results Report for 2016-17, WHO summarised the results it has achieved during the latest biennium, and more detailed data and indicators are published in the Programme Budget portal.

Analysis by the MOPAN assessment team found that WHO was achieving or mostly achieving its targets in about two-thirds of the 150 indicators for which data were available, which is a satisfactory level overall. The first key results area of the MOPAN assessment framework is development outcomes, and about a third of the WHO indicators appear to be most directly relevant to this. WHO was achieving its targets in about 60% of indicators for which data are available, which is broadly satisfactory allowing for the measurement challenges in this area.

Significant progress on health emergencies since the Ebola crisis is bringing “speed and predictability” in how WHO responds. The Results Report and data show some notable successes and progress on the health emergencies programme, where WHO helps countries to build their capacity to prepare, prevent, detect and respond to crisis situations and potential outbreaks of disease. Results against WHO’s targets in this area were consistently high, for example 89% of rapid response teams from the WHO health emergencies programme were deployed within 72 hours (compared with a target of 75%). The report of the Independent Oversight and Advisory Committee commended the important progress made in the area of emergency response since mid-2017 and noted that a suitable foundation has been laid for making WHO fit for purpose on emergencies. The committee also reported that while considerable progress is still needed, the WHE has brought speed and predictability to WHO’s work on emergencies and put in place the basic structures and systems to guard against the sort of catastrophic failure that occurred with the Ebola outbreak.⁷

WHO has played an important role globally in tackling a wide range of communicable and non-communicable diseases and in improving health. One of the most widely known examples is the work to eradicate polio, which is in the final phase. Almost 1 billion cases of malaria have been averted since 2000, and 80.3 million people have been diagnosed and successfully treated for tuberculosis since the adoption of the WHO strategy. Another key achievement noted in the WHO Results Report is a 9% reduction in the prevalence of tobacco use for persons aged 15 and over between 2010 and 2016. Meanwhile, the proportion of households without access to improved sanitation was reduced to 23.8%, compared with a target of 30% and a baseline of 32%.

A major part of WHO’s work supports countries to build capacity of health systems, with the ultimate aim of strengthening universal health coverage. Nearly half of WHO’s results indicators relate to work which is about building systems and capacity, and about two-thirds are fully or mostly achieved and on track, which is a satisfactory result. This includes some highly satisfactory work in key health agreements at the global level and in support at the national level, of which there are many examples. WHO aided with the development of the Global Strategy on Human

7. Another key aspect of WHO’s role in relation to health emergencies is to co-ordinate research during an outbreak. The report of the Interim Ebola Assessment Panel (July 2015) noted that WHO had played a critical role in the Ebola crisis with its research and development (R&D) work, despite the erosion of core funding and continued inadequate funding for R&D for neglected diseases. The report recommended that WHO play a central convening role in R&D efforts in future emergencies, including accelerating the development of appropriate diagnostics, vaccines, therapeutics, and medical and information technology. WHO’s work on developing the R&D blueprint since 2016 has followed.

Resources for Health: Workforce 2030, which sets out a strategic vision for attaining universal health coverage and the Sustainable Development Goals. In addition, WHO contributed to the agreement by the global health community of 100 indicators to track health trends and situations for global standards on health data. WHO helped 82 countries put in place policies, financing and human resources to increase access to integrated, people-centred health services. WHO also supported 69 countries in improving access to, and rational use of, safe, efficacious and quality medicines and other health technologies. One hundred forty-six countries are now incorporating the fight against non-communicable diseases in their national development agenda, including in United Nations Development Assistance Frameworks.

Progress on polio has been much more difficult to sustain, according to the latest figures. In its report for 2018, the polio Independent Monitoring Board noted that the total number of wild poliovirus cases globally has increased (Box 4).

Cross-cutting work is satisfactory in most areas including on gender equality and the empowerment of women as part of a healthy life course approach. This includes WHO's work on reducing maternal mortality – for example in promoting the availability of skilled birth attendants; in 2017 with WHO support, 80% of deliveries were attended by a skilled birth attendant. This is both part of a broader approach WHO takes to promote a healthy life course and part of the roadmap to achieving the SDGs through its leadership role in the Global Strategy for Women's, Children's and Adolescents' Health.

Seventeen WHO programme areas have integrated gender equality, equity and human rights (compared with a baseline of 10 and a target of 15). Of the 22 indicators directly relevant to gender, about two-thirds were fully or mostly achieved or on track. For example, WHO helped 61 countries set targets for ending preventable maternal and neonatal deaths by 2030 (compared with a baseline of 48 countries and a target of 50). As WHO's Results Report notes, 30 million more women are using modern contraceptives since 2012, in countries with the greatest unmet family planning needs.

With its expertise on health systems, WHO makes a substantial contribution to help improve good governance of health systems. About 75% of indicators relevant to governance were achieved or mostly achieved. WHO plays an active role in supporting partnerships and implementation of policies, strategies and plans. This includes encouraging alignment with the SDGs and acting "as a broker among partners and to support the government in effectively co-ordinating the health sector". The WHO's co-ordination role in countries is also increasing. Around 60 indicators are directly relevant to this area and about two-thirds were achieved, mostly achieved or on track. For example, 47 countries were enabled to monitor the progress of their national health policy, strategy or plan during the biennium (compared with a baseline of 0 and a target of 25). Helped by WHO advice and support, 158 countries have a food safety system with an appropriate legal framework and enforcement structure (compared with a baseline of 136 and a target of 148).

WHO plays a strong leadership role on environmental health. Increasing environmental awareness is a major part of how WHO supports countries and works globally to improve health. It has drawn global attention to the importance of environmental health risks through international assessments and a leadership role in areas such as the BreatheLife campaign. One achievement noted in the WHO Results Report is a drop of more than 10% in air pollution in one-third of monitored cities in low- and middle-income countries and almost half of monitored cities in high-income countries in the five-year period 2008-14. Another important area is clean water – 46 countries have adopted legislation in line with WHO guidelines on safe drinking water. WHO's leadership is clearly significant on international agreements in support of environmental health and global conferences, such as the Minamata Convention on Mercury which came into force in May 2017 and the Second Global Conference on Health and Climate in 2016.

WHO has relatively fewer results indicators on the environment and climate change. In its 2016-17 progress indicators available on its Programme Budget portal, which underpin the latest published WHO Results Report, WHO provides progress on 9 results indicators for environmental health, 3 of which are outcome based. Few of the 2016-17 indicators relate specifically to climate change, which is perhaps not surprising since WHO's mandate is to focus more on health and the environment. For 2018-19, WHO has 11 outcome-based indicators. One such indicator showed that WHO supported 42 countries in developing health adaptation plans for climate change (compared with a baseline of 28 and a target of 40).

Another cross-cutting area which seems to have had less attention from WHO in its results framework is on human rights. This may be because it tends to be bundled together with related issues of gender, equity and health, whereas in other UN agencies it might be addressed separately in a more clearly identifiable way.

KPI 10: Interventions are relevant to the needs and priorities of partner countries and beneficiaries, and the organisation works towards results in areas within its mandate.

This KPI centres on the relevance of WHO's engagement given the needs and priorities of its partner countries and its results focus.

Needs of different groups are targeted through the life course approach, addressing different types of health needs and by disease area. Much of the WHO work already described above, as well as the results achieved in relation to health outcomes and cross-cutting areas, is targeted at specific groups, particularly when considered by health needs and disease type. As explained in the Results Report, one of the ways that WHO works is through the healthy life course approach, which recognises the specific health concerns of different stages of life: early childhood development, women's health during and beyond reproduction, adolescence, and healthy ageing. The approach also aims to identify the social, economic and environmental factors that impact health and lead to inequitable health outcomes, with the overall goal of promoting health equity, human rights and gender equality.

Over the past few decades, there have been major achievements by countries and the global health community in reducing maternal and child mortality, and WHO has been part of this effort. Between 1990 and 2015, the maternal mortality ratio fell from 385 to 216 per 100 000 live births and the under-5 mortality rate fell by more than half, from 93 to 41. Key achievements in specific areas where WHO works include, for example, that 81% of emergency-affected populations have received one or more basic health services. One billion people were protected from treatable neglected tropical diseases by receiving 1.5 billion treatments in 2017.

Support to health policies at national level through member states is a key channel by which WHO targets the needs of beneficiaries. These achievements are led and delivered, of course, mainly by WHO's member states, rather than by WHO on its own. Its role in supporting national health policies has already been referred to, and many of the indicators in the WHO results framework cover this. For example, between 2013 and 2018, WHO aided 142 countries in creating or updating a comprehensive national health sector policy, strategy or plan with goals and targets (compared with a baseline of 103 and a target of 115). WHO supported 82 countries to develop and implement strategies for improving patient safety and the quality of health services. It also helped 63 countries to strengthen and expand their implementation of population-based policy measures to reduce the harmful use of alcohol.

Targeting responses to specific health problems is part of how WHO delivers results. Delivery of results as part of a coherent response is reflected in the way WHO reacts to health emergencies and in how it responds to specific diseases and health problems. Major achievements include progress on tackling malaria, HIV/AIDS, hepatitis, tuberculosis and polio. The results portal data show, for example, that 89% of confirmed malaria cases in the public sector receive first-line antimalarial treatment according to national policy and that 20 focus countries have national action plans for viral hepatitis prevention and control that are in line with the global hepatitis strategy.

KPI 11: Results are delivered efficiently.

This KPI looks at the extent to which WHO is meeting its own aims and standards on delivering results efficiently.

A significant number of WHO's performance indicators in the existing results frameworks relate to efficiency – both resource/cost efficiency and delivering on time – and, taken together, show a satisfactory performance overall. The improvement in WHO's indicators on health emergency response underpins a highly satisfactory performance in the area of timely implementation; these indicators relate to the 2016-17 biennium. More recently, WHO has also clearly recognised that it can strengthen its approach to resource/cost efficiency through its new Value for Money strategy, which is part of GPW13.

WHO began implementing a new Value for Money strategy in 2018. This strategy is perhaps reflected in the recognition of the need to do better and the attention which the new leadership team is giving to this issue in the GPW13 process and planning. The Director-General's 2018 report, *WHO Reform, Better Value, Better Health: Strategy and Implementation Plan for Value for Money in WHO*, states, "Although WHO already has some value-for-money processes, they are not applied uniformly or systematically, and are not always well documented or appropriately evaluated."

WHO has translated the key dimensions of value for money into a framework for action for the organisation to build on through the following: (i) global strategic priority-setting; ii) programme design and implementation with a focus at the country level; and iii) leadership and enabling functions. The framework's key areas and objectives are to ensure that value-for-money principles guide WHO's priority setting; encourage cross-sectoral work and reduce fragmentation; establish strong value propositions at intervention/programme inception, implementation and reporting; ensure and demonstrate that value for money is embedded in WHO policies and business rules; and manage cultural change in WHO.

WHO's main successes relate to greater timeliness of emergency response. In the WHO Programme Budget portal, various indicators are directly or indirectly relevant to efficient delivery. Twenty-six indicators were found to have at least some linkage to resource/cost efficiency, and most of these were being achieved or on track. However, this does not provide a very solid basis for assessing information, since the linkages are quite weak or the indicators are more about process than results. The main successes were in the area of timely response, where the progress noted by the Independent Expert Oversight Committee following the Ebola crisis has already been mentioned. Another example is that 86% of all graded emergencies which activate an Incident Management System at country level have a response within 72 hours.

KPI 12: Results are sustainable.

This KPI looks at the degree to which WHO successfully delivers results that are sustainable in the longer term.

Much of WHO's work is naturally well-oriented towards delivering long-term, sustainable results. The organisation is helping to eradicate major diseases, increasing sustainable health financing and promoting universal health coverage. WHO also works at country level to support building capacity and systems and to improve the enabling environment for response in key areas such as managing health emergencies.

A large share of WHO's results indicators are relevant for sustainable results, and the majority are being achieved or are on track. One dimension of this covered by the MOPAN assessment framework is benefits continuing or likely to continue after the intervention is completed. Around one-third of indicators in WHO's Programme Budget portal were found to be relevant to this key performance indicator, and about two-thirds are fully achieved, mostly achieved or on track. Examples of relevant results include eliminating polio worldwide, which is in its final phase

(albeit facing challenges, as noted in Box 4, in the three remaining countries), eliminating measles in the Americas, helping countries to end preventable maternal and neonatal deaths, and supporting the process of meeting unmet needs in family planning. On the other hand, the assessment also found that the evaluation evidence on sustainability of results is weak, and on balance this led to an unsatisfactory rating in this element of KPI 12.

Other aspects of sustainability include building institutional capacity and strengthening the enabling environment. A similarly large share (numbering 50-60) of WHO results indicators are relevant to these areas, and more than two-thirds are being achieved or on track. WHO has helped countries to build capacity around emergency response. Health situation assessment and trends were analysed in 37 countries in 2016-17, in addition to the 82 countries WHO had already helped, providing important data and evidence for policy making.



3. OVERALL PERFORMANCE OF WHO

Chapter 3. Overall performance of WHO

The performance conclusions first consider four key attributes of an effective organisation: (1) whether it understands future needs and demands; (2) whether it is organised and makes use of its assets and comparative advantages; (3) whether it has mandate-oriented systems, planning and operations; and (4) whether it makes consistent developments according to its resource level and operational context.

Then, the journey of the organisation is mapped against MOPAN's previous assessment of WHO.

Lastly, the assessment report presents the key findings: the observed strengths and areas for improvement.

3.1. CURRENT STANDING AGAINST THE REQUIREMENTS OF AN EFFECTIVE ORGANISATION

Is WHO future facing?

WHO presents itself as an increasingly reflective organisation. It is mindful of its global role in a rapidly changing world and is aware of its organisational responsibility to meet evolving demands on its normative, technical and emergencies work. WHO is capable of organisational change to ensure that previous experience and learning allow it to maintain relevance for today's and tomorrow's world.

The new Director-General has set out a clear vision, backed by a new senior team, and enjoys a strong mandate and support for his approach to engagement. An ambitious new strategy – the 13th General Programme of Work (GPW13) – and transformation agenda continue the necessary reforms of the organisation, step up the pace of change on WHO's performance journey and focus on results at country level. They integrate and build on the previous reform agenda, which made progress in key areas such as bringing WHO forward on an integrated approach to management (Global Policy Group), internal controls, evaluation and transparency, and integrating the programme budgeting and results system.

Considering the demands that WHO faces presently and those anticipated in the future, the main feature of GPW13 is a clear acceleration towards focusing on results and impact at country level. GPW13 addresses how this focus benefits countries and joins up across WHO's traditional programme areas (disease areas, health systems, emergency preparedness and response, and normative work). GPW13 sets new ambitious goals of "triple billion" in line with Sustainable Development Goals.

GPW13 appears to have built ownership rapidly. This is thanks to the dynamic and externally-focused approach of the Director-General and the well-considered approach to leading change internally. Recently approved by World Health Assembly with strong support across different levels, including member states, the strategic development process undertook well-considered consultation at regional and country levels.

Through successive periods, WHO has demonstrated high levels of strategic alignment with global development goals. It aligned to the Millennium Development Goals in the 12th General Work Programme (GPW12) and, through GPW13, rooted its work in substantively improving health outcomes consistent with the 2030 Agenda for Sustainable Development. The foundation of WHO's work is SDG 3: ensuring healthy lives and promoting well-being for all at all ages. Through its commitment to achieving this goal, WHO has embarked on a transformative agenda aimed at supporting countries to reach all health-related SDG targets.

Where WHO's response to the demands placed on it have been assessed as falling short of expectations, WHO has undertaken extensive and rapid reform. As an example, the complete redesign and reconfiguration of its emergency preparedness and response programme (WHO Health Emergencies Programme) present an illustrative case. These have

resulted in greater levels of responsiveness and relevance and helped to rebuild WHO's credibility following criticism of its response to the Ebola outbreak. The Independent Oversight and Advisory Committee has played an important role here. Reforms are however on-going and it is too early to assess the full effectiveness of implementation.

This assessment comes at a significant point of transition. The perennial presence of significant organisational change is pronounced. While it has been over 70 years since the founding of WHO, the pace and scale of reform and change over the past 15 years, and particularly since 2009, have accelerated significantly as WHO seeks to remain fit for purpose. External, independent evaluation notes the presence of "change fatigue" among staff. While senior leaders and member states clearly demonstrate an appetite and dynamic drive for the next phase of organisational change, some staff expressed a need to "pause and take stock" and "let the recent reforms bed-in properly". Staff are highly committed to their work. However, they will need to find the balance between maintaining sufficiently constant systems, structures and processes to allow important work to get done, on one hand, and simultaneously nudging and in some instances making a step change in working behaviours. This will be a delicate change management task.

To improve the relevance and impact of its global agenda, WHO intends to "supercharge" its normative work. This includes taking reasonable credit more visibly for its important work on public goods, convening, and leadership around the health SDGs and health systems, alongside its strong global and country-level partners.

Securing sufficient and sustainable financing remains problematic, with the proportion of earmarked funds increasing year on year compounding the challenge. WHO has set out its ambition to seek good-quality, multiyear funding with greater flexibility in its GPW13, with an expectation that the focus on demonstrating impact will strengthen the case for investing resources over and above the assessed contributions. WHO embarked on a financing campaign in 2018, launching a number of integrated approaches to securing investment funding linked to the projected impact of its work. Greater flexibility in funding will be crucial to shift resources (financial and human) within WHO to align with the GPW13 goals and to support country-level results. However, WHO has not yet succeeded in significantly diversifying its donor base, with 76% of voluntary contributions paid by 20 contributors in 2016-2017. In addition, the 3 000 donor agreements presents a significant administrative and reporting burden on the organisation, besides placing constraints on addressing priority issues.

Is WHO making best use of what it has?

WHO has many recognised strengths in terms of its technical expertise and engagement at country level and has an established role on global public goods. Its normative work is central to the SDG agenda. As a trusted partner of health ministries, WHO is well respected for its technical work and convening role and is able to draw in expertise through its many partnerships.

Across all levels of the organisation, much of WHO's delivery approach is actively based around partnerships, synergies and leverage. WHO continues to develop and refine a stronger articulation of its comparative advantages in the complex global health environment and increasingly gears its programming and collaborative working to this. An example is the Global Strategy for Women's, Children's and Adolescents' Health and the related partnerships and platforms whereby WHO's and other stakeholders' roles are clearly identified and monitored. Understanding and articulating its comparative advantage constitute an important element of WHO's overall approach to partnerships. The Framework of Engagement with Non-State Actors (FENSA) provides a clear framework and mechanism for defining and guiding WHO's engagement with non-state actors and managing reputational risk. It is however in a too early stage of implementation to assess its effectiveness.

At the same time, WHO is resetting and repositioning its role in key partnerships. Without the same level of resources as key multilateral partners, WHO's contribution is sometimes less visible, even if important. Given WHO's financial constraints relative to key multilateral partners, it is, by default, better able to bring expertise, leadership, data,

knowledge and networks to the table than the financial resources that others can provide. WHO is hence in the process of reviewing the effectiveness of its partnerships across its portfolio and seeking to exert appropriate influence within their parameters, in relation to its comparative advantage.

There are acknowledged variances in capacity of country offices; staffing levels and capability at country level are not always adequate to meet needs and expectations. Through ongoing functional reviews, WHO is already moving towards strengthening country offices using re-profiling exercises. To be effective in its intensified focus on results at country level, WHO will need to align the staffing levels of headquarters and regional and country offices and actively address the distribution and development of staff skills and expertise to support the ambitions of GPW13. The implementation of the next stage of the mobility policy presents opportunities here.

WHO is shifting to a more results-orientated budgeting model, most recently applying a costing of results approach for the Programme Budget 2018-19. WHO continues to become more cost-conscious. Recognising the continued risk of rising costs and the adverse financial consequences of exchange rate fluctuations, WHO has made various efficiency savings and improved budgetary discipline.

WHO, considered by some as the “organisation of last resort” for health-related global issues, is also increasingly called on in emerging events or circumstances which may be outside its comparative advantage, but where there are no other agencies to respond. The management of emerging, and sometimes competing, priority demands continues to pull WHO in diverse directions, which causes organisational inefficiencies.

Is WHO a well-oiled machine?

The successive reform and transformation agendas have been designed to improve the effectiveness of WHO. They have made demonstrable progress in strengthening the operating model to meet the requirements of successive General Programmes of Work. Reform and organisational transformation are ongoing.

This assessment found consistency with independent evaluation findings on WHO, highlighting that programmatic priority setting and managerial reforms have yielded significant progress. WHO has well-organised, robust systems for oversight, risk management and fraud detection. WHO has robust internal and external audit functions, with arrangements meeting international standards. It has comprehensive and strong internal control mechanisms, comprising a set of operational and financial safeguards using an organisation-wide common framework and harmonisation of risk management practices. Progress of audit work is routinely tracked and monitored. An innovative integrity hotline provides a safe and independent mechanism to report any concerns.

With adoption of the comprehensive risk management policy in late 2015, risk management is now firmly embedded into operational planning and is more consistently built into work plans, ensuring that risks and risk mitigation measures are identified and enacted. Managing resourcing risks related to redeploying staff towards different areas of work based on the evolution of the current polio programme and the realities of implementing the strategic transition action plan will however constitute a test of this capacity. WHO is diligent and active in protecting its reputational asset and is very serious about not compromising or negatively influencing its normative function. Fulfilling its normative role requires the organisation to be able to (and to be seen to) provide credible, independent and expert advice. This in turn depends on protecting its reputation and ensuring that, for example, it is not subject to conflicts of interest and undue influence in the way it interacts with partners or receives funding of specific programmes. WHO's risk management and approval processes in managing donor grants, for example around FENSA, are part of how it achieves this.

Human resources systems and policies are increasingly performance-based and geared to results. Notable achievements include the development and voluntary piloting of a geographical mobility policy; a harmonised selection process for longer-term positions in the professional and higher-level categories; a new internal assessment process for candidates

for positions as heads of WHO offices; a Performance Management and Development Framework; an enhanced WHO Global Competency Model; and a Corporate Framework for Learning and Development.

Allied to a clear relevant vision and aligned to global development goals, WHO has a more clearly prioritised operational planning process anchored to national health priorities. It uses these as the starting point to develop Country Cooperation Strategies (CCSs). Significant headway has been made in the approach to planning and prioritising activities based on country needs, with extensive stakeholder consultations actively undertaken early and throughout the CCS development process to strengthen relevance and effectiveness at country level.

Is WHO making a difference?

The new Results Report, presented to the World Health Assembly in May 2018, provides the first overall picture of what WHO is achieving in a clear, aggregated way and as a step towards results at outcome level. As shown in the Results Report, WHO has delivered important results in a wide range of targeted areas that are relevant and inclusive. Its own comprehensive system of performance indicators shows satisfactory progress on most targeted objectives including tackling diseases, supporting health at key stages of the life cycle and addressing the determinants of ill health. Health emergencies is a highly scrutinised area. The progress made since the Ebola crisis is clear in both the indicators and the independent assessment by the expert committee on health emergencies.

One of the large areas of WHO's work, with many indicators, is health systems. WHO's expertise on policy, system and capacity building means that sustainability and long-term results are inherently a strong focus. Cross-cutting work is also generally strong, particularly on gender. The results indicators are harder to relate to the specific cross-cutting areas of human rights and environmental sustainability. It is also less clear how WHO ensures that results are delivered in an efficient way, except, for example, in the clear improvements in timely response on emergencies. On the question of efficient delivery of results, it is worth noting the attention given to this by the new WHO leadership and that a new value-for-money strategy is currently being rolled out.

WHO has shown strong commitment to building its approach to results-based management and has implemented an integrated system to track what it achieves. There has been substantial evolution in the approach WHO has taken; the implementation of a well-developed system created for GPW12 represents an important achievement that brings together WHO's many areas of work in an integrated, bottom-up approach to programme budgeting. WHO has made good progress in tracking outputs and some aspects of outcomes across the 37 programme areas. The new WHO leadership has set out an ambitious vision to take results-based management to the next level, focusing on outcomes at country level and the new "triple billion goals". This fits well with the SDGs and WHO's strategy to "be bolder" in showing what it achieves, but there are significant technical challenges to overcome.

There has been good progress on WHO's evaluation work, and the latest step in this evolution is the recently agreed evaluation policy. This responds constructively to the peer review, for example in specific provisions on independence and management responses. Further clarity on where organisational learning sits within WHO would be useful.

3.2. PERFORMANCE JOURNEY

Comparison with previous assessments

In 2011, WHO initiated a far-reaching **reform** agenda to improve its overall performance and accountability in order to address the changing public health needs of the population. In 2018, the organisation continues this drive for improvement through an ambitious **transformation** agenda, linked to GPW13. While both have, or are planned to have, a marked change on the organisation, the drivers for change appear quite different. While external drivers seem to have catalysed the reform agenda, WHO's current transformation agenda appears to be much more internally driven and owned.

The current assessment finds an organisation that has independently evaluated and built on these reform initiatives, addressing areas for improvement from the 2013 MOPAN assessment along the way. WHO's increasing ability to act on lessons learned, sometimes publicly learned, has allowed it to re-establish its role in directing and co-ordinating international health within the United Nations System. WHO has explicitly used learning from its evaluations and from successive MOPAN assessments.

Progress has been made in a number of the areas identified for attention in the 2013 MOPAN assessment. Specifically, there has been a substantial evolution in WHO's results-based management approach, with a well-developed system created for GPW12. WHO now needs to take the next step to support GPW13. Evaluation has likewise moved forward, and the central evaluation unit is well placed to make further improvements in key areas provided resourcing is realistically allocated. WHO's new evaluation policy shows a positive and visible step up to the next level, building on the peer review and previous work over several years to create and strengthen the function. WHO has demonstrated how lessons learned and good practices are transforming the organisation's programming; for example, a re-shaped operating model of the emergencies programme (WHO Health Emergencies Programme [WHE]) enables much greater levels of responsiveness and relevance. An embedded Country Cooperation Strategy process is in place, resulting in higher levels of alignment with national priorities (e.g. national health strategies and plans) and United Nations Development Assistance Frameworks (UNDAFs); this process has enhanced and integrated planning and prioritising activities based on country need by applying a coherent bottom-up process.

The following tables present the strengths and weaknesses identified in the 2013 MOPAN assessment (Box 5) and in the current 2018 assessment (Boxes 6 and 7). They demonstrate the positive trajectory of change in WHO, while retaining the core values and mandate which maintain WHO's uniqueness. There remain some persistent areas for attention where change has been limited; WHO recognises that in some instances, these are outside WHO's direct span of control. Those other areas identified for attention have emerged as a result of WHO's new strategic direction

Change is the only constant

WHO's improvements in organisational and results effectiveness show positive change since MOPAN 2013, and there has been much progress across the performance areas. Nonetheless, the advent of GPW13, and the significant transformational realities behind it, will necessitate further important changes to the architecture, operating model and mindset of WHO. The necessary fundamental transformation and organisational shifts will require considerable resources, resolve and political will if they are to be designed, rolled out and embedded before their full impact can be understood. Questions remain about the organisation's ability to absorb such high levels of constant change; "change fatigue" is a very visible indicator of the challenges of managing organisational change, while concurrently having to deliver a global portfolio of normative and technical work.

Box 5: Main strengths and areas for improvement from the MOPAN 2013 assessment

Strengths in 2013

- WHO has an organisation-wide strategy based on a clear mandate.
- The systems and practices in place for external and internal audits are well-detailed and there is evidence that policies are followed. Financial accountability is seen as one of WHO's strengths.
- Procedures are decentralised, and country offices have a certain level of autonomy.
- WHO makes adequate use of country systems and is recognised for ensuring that ODA disbursements are recorded in national budgets and for avoiding parallel implementation structures.
- WHO's stakeholders appreciate the organisation's contributions to policy dialogue and its respect for the views of its partners.

Areas for improvement in 2013

- WHO has taken steps to strengthen its corporate and country focus on results, in particular the quality of its results frameworks and indicators, and its results management practices at the country level. The organisation is in the midst of a major reform process that will be fully implemented in 2014 and should lead to considerable improvements in this area.
- As part of its reform process, WHO will implement a new results-based budgeting system. This is welcome as WHO's reports to its stakeholders do not yet demonstrate the link between budget allocation and expenditures and expected results.
- Even though WHO has an independent evaluation unit, it needs to increase the coverage of evaluations and improve the quality of evaluations conducted. Reforms are underway in this area.
- WHO could improve its reporting on how lessons learned and good practices are transforming the organisation's programming.
- Evidence of the progress that WHO is making towards the contributions to organisation-wide outcomes and country-level goals is limited and unclear.

Box 6: Main strengths identified in the MOPAN 2017-18 assessment

- WHO has a clear long-term vision which informs and drives its strategy and results framework. The transition from GPW12 through an effective strategy development process for GPW13 has been rolled out as an inclusive, participatory and consultative process resulting in high levels of understanding and buy-in reflected across the levels of the organisation.
- Reform efforts have provided a strong foundation for continued institutional development and transformation to support implementation of GPW13. WHO's reform efforts strengthened internal controls and made them more robust; effectively organised category and programme areas; implemented an in-country, bottom-up prioritisation and planning process; strengthened the organisation's ongoing commitment to results-based management and evaluation; achieved significant human resources reform; and reconfigured WHO's emergency preparedness and response programme greater responsiveness and relevance.
- WHO continues to develop and refine a stronger articulation of its comparative advantages in the complex global health environment and increasingly gears its programming and collaborative working to this. Understanding and articulating its comparative advantage constitute an important element of WHO's overall approach to partnerships. In particular, WHO plays a unique role among global health organisations in its mandate to provide independent normative guidance and often provides less-visible work creating the foundation for the work of partners.
- WHO has brought decision making closer to country needs. WHO's schemes of delegation across the levels of the organisation provide clarity on accountability and authority. Annual Accountability Compacts between the Director-General and Assistant Directors-General, and extended Delegations of Authority across the regions and countries, promote increased responsiveness to local conditions by placing decision-making with those closer to the work to be done. WHO has also made significant strides in its planning and prioritising activities based on country need by applying a coherent, bottom-up process. The embedded Country Cooperation Strategy process has resulted in higher levels of alignment with national priorities and UNDAFs.

Box 7: Main areas for improvement identified in the MOPAN 2017-18 assessment

- WHO remains reliant on a small number of major contributors, despite considerable efforts to shift the funding environment. Securing sufficient funding remains problematic, and high levels of earmarked funds remain a challenge to adaptability, flexibility and agility. At the same time, WHO manages a significant number of donor agreements, creating transactional burden on the organisation and hindering the capacity to streamline its focus
- Capacity and capability vary across the levels of the organisation and are not always adequate to meet needs and expectations. To be effective in its intensified focus on results at country level, WHO will need to align the staffing levels of headquarters and regional and country offices. Further attention is required on implementing effective staff geographic mobility. Given the ambitions of GPW13, WHO has the opportunity to capitalise on extensive knowledge, skills and experience through staff rotation and deployment to different levels of the organisation.
- Further progress is needed towards a more integrated approach to external engagement. While WHO has made incremental adjustments to working with partners and mobilising resources, a more fundamental shift in approach and intensified, interconnected efforts are needed to capitalise on WHO's comprehensive portfolio of partners. Evidence highlights that WHO is in the process of resetting and repositioning its role within key partnerships; this should provide the context for more robust relationships with partners based on comparative advantage and more routine monitoring of the partnership effectiveness.⁸
- The ambitions of GPW13 present significant technical challenges around measuring and reporting on results. In line with the increased impact- and outcome-focused approach of GPW13, finalising the frameworks, instruments and tools for accurate and reasonable measurement of WHO's contribution is necessary to ensure staff, stakeholders and reporting systems are clear on what is being tracked and measured.

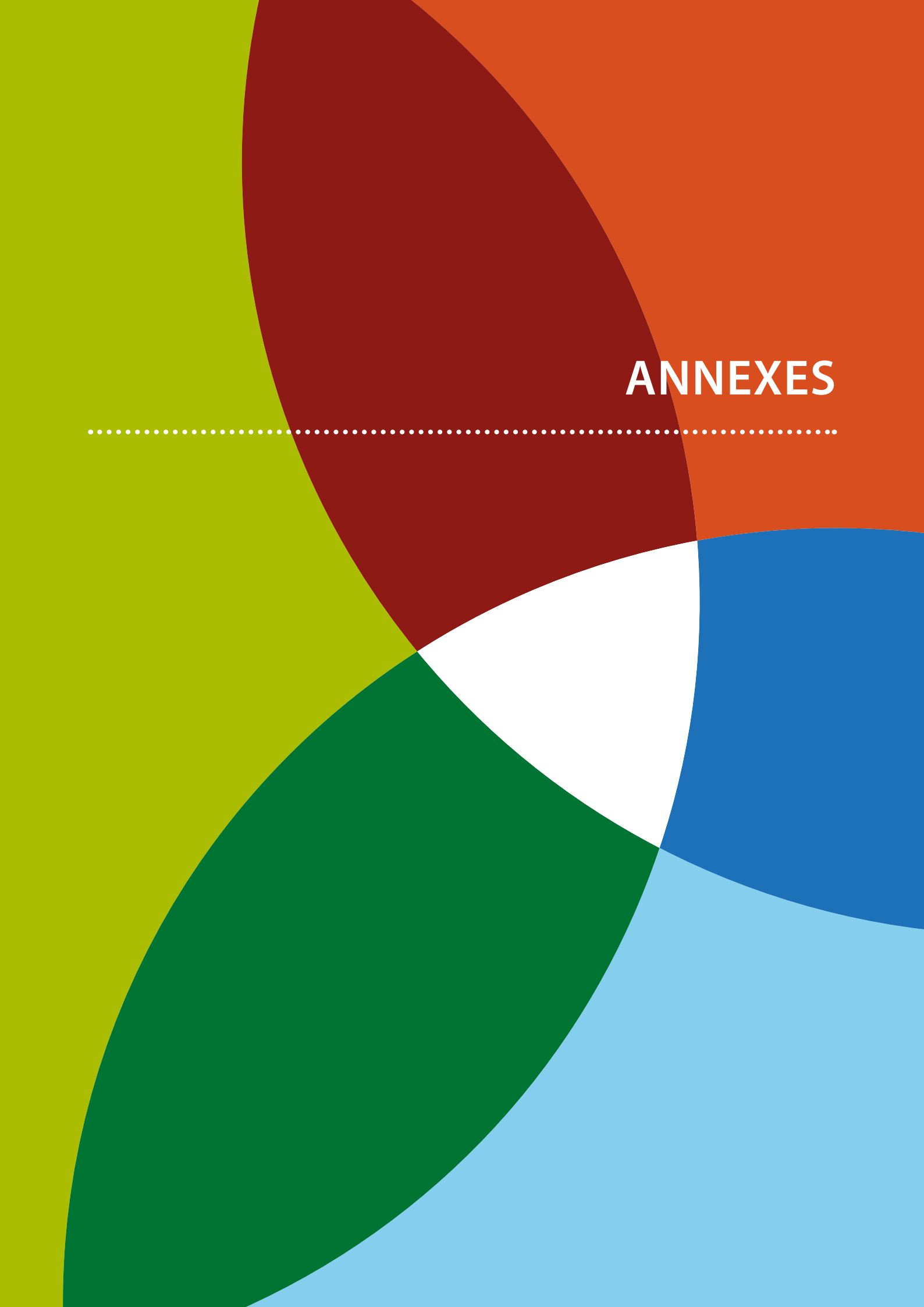
The journey continues

The pace and trajectory of change outlined in the WHO Transformation Plan and Architecture are ambitious, though the case and destination for change are clearly articulated. WHO has sought to carefully examine and learn lessons from past reform to inform this transformation agenda. Intensive steps towards this transformation are already well underway, building on the “deep listening and broad consultation” undertaken during the Director-General's transition. WHO is not alone in determining its success in these areas. In addition to support from its partners, the role of the World Health Assembly in helping to fund and prioritise the most important aspects of this change agenda will be pivotal, and a prerequisite, to sustainable success.

With the approval by the World Health Assembly of GPW13 and the transformation agenda which sits alongside it, a number of “quick wins” and “fast-track initiatives” have been achieved which provide some indication of organisational intent; but it is too soon to tell if these ambitious goals will remain aspirations or will materialise into measurable outcomes and impacts for the countries and people WHO seeks to serve.

WHO has a critical role in leading the changes required to achieve the ambitious goal of health for all as described in the 2030 Agenda for Sustainable Development and the SDG 3 targets and indicators. To play this role, and to better manage the global health threats of the future, WHO needs to be a more effective, thoughtful, respected, results-focused and nimble leader. This applies to its normative, strategic, operational and programme implementation work at global, regional and country levels.

8. At the time this assessment was being carried out, WHO was in the process of developing a new Resource Mobilisation Strategy and implementing engagement strategies for its major partners.



ANNEXES

Annex 1. Evidence table

Methodology for scoring and rating

The approach to scoring and rating under MOPAN 3.0 draws from the OECD *Handbook on Constructing Composite Indicators: Methodology and User Guide* (OECD/EU/JRC, 2008). Each of the MOPAN 3.0 key performance indicators (KPIs) contains a number of micro-indicators (MIs) which vary in number. The MIs, in turn, contain elements representing international best practice; their numbers also vary.

The approach is as follows:

a) Micro-indicator level

Scores ranging from 0 to 4 are assigned per **element**, according to the extent to which an organisation implements the element.

For **KPIs 1-8**, the following criteria frame the scores:

- 4 = Element is fully implemented/implemented in all cases
- 3 = Element is substantially implemented/implemented in the majority of cases
- 2 = Element is partially implemented/implemented in some cases
- 1 = Element is present, but not implemented/implemented in zero cases
- 0 = Element is not present

Taking the average of the constituent elements' scores, a rating is then calculated per MI. The rating scale applied is as follows:

3.01-4	Highly satisfactory
2.01-3	Satisfactory
1.01-2	Unsatisfactory
0.00-1	Highly unsatisfactory

The ratings scale for **KPIs 9-12** applies the same thresholds as for KPIs 1-8, for consistency, but pitches scores to the middle of the threshold value (to guard against skewing in favour of higher ratings).

3.01-4	Highly satisfactory
2.01-3	Satisfactory
1.01-2	Unsatisfactory
0.00-1	Highly unsatisfactory

A score of zero (0) for an element means the assessment team had expected to find evidence but did not find any. A score of zero counts towards the MI score.

A score of “N/E” means “no evidence” 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 equal 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).

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

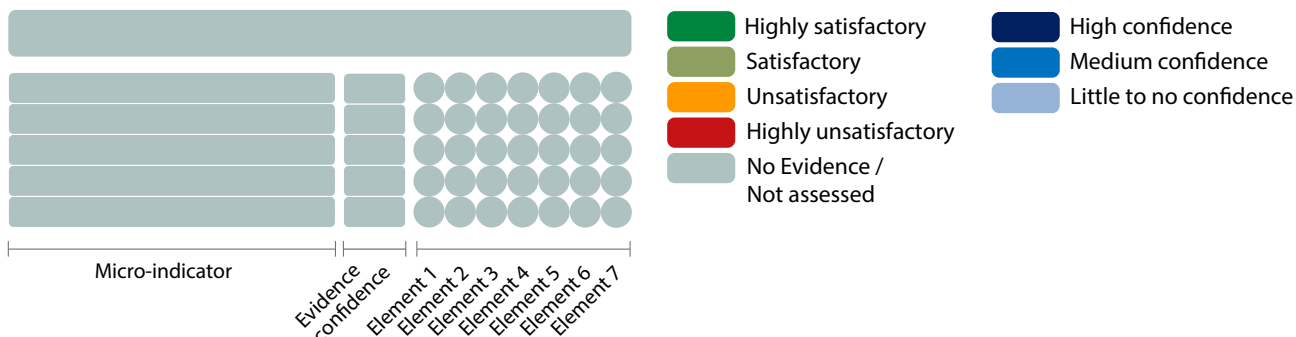
b) Aggregation to the KPI level

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, a rating is then calculated per KPI.

The calculation for KPIs is the same as for the MIs above, namely:

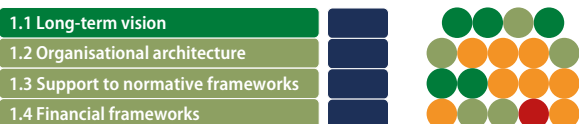
3.01-4	Highly satisfactory
2.01-3	Satisfactory
1.01-2	Unsatisfactory
0.00-1	Highly unsatisfactory

Key



Strategic management

KPI 1: Organisational and financial framework



KPI 2: Structures for cross-cutting issues



Operational management

KPI 3: Relevance and agility

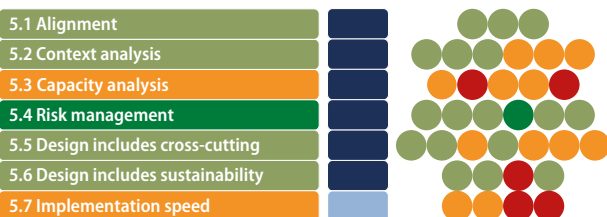


KPI 4: Cost effective and transparent systems

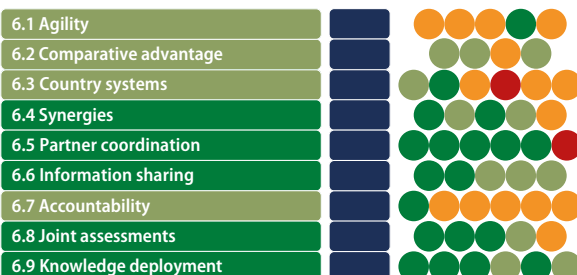


Relationship management

KPI 5: Relevance and agility in partnership



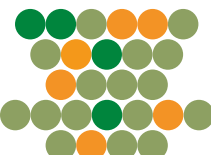
KPI 6: Partnerships and resources



Performance management

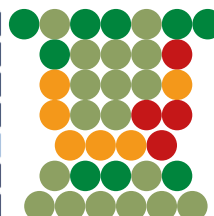
KPI 7: Results focus

7.1 BRM applied		
7.2 RBM in strategies		
7.3 Evidence-based targets		
7.4 Effective monitoring systems		
7.5 Performance data applied		



KPI 8: Evidence-based planning

8.1 Evaluation function		
8.2 Evaluation coverage		
8.3 Evaluation quality		
8.4 Evidence-based design		
8.5 Poor performance tracked		
8.6 Follow-up systems		
8.7 Uptake of lessons		



Results

KPI 9: Achievement of results

9.1 Results deemed attained	
9.2 Benefits for target groups	
9.3 Policy/capacity impact	
9.4 Gender equity results	
9.5 Environment results	
9.6 Governance results	
9.7 Human rights results	

KPI 10: Relevance to partners

10.1 Target groups	
10.2 National objectives	
10.3 Coherence	

KPI 11: Results delivered efficiently

11.1 Cost efficiency	
11.2 Timeliness	

KPI 12: Sustainability of results

12.1 Sustainable benefits	
12.2 Sustainable capacity	
12.3 Enabling environment	

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	2.79
WHO has a clear long-term vision, which informs and drives its strategy and results framework. WHO's publicly available strategies (General Programmes of Work, GPW) provide high-level strategic vision, priorities and direction; outlining key reform initiatives alongside the work of WHO. During the timeframe of the assessment and following the election of a new Director General in July 2017, a transitional period commenced where a new senior leadership team was appointed, took up positions, and began extensive strategic work on GPW13. GPW 13 is now complete and received approval at the WHA in May 2018, following a highly consultative and participatory process of stakeholder engagement. WHO has clearly articulated its comparative advantages; and gears its programming to this whilst necessarily responding to emerging Member States demands and sudden onset crisis. Whilst considerable effort and significant progress has been made on articulating and reporting against WHO's results chain, challenges remain. WHO is a complex, globally distributed organisation with multiple levels of strategic oversight, management and operational intricacy. Whilst WHO's organisational architecture has some congruence with strategic plans, WHO has undergone extensive reform aimed at improving programmes and priorities, governance and management within the organisation. Due to the operating model, issues of strategic alignment across the levels to the strategic plan are a constraining factor and challenge; alongside the organisation's ability to be sufficiently adaptable and financially flexible to the changing context within which it operates. WHO has a unique role among global health organisations in its mandate to provide independent normative guidance. Following an independent evaluation of WHO's normative function, WHO aims to strengthen its normative work as set out in GPW 13. WHO demonstrates high levels of alignment with the MDGs, which is evidenced in GPW 12 and with the SDGs in GPW 13. WHO contributed to the preparatory process leading up to the QCPR resolution in various ways. It is actively involved and reports progress annually on the implementation to the QCPR through the UN DESA Survey of UN Agencies' HQ for the SG report on the implementation of the QCPR resolution. High levels of tightly earmarked funds, by donors, is a major challenge to adaptability, flexibility and agility. Whilst restructuring of finances was a key component of the reform, all evidence streams signal that securing sufficient funding remains problematic; with the proportion of earmarked funds increasing year on year compounding the challenge. Financial accountability has seen incremental improvements. WHO has made continuous refinements to its primary tool for ensuring accountability and transparency, with the entire Programme Budget – both assessed and voluntary contributions – approved by Member States to improve transparency and the Programmatic and Financial Report presenting the governing body with more accurate, timely and robust reporting. Despite considerable efforts to shift the funding environment, WHO remains reliant on a small number of major contributors. Whilst the level of predictability in financing has improved, the level of flexibility has not significantly improved, with the share of specified voluntary contributions (i.e. earmarked funding) has increased. Financial alignment to priority areas remains a challenge. Evidence shows some programme areas that came out as high priority on the bottom-up prioritisation by Member States are still chronically underfunded.	
MI 1.1: Strategic plan and intended results based on a clear long-term vision and analysis of comparative advantage	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	4
Element 3: A strategic plan operationalises the vision, including defining intended results	3
Element 4: The Strategic Plan is reviewed regularly to ensure continued relevance	4

MI 1.1 Analysis	Source document
The WHO's publicly available Twelfth General Programme of Work 2014-19 (GPW 12) provides a high-level strategic vision, including priorities and direction; outlines key reform initiatives; and goes on to outline the work of WHO. This document provides a clear long-term vision to which WHO gears its operations. During the timeframe of the assessment and following the election of a new Director General in July 2017, a transitional period commenced where a new senior leadership team were appointed; took up their positions and began extensive strategic work on GPW13. GPW 13 is now complete and received approval at the WHA in May 2018, following a highly consultative and participatory process of stakeholder engagement. This strategy provides a high-level, ambitious strategic vision and clear demonstration of strategic intent based around the 'triple billion' targets. Strategic documentation clearly articulates WHO's 4 comparative advantages, as part of the criteria used in setting priorities in WHO. These were clearly understood and articulated in the interviews and consultations undertaken. As agreed by Member States in advance of GPW 12, the following criteria are used in setting priorities building on WHO's comparative advantage: (a) capacity to develop evidence in response to current and emerging health issues; (b) ability to contribute to capacity building; (c) capacity to respond to changing needs based on an on-going assessment of performance; and (d) potential to work with other sectors, organisations and stakeholders to have a significant impact on health. Extensive documentation, including GPW 12, highlights WHO's results chain and presents how WHO's work has been organised over the strategic period; how the work of the WHO contributes to the achievement of a defined set of outcomes and impacts; and how WHO can be held accountable for the way resources are used to achieve specified results. Furthermore, the three programme budgets in the period set out the details of what will be achieved during each biennium. Documentary evidence notes continuous improvements each biennium in the definition and reporting of results, though a number of independent, external sources note that WHO is "yet to articulate a systematic demonstration of their contribution to the health of all". Given WHO's extensive work with and through national governments partners, this will remain a challenge as the organisation transitions into delivery against GPW 13 and the ambitious impact goals it sets out. GPW 12 has been reviewed routinely and regularly through milestone annual mid-term reviews, presented in mid-term programmatic and financial reports, which include audited financial statements and biennial budget performance assessments. Supporting documentary evidence, alongside interviews and consultations with staff, notes the active use of these reviews to make adjustments as necessary. Significant assessments of WHO, including for example the response to the Ebola crisis, have also provided WHO the catalyst to make significant strategic and operational changes to ensure relevance. This was noted across all evidence streams in relation to the extensive refinements of WHE. During 2018, the new WHO Results Report (2016–2017) was launched which seeks to summarise WHO's key programmatic achievements and financial highlights during the biennium. In bringing these two areas together and effectively pairing achievement of specific results with the resources allocated, WHO is seeking to hold itself more accountable for investments made by Member States and donors. This report also seeks to review results through the lens of outcomes and impacts rather than processes and outputs, or, more simply put, by achievements rather than activities.	1, 9, 17, 20, 70, 155, 162
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	2.4
Element 1: The organisational architecture is congruent with the strategic plan	3
Element 2: The operating model supports implementation of the strategic plan	2
Element 3: The operating model is reviewed regularly to ensure continued relevance	2
Element 4: The operating model allows for strong cooperation across the organisation and with other agencies	2
Element 5: The operating model clearly delineates responsibilities for results	3
MI 1.2 Analysis	Source document
WHO's organisational architecture has some design congruence with its strategic plan objectives and mandate. Over successive GPWs, the basis by which the work of WHO is organised (around six core functions) has been set out clearly and remained the basis for GPW12. During the strategic period of GPW 12, WHO has undergone an extensive process of internal reforms designed to facilitate effective delivery of the strategy. WHO's core functions are organised across its three organisational levels in the context of six focus areas (categories) of results (five technical and one managerial). During the 2016-17 biennium, the Category and Programme Area Networks were established with the aim of achieving coherence in programme work across the Organisation's three levels and better coordination of planning and monitoring. Interview and consultations with staff presented evidence that the CPNs had been effective in achieving this aim. Interview and consultation evidence also noted that the high levels of earmarked funds gets in the way of effective working within the organisational architecture. The advent of GPW 13, and the ambitions behind it - bringing in an increased country focus - will likely results in necessary changes to the architecture and operating model. GPW 13 is structured around three interconnected strategic priorities to ensure healthy lives and well-being for all at all ages: achieving universal health coverage, addressing health emergencies and promoting healthier populations. WHO is a complex, globally distributed organisation. Its operating model is constructed to support the implementation of its strategic plan, organised across three levels: headquarters, regional and country offices. WHO headquarters in Geneva, Switzerland is responsible for overall management and administration of the organisation. WHO is divided into six regions, each of which has a Regional Office. The Regional Offices play an important role in WHO's organisational and management structure; they are the link between headquarters and the country offices for all of the policy setting, planning, results and data-related functions. The WHA is the decision-making body for WHO attended annually by all 194 member states. The WHA is supported by the Executive Board: 34 technically qualified members in the field of health. The Board advises the WHA, facilitates its work, and gives effect to the Assembly's decisions and policies. Due to the operating model, issues of strategic alignment across the levels to the strategic plan were noted in staff interviews and consultations as a constraining challenge; alongside the organisation's ability to be sufficiently adaptable to the changing context within which it operates. Following the extensive reform of WHE programme, the operating model of this programme has enabled much greater levels of responsiveness and relevance. Various examples were noted (e.g. in the Western Pacific region and in AFRO) during the assessment of WHO reviewing aspects of its operating model at country level to ensure continued relevance.	1, 2, 14, 17, 34, 70, 71, 155

WHO has undergone extensive reform aimed at improving programmes and priorities, governance and management within the organisation. Reform efforts have been regularly and extensively reviewed to ensure relevance; including an extensive independent evaluation of the 3rd stage of reform. Notable reform achievements include the creation of the Global Policy Group in 2008, the implementation of category and programme area networks (CPNs) in 2012, and work done on the roles and responsibilities across the three levels of the Organisation in 2013 to strengthen where decisions are taken based on collaboration and consensus. Interviews and consultations with staff note that continuous reform and review does not lead to continuous improvement; and that reform/change fatigue is a known issue for the organisation. This is echoed in staff perception data gathered as part of the independent Evaluation of Reform efforts, which noted a sharp deterioration in the belief that reform would improve the situation of the Organisation. This included staff disagreement that reform was making the Organisation more fit for purpose in the future; or improving the effectiveness or human resources capacity of the organisation to deliver on its mandate; or improving the focus of the organisation. A paper presented by the secretariat to the EB in early 2016 on progress against the reform noted that most (84%) of the indicators of progress on the reform had reached implementation stage but in 2015 progress had stalled, partly due to the need to focus on urgent matters around the Ebola crisis. While the indicators demonstrated measurable improvement in organisational performance in several areas, further progress was urgently needed in areas such as governance, human resources, accountability, and information management.

Whilst WHO has prioritised and actively encouraged multisectoral collaboration with numerous partners through its ongoing work, including for example its role in the SDG3 Global Action Plan, the complex operating model does not allow for strong co-operation within the organisation and with partners in all cases. Staff interviews and consultations note some internal challenges of operating in what has been described as a 'coordinated federated institution' have presented themselves, including examples of WHO engaging inconsistently with agencies through multiple touch points; leading to a lack of a coordinated and coherent approach to cooperation. The reshaping of the operating model detailed in GPW 13, to increase emphasis on country impact, will necessitate further organisational transformation and a recognition of the need for greater still levels of partner collaboration to achieve the 'triple billion' goal.

Despite steady improvements of the strategic biennium covered by the assessment in the definition and reporting of results, part of the organisational DNA is that WHO is both the Secretariat and member states. Separating accountability and responsibility for, alongside contribution towards, results remains an intractable challenge to the organisation. Tracking WHO results necessitates collaboration with member states on what they are delivering jointly with WHO; and what WHO's contribution to the achievement of those results is. This is acknowledged as a key organisational challenge for GPW 13, with an expert panel undertaking extensive consultation and efforts to deal with this complexity.

1, 2, 14, 17, 34, 70,
71, 155

MI 1.2 Evidence confidence

High confidence

MI 1.3: The strategic plan supports the implementation of wider normative frameworks and associated results, including Agenda 2030 and others where applicable (e.g. the quadrennial comprehensive policy review (QCPR), Grand Bargain, replenishment commitments, or other resource and results reviews)	Score
Overall MI rating	Satisfactory
Overall MI score	2.8
Element 1: The strategic plan is aligned to wider normative frameworks and associated results, including Agenda 2030, and others, such as the QCPR and the Grand Bargain (where applicable)	4
Element 2: The strategic plan includes clear results for normative frameworks, including Agenda 2030, and others, such as the QCPR and the Grand Bargain (where applicable)	4
Element 3: A system to track normative results is in place for Agenda 2030, and any other relevant frameworks, such as the QCPR and the Grand Bargain (where applicable)	2
Element 4: The organisation's accountability for achieving normative results, including those of Agenda 2030, and any other relevant frameworks, such as the SDGs and their targets and indicators, the QCPR and the Grand Bargain (where applicable), is clearly established	2
Element 5: Progress on implementation on an aggregated level is published at least annually	2
MI 1.3 Analysis	Source document
WHO has sought to find greater alignment of its programming with its mandate, member states' priorities and global normative frameworks including the MDGs and SDGs health-related goals; recognising that a drawback of using internationally agreed goals is that the time frame for their achievement does not coincide exactly with the time frame of organisational strategic periods. Nonetheless, alignment with the MDGs is evidenced in GPW 12 and with the SDGs in GPW 13. GPW 13 includes alignment on Agenda 2030 and has strong emphasis on multisectoral work. GPW 13 notes "WHO has the potential to dramatically improve the health of our world over the coming five years. The purpose of this thirteenth general programme of work 2019–2023 (GPW 13) is to seize this opportunity. WHO will only succeed, however, if it bases its work on the Sustainable Development Goals (SDGs)". Documentary evidence, including the report on WHO's collaboration within the United Nations system and with other intergovernmental Organisations, highlights WHO's efforts to align its work with wider normative frameworks. Noting resolutions on the quadrennial comprehensive policy review, adopted at the end of 2016, seek to significantly influence and provide a framework for the way the United Nations system as a whole engages in planning, budgeting, implementation, monitoring and evaluation, and reporting as it strives to support Member States in implementing the 2030 Agenda for Sustainable Development, especially at country level. WHO's engagement in UNDAF and alignment with this process are clearly evidenced across the streams. WHO's lead monitoring role on Universal Health Coverage provide evidence of its work with countries to ensure that progress towards UHC is cost effective and in line with countries' national priorities and context. WHO unique role among global health Organisations in its mandate to provide independent normative guidance. WHO's Framework Convention on Tobacco Control, the International Health Regulations (2005), and the Pandemic Influenza Preparedness Framework are examples of unique instruments in global health governance. WHO actively reports progress annually on the implementation to the QCPR through the UN DESA Survey of UN Agencies' HQ for the SG report on the implementation of the QCPR resolution. The Report by the Secretariat on Collaboration within the UN system and with other intergovernmental organisations highlight efforts made by the Secretariat to respond to the QCPR resolution. The 'Roadmap to implement the 2030 Agenda for Sustainable Development, building on Health 2020, the European policy for health and well-being' provides evidence of this applied in practice in the EURO region.	1, 2, 16, 20, 21, 28, 29, 50, 61, 70, 71, 155, 162, 163, 164, 165, 166

Documentary evidence, including the Health in the 2030 Agenda for Sustainable Development, details how WHO will adapt its country approach to the SGDs. The WHO team working on governance and health financing is a major part of the global public goods and normative role of WHO, focusing particularly on universal health coverage and a key pillar in the triple billions overarching goals for WHO. As noted above, WHO reports progress annually on the implementation to the QCPR through the UN DESA Survey of UN Agencies' HQ for the SG report on the implementation of the QCPR resolution.	1, 2, 16, 20, 21, 28, 29, 50, 61, 70, 71, 155, 162, 163, 164, 165, 166
MI 1.3 Evidence confidence	High confidence
MI 1.4: Financial Framework (e.g. division between core and non-core resources) supports mandate implementation	Score
Overall MI rating	Satisfactory
Overall MI score	2.2
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	3
Element 3: The financial framework is reviewed regularly by the governing bodies	3
Element 4: Funding windows or other incentives in place to encourage donors to provide more flexible/un-earmarked funding at global and country levels	1
Element 5: Policies/measures are in place to ensure that earmarked funds are targeted at priority areas	2
MI 1.4 Analysis	Source document
WHO is funded by voluntary contributions from both state and non-state actors, as well as through assessed contributions provided by member states. Whilst restructuring of finances was a key component of the reform, documentary and interview evidence suggests that securing sufficient funding remains problematic. High levels of tight earmarked funds by donors represents a major challenge to flexibility. Significant reform efforts have been undertaken to define a financing model for WHO that ensures the predictability, flexibility, transparency and strategic alignment of financing with priorities. This included the establishment of regular Financing Dialogues with donors; efforts to improve and coordinate resource mobilisation with the view to broaden the donor base; proposals to Member States to increase the level of Assessed Contributions; and improvements in the financing and recovery of Administration and Management costs.	1, 2, 16, 17, 36, 38, 49, 50, 54, 70, 86
WHO's Programme Budget is the primary tool for ensuring accountability and transparency. The entire Programme Budget – both assessed and voluntary contributions – is approved by Member States to improve transparency. Documentary evidence notes that reform efforts have led to substantial improvements in the way priorities are set for the programme budget; this was confirmed through staff interview and consultation evidence. A structured process was put in place in 2014, for the development of the programme budget 2016-17 onwards. At that time, only about half of country level were setting their priorities through the process outlined above. For 2018-19, evidence notes that nearly all countries went through the structured process of prioritisation and have identified a focused set of priorities.	

Financial accountability has seen incremental improvements, with WHO's Programmatic and Financial Report presenting the governing body with accurate and timely financial information. Documentary evidence, including Programme Budget reports (2016-17) notes that review of the budget is undertaken by member states and the governing body: "Consultations are held with Member States and partners during the different stages of the development of the Programme Budget. This process began at the country level, and was followed by presentations to all six regional committees and the Executive Board".

Despite considerable efforts to shift the funding environment, WHO remains reliant on a small number of major contributors. The member states which provide the highest levels of combined assessed and voluntary contributions are United States of America; United Kingdom of Great Britain and Northern Ireland; Japan; Germany; Canada; Australia; Norway; China; France; Sweden; Republic of Korea; Netherlands. Whilst the level of predictability in financing has improved with 83% of funding assured at the start of the 2016-2017 biennium versus 62% in 2012; the level of flexibility has not significantly increased, with the over-reliance on specified voluntary contributions and the share of these (i.e. earmarked funding) reported to have increased to represent 71% of total funding in 2014-2015, versus 68% in 2012-2013 as reported in the 2016-2017 mid-term programmatic and financial report). WHO notes this trend is continuing into 2016-2017 and the split is predicted to be the same as in 2014-2015. The WHO results report for 2016-17 reports on the Core Voluntary Contributions Account, which stands at \$148m and is a key vehicle for flexible funding in programme areas which would otherwise be underfunded. The CVCA had reduced compared with the previous biennium as several contributors stopped or reduced their funding to it. Interview and consultation evidence notes that the expectation was that as more transparency on result and resource allocation was provided, donors would un-earmark their contributions but this has not materialised.

Interview and consultation evidence consistently highlight expressed level of frustration regarding tight earmarking, with the majority of staff noting that less earmarking of funds would be helpful as currently budget allocations are driven mainly by grant and donor requirements and that greater alignment on funding to policy/programmatic areas would be beneficial. Reducing earmarking and increasing flexible funding remain key strategic issues for WHO and the DG is pushing for greater flexibility. The programme budget is highly earmarked by disease areas (e.g. tuberculosis, polio, etc) but at country level often different priorities apply. This means that typically WHO cannot easily fund/provide technical advice in country on health systems strengthening due to the earmarking. Whilst a number of approaches and incentives have been adopted to encourage donors to provide more flexible/un-earmarked funding at global and country levels, this has to date had limited impact.

Financial alignment to priority areas remains a challenge; with evidence showing some programme areas that came out on top of the bottom-up prioritisation by Member States for the 2018-19 Programme Budget are still chronically underfunded. A difference exists between the priorities identified by the WHA and what is implicitly signalled as a priority through earmarking. Funding is going disproportionately to certain targeted areas, while others are chronically underfunded. Interview and consultation evidence also notes a challenge exists in pooling funds due to earmarking which further presenting a lack of flexibility in finances.

1, 2, 16, 17, 36, 38, 49, 50, 54, 70, 86

MI 1.4 Evidence confidence

High confidence

KPI 2: Structures and mechanisms in place and applied to support the implementation of global frameworks for cross-cutting issues at all levels	KPI score
Satisfactory	2.71
WHO's frameworks for cross cutting issues are assessed as satisfactory overall, with gender indicators and targets rated as highly satisfactory. The new Senior Leadership Team has brought renewed vigour to existing initiatives on equality to the organisation, with a more gender balanced team built at DDG/ADG level and effective cross-departmental working addressing issues pertaining to equality are in play. Progress on improving gender equality is effective and WHO's ongoing and cross-cutting activities, especially efforts in respect of equity, are interwoven with the Sustainable Development Goals. Moving forward into GPW 13, WHO intends to take a greater equity focus. Human rights sit at the core of WHO's values and are addressed across the different levels of the organisation and areas of its work. WHO is committed to a rights-based approach to programming in line with international standards and leaving no one behind. Concrete examples of using and integrating human rights in core work are visible. There is a dedicated Gender, Equity and Rights (GER) team, providing a source of both internal and external technical advice and guidance on GER issues. WHO addresses aspects of climate change and health in its work and the new strategy (GPW 13) extends the ambitions of GPW 12 and makes clear WHO's commitment to tracking progress against particular SDG targets, seeking to support national health authorities to better understand and address determinants of health and the effects of climate and environmental change on health. WHO has internal tools, instruments and guidance in place, though these are presently being revised. WHO has a dedicated Environmental Services Team to support implementation and oversight of WHO's internal environmental safeguard activities. WHO's work to promote the principles of good governance is interpreted through its work strengthening the governance of health systems as a form of good governance. Whilst no 'standalone' dedicated policy document exists; health governance runs throughout much of WHO's work and is central to the mandate of WHO. WHO's work on health governance, including national health systems strengthening and health policy, is extensive. WHO's work with health systems on voice and accountability, as well as global governance of health, is significant. Much of WHO's work is predicated on sustainability. WHO's normative work, for example, provides a foundation of the work of other partners - guiding their work, innovation, and providing effective strategies to address health issues by building sustainable institutional capacity (through institutional development and capacity building). Effective technical training and online capacity development opportunities for staff on GER, climate change and health and are in place and uptake is satisfactory.	
MI 2.1a: Gender equality and the empowerment of women	Score
Overall MI Rating	Highly satisfactory
Overall MI score	3.17
Element 1: Dedicated policy statement on gender equality available and showing evidence of use	4
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	3
Element 4: Gender screening checklists or similar tools used for all new Interventions	3
Element 5: Human and financial resources (exceeding benchmarks) are available to address gender issues	3
Element 6: Capacity development of staff on gender is underway or has been conducted	3

MI 2.1a Analysis	Source document
WHO has a dedicated gender policy in place, WHO Gender Equity in Staffing Policy, 2017 which sets out internal commitment to gender equality. Internally, gender equality notes some progress, with 42.8% of female staff in the professional and higher category globally in 2016 with some regions lagging behind (30% in EMRO, 31% in SEARO). Global female representation in this category improved by 2.1 points between January 2014 and December 2016. Likewise, the percentage of female candidates increased from 33.2% in 2013 to 34.4% in 2016. Other documentary evidence, including GPW 12, highlights WHO is committed to addressing gender equality through its programming efforts and commitments through UN-SWAP. This commitment is also evident in the WHO Country Cooperation Strategy Guide 2016: "The CCS facilitates the integration of the principles of "gender, equity and the right to health" into the work of WHO at country level". Moving forward GPW 13 has cross-cutting aspects, particularly on the triple billion target around the serving the health needs of the most vulnerable 1 billion directly. One of the strategic alterations is towards human rights and gender and the language in the GPW includes quite a radical shift towards serving the vulnerable. Perception information from the partner survey highlights that WHO promotes gender equality; with 36.75% rating WHO as very good or excellent (12.87; 23.88%). Likewise, levels of familiarity with WHO's gender equity policy showed a level of familiarity with 45.07% rating their familiarity as "know it very well" or "know a fair amount about it" (15.15; 29.92%). The DG's approach appears supportive on gender - bringing more gender balance at DDG/ADG level, ensuring the gender policy in place and actively applied, addressing barriers underneath top level. Interview and consultation evidence suggests the DG is taking concrete action, implementing for the first time the existing policies on gender equality. Human Resources Management Department (HRD) produces a six-monthly report with metrics on gender equality in staffing, by Cluster and Departments in HQ, Regional and Country Offices, to determine progress and challenges. Documentary evidence, including the Programme Budget 2018-19, notes WHO's ongoing and cross-cutting activities, especially efforts in respect of equity, are interwoven with the Sustainable Development Goals. To strengthen this work, the programme areas of gender, equity and human rights and the social determinants of health have been merged into a single, new programme area. This new area aims to create even greater opportunities to anchor the relevant integrative work across other programmes, through implementation of the Sustainable Development Goals across the organisation. The Global Strategy for Women's, Children's and Adolescents' Health 2016-30, and associated indicator and monitoring framework, outlines and tracks WHO's approach to promoting gender equality. Global action plans represent good opportunities for integrating cross-cutting issues. The GER team is involved in work with UN SWAP with GER criteria used to review how well programmatic areas meet standards for integrating gender. The measurement of cross-cutting issues progress on gender and rights within GPW13 and the accompanying Impact Framework takes a greater equity focus, including an indicator on equity, though at this stage it is not clear how much other impact indicators includes consideration of cross-cutting issues or gender. Documentary evidence notes that cross-cutting issues are integrated more at strategic level than operationalised but this is changing, with principles being more and more integrated.	1, 6, 7, 11, 17, 20, 21, 24, 30, 31, 50, 70, 71, 73, 74, 75, 76, 98, 141, 142, 143, 155

At a strategic level, GPW 12 notes “Evaluation processes are in place to ensure gender, equity and human rights are measured in Secretariat programmes...”. Furthermore, the Global Strategy for Women’s, Children’s and Adolescents’ Health 2016-30 details the use of an accountability framework, independent review and annual report to assess progress towards gender targets, referencing “A harmonized, multi-stakeholder accountability framework based on existing mechanisms and an Independent Accountability Panel will ensure unified reporting and independent review”.

The GER team, in conjunction with other WHO Departments (including Department of Information, Evidence and Research (IER), Health Systems Governance and Financing (HGF), and the Unit of Social Determinants of Health (SDH) provide a Country Support Package for Equity, Gender and Human Rights (in Leaving No One Behind in the path to Universal Health Coverage). There are four components of a Country Support Package, which provide country-level support to LNB and benefit health information systems, national health policies and strategies, and national health programmes. The WHO Handbook for Guideline Development provides guidance and tools on incorporating Equity, Gender, Human Rights and Social Determinants into guidelines. The WHO Country Cooperation Strategy Guide 2016 refers to a priority-setting tool, which country teams can use to ensure gender issues are adequately incorporated. Furthermore, the ‘Innov8’ approach for reviewing national health programmes to ‘leave no one behind’, further offers support operationalisation of the SDGs commitment to ‘leave no one behind’ at the programmatic level through an 8-step review process - reflective of UNDAF - barrier analysis tool. Evidence from staff interviews and consultations notes the active use of these tools and instruments in practice.

There is a dedicated Gender, Equity and Rights (GER) team, providing a source of both internal and external guidance on GER issues with a core team based at HQ, complemented by the use of Gender Focal Points regionally in the organisation. However, due to resource constraints this is more limited at country level with HQ and regional offices taking up the shortfall wherever possible. Evidence from staff interviews and consultations notes human and financial resources are not always available to address gender issues in all cases. This means that, mainstreaming gender equity and rights across WHO’s work is an ongoing process and there is scope to improve further in specific areas. This is not surprising and is consistent with the experience in many other large multilateral organisations that mainstreaming gender is a challenging process both on measurement and on implementation.

WHO’s iLearn online platform for staff training available to all WHO Country Office staff offers an e-learning series on equity, gender and human rights (3 hours 30 mins), alongside a gender and health awareness, analysis and action virtual course, though this is not mandatory. The GER team offers face-to-face training workshops upon request for more in-depth and hands-on capacity building of WHO Country Office staff. Evidence from staff interviews and consultations notes good uptake of this capacity development.

1, 6, 7, 11, 17, 20, 21,
24, 30, 31, 50, 70, 71,
73, 74, 75, 76, 98, 141,
142, 143, 155

MI 2.1a Evidence confidence

High confidence

MI 2.1b: Environmental Sustainability and Climate Change	Score
Overall MI Rating	Unsatisfactory
Overall MI score	2
Element 1: Dedicated policy statement on environmental sustainability and climate change available and showing evidence of use	2
Element 2: Environmental sustainability/ climate change indicators and targets are fully integrated into the organisation's strategic plan and corporate objectives	2
Element 3: Accountability systems (including corporate reporting and evaluation) reflect environmental sustainability and climate change indicators and targets	2
Element 4: Environmental screening checklists/impact assessments used for all new Interventions	2
Element 5: Human and financial resources (exceeding benchmarks) 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 taken place	2
MI 2.1b Analysis	Source document
The WHO workplan on climate change and health, aims and objectives 2014-19, provides a framework for countries to follow to mitigate climate risks and as such provides a position on environmental sustainability and climate change. WHO has an Environmental Management Procedure (2010); though at the time of assessment these were undergoing review with the aim of being updated to reflect and align with the priorities of the DG and with the SDGs. There was a mixed response from the partner survey, showing perceptions that WHO promotes environmental sustainability/ addresses climate change of 60.59% considering WHO excellent; very good; or fairly good (9.09; 22.34; 29.16%). Levels of familiarity with WHO's environmental sustainability strategy were mixed, with 33.33% considering their familiarity as know it very well or know a fair amount about it (12.12; 21.21%). The WHO workplan on climate change and health suggests the need for an agreed set of indicators for countries, though this is only on a voluntary basis. It would create a system for countries to report their progress in increasing the resilience of health systems to climate change and gain health benefits from mitigation policies using an agreed set of indicators. GPW 13 extends the ambitions of GPW 12 and makes clear WHO's commitment to tracking progress against particular SDG targets, seeking to support national health authorities to better understand and address determinants of health, the effects of climate and environmental change on health; focus on green health facilities; substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination; and improve water and sanitation, and energy. Additional documentary evidence of implementation was noted, including a number of strategies on health and the environment, which are endorsed at a regional level. While WHO's programmatic area on health and environment has fully integrated issues on environmental sustainability and climate change, through accountability systems, human and financial resources etc, this is not the case for WHO's overall strategic plan nor the majority of programme areas outside WHO's area of health and environment.	1, 2, 7, 20, 25, 31, 33, 61, 76, 77, 78, 79, 80, 81, 155, 162, 167, 168, 169, 170

Corporate reporting evidence notes WHO monitors progress across all its regions towards the SDGs, which have particular relevance for environment and health. Documentary evidence, including the Mid-term Review Implementation of Programme budget 2016-2017, concludes that “All outputs under this programme area [Programme 3.5 environmental sustainability and climate change] are assessed to be fully on track”. Whilst documentary evidence presents internal environmental screening and review procedures, as is noted by the guidance within the Environmental Management Procedure (2010). However, interview and consultation evidence demonstrates this is not always consistency applied given the current review and revision process. Moreover, due to an increased interest coming from specific partners and donors to align with the GEF and GCF safeguard standards, staff interviews observe that WHO utilises partner environmental and social screening templates where appropriate and relevant, for example in the context of joint projects. WHO has a dedicated Environmental Services Team to support implementation and oversight of WHO’s internal environmental safeguard activities. Furthermore, within the programme budget section addressing health and environment, an overview cites a total budget for staffing and activities to be carried out in support of environmental sustainability and climate change issues: in 2014-15 this was 102 million USD and 2016-17 this was 110 million USD. Evidence from staff interviews and consultations notes human and financial resources are not always available to address environmental sustainability and climate change issues in all cases. Technical training and capacity building support is available, in particular related to climate change, including an online module on climate change and health (jointly developed with UNITAR) as part of the UNCC Learn initiative. Evidence from staff interviews and consultations noted some uptake of this capacity development and WHO advises that capacity development is underway for around 80 staff working on the programme area of health and environment.	1, 2, 7, 20, 25, 31, 33, 61, 76, 77, 78, 79, 80, 81, 155, 162, 167, 168, 169, 170
MI 2.1b Evidence confidence	Medium confidence
MI 2.1c: Good governance	Score
Overall MI Rating	Satisfactory
Overall MI score	2.67
Element 1: Dedicated policy statement on the principles of good governance and effective institutions available and showing evidence of use	3
Element 2: Indicators and targets related to the principles of good governance and effective institutions are integrated into the organisation’s strategic plan and corporate objectives	4
Element 3: Accountability systems (including corporate reporting and evaluation) reflect the principles of good governance and effective institutions	3
Element 4: New interventions are assessed for relevant governance/institutional effectiveness issues	2
Element 5: Human and financial resources are available to address the principles of good governance and issues related to effective institutions	2
Element 6: Capacity development of staff on the principles of good governance and effective institutions is underway or has taken place	2

MI 2.1c Analysis	Source document
This MI and associated criteria were interpreted to WHO's work to promote the principles of good governance through its efforts strengthening the governance of health systems as a form of good governance. This MI and associated criteria was analysed through WHO's work of strengthening the governance of health systems, which links to WHO's underlying principles of good governance. Whilst no 'standalone' dedicated policy document exists, health governance and systems strengthening runs throughout much of WHO's work and is central to the mandate of WHO. WHO's work on health governance (i.e. national health systems strengthening and supporting all countries to have health policies, strategies and plans towards universal health coverage) is extensive and has been a key part of its work for many years as detailed in successive strategic and operational plans. In relation to governance for health, documentary evidence including the Programmatic and Financial Report (2014-15) notes "... an advocacy and public policy function that seeks to influence governance in other sectors in ways that have a positive influence on health has become an increasing part of WHO's work. The overarching concern of the last two years has been to secure the place of health in the Sustainable Development Goals". Evidence from the partner survey highlighted a positive response; showing that partner perceptions where positive that WHO promotes principles of good governance with 85.21% considering WHO excellent; very good; or fairly good (17.80; 38.63; 28.78%). Levels of familiarity with WHO's good governance promotion strategy were somewhat mixed, with 68.55% considering their familiarity as know it very well or know a fair amount about it (25.75; 42.80%). Documentary evidence identifies WHO support to the development of appropriate national policies for medicines and health technologies, based on principles of good governance, rational procurement and the management of prices. It recognises that a key part of the health governance approach consists in giving citizens a voice in decision-making processes, as well as in the implementation, monitoring and evaluation of activities to increase accountability, participation, coherence and transparency. WHO's work with health systems on voice and accountability, as well as global governance of health strengthening, were noted in interview and consultations as "significant" area of work with considerable emphasis placed on this area of work within the top 10 country priorities. In line with WHO's strategic commitment to governance for health, documentary evidence and corporate reporting (including the Programme Budget reports and Results reports), outcome and output indicators pertinent to the principles of good governance and effective institutions have been identified and are actively tracked. These include "Improved country governance capacity to formulate, implement and review comprehensive national health policies, strategies and plans (including multisectoral action and health in all policies and equity policies); countries with comprehensive national health policies, strategies and plans aimed at moving towards universal health coverage". Documentary evidence, alongside the results portal, shows these are actively tracked; with targets met and exceeded against those strategically set. Corporate reporting through the indicator framework which monitors health governance and related SDG targets is evidenced through the WHO Programme Budget (2016-17). In addition, WHO is presently developing a global SDH action monitoring system is part of the broader WHO initiative to strengthen both national and global SDH focused monitoring and associated intersectoral governance capacities.	1, 2, 21, 50, 70, 71, 83, 146, 155, 170, 171

Strategic documents highlight much of WHO's work is focused on building strength and sustainability into the governance of health systems, including the health systems category of work which has 4 programme areas (National health policies, strategies and plans; People centred services; Access to medicines and health technologies and strengthening regulatory capacity; and Health systems, information and evidence). Corporate reporting tracks specific indicators in relation to improving country governance capacity amongst a basket of outcome/ output indicators on health systems strengthening. Evidence from interviews and consultations notes WHO's normative work, for example, provides a foundation of the work of other partners, guiding their work, innovation, and provides effective strategies to address health issues by building sustainable institutional capacity (through institutional development and capacity building). Whilst WHO strategically focuses its human resources towards its work of strengthening the governance of health systems, which links to WHO's underlying principles of good governance; a budget shortfall is often present for health systems work. For example, a budget shortfall for the 2016-17 biennium as of Q4 2016 was 34%. Given WHO's work to promote the principles of good governance through its work strengthening the governance of health systems, staff demonstrated a clear understanding on the principles of good governance and effective institutions through interviews and consultations, noting induction, and specific category of work training.	1, 2, 21, 50, 70, 71, 83, 146, 155, 170, 171
MI 2.1c Evidence confidence	High confidence
MI 2.1d: Human Rights	Score
Overall MI Rating	Satisfactory
Overall MI score	3
Element 1: Dedicated policy statement on human rights issues available and showing evidence of use	4
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	2
Element 4: Human rights screening checklists or similar tools used for all new interventions	3
Element 5: Human and financial resources (exceeding benchmarks) are available to address human rights issues	3
Element 6: Capacity development of staff on human rights is underway or has been conducted	3

MI 2.1d Analysis	Source document
Significant documentation evidence exists stating human rights sit at the core of WHO's values. A Joint WHO/UN statement on ending discrimination in health care settings exists and sets out the context and commitments; recognizing that discrimination in health care settings presents a major barrier to the achievement of the SDGs and publicly commits. Along with United Nations entities, it suggests to work together to support Member States in taking coordinated Multisectoral action to eliminate discrimination in health care settings. Further documentary evidence identifies a rights-based approach to programming in line with international standards and 'leaving no one behind'. This was further supported by staff interviews and consultations in the GER team and country offices. There was a very positive response from the partner survey, showing perceptions that WHO promotes human rights, presenting 94.69% considering WHO excellent; very good; or fairly good (30.68; 36.74; 27.27%). Levels of familiarity with WHO's policy commitments on human rights were mixed, with 48.48% considering their familiarity as know it very well or know a fair amount about it (18.18; 30.30%). Strategic documentation, including GPW 12, incorporates aggregated indicators for human rights, ensuring gender, equity and human rights are fully integrated into the Secretariat's and countries' policies and programmes. These are actively tracked. The WHO Programme Budget Web Portal provides quarterly updates on programmes, outputs, and deliverables in relation to Gender, Equity, and Human Rights mainstreaming. Whilst Programme budgets include indicators on cross-cutting issues, accountability systems are not yet strong enough to ensure integration of human rights as cross cutting. WHO's Ethics unit checks systematically for research projects, but not many mechanisms for enforcing integration of cross-cutting issues into implementation projects exist. Specific progress is monitored towards the achievement of the objectives in the WHO Global Disability Action Plan 2014–2021; alongside the WHO MiND Bank – an online platform bringing together country and international resources, covering mental health, substance abuse, disability, general health, human rights and development. The GER team, in conjunction with other WHO Departments, including Department of Information, Evidence and Research (IER), Health Systems Governance and Financing (HGF), and the Unit of Social Determinants of Health (SDH), provide a Country Support Package for Equity, Gender and Human Rights (in Leaving No One Behind in the path to Universal Health Coverage). There are four components of a Country Support Package, which provide country-level support to LNB and benefit health information systems, national health policies and strategies, and national health programmes. The WHO Handbook for Guideline Development provides guidance and tools on incorporating Equity, Gender, Human Rights and Social Determinants into guidelines. The WHO Country Cooperation Strategy Guide 2016 refers to a priority-setting tool, which country teams can use to ensure gender issues are adequately incorporated. Furthermore, the 'Innov8' approach for reviewing national health programmes to leave no one behind, offers support operationalisation of the SDGs commitment to 'leave no one behind' at the programmatic level through an 8-step review process. There is a dedicated Gender, Equity and Rights (GER) team, providing a source of both internal and external guidance on human rights issues with a core team based at HQ. However, capacity is limited (4 people in GER team on this); with evidence from staff interviews and consultations noting that human and financial resources are not always available to address rights issues in all cases.	1, 2, 5, 21, 31, 50, 67, 71, 72, 73, 74, 75, 83, 84, 86, 98, 172, 173, 174, 175, 176, 177

Documentary evidence provides concrete examples of using and integrating human rights in the core work of WHO including, WHO Quality Rights guidance and training tools which include for instance: (i) training modules to staff on human rights and mental health; (ii) integrating human rights in WHO's core normative function; (iii) expanding WHO's understanding and approach to human rights-related issues such as lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI) people.	1, 2, 5, 21, 31, 50, 67, 71, 72, 73, 74, 75, 83, 84, 86, 98, 172, 173, 174, 175, 176, 177
WHO's iLearn online platform for staff training available to all WHO Country Office staff offers an e-learning series on equity, gender and human rights (3 hours 30 mins). The GER team offers face-to-face training workshops upon request for more in-depth and hands-on capacity building of WHO Country Office staff. Evidence from staff interviews and consultations notes good uptake of this capacity development.	
MI 2.1d Evidence confidence	High confidence

OPERATIONAL MANAGEMENT

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

KPI 3: Operating model and human/financial resources support relevance and agility	KPI score
Satisfactory	2.67
Significant reforms clearly linked to strategic direction have been undertaken, including adjustments to organisational structures and staffing. Human resource systems and policies are increasingly performance-based and geared to results. Notably achievements include the development of geographical mobility policy; a harmonised Selection Process for Longer-Term Positions in the Professional and Higher-Level Categories; a new internal assessment process for candidates for positions as Heads of WHO offices; a Performance Management and Development Framework; an enhanced WHO Global Competency Model; and a Corporate Framework for Learning and Development. Reform and organisational transformation is ongoing. The advent of GPW 13, and the significant transformational realities behind it, will necessitate further changes to the architecture and operating model of WHO. The anticipated change required in staffing and mind-set will require considerable resolve and time to design, roll out and embed. Substantial effort has been exerted on allocating resources across the levels of the organisation to more explicitly align to organisational priorities and goals, however challenges remain in matching resources to requirements. Financial and Human Resources will continue to require a shift from HQ to country level with GPW13 encouraging more impact focus at country level. From a point of relative weak resource mobilisation capacity at all levels of the Organisation at the start of the reform, WHO has exerted significant effort to strengthen resource mobilisation in line with strategic objectives. Improvements in predictability of funding have been achieved over time. There is clear recognition of the need to diversify the funding base of WHO, though with limited success to date. There is a recognised requirement to rationalise the significant number of grants. Delegated decisionmaking authority, including Annual Accountability Compacts between the Director-General and Assistant Director-Generals, are in place and effectively applied. The Health Emergencies Programme (WHE) represents a successful and fundamental development for the Organisation, complementing WHO's traditional technical and normative role with new operational capacities and capabilities for its work in outbreaks and humanitarian emergencies. The utilisation of the Strategic Budget Space Allocation has promoted predictability and transparency in the allocation of more flexible resources at the country level. During the significant reform efforts, clearly linked to strategic direction, a number of initiatives were launched which have strengthened performance and career management.	

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	2.33
Element 1: Staffing is aligned with, or being reorganised to, requirements set out in the current Strategic Plan	2
Element 2: Resource allocations across functions are aligned to current organisational priorities and goals, as set out in the current Strategic Plan	2
Element 3: Internal restructuring exercises have a clear purpose and intent, aligned to the priorities of the current Strategic Plan	3
MI 3.1 Analysis	Source document
Significant reforms are clearly linked to the strategic direction, GPW 12, including adjustments to various functions including organisational structures and staffing and have clear intent. As part of the reform, a comprehensive range of HR initiatives has been launched, providing strong coherence between different elements of the HR reform process. Notably the geographical mobility policy; a harmonised Selection Process for Longer-Term Positions in the Professional and Higher-Level Categories; a new internal assessment process for candidates for positions as Heads of WHO offices; a Performance Management and Development Framework; an enhanced WHO Global Competency Model; and a Corporate Framework for Learning and Development. The Evaluation of WHO Reform notes: "... reform has sought to delineate clear roles and responsibilities for the three main levels of WHO, seeking synergy and alignment around common organisation-wide policy and strategic issues, at the same time as striving for a clear division of labour with accountability for resources and results". Given that human resources policies have inherent rigidities within them when applied to a complex, globally dispersed tri-layered organisation, there is further work to be done to fully implement the policies, procedures and translating these into effective ways of working. Evidence from staff interviews and consultations notes that whilst policy level changes have been effectively implemented, the necessary changes in working practices is more mixed; with historic practice often remaining the predominant way of working with meaningful change taking time to embed. Reform is ongoing. The advent of GPW 13, and the significant transformational realities behind it, will necessitate further changes to the architecture and operating model of WHO. Whilst some strategic consideration to this was underway during the assessment, these were conceptually-orientated related to the strategic intent. Evidence from staff interviews and consultations noted that at regional and country-office level the realities of a greater focus on country impact was being carefully considered in terms of the likely capacity and competence gaps and the likely resource implications for filling them, mindful of existing country capacity issues. Whilst not an Organisational-wide, systematic assessment of workforce composition at country level, there was evidence from country office staff interviews that this was being pursued in some offices.	1, 2, 6, 11, 36, 50, 58, 61, 64, 70, 155

A comprehensive WHO Human Resources Strategy was developed late 2013/early 2014, which outlined a number of strategic human resources priorities and activities for the Organisation organised around three main pillars that describe the strategic intent of WHO. These are 'attracting talent', 'retaining talent', and an 'enabling work environment' intersected with four cross-cutting strategic principles: gender balance, diversity, collaboration and accountability. Documentary evidence including independent, external evaluative findings note significant progress has been achieved in the implementation of the strategy across all its dimensions - notably in the areas of recruitment, contracting modalities, performance management and career development. A detailed progress update on each of the strategy components is provided to the Executive Board and World Health Assembly. Though considerable effort has been exerted, some strategic initiatives have also met with notable 'resistance'; specifically, the geographical mobility policy has encountered particularly limited buy-in, with relatively low staff voluntary mobility achieved during the pilot phase. In accordance with the policy, an internal evaluation of the Implementation of the Geographical Mobility Policy is undertaken annually during the voluntary phase of policy implementation (2016-2018) by the Evaluation Office. In 2017, the internal evaluation was undertaken to examine how the geographical mobility policy is being implemented; identify the main results achieved; explore whether the current implementation of the policy likely to achieve its intended benefits once it becomes mandatory; and identify the main lessons learned. The 2017 evaluation found that only a limited number of managers chose to advertise vacant positions in the 2016 compendium: 44 positions, of which four were subsequently withdrawn due to lack of funding. Out of the 71 eligible IP candidates, 12 were successfully placed at the end of the exercise. It found that as the mobility compendium exercise is a new modality for WHO, the effectiveness needs to be assessed over time; with trust needing to be built. It is reported that many managers hesitated to advertise in the first mobility compendium. The evaluation presents eight recommendations and related specific actions, cross-cutting the three levels of the Organisation with an over-arching recommendation that in order for the specific actions to have maximum impact, a cultural mind -shift needs to be sustainably supported by WHO's senior leadership, at headquarters, in the regional offices and at the country levels, taking the appropriate implementation measures for a unified 'One WHO' geographical mobility approach.

At the time of assessment, the full roll-out of the mandatory rotation policy was on hold, pending decisions by the Senior Leadership Team. Achieving the ambitions of GPW 13 requires notable increases of staff mobility at all administrative tiers in line with the demands at each level, as well as strengthening the mechanisms to deliver in a more integrated way. The perception partner survey shows somewhat positive results, noting 38.63% of respondents responded that WHO was excellent or very good (12.12; 26.51%) at providing sufficient staff to deliver results. Likewise, when asked whether WHO maintained sufficient continuity of staff to build relationship, 35.22% noted either excellent or very good (7.19; 28.03%).

Considerable effort has been exerted on allocating resources across the levels of the organisation to more explicitly align to organisational priorities and goals, particularly to strengthen the identification and prioritisation of country need; however, challenges remain in matching resources to requirements. Documentary evidence, including successive Programme Budgets, notes continued attention to human resource cost and planning is vital to ensure WHO sharpens the linkage between the programmatic priorities and the assessment of the staff and non-staff resources required in order to respect those priorities. Cost implications of these resources are determined through existing standardised approaches as well as by advancing the roll-out of human resources planning across the Organisation.

1, 2, 6, 11, 36, 50, 58,
61, 64, 70, 155

An enhanced RBM system (see KPI 7, below) is used for priority setting, resource allocation and making choices, although the financing does not always follow the need since demands on WHO far outweigh capacity. At a country level, nations (through developing their CCSs) pick up to 10 priority areas and put 80% of resources against these applying an 80/20 rule of thumb (i.e. 80% investment on core targets, 20% flexibility). A country can have a goal that is not fully aligned to the 42 targets to provide flexibility to respond to the unique context of the operating environment of each WHO country presence. This context specific priority setting is a significant achievement since the MOPAN 2013 assessment. Nonetheless, the use of RBM in priority setting and resource allocation is a sensitive process both internally and with donors in an Organisation with excess demands on it, as well as high levels of earmarking and disease specific funding by donors. In practice, evidence from staff interviews and consultations highlights that WHO finds it difficult to refuse countries within what is a political dialogue. Considerable progress have been made with WHE, in allowing more responsive resource allocation, enabling quicker action to deal with sudden onset and emergency situations. Resources will continue to need to shift from HQ to some countries with GPW13, in principle, allowing more focus at country level through a more bottom-up approach. Under GPW13 and triple billion goal, the list of choices will be tighter still and more integrated across WHO (e.g. the 3 outcomes in UHC). Planning includes fewer options, requiring all offices to map their outcomes, and there will likely be a need for greater arbitration. A planning framework is in place to support selection (from limited menu) and align with country priorities.	1, 2, 6, 11, 36, 50, 58, 61, 64, 70, 155	
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		Unsatisfactory
Overall MI score	2	
Element 1: Resource mobilisation strategy/case for support explicitly aligned to current strategic plan	2	
Element 2: Resource mobilisation strategy/case for support reflects recognition of need to diversify the funding base, particularly in relation to the private sector	2	
Element 3: Resource mobilisation strategy/case for support seeks multi-year funding within mandate and strategic priorities	2	
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: Resource mobilization strategy/case for support contains clear targets, monitoring and reporting mechanisms geared to the Strategic Plan or equivalent	2	

MI 3.2 Analysis	Source document
From a point of weak resource mobilisation capacity at all levels of the Organisation at the start of the reform, WHO has exerted significant effort to strengthen this capacity in line with its strategic objectives. Financing and resource mobilisation were part of the reform agenda under Dr Chan; which included active outreach as part of the financing dialogue to fund the Programme Budget. Some improvements in predictability of funding were noted over time. Recent efforts have culminated in the development and implementation of WHO's "Strategic Approach and Organisational Model for Global Resource Mobilization". This strategic framework seeks to focus WHO's resource mobilisation efforts on five strategic priorities to enable a comprehensive programme delivery, and ensure a fully-funded Programme Budget (PB) and appeals budget, while maximizing the quality of resources. WHO has endeavoured to expand and protect resources from major contributors of development assistance for health; embrace the growing funding potential at the country level; identify and engage emerging contributors and new funding sources; increase assessed contributions (AC) and flexibility in VC grant agreements. The implementation is linked to the GPW 13 and development of resource mobilisation targets; so evidence of effectiveness is not fully visible. Resource mobilisation is now considered a much broader effort; not focused on a specific programme budget but rather on broad priorities. Financing dialogue has evolved towards a different form of funding discussion with donors. The transformation of WHO's approach to resource mobilisation includes internal reorganisation to deliver a clear engagement strategy for each donor; and through a dedicated team to work on resource mobilisation. Additionally region and country level and program area leads are tasked with mobilising resources. The new resource mobilisation strategy/ approach seeks to transform the external relations model and progress beyond the financing dialogue model of engagement (as although this represented a good innovation, more was needed). The new investment case approach was completed in June 2018, providing an advocacy document on how WHO finance links to Agenda 2030. There is clear recognition of the need to diversify the funding base of WHO. Documentary evidence, including the Evaluation of WHO Reform, notes there is too great a reliance on a small base of donors, "despite 30 new contributors joining the contributor base since 2011, 76% of voluntary contributions are paid by 20 contributors in 2016-2017. This is a sign that the dependency on key donors is not reducing in material ways". Specific activities linked to expanding WHO's donor base with BRICS, Gulf donors, Saudi Arabia, EU, foundations (e.g. Bloomberg, Wellcome Trust). There is some evidence of WHO diversifying its funding through partnerships with private sector/ pharma: these have grown since the 1970s and included an important partnership with GSK. WHO now has over 10 MoUs; an example of this is a partnership with MSD (pharma company) in relation to river blindness. The need to ensure sustainable financing for WHO is well evidenced and forms the basis for strategic resource mobilisation. This is hardwired into both the GPW 12 and 13 with a recognition that the stable nature of assessed contributions enables the Organisation to make commitments on important agendas, resolutions and strategies that require significant initial and multi-year investments. GPW 13 states the intention of seeking "...good-quality, multi-year funding with greater flexibility". Based on this intent, the DG and the external relations team are initiating dialogue based on the 'triple billions' and renewing efforts to find funding on that basis. There is a renewed call to deal with all member states equally, independently of financial contribution.	1, 2, 6, 11, 14, 32, 38, 47, 49, 50, 70, 85, 86, 87, 155

There is a recognised need to rationalise the significant number of awards (circa 3000). Interviews and consultations have noted the need to shift funding towards programme priorities without being overdriven by donor priorities. Within WHO's new strategic plan, GPW 13, the following intent is made to advocate with Heads of Government, and engage with non-State actors, to make the case for domestic investment in health that it "minimizes out-of-pocket expenses and reduces catastrophic expenditures on health. WHO will also use its leadership position and its convening power to call for an adequate, continued and predictable official development assistance and humanitarian funding for health, as well as innovative finance". It is too early in the strategic period to assess the translation of this intent. Whilst there is some imbalance between resources at HQ, regional and country levels, WHO recognises it is essential to operate in a decentralised structure, so partnerships are discussed and negotiated at all 3 levels. WHO Programme Budget Portal provides quarterly updated details on WHO's financing and implementation.	1, 2, 6, 11, 14, 32, 38, 47, 49, 50, 70, 85, 86, 87, 155
MI 3.2 Evidence confidence	High confidence
MI 3.3: Aid reallocation/programming decisions responsive to need can be made at a decentralised level	Score
Overall MI Rating	Satisfactory
Overall MI score	2.75
Element 1: An organisation-wide policy or guidelines exist which describe the delegation of decision-making authorities at different levels within the organisation	3
Element 2: (If the first criterion is met) The 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 aid reallocation/ programming	3
Element 3: Evaluations or other reports contain evidence that reallocation/programming decisions have been made to positive effect at country or other local level, as appropriate	3
Element 4: The organisation has made efforts to improve or sustain the delegation of decision-making on aid allocation/programming to the country or other relevant levels	2
MI 3.3 Analysis	Source document
Clear guidelines exist on delegated decisionmaking authority, including Annual Accountability Compacts between the Director-General and Assistant Director-Generals: developed in 2014 and now published on the WHO website. 'Compacts include a number of leadership, stewardship and behavioural objectives. Delegations of Authority and Letters of Representation of Regional Directors are also in place and publicly available, describing delegation of decision-making authorities for Programme, Administration, Finance, Resource Mobilisation/Donor Agreements, Staffing and ReDelegation. Similar mechanisms have been introduced between Regional Directors and Heads of Country Offices, for example in SEARO, AFRO and WPRO regional offices. The perception survey positively notes that staff can make critical strategic and programming decisions locally, with 68.16% rating fairly good, very good or excellent (9.84%; 28.78%; 29.54%). The specific guidance above details sufficient level of decision making autonomy available at the country level (or other decentralised level as appropriate) regarding aid reallocation/programming amongst other identified provisions.	1, 2, 62, 64, 70, 88, 89

The re-organisations of WHO's Health Emergencies Programme (WHE) represents a fundamental development for the Organisation, complementing WHO's traditional technical and normative role with new operational capacities and capabilities for its work in outbreaks and humanitarian emergencies. Following the highly critical assessment of WHO's response to the Ebola crisis, WHE has been re-designed to bring increased speed and predictability to WHO's emergency work, using an all-hazards approach, promoting collective action, and encompassing preparedness, readiness, response and early recovery activities. The re-organisations of the WHE programme is now aligned on the principles of a single programme, with one clear line of authority, one workforce, one budget, one set of rules and processes, and one set of standard performance metrics. The independent, external evaluation of the reform of WHO's work in health emergency management noted positively the significant improvements and impact in WHO's programming for outbreaks and humanitarian emergencies. WHO's work on surveillance and eradication of polio provides a further example of the positive global impact of WHO programming decisions, with WHO's strategic transition action plan on polio identifying the next steps on priority countries to target, including those with limited capacity. This includes a special working arrangement led in the Immunisation, Vaccines and Biologicals department which requires collaboration across programmes; close working relationship between immunisation and Polio programme and essential medicines programmes; capacity within WHO which includes human resources, technology and institutional knowledge. Country office/ programme evaluations also present some evidence that programming decisions at country level have been made to positive effect. To promote predictability and transparency in the allocation of flexible resources at the country level, Regional Office utilise a <i>strategic budget space allocation</i> approach to distribute its resources. This approach methodology has added a needs-based element to resource distribution and decisions on resource amounts are clearly set out. Evidence from staff interviews and consultations notes this is implemented in all regions. The 'Methodology for the Programmatic Priorities Stratification Framework of the PAHO Strategic Plan' highlights how PAHO adjusts its methods of resource allocation within its programmes, though not specific to allocating funds directly to partners, as "Guidelines, tools, and criteria have been developed to ensure the consistent application of the methodology across all Member States and to avoid potential errors".	1, 2, 62, 64, 70, 88, 89
MI 3.3 Evidence confidence	High confidence
MI 3.4: HR systems and policies performance based and geared to the achievement of results	Score
Overall MI Rating	Highly satisfactory
Overall MI score	3.6
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	4
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 agencies	3
Element 4: The performance assessment of staff is applied in decision making relating to promotion, incentives, rewards, sanctions, etc.	3
Element 5: A clear process is in place to manage disagreement and complaints relating to staff performance assessments	4

MI 3.4 Analysis	Source document
Since the last MOPAN assessment (2013), WHO has implemented significant reform to Human Resources, including the definition of an HR strategy, the endorsement of mobility policy, important updates to Staff Rules and Regulations and the implementation of a new performance management system. During the significant reform efforts, clearly linked to the strategic direction (GPW 12), a number of initiatives were launched to further strengthen performance and career management, including a new Performance Management and Development Framework supported by two policies 'Recognizing and Rewarding Excellence' and 'Managing Underperformance', and by a performance management tool (ePMDS+). The Performance Management and Development (PMD) Framework applies to all staff members in the General Service, National Professional Officer, and Professional and higher categories. The intent of PMD is to ensure that staff members are able to perform at their highest level and are accountable for their work. Identified within the Evaluation of WHO Reform as a 'major achievement', the effectiveness of these performance management and development systems was noted: "Significant progress has been achieved in the implementation of the [HR] strategy across all its dimensions, notably in the areas ... performance management and career development". Since the introduction of the ePMDS, performance assessments have been systematically organised into three phases, Begin-Year, Mid-Year and End-Year. WHO's Performance Management Portal (an internal site) provides a Users' Guide (2015) and offers guidance on using ePMDS+. Documentary evidence supports WHO's approach to performance assessment of staff, noting "All performance management evaluations (100%) were completed by February 2017. Key performance indicators have been institutionalised and monitored for all professional and general service category staff. In 2016, 100% of staff workplans and performance reviews (including personal development plans) were completed on time. The Evaluation of WHO Reform 2017 provides evidence of an improved compliance rate with ePMDS which "has consistently increased and is now above 90% globally". The high compliance rate with ePMDS allows WHO to monitor, align and cascade individual, departmental, programmatic, global programmes of work to achieve corporate objectives. The PMD Framework is designed to ensure that staff members are able to perform at their highest level and are accountable for their work. This is clearly linked to organisational improvement as evidenced by the promotion of a culture of high performance, staff development and continuous learning; empowering managers and holding them responsible and accountable for managing their staff and creating a transparent and participatory work environment; encouraging a high level of staff participation in the planning, delivery and evaluation of work; recognizing and rewarding excellence; and managing underperformance. WHO has a number of interlinked policies to support the performance assessment process, ensuring the PMD Framework provides the foundation and main elements of performance management and development across the Organisation supported by the "Recognizing and Rewarding Excellence" policy. This policy provides a variety of options for recognizing and rewarding good and exceptional performance. Decisions following an unsatisfactory Overall Rating are set out in detail in the "Managing Underperformance" policy. A PIP (Performance Improvement Plan) is to be used by supervisors in most cases involving underperformance. Evidence from staff interviews and consultations notes these tools and instruments to management performance are implemented in the majority of cases.	7, 8, 11, 13, 35, 59, 62, 70, 90

The Code of Ethics and Professional Conduct clearly outlines the process to deal with disagreements, such as work-related disagreement, under the provisions of the Performance Management and Development Framework. Guidance is set out noting that as the Code is not intended to cover every situation or problem that may arise, staff members are encouraged to seek guidance and assistance from the Office of Compliance, Risk Management and Ethics (CRE) in order to resolve issues and ensure the ethical performance and discharge of their professional responsibilities. Evidence from staff interviews and consultation notes clarity on the process and evidence of use.	7, 8, 11, 13, 35, 59, 62, 70, 90
MI 3.4 Evidence confidence	High confidence
KPI 4: Organisational systems are cost- and value-conscious and enable financial transparency/accountability	KPI score
Highly satisfactory	3.46
WHO's key financial information is published regularly, promoting transparency. WHO monitors and reports implementation progress of the Programme Budget at the mid-point of the biennium. Clear policy and guidelines (FENSA) sets out parameters and regulates the receipt and allocation of resources to nongovernmental and private Organisations for implementation of work in accordance with the Programme Budget, Financial Regulations and Financial Rules. The financial situation of WHO remains challenging within a context of specified voluntary contributions and limited funding flexibility. Financial information indicates that there are often shortfalls in funding across programme areas, with expenditure exceeding total revenue. This is largely due to heavily earmarked funds from donors which restrict the flexible use of resources. WHO has made significant strides in its planning and prioritisation process, applying a coherent bottom-up process; more clearly aligning resources with the focus of work and identification of priorities at the country level and resulting in greater alignment of financial resources with strategic objectives. WHO is shifting to a more results-based budgeting model, most recently applying a <i>Costing of Results</i> approach for the Programme Budget 2018-19. WHO continues to become more cost-conscious. Recognising the continued risk of rising costs and the adverse financial consequences of exchange rate fluctuations, WHO has made various efficiency savings and improved budgetary discipline. WHO has robust internal and external audit functions, with arrangements meeting international standards. WHO has comprehensive and robust internal control mechanisms, comprising a set of operational and financial safeguards using an organisation-wide common framework and harmonisation of risk management practices. Progress of audit work is routinely tracked and monitored. An innovative integrity hotline provides a safe and independent mechanism to report any concerns. There is a dedicated WHO Whistle-blower Protection Policy and Procedures.	
MI 4.1: Transparent decision-making for resource allocation, consistent with strategic priorities	Score
Overall MI Rating	Satisfactory
Overall MI score	3
Element 1: An explicit organisational statement or policy exists 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: The organisational policy or statement is regularly reviewed and updated	3
Element 4: The organisational statement or policy is publicly available	4

MI 4.1 Analysis	Source document
WHO sets out explicitly intended resource allocation within each biennial Programme Budget which are aligned with the strategic priorities defined in the GPW. Documentary evidence presents several policies which govern the allocation of resources to partners, with staff interviews and consultations noting active use. The FENSA sets out parameters and regulates the receipt and allocation of resources to nongovernmental and private Organisations for implementation of particular work in accordance with the Programme Budget, Financial Regulations and Financial Rules. The Financial Regulations and Financial Rules regulates the procurement of goods and services. Staff interviews and consultations note higher level of transparency have been achieved on engagement with non-state actors with a register and clear categories, alongside institutional requirements on declaration of interest. FENSA also acts an important tool for risk management – with WHO introducing a new IT system for managing risks / partnerships. Further efforts to improve transparency in resource allocation have been made through the Strategic Budget Space of Allocation. The perception survey positively notes that transparent criteria for financial resource allocation exist, with 69% rating fairly good, 73% very good and 29% excellent. A combination of the GPW and Programme Budget present the priority categories and programmes of work outlining where resources are allocated, with criteria for allocation outlined in the Financial Regulations, Financial Rules and the FENSA. The Strategic Budget Space of Allocation methodology provides formulas for allocating programme resources based on these priority categories and programmes of work across the organisation. Routine revisions and refinement have been made to the Strategic Budget Space of Allocation methodology and implementation to support the definition of the Programme and Budget. The Financial Regulations and Financial Rules, FENSA and Strategic Budget Space of Allocation methodology are all publicly available via the Programme Budget web portal. WHO has also committed to being a more transparent organisation through its membership to the IATI in 2017. The agency has published information on over 7000 projects; which can be search their data at d-portal.org.	22, 23, 50, 59, 70, 87, 140
MI 4.1 Evidence confidence	High confidence
MI 4.2: Allocated resources disbursed as planned	Score
Overall MI Rating	Satisfactory
Overall MI score	3
Element 1: The institution sets clear targets for disbursement	4
Element 2: Financial information indicates that planned disbursements were met within institutionally agreed margins	3
Element 3 Clear explanations are available in relation to any variances	3
Element 4: Variances relate to external factors rather than internal procedural blockages	2

MI 4.2 Analysis	Source document
WHO sets out planned disbursements through each of its biennial programme budgets. Programme Budgets highlights proposed spend disaggregated by major office, level, category, and programme area. The perception survey positively notes that in relation to the predictability of financial allocations and disbursements, 72% rating fairly good, 61% very good and 29% excellent. A combination of annual Programme Budgets and the WHO Programme Budget Portal provide financial information on planned disbursements biennially and are publicly available. Financial information indicates that there are often shortfalls in funding across programme areas, with expenditure recently exceeding total revenue. The financial situation of WHO remains challenging. Explanations for variations in spending are provided within the Programmatic and Financial Reports. Notable recent examples include the Ebola response, which resulted in an additional US\$ 27 million within the biennium 2014-15 with the Emergencies programme. Given WHO's reliance on external donors and member states for funding its programmes, there are often shortfalls in funding for particular programmes. This is largely due to heavily earmarked funds from donors, which restrict the flexible use of resources, which are largely external factors. Thus, variance is attributed largely external factors. However, WHO is also aware of and seeking to address internal procedural blockages, which have affected Country Office capacity; for example appointing staff and organisational delays in deploying staff rapidly in response to emergencies.	2, 17, 50, 70
MI 4.2 Evidence confidence	High confidence
MI 4.3: Principles of results based budgeting applied	Score
Overall MI Rating	Highly satisfactory
Overall MI score	3.75
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 through 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)	4
MI 4.3 Analysis	Source document
WHO has made a significant and coordinated shift in its planning and prioritisation process: it is now driven from the bottom-up, with the aim of more clearly aligning resources to focus on work and identification of priorities at the country level. Documentary evidence notes instructions, support and guidance issued to country offices assists them to prioritise their work and budgets to ensure that 80% of resources are in line with (up to 10) country priorities. The programme budget followed this bottom-up prioritisation process, which includes consultations with Member States during regional committees and the Executive Board. Staff interviews and consultations note this process is resulting in greater alignment of financial resources with strategic objectives. This bottom-up approach is complemented by a top-down process to identify global priorities expressed through resolutions of the governing bodies.	2, 36, 50, 86, 90

The WHA endorsed the strategic budget space allocation model in 2016, and this has guided subsequent budgets. The bottom-up process has also meant that WHO needed to introduce working mechanisms to achieve coherence between the levels of the Organisation, such that global, regional, and country priorities were aligned. This was driven through the established category and programme area networks, achieving greater levels of coherence in programme work across the Organisation's three levels and better coordination of planning and monitoring. Staff interviews and consultations note these networks has resulted in significant improvements.

Most recently, for the Programme Budget 2018-19, the Costing of Results (outputs) was presented to the WHA in May 2017 which provided an overview of the iterative process for costing the output and full costing of outputs by programme area and by category, with breakdown by staff and activities. This information is also publicly available in the Programme Budget web portal. It is further noted that the initial costing provided in the Programme Budget web portal may change during operational planning and is updated at regular intervals.

WHO's Programme Budgets present costings for each category and programme of work. Budgets are reviewed by the Global Policy Group, which provides advice for its finalisation. This is done with every budget submitted for the Regional Committee consultations, the Executive Board and the World Health Assembly.

WHO Programme Budgets establish regular review points in order to assess progress towards financial and programmatic targets. WHO monitors and reports on progress in the implementation of the Programme budget through the mid-term review which is issued at the mid-point of the biennium. Overall performance towards achieving results and use of strategically allocated resources is assessed and reported on through the programme budget assessment at the end of each biennium. The established Programme Budget Portal provides publicly accessible and up-to-date details of its work, financing and implementation progress. Interview and consultation evidence notes WHO's awareness of the need to ensure more precise tracking of results from the allocation decisions: it continues to strengthen the links between financial and programmatic reporting to provide a better understanding of the adjustments needed on allocation decisions.

Given past prominence in the global news, WHO has sought to become a more cost-conscious organisation as part of a recent reform process. Recognising the continued risk of rising costs and the adverse financial consequences of exchange rate fluctuations, WHO has made various efficiency savings and improved budgetary discipline. Savings in staff costs have been made (from 47% to 41% of expenditure over three-year period). Other savings have been made by off-shoring administrative work to countries where staff costs are lower; better management of travel, with greater use of video conferencing instead of face-to-face meetings. There is also documentary and interview evidence of cost savings becoming a more systematic aspect of future programme budgets. A comprehensive value-for-money plan has recently been developed and submitted to the governing bodies. It examines all efficiencies, not only in administration and management, but also in the operations of technical programmes. It seeks to examine different approaches and options, together with the implications of these, on the overall achievement of results and efficient allocation and use of resources to achieve these results.

2, 36, 50, 86, 90

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	3.33
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	0
Element 4: Management response provides clear action plan for addressing any gaps or weaknesses identified by external audit	4
Element 5: Internal audit functions meet international standards, including for independence	4
Element 6: Internal audit reports are publicly available	4
MI 4.4 Analysis	Source document
Documentary evidence in the form of WHO's Financial Rules and Regulations require that external audits are conducted to specified international standards and in conformity with generally accepted common auditing standards. The Report of the External Auditor (2017) notes financial statements of WHO are audited in accordance with the Financial Regulations and in conformity with the International Standards on Auditing issued by the International Auditing and Assurance Standards Board. WHO Financial statements are prepared in accordance with International Standards on Auditing (ISAs) and International Public-Sector Accounting Standards (IPSAS). Where a specific matter is not covered by IPSAS, the appropriate International Financial Reporting Standards (IFRS) is applied. The Report of the External Auditor 2017 complied with international standards. No management response was available against the Report of the External Auditor 2017, nor for earlier years. However, whilst no stand-alone management response is prepared against the Auditor reports, progress on implementation is routinely reported against the external and internal audit recommendations, through an annual report which provides an update of actions taken by the Secretariat to ensure full implementation of external and internal audit recommendations. Documentary evidence on the implementation of external and internal audit recommendations is available for successive years (2015; 2016; 2017). Internal Oversight Services (IOS) reports directly to the Director-General. Documentary evidence notes IOS 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 the Uniform Guidelines for Investigation, endorsed by the 10th Conference of International Investigators in 2009. Internal Audit reports and progress of audit work since last year operates within the COSO framework for internal control, with an internal dashboard shared with DG. Internal control effectiveness has gone up to 75%. Implementation of audit recommendations has improved and gone from 15 months to 4-6 months, with DG and GPG encouraging increased implementation. The Report of the Internal Auditor 2017 is publicly available.	15, 17, 41, 42, 50
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	Highly satisfactory
Overall MI score	3.67
Element 1: A clear policy or organisational statement exists on how any issues identified through internal control mechanisms will be addressed	4
Element 2: Management guidelines or rules provide clear guidance on the procedures for addressing any identified issues, including timelines	4
Element 3: Clear guidelines are available for staff on reporting any issues identified	4
Element 4: A tracking system is available which records responses and actions taken to address any identified issues	3
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)	4
Element 6: Timelines for taking action follow guidelines/ensure the addressing of the issue within twelve months following its reporting	3
MI 4.5 Analysis	Source document
WHO has a robust internal control mechanisms comprising of a set of operational and financial safeguards, using an organisation-wide common framework and harmonisation of risk management practices. The Office of Compliance, Risk Management and Ethics (CRE) promotes transparency and management of corporate-level risk, within the framework of WHO's ethical principles. The WHO Internal Control and the WHO Accountability Framework provides WHO's overall approach to internal control. WHO's Corporate Risk Policy and Risk Register provide the structure and tools for risk management and analysis - data is available online, allowing data on risk to be shared easily, including Risk management committee with senior management. Evidence from staff interviews and consultations across the levels of the organisation notes risk management is built into the planning process and reflected work plans. WHO Accountability Framework is based on the "Three Lines of Defense" model, recommended and enacted by nine UN agencies as a suitable common reference model for providing assurance and enhancing accountability in the UN system. WHO's overall approach to internal control is strengthened through regional level frameworks to address localised risks, with compliance functions established in all major offices alongside the organisation-wide risk management system. Staff interviews and consultations note this multi-level approach is effective. A set of independent departments within WHO are responsible for monitoring adherence to internal controls and WHO provides guidelines to assess the overall effectiveness of internal control and to identify risks, gaps and weaknesses within existing controls. All budget centres conduct an annual assessment of internal controls using a standardised tool: the Internal Control Framework self-assessment checklist. The checklist provides a structured set of questions to guide managers and help them to better understand the management environment and operations. The Internal Control Framework self-assessment checklist is a web-based tool must be completed on an annual basis. Guidance set out in the Internal Control Framework states that issues must be dealt with the relevant person within a timely manner to address identified deficiencies though does not give further details. Additional detailed guidance is provided in the Corporate risk register.	1, 7, 13, 15, 17, 18, 26, 27, 36, 38, 39, 40, 42, 44, 45, 70, 91, 93

Clear guidance, checklists and tools exist to guide staff in complying with its risk management policies. WHO's Code of Ethics and Professional Conduct outlines the requirement for accurate records to be kept regarding internal control, noting: "It is crucial that WHO maintains accurate records and internal control systems. As such, staff members must record all transactions and prepare accurate and complete records, in accordance with established procedures". Induction for all staff on internal audit mechanisms to achieve greater risk awareness and training on risk management are routinely undertaken; with regional counterparts supporting the CRE process. Additional guidance is provided by the Independent Expert Oversight Advisory Committee and the Executive Board following the risk evaluation process (risk registers). Risk registers keep an up-to-date record of all risks identifies within WHO budget centres, with guidance noting "All risks at an office level are captured in a formal risk register, subject to regular review by managers and escalated to more senior levels for attention as required". The Evaluation of WHO Reform 2017 notes: "Risk registers have been established in 98% of WHO budget centres with around 2,800 risks identified and dedicated risk mitigation plans are in place for 98% of all identified risks across the Organisation". WHO's internal audit coverage responds to the principle risks identified. The risk assessment process considers three potential risk areas including country, technical work, cross cutting issues. A 3-year rolling plan for audit is presented to Independent Expert Oversight and Advisory Committee (IEOAC), which is then presented to the DG. Within a biennium the work plan covers all regions – except PAHO which has its own inspector general. Input is solicited from management into the audit planning. IEOAC meeting reports are published, but some aspects are necessarily kept confidential. Efforts to enhance accountability in recent years have resulted in a reduction of outstanding audit recommendations from 25% in 2010 to 3% in 2016. A process for reporting and implementing recommendations regarding internal control mechanisms exists, with reports issued by the Office of Internal Oversight (IOS) and the reports of the WHO External Auditor, together with recommendations for improvement that are provided to the Office of the DG. Reports of the IEOAC (which reviews all audit reports, risk reports, as well as financial reports and other information relevant to the overall control framework) are provided to the DG, and to the Executive Board, with the purpose of advising upon risk management, financial and internal control matters, identifying any potential areas for improvement and providing advice on how to address weaknesses. WHO publishes annually external and internal audit recommendations with progress on implementation (ref: 2015, 2016, and 2017), though these are not always implemented within 12 months in all cases.	1, 7, 13, 15 ,17, 18, 26, 27, 36, 38, 39, 40, 42, 44, 45, 70, 91, 93
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	4
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 of management and staff in implementing/ complying with the guidelines	4
Element 3: Staff training/awareness-raising has been conducted in relation to the 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	4
MI 4.6 Analysis	Source document
WHO has in place a clear Fraud Prevention Policy supported by Fraud Awareness Guidelines; this is reinforced by its Code of Ethics and Professional Conduct. The Office of Internal Oversight Services is empowered to initiate and conduct investigations. Staff interviews and consultations notes this is actively applied. The Code of Ethics and Professional Conduct highlights the role of management and supervisors, as well as WHO staff, have in promoting a workplace culture that upholds WHO’s ethical principles. WHO requires all staff members in designated employment categories to complete an annual declaration of interests. The aim of the exercise is to ensure that identified WHO staff members are free from any direct or perceived conflict of interest that may have adverse consequences on their, and therefore WHO’s, credibility, competence and independence. Currently, senior staff (at the P5 level and above), procurement staff and other staff in sensitive functions (at the G5 level and above) are requested to complete a declaration of interest form WHO ensures all existing staff have undertaken ethics and professional conduct training, with briefings provided to all new WHO staff during induction/orientation sessions. Annual training is conducted for newly-appointed heads of offices in countries, territories and areas and all staff members in headquarters to provide information on ethical behaviour, whistleblowing, protection from retaliation, and the risk of fraud. Advice and guidance on specific issues is provided through CRE, Ombudsperson, HRD or DAFs as applicable. Fraud risks are a specific component of the annual risk management exercise introduced in 2014 and are reported on an annual basis to WHO’s governing bodies. Regular reporting is also provided in WHO’s mid-term programmatic and financial report, which notes the effectiveness of internal controls alongside the signed External Audit Statement. Documentary evidence including internal and external audit reports, in addition to IAOC reports, have all shown improvements in financial management; noting tighter use of IMPREST system and reduction in unreconciled accounts. Significant efforts to reduce financial mismanagement within country teams has targeted DFC; this was also noted during staff interviews and consultations. There is a dedicated WHO Whistle-blower Protection Policy and Procedures; alongside guidance on contacting CRE. An <i>Integrity Hotline</i> has been established to provide a safe and independent mechanism to report any concerns about issues involving WHO. It is managed by a professional company selected competitively by WHO. The integrity hotline is contractually bound not to share an individual’s personal details with WHO without permission from that individual and accepts anonymous reports. CRE issues an annual report outlining a typology of actions taken pertaining to the Whistleblowing policy. The Report of the Internal Auditor 2017 notes the number of investigations and by type as well as details of each case made public.	5, 7, 12, 17, 40, 42, 43, 61
MI 4.6 Evidence confidence	High confidence

RELATIONSHIP MANAGEMENT

Engaging in inclusive partnerships to support relevance, to leverage effective solutions and to maximise results (in line with Busan Partnerships commitments)

KPI 5: Operational planning and intervention design tools support relevance and agility (within partnerships)	KPI score
Satisfactory	2.31
WHO's operational planning aligns with national health priorities and uses this as the starting point for health situation analyses to identify priorities and develop Country Cooperation Strategies (CCSs). Significant headway has been made in the approach to planning and prioritising activities based on country needs with an improving trajectory as CCS are routinely updated. External stakeholder consultations are actively undertaken early and throughout the CCS development process to strengthen relevance. WHO has well established access and strong relationships with Ministries of Health in country; as well as other ministries and partners given its prominent convening and chair/ co-chairing roles. This allows WHO to develop its CCSs based on joint understanding and close working with partners; ensuring strong emphasis on participation, contextual analysis and country ownership. CCSs contain a focus on cross cutting issues in most cases, though as yet this is not universally applied nor do they address all cross-cutting issues consistently. Significant progress has been made to the management and mitigation of risk since the 2013 MOPAN assessment. With adoption of the comprehensive risk management policy in late-2015, risk management is now firmly embedded into operational planning and is more consistently built into work plans ensuring that risks and risk mitigation measures are identified and enacted. WHO is diligent and active in protecting its reputational asset and is very serious about not compromising or negatively influencing its normative function. FENSA provides an effective framework and mechanism for defining and guiding WHO's engagement with non-state actors and managing reputational risk. A clear process exists related to 'official relations' with WHO and a review committee approves partnerships to avoid conflict of interest. WHO's normative work is predicated on sustainability. Built within its mandate and core function, WHO's technical support seeks to enable and empower countries to implement the health-related interventions. WHO actively considers and is engaged in strengthening the enabling policy and legal environment required to sustain expected benefits of its intervention. The CCSs and regional frameworks provide detailed monitoring for interventions, however they do not explicitly note speed of implementation universally and consistently.	
MI 5.1: Interventions aligned with national/regional priorities and intended national/regional results	Score
Overall MI Rating	Satisfactory
Overall MI score	3
Element 1: Reviewed country or regional strategies make reference to national/regional strategies or objectives	3
Element 2: Reviewed country strategies or regional strategies link the results statements to national or regional goals	3
Element 3: Structures and incentives in place for technical staff that allow investment of time and effort in alignment process	3

MI 5.1 Analysis	Source document
The assessment reviewed a selection of current Country Cooperation Strategies (CCS) across the countries of interest in the 2017-18 cycle; as well as corporate guidance issued on developing CCSs. Guidance identifies the starting point for the development of CCS as the national health priorities and analysis of needs (health situation analysis to identify priorities). The Evaluation of WHO Reform notes that “significant headway has been made in the approach to planning and prioritising activities based on country needs. This includes notably increased alignment of Country Cooperation Strategies with national health strategies and plans, as well as the allocation of 80% of country office’s budget on a maximum of 10 priorities agreed with each Member State”. Efforts are underway to ensure full implementation in all cases as new CCSs are developed. The perception survey positively notes that interventions fit with national priorities and results of partner countries with 89.38% rating fairly good, very good or excellent (14.39; 45.45; 29.54%). Documentary and interview evidence notes that regional and country planning frameworks are well established and enacted. Evidence of regional office engagement in the CCS development process was well noted throughout the interviews across the three levels of the organisation. A process of review together with regional offices and PRP and sector specialists prior to CCS launch was evidenced through staff interviews and consultations. As noted above, the use of national health priorities and goals are incorporated into CCSs and country biennial workplans and targets. Significant effort has been exerted in the development of structures, systems and processes of how a country co-operation strategy is developed and aligned. External stakeholders are included in the beginning and throughout the CCS development process; with an agreed roadmap for consultation process developed which involves the stakeholders meeting early (e.g. Ministry of Health; and others such as the Ministry of Planning, Parliament, state governors). Documentary and interview evidence notes the SDG agenda and country priorities are very strong drivers in CCSs; with emphasis on the country level than an HQ driven approach. Alignment of WHO’s contribution to the UNDAF health component and overarching UN reform priorities working in partnership with UN in country is also noted in documentary and interview evidence. It is recognised that national health planning cycles have varying time frames and a country cooperation strategy is usually developed for 4–6 years, which can make aligning these strategic documents complex. The Evaluation of Reform noted that “Seventy-four per cent of the country offices reported alignment between the time frame of country cooperation strategies and national health policies, strategies and plans, showing a significant increase of more than 30 percentage points compared with the 2012 (36%) and 2015 (43%) country presence reports”.	49, 70, 95, 96
MI 5.1 Evidence confidence	High confidence

MI 5.2: Contextual analysis (shared where possible) applied to shape the intervention designs and implementation	Score
Overall MI Rating	Satisfactory
Overall MI score	2.5
Element 1: Intervention designs contain a clear statement that positions the intervention within the operating context	3
Element 2: Context statement has been developed jointly with partners	3
Element 3: Context analysis contains reference to gender issues, where relevant	3
Element 4: Context analysis contains reference to environmental sustainability and climate change issues, where relevant	2
Element 5: Context analysis contains reference to governance issues, including conflict and fragility, where relevant	2
Element 6: Evidence of reflection points with partner(s) that take note of any significant changes in context	2
MI 5.2 Analysis	Source document
The reviewed Country Cooperation Strategies (CCS) provide detailed situational analysis for each of the priority programmes with national health programmes described in the national operating context. Efforts are underway to ensure full implementation in all cases as new CCSs are developed. The perception survey positively notes that interventions are tailored to the needs of local context with 69.68% rating fairly good, very good or excellent (11.36; 36.36; 21.96%). The perception survey further notes that WHO/ interventions are adaptive to changes in context with 67.41% rating fairly good, very good or excellent (13.25; 23.48; 30.68%). WHO has well established access and strong relationships with Ministries of Health in country; as well as other ministries and partners given its prominent convening and chair/ co-chairing roles. Evident to this, the Evaluation of WHO reform notes: "Of the 113 WHO offices reporting participation in coordinating mechanisms for health sector partners at the country level (76%), WHO staff members chaired or co-chaired in 60 (53%) and participated in such mechanisms in the other 53 (47%). The number of countries, territories and areas in which WHO has a leadership role in coordinating the health sector has increased by 5 percentage points between 2015 and 2017, suggesting a growing role of WHO in coordinating health development partners at the country level". Interview evidence notes that this level of access and engagement allows WHO to develop its CCSs based on joint understanding and close working with partners - including workshopping to ensure strong emphasis on participation, contextual analysis and country ownership. The reviewed Country Cooperation Strategies (CCS) contained specific reference to gender issues, with consideration given to issues pertaining to gender equality; access to reproductive health services; violence against women; links to National Women's Development Plan (where relevant); as well as global targets (e.g. MDGs and SDGs). Efforts by the GER team to build capacity in country are noted in MI 2.1a, above. This includes GER guidance for WHO programmes and CCS development; the Innov8 approach at country level include gender (as well as equity and human rights) as one of the core elements of context analysis and online courses on the iLEARN platform.	49, 63, 95, 96, 98

Guidance on the development of CCSs identifies specific questions with reference to environmental sustainability and climate related contextual factors, including vulnerability to natural disasters and climate change. Evidence of its use was seen in some cases. Of the reviewed Country Cooperation Strategies (CCS), a number contained some reference to environmental sustainability and climate change issues, for example Myanmar and Thailand 2017-21 note a focus on the impact of climate change on health and adolescent health. Of those reviewed Country Cooperation Strategies (CCS), reference to governance and accountability issues related to improving health status compounded by conflict and conflict-related complex emergencies were noted where relevant. Evidence of its use was therefore seen in some cases. Whilst evidence exists that reviews are undertaken during each planning cycle to ensure that the CCS priorities and their strategic approaches continue to provide a sound basis for the collaborative workplans and their outcomes and that evidence exists of mid-term reviews in every biennium, it is not clear that key partners are involved in the majority or all cases.	49, 63, 95, 96, 98
MI 5.2 Evidence confidence	High 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	1.6
Element 1: Intervention designs contain a clear statement of capacities of key national implementing partners	2
Element 2: Capacity analysis considers resources, strategy, culture, staff, systems and processes, structure and performance	1
Element 3: Capacity analysis statement has been developed jointly where feasible	2
Element 4: Capacity analysis statement includes clear strategies for addressing any weaknesses, with a view to sustainability	2
Element 5: Evidence of regular and resourced reflection points with partner(s) that take note of any significant changes in the wider institutional setting that affect capacity	1
MI 5.3 Analysis	Source document
Guidance for the formulation and development of CCSs notes that a capacity analysis should be conducted and included in the development of the CCS. However, limited documentary evidence within the reviewed CCSs was available to demonstrate that intervention designs contain clear statements of capacities of key national implementing partners. This guidance also details methods of conducting a health situation analysis of the country health system. This health situation assessment and analysis includes understanding whether the core response capacity requirements for the International Health Regulations (IHR) have been met by the country and whether the country has the capacity to respond in a timely and coordinated fashion to a major epidemic or pandemic. The perception survey positively notes that assessments of national/ regional capacities are realistic; with 65.89% rating fairly good, very good or excellent (13.25; 26.51; 26.13%).	31, 127, 135

CCS guidance notes that country offices should consider the implications for the biennial workplan and HR plan and ensure that the country office has the core capacity (in terms of infrastructure, human and financial resources) and other resources needed to implement the intervention. Where capacity is found to be insufficient, consideration is made to fill the gaps in terms of priority-setting, programming and accountability. To guide the health situation analysis, a series of questions to assess the countries capacity are posed under the IHP, for example: “Have the core response capacity requirements for the IHR been met by the country? Is the country prepared, and does it have the capacity, to respond in a timely and coordinated fashion to a major epidemic or pandemic?” This information is subsequently used to inform the JEE assessment of a country’s capacity under the International Health Regulations (2005) to prevent, detect, and respond to public health threats whether occurring naturally or not. In using the JEE to develop its plan of action, the country is able to highlight gaps and needs for both current and prospective donors and partners in an effort to fill gaps with resources”. Annual reporting on the IHR M&E Framework is then made available online and provides data across WHO member states through the JEE Dashboard. Whilst available documentary evidence is somewhat limited on specific country focussed intervention design and implementation, the Strategic Partnership for International Health Regulations and Health Security (SPH) and associated Joint External Evaluations (JEE) provides some evidence of a voluntary, collaborative, multisectoral process to assess country capacity to prevent, detect and rapidly respond to public health risks occurring naturally or due to deliberate or accidental events. The JEE process, as detailed above, provides some evidence of addressing weaknesses, with a view to sustainability. There is limited evidence found of regular and resourced reflection points with partners, though some examples of after action reviews were available after the JEEs. There was no evidence that this is systematically applied to take note of significant changes in the wider institutional setting that affect capacity.	31, 127, 135
MI 5.3 Evidence confidence	High 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	Highly satisfactory
Overall MI score	3.17
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	3
Element 4: Intervention designs include detailed analysis of and mitigation strategies for reputational risk	4
Element 5: Risks are routinely monitored and reflected upon by the partnership	3
Element 6: Risk mitigation actions taken by the partnership are documented and communicated	3

MI 5.4 Analysis	Source document
Significant progress has been made to the management and mitigation of risk since the 2013 MOPAN assessment. With the adoption of the comprehensive risk management policy in November 2015, risk management is now firmly embedded into operational planning. Risk management is more consistently built into work plans ensuring that risks and risk mitigation measures have been identified, documented and incorporated. This has resulted in better risk analysis and mitigation planning into regular implementation on work plans. A risk management online tool has also been developed with built in validation and feedback loops. At a corporate level, WHO's Risk Management Policy sets out the high-level objectives of WHO's risk management process: to inform effective decision-making to improve delivery of results; and to embed risk management in operational processes and in the results-based management cycle (planning, performance assessment, budgeting), in addition to the accountability and internal control frameworks. Documentary evidence, including guidance on the formation of CCSs, states that all country strategies must include risk management strategies, requiring an office risk management strategy with measures such as readiness and business continuity plans to address internal and external risks to WHO operations, e.g. financial, security and natural hazards. Evidence of implementation was noted within CCSs and through staff interviews and consultations. Linking to the operational planning process, each WHO Budget Centre is requested to define and record key risks that could be impacting the achievement of its key objectives next biennium, outlining also the related risk response actions. Risks and risk response actions are then prepared and submitted in line with the new Risk Management Tool. The Evaluation of WHO Reform 2017 highlights that the presence of the risk management policy with a country level approach to financial risk management "Risk registers have been established in 98% of WHO budget centres with around 2,800 risks identified and dedicated risk mitigation plans are in place for 98% of all identified risks across the Organisation". Of those CCSs reviewed, including those most recent CCSs developed based on the latest guidance (2016), explicit chapters or sections on risk management are included, including operational risks. However, this is not yet universally applied as some of those CCSs reviewed do not have risk mitigation measures in place. This will undoubtedly be addressed as older CCSs are completed/ phased out and new CCSs developed. The perception survey positively notes that WHO appropriately manages risk in a given context; with 67.79% rating fairly good, very good or excellent (10.22; 33.33; 24.24%). Detailed risk categories are captured within WHO's risk management framework. WHO's risks are based on categories of risks identified in the corporate risk register linked to country offices, regional offices, technical clusters, management and administration, and enable an organisation-wide view to be taken of major/ strategic risks. Given WHO's diverse operating environment, including WHO identified priority risk countries (due to conflict; emergency and outbreak; countries in crisis; and at risk of crisis), risk management and mitigation strategies are adaptive across the three levels of the organisation. Political, strategic and higher risks associated with certain types of programmes such as health emergencies are analysed in detail. Guidance on operational planning has recently been issued for budget centres to ensure that reputational risks (among others) are planned and budgeted for in the operational planning process. In concert to this, the Compliance, Risk and Ethics (CRE) department play a key role in supporting other departments function smoothly by supporting them and senior management in managing reputational risk for WHO. In staff interviews, this was noted positively as an enabling function for programmatic work.	14, 31, 50, 95, 96, 109, 121

FENSA is an effective framework and mechanism for defining and guiding WHO's engagement with non-state actors, classifying partnerships and managing reputational risk. A clear process exists related to 'official relations' with WHO, being accredited with a joint work plan, which has to be reported against to WHA every 3 years. A review committee approves partnerships to avoid conflict of interest. Staff interviews and consultations note the significance of managing reputational risk and conflict of interests: this was seen universally as of significant importance. WHO is active in protecting its reputational asset and is very serious about not compromising or negatively influencing its normative function. For engagements with non-State actors, WHO actively manages and mitigates risks in accordance with FENSA; which incorporates detailed principles and policies to improve the management of conflicts of interest and other risks of engagement with Non-State Actors and to bring greater transparency in WHO's relations with Non-State Actors. WHO hosted partnerships, such as such as PMNCH, TDR, HRP, apply and document the risk using the risk management framework. UNITAID and the Framework Convention for Tobacco Control secretariat have their own risk management process. Each WHO budget centre is required to identify risks; report these risks to senior management according to their level of criticality; and provide recommendations for action to implement mitigation measures. Evidence of the establishment and use of a systematic central monitoring mechanism to facilitate this exercise and ensure regular follow-up was noted in documentary and interview evidence.	14, 31, 50, 95, 96, 109, 121
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	Satisfactory
Overall MI score	2.43
Element 1: Intervention design documentation includes the requirement to analyse cross-cutting issues	3
Element 2: Guidelines are available for staff on the implementation of the relevant guidelines	3
Element 3: Approval procedures require the assessment of the extent to which cross-cutting issues have been integrated in the design	2
Element 4: Intervention designs include the analysis of gender issues	3
Element 5: Intervention designs include the analysis of environmental sustainability and climate change issues	2
Element 6: Intervention designs include the analysis of good governance issues	2
Element 7: Plans for intervention monitoring and evaluation include attention to cross cutting issues	2
MI 5.5 Analysis	Source document
Guidance on the formation and development of CCSs gives clear requirements to address cross-cutting issues to include gender, equity, human rights, and the environment. Country programme documents (CCSs or workplans) reviewed refer to one or more cross-cutting priorities but they do not consistently identify all four thematic priorities. WHO tracks the number of WHO programme areas that have integrated gender, equity and human rights; and the number of countries implementing at least two WHO-supported activities to integrate gender, equity and human rights in their health policies and programmes.	31, 73, 74, 75, 94, 95, 96, 149

Guidance on the formation and development of CCSs provide checklists on integrating essential criteria of gender, health equity and human rights into the CCS development process and document. Specific examples include a priority-setting tool which can be used for country teams to ensure gender issues are adequately incorporated. As noted in KPI 2, the GER team in conjunction with other WHO Departments (incl. Department of Information, Evidence and Research (IER), Health Systems Governance and Financing (HGF) and the Unit of Social Determinants of Health (SDH) further provide a Country Support Package for Equity, Gender and Human Rights (in Leaving No One Behind in the path to Universal Health Coverage). At a CCS level, twelve CCSs (19%) among 64 have prioritised strategies addressing cross-cutting interventions. WHO internal analysis (WHO Country Cooperation Strategies Global Analysis 2017) notes the percentage of WHO CCSs developed during the biennium 2016–2017 that are explicitly guided by the Organisation's core values and approaches based on equity, human rights, gender and social determinants, show the following results for 39 CCSs, which belong to the biennium 2016–2017. Thirty-five (95%) addressed social determinants of health, 89% (33) addressed equity, 86% (32) addressed gender, and human rights was addressed by 65% of them (24). At a CCS level, there is positive evidence to highlight existing efforts and continued commitment to addressing gender. A number of CCSs and work plans included an explicit focus on poverty and inequality, gender equality, violence against women and gender-based violence; but this was not universally applied in all cases for human rights. There is also positive evidence of the inclusion of analysis of environmental sustainability and climate change issues, including the use of environmental screening tools; alongside reporting on results of environmental management measures taken. WHO also tracks at a corporate level the number of countries that have developed health adaptation plans for climate change. At a CCS level, there is positive evidence to highlight efforts to promote the principles of good governance in intervention design through WHO's work strengthening the governance of health systems as a form of good governance. Monitoring targets for cross-cutting issues are integrated into the CCSs reviewed and are tracked at a country, regional and global level, though this is not yet universally applied in all cases.	31, 73, 74, 75, 94, 95, 96, 149
MI 5.5 Evidence confidence	High 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	2.25
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: Key elements of the enabling policy and legal environment that are required to sustain expected benefits from a successful intervention are defined in the design	3
Element 3: The critical assumptions that underpin sustainability form part of the approved monitoring and evaluation plan	0
Element 4: Where shifts in policy and legislation will be required these reform processes are addressed (within the intervention plan) directly and in a time sensitive manner	3

MI 5.6 Analysis	Source document
Much of WHO's work is predicated on sustainability. Much of WHO's normative work, for example, provides a foundation for the work of other partners, guiding their work, innovation, and effective strategies to address health issues sustainably (through institutional development and capacity building). Built within its mandate and core function, WHO's technical support seeks to enable and empower countries to implement the health-related interventions, rather than WHO doing it for them. Documentary evidence, including guidance of the formation and development of CCSs and those CCSs reviewed, identifies that a key consideration of intervention design and work planning of country interventions on health system strengthening are designed to support long-term sustainability. The capacity building programmes of WHO, through fellowships and trainings, seeks to build human capacity, with the aim that they will eventually lead implementation and ensure sustainable results. Across those CCS reviewed, evidence exists that where WHO operates to substitute capacity in countries, WHO works towards building the capacity in countries, until the countries are ready to operate and conduct the interventions. The overall intention of WHO's support model is to ensure that, ultimately, results are sustained and not merely provide short-term solutions. The Polio Eradication & Endgame Strategic Plan demonstrates WHO's focus on sustainability. As part of the Polio transition planning, for example, WHO will provide technical assistance to ensure that polio eradication capacities fully support country priorities, whilst also meeting the need to sustain polio-free status after eradication. WHO will provide technical assistance to enhance the mobilisation of domestic and external financing, in order to support all three tiers of polio transition countries and to ensure sustainability. The perception survey positively notes that WHO interventions are implemented to sustain impact over time; with 62.49% rating fairly good, very good or excellent (8.71; 25; 28.78%). Evidence that WHO ensures that key elements of the enabling policy and legal environment required to sustain expected benefits its intervention are clearly evident. For example, WHO's work programme on law and universal health coverage supports countries to ensure that their existing (or proposed) legal, administrative and institutional settings enable and do not hinder the path towards universal health coverage (UHC). Creating an enabling legal environment for UHC means taking steps to remove legal barriers to UHC as well as developing and maintaining laws which support the different dimensions of universal health coverage. Staff consultations highlight an important part of WHO's work program on law and UHC is working to unpack the details of what makes up an enabling legal environment for universal health coverage, looking across all the building blocks of the health system. WHO also provides the Health law library: a free online collection of information about health law. It aims to provide free access to information about health law to governments, health system users and all organisations and individuals who play a role in the health system. Still under development, WHO is creating a guide to health law diagnostics: a new manual that will offer step-by-step guidance on how to carry out a health law diagnostic, a methodology for assessing the strengths and weaknesses of a health system's legal environment. A further example includes the Global technical strategy for Malaria (2016-30), which highlights a stronger focus on improved supply chains and better regulation and oversight of the activities of private sector pharmaceutical vendors as being crucial to making systemic improvements.	94, 95, 96, 97, 98, 107

Whilst the reviewed CCSs note the importance of sustainability in design and delivery, no clear articulation of the assumptions that underpin sustainability were noted as forming part of the approved monitoring and evaluation plan. Documentary evidence, including global strategies and intervention documentation, highlight the implications of shifts in policy and legislation in reform processes.	94, 95, 96, 97, 98, 107
MI 5.6 Evidence confidence	High confidence
MI 5.7: Institutional procedures (including systems for engaging staff, procuring project inputs, disbursing payment, logistical arrangements etc.) positively support speed of implementation	Score
Overall MI Rating	Unsatisfactory
Overall MI score	1.25
Element 1: Internal standards are set to track the speed of implementation	2
Element 2: Organisation benchmarks (internally and externally) its performance on speed of implementation across different operating contexts	2
Element 3: Evidence that procedural delays have not hindered speed of implementation across interventions reviewed	0
Element 4: Evidence that any common institutional bottlenecks in speed of implementation identified and actions taken leading to an improvement	1
MI 5.7 Analysis	Source document
The CCSs and regional frameworks provide detailed monitoring for interventions however, they do not explicitly note speed of implementation. The Health Emergencies Programme actively tracks the percentage of requests for initial emergency funds (of up to US\$ 500 000) disbursed within 24 hours of request with evidence suggesting this was mostly successful. The Health Emergencies Programme also tracks how effectively the programme is managed, sustainably staffed and financed. Documentary evidence notes that external events, such as health emergencies, impact the speed of implementation. The Contingency Fund for Emergencies has disbursed more than US\$ 18 million since its inception in May 2015, whilst the Programme as a whole has acted rapidly in response to outbreaks such as Zika and Yellow Fever, humanitarian crises such as the emergency in northern Nigeria, and natural disasters such as Hurricane Matthew in Haiti. Responses to the five most severe (Grade 3) emergencies — Iraq, Nigeria, South Sudan, Syrian Arab Republic, and Yemen — are being managed according to the newly adopted Incident Management approach, which requires substantial Organisation-wide support”. In relation to tracking of implementation, WHO management regularly monitors implementation rates both at HQ and regional level, for example through its internal monthly financial update, management follow up with award managers at key stages (50% and 75% of the period) and subsequent tracking through business intelligence systems. Any exceptions to timely implementation would also be picked up in donor reporting. Where bottlenecks are identified, actions have been taken to improve in certain cases, such as in the process for approval of the Award Budget which previously delayed the provision of funds for implementation or in how HR recruitment is actioned in WPRO. Some limited evidence was identified that WHO benchmarks its performance on speed of implementation across different operating contexts. It is not clear whether it monitors if that procedural delays have hindered speed of implementation across interventions.	54, 94, 95, 96, 97, 98
MI 5.7 Evidence confidence	Little to no confidence

KPI 6: Works in coherent partnerships directed at leveraging and/or ensuring relevance and catalytic use of resources	KPI score
Satisfactory	3
Significant and necessary improvements in WHO's operational agility on emergency response has been achieved. Earmarking of resources remains a material constraint on agility. WHO has a well-developed, flexible, sophisticated and increasingly transparent approach to partnerships and collaborations – a key instrument in most areas of its work. Within its partnership approach, WHO carefully considers its comparative advantage and role. Across all levels of the organisation, much of WHO's delivery approach is actively based around partnership, synergies and leverage. As part of its new external engagement strategy, WHO is in the process of resetting and repositioning its role within key partnerships. Aligning WHO's resources to fit with comparative advantage seems to happen more effectively on people and expertise than on financial resources. Alignment with country objectives and building national capacity is central to how WHO works. While joint planning, programming, monitoring and information sharing is clearly a strength, joint evaluation work by WHO of the type which other UNEG members engage is less common. The 'secret work of WHO' is often much less visible and thus less funded: resources are in short supply relative to potential value added. WHO's knowledge generation is a central part of its role in the global health system and has a strong reputation. Its work with member states on health statistics and standards is central in building the infrastructure for monitoring health of beneficiaries, which is a major contribution.	
MI 6.1: Planning, programming and approval procedures enable agility in partnerships when conditions change	Score
Overall MI Rating	Satisfactory
Overall MI score	2.4
Element 1: Mechanisms in place to allow programmatic changes and adjustments when conditions change	2
Element 2: Mechanisms in place to allow the flexible use of programming funds as conditions change (budget revision or similar)	2
Element 3: Institutional procedures for revisions permit changes to be made at country/regional/HQ level within a limited timeframe (less than three months)	2
Element 4: Evidence that regular review points between partners support joint identification and interpretation of changes in conditions	4
Element 5: Evidence that any common institutional bottlenecks in procedures identified and action taken leading to an improvement	2

MI 6.1 Analysis	
WHO's agility in making changes and adjustments to programmes and using resources flexibly as conditions change is quite heavily constrained by one overriding factor - the high level of donor earmarking of resources. With certain exceptions, this earmarking means that WHO's ability to make flexible use of programming funds as conditions change is rather limited. This in turn impacts on the whole process - even though planning processes, including country cooperation strategies, identify required changes in programmes as conditions change, those changes cannot happen quickly (and certainly not within 3 months) because earmarked resources do not move flexibly and/or there is a requirement to prioritise areas which are set by donors rather than determined by needs assessments with country partners. Addressing bottlenecks is also affected, as this also depends on being able to redeploy resources flexibly. This constrained environment affects WHO's agility across the board and is reflected in the lower ratings for all but one element in micro indicator. On the positive side, the feedback from country partners suggests that WHO clearly works well with partners to review and identify changes in conditions regularly, to understand how the programmes should evolve. Most respondents in the survey identify WHO as fairly good, good or excellent at adapting to local context, and good or very good at building in regular review points with partners, hence this area is rated more positively. When asked how far WHO's operational procedures cause delays for partners, the most common response was the WHO was 'fairly good'. Overall the higher rating on element 4 pushes up the rating for the MI to satisfactory level, despite the rigidities caused by earmarking. In summary, it appears that WHO has mechanisms in place to review the changing context and identify the programmatic changes that would be required - including for example through the country planning processes - but speed and agility in making changes operational is constrained when resources have to move. There are one or two important exceptions to this overall picture, where progress is being made towards much greater agility in programming partly because specific procedures have been agreed with donors which enable this. One crucial area, where speed and agility of response is fundamental, is emergency response. There have been significant and necessary improvements in WHO's agility on emergency response, as shown by the IOAC report. The WHA resolution 68.1 gives the DG authority to make budget transfers of up to 5%, with additional spending where necessary for outbreak and crisis response. Specific mechanisms such as the regional hubs and the global alert network within the WHE allow staff and experts to respond quickly in crisis situations. Another area of progress is the ongoing transformation process at regional and country level, notably in AFRO, which seeks to match capacity better to needs and priorities. The PAHO Program and Budget 2018-19 includes the flexibility to shift PB allocation among the six categories in order to accommodate emerging priorities and changes in funding availability during the biennium. WHO is fully aware that tackling the issue of earmarking of resources is important and this is something which the DG is focusing on with member states and donors. The Organisation is also seeking to create flexibility where it can internally. Earlier changes such as how GPG is used, joining up across the category and program area networks and the PB process aimed at joining up across the 3 levels. This is being accelerated under GPW13 with the aim to focus much more on country level needs. Flexibility on the funding side is a priority for the DG but will take time.	17, 47, 92, 101
MI 6.1 Evidence confidence	High confidence

MI 6.2: Partnerships based on an explicit statement of comparative advantage e.g. technical knowledge, convening power/partnerships, policy dialogue/advocacy	Score
Overall MI Rating	Satisfactory
Overall MI score	2.75
Element 1: Corporate documentation contains clear and explicit statement on the comparative advantage that the organisation is intending to bring to a given partnership	3
Element 2: Statement of comparative advantage is linked to clear evidence of organisational capacities and competencies as it relates to the partnership	3
Element 3: The organisation aligns its resources/competencies to its perceived comparative advantage	2
Element 4: Evidence that comparative advantage is deployed in partnerships to positive effect	3
MI 6.2 Analysis	Source document
WHO has a well-developed, flexible, sophisticated and increasingly transparent approach to partnerships and collaborations – a key instrument in most areas of its work. Within this approach it carefully considers its comparative advantage and role – recognised strengths include its convening role, expert knowledge, data, ability to be seen as an honest broker/adviser, close relationships and trust with health ministries and governments, and its presence across the full range of member states (i.e. both developed and developing countries). The 12th and 13th GPW, the WHO policy on partnerships and the FENSA documentation show that understanding its comparative advantage is an important element of WHO's overall approach to partnerships. Meanwhile, HQ interviews suggested that WHO, as part of its new external engagement strategy, is in the process of resetting and repositioning its role within key partnerships, e.g. with global funds, so that its technical expertise and added value is more clearly recognised – not being able to bring resources to the table as often as other partners can affect this. Survey responses show that WHO is seen by partners as 'very good' – often 'excellent' – at prioritising working in synergy and it was clear from HQ interviews how diverse and numerous these partnerships are but also how central they are to WHO's ability to deliver. Aligning WHO's resources to fit with comparative advantage seems to happen more effectively on people and expertise than on financial resources. WHO is able to bring expertise, leadership, data, knowledge and networks to the table, but others provide the finances. HQ interviews suggested that in areas such as non-communicable diseases, health promotion, normative work (e.g. ICD classification, access to medicines) and health systems, the 'secret work of WHO' is often much less visible and underfunded: resources are in short supply relative to potential value added. This may also relate to how WHO views itself and presents itself externally, which is a key priority for the new leadership. The evaluation of the WHO reforms 3rd stage recommends that WHO identify its critical differentiating capabilities, capabilities of the Secretariat and its ability to be self-critical on WHO's actual uniqueness. HQ interviews also stressed the need for WHO to be bolder in taking credit for what it is achieving, though how it is able to capture a 'reasonable' level of contribution is yet to be defined.	1, 14, 28, 47, 48, 71, 105, 155
MI 6.2 Evidence confidence	High confidence

MI 6.3: Clear adherence to the commitment in the Busan Partnership for Effective Development Cooperation on use of country systems	Score
Overall MI Rating	Satisfactory
Overall MI score	2.33
Element 1: Clear statement on set of expectations for how the organisation will seek to deliver on the Busan commitment/QCPR statement (as appropriate) on use of country systems within a given time period	3
Element 2: Internal processes (in collaboration with partners) to diagnose the condition of country systems	4
Element 3: Clear procedures for how the organisation should respond to address (with partners) concerns identified in country systems	2
Element 4: Reasons for non-use of country systems clearly and transparently communicated	1
Element 5: Internal structures and incentives supportive of greater use of country systems	2
Element 6: Monitoring of the organisation trend on use of country systems and the associated scale of investments being made in strengthening country systems	2
MI 6.3 Analysis	Source document
The corporate documentation reviewed (including GPWs, guidance on country cooperation strategies, and CCSs themselves) suggest that effective partnership at country level is a high priority for WHO. This provides a clear set of expectations but one which is more explicit on WHO's QCPR commitment to working as part of one UN and working closely with countries than on Busan. There was much less specifically mentioned on the Busan commitment itself. Use of country systems is referred to but does not seem to be mandatory nor monitored directly, and perhaps not surprisingly this means that there was less evidence of supporting procedures, internal structures and incentives to underpin this. Reasons for non-use of country systems were also not explicitly communicated. In practice, much of what WHO does is about working with partners to understand their country systems – not so much in project implementation role but more in its capacity building role. Diagnostic work on the condition of those systems is a key strength of its technical assistance role. Alignment with country objectives and building national capacity appear to be central to how WHO works for example its role on the SDGs, advice/leadership role on universal health coverage, health data, health systems and policy, and monitoring and responding in specific disease areas. WHA is seen as very good (sometimes excellent) on relevant questions in the survey on coherence of its approach to partnership, coordination of resources, capacity building and channelling resources through country systems. Interview respondents cited examples of using country systems, but the extent and approach varied by country and region. One WR, for example, described an important step away from direct financial support in favour of technical assistance and expertise and strengthening systems in other ways. While WHO may not be focused on the Busan agreement specifically and in formal terms, including monitoring against it, it clearly works in a very collaborative manner, leading on the health SDGs and Agenda 2030 where required, building ownership with countries and working through UNDAF. In HQ interviews, examples were cited of WHO having access at the highest level with government, which seems to be helped by the way WHA and regional assemblies operate in that member states are consulted and have ownership of WHO decision/resolutions and strategies.	1, 32, 49, 71, 102, 103, 104
MI 6.3 Evidence confidence	High confidence

MI 6.4: Strategies or designs identify synergies, to encourage leverage/catalytic use of resources and avoid fragmentation	Score
Overall MI Rating	Highly satisfactory
Overall MI score	3.2
Element 1: Strategies or designs clearly recognise the importance of synergies and leverage	4
Element 2: Strategies or designs contain clear statements of how duplication/fragmentation will be avoided based on realistic assessment of comparative advantages	3
Element 3: Strategies or designs contain clear statement of where an intervention will add the most value to a wider change	4
Element 4: Strategies or designs contain a clear statement of how leverage will be ensured	3
Element 5: Strategies or designs contain a clear statement of how resources will be used catalytically to stimulate wider change	2
MI 6.4 Analysis	Source document
WHO's strategies and designs clearly recognise the importance of synergies and leverage achieved through partnership, and this is a major feature of their approach. At the global strategy level, and building on successive general programmes of work, the recently approved GPW13 agreed by the WHA sets out very clearly the importance of synergies and leverage in recognising that the 'triple billions' goals will not be achieved by WHO alone, and involve close working with member states and a wide range of other partners. Within specific program areas and at regional and country level, it was clear both from specific strategies and HQ interview and survey responses that WHO's whole intended approach to delivery is based around partnership, synergies and leverage. WHO has considerable experience and well-developed strategies for identifying where interventions can add value more broadly as part of a partnership and ensuring its leverage. Elements 1 and 3 are therefore rated as highly satisfactory. WHO's approach typically also includes making a realistic assessment of comparative advantage and ensuring an appropriate division of labour to avoid duplication and fragmentation, and a clear statement of how leverage will be ensured. Often this is achieved as part of an ongoing partnership (sometimes informal, sometimes more structured and formal) which has evolved over many years. These elements are rated as satisfactory (Elements 2 and 4). It should be noted however that while FENSA now defines and guides WHO's engagement with non-state actors, evidence from interviews across layers of the organisation points to inconsistency in engagement with different partners.	21, 34, 38, 49, 50, 71, 155

In some areas such as immunisation and malaria, the agreements with partners such as the global funds are evolving further in response to changes on both sides, and discussions are continuing about what this means and how to share the resources. In certain areas the partnerships are stronger/more mature than others, and agreeing how resources will be used (catalytically or otherwise) can be a source of frustration and contention in a few cases. Sometimes WHO is constrained by the fact that it has limited leverage over resources directly, and other partners come with deeper pockets and are pursuing change agendas in their own right – despite the fact that it originally hosted several of the key partnerships and continues to have a role on their boards. This rather more mixed picture is reflected in the lower rating for element 5. WHO's own governance structures also mean that specific types of partners (e.g. private foundations) do not have a formal seat at the table to be involved in consultations and decision making at the highest level in a formal way, so this is part of its new external engagement strategy. Overall, however, there seems to be high priority attached and considerable success in achieving synergy based on realistic assessment of comparative advantage, and the overall rating for this MI is highly satisfactory.	21, 34, 38, 49, 50, 71, 155
MI 6.4 Evidence confidence	High confidence
MI 6.5: Key business practices (planning, design, implementation, monitoring and reporting) co-ordinated with other relevant partners (donors, UN agencies, etc.)	Score
Overall MI Rating	Highly satisfactory
Overall MI score	3.5
Element 1: Evidence that the organisation has participated in joint planning exercises, such as the UNDAF	4
Element 2: Evidence that the organisation has aligned its programme activities with joint planning instruments, such as UNDAF	4
Element 3: Evidence that the organisation has participated in opportunities for joint programming where these exist	4
Element 4: Evidence that the organisation has participated in joint monitoring and reporting processes with key partners (donor, UN, etc.)	4
Element 5: Evidence of the identification of shared information gaps with partners and strategies developed to address these	4
Element 6: Evidence of participation in the joint planning, management and delivery of evaluation activities	1
MI 6.5 Analysis	Source document
All evidence streams highlight that WHO is clearly very active in joint planning, programming and monitoring/reporting at country level. The Presence in Countries Evaluation found that WHO had participated in UNDAF in 99% of cases where an UNDAF existed in the countries where it operates. The engagement on the IASC is just one key example of joint planning, monitoring and implementation. Joint monitoring on health is often led by WHO in country, and this is key area of its expertise and value added. Its role in the SDGs in health is very important, and on UHC is crucial (with other partners such as the World Bank).	28, 31, 43, 50, 57, 58, 59, 71, 64, 144

While joint planning, programming, monitoring and information sharing is clearly a strength, joint evaluation work by WHO of the type which other UNEG members engage in appears to be less common – at least in the conventional sense of evaluation commissioned by WHO at the HQ level working with other UN evaluation teams and proactively participating and cooperating within the UN evaluation group. WHO has been engaged in some joint evaluation activities, including of the African Program for Onchocerciasis Control in 2015 and of the implementation of International Health Regulations (2017). The DG Representative for Evaluation and Organizational Learning also sits on the Inter-Agency Humanitarian Evaluation Steering Group, with WHO part of the ongoing/planned inter-agency humanitarian evaluation of the system-wide humanitarian response to the drought in Ethiopia. It is possible to find examples of joint evaluations and appraisals within specific partnerships such as IHP+, partnership with the Global Fund, WHE and at regional level. However, this is by no means a major part of EVL's work when compared with evaluation units in other UN agencies of similar size to WHO. This infrequency of joint evaluations led by EVL itself may be an area to address going forward, to support Organisational learning. It could be due to staffing constraints as the EVL unit is relatively small and also has to coordinate WHO's engagement with numerous JIU reviews. While JIU reviews are an important process and a source of learning across the UN, they are not a substitute for joint evaluations led by WHO with partners for joint health programs. EVL has recently started to engage with other health focused agencies in Geneva to share knowledge on evaluation.	28, 31, 43, 50, 57, 58, 59, 71, 64, 144
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	Score
Overall MI Rating	Highly satisfactory
Overall MI score	3.4
Element 1: Information on the organisation's website is easily accessible and current	4
Element 2: The organisation has signed up to the International Aid Transparency Initiative or reports through the OECD-DAC systems	4
Element 3: Accurate information is available on analysis, budgeting, management and is in line with IATI or OECD-DAC (CRS) guidelines	3
Element 4: Evidence that partner queries on analysis, budgeting, management and results are responded to in a timely fashion	3
Element 5: Evidence that information shared is accurate and of good quality	3
MI 6.6 Analysis	Source document
WHO publishes much of its key information publicly on its website and has improved this through its recent membership to the IATI. This is an area where WHO has made important progress both in transparency and the quality and range of the data which it generates. The FENSA approach outlines how WHO intends to be transparent in the ways in which it deals with non-State actors, including providing an annual report to the governing bodies on its engagement with non-State actors, including summary information on due diligence, risk assessment and risk management undertaken by the Secretariat. WHO makes appropriate information on its engagement with non-State actors publicly available.	2, 13, 14, 17, 36, 37, 38, 40, 59, 61, 70, 87

The “WHO register of non-State actors is an Internet-based, publicly available electronic tool used by the Secretariat to document and coordinate engagement with non-State actors”. Sources of funds from private sector are also required to be publicly disclosed. For reasons of transparency, contributions from private sector entities must be publicly acknowledged by WHO in accordance with its policies and practices. There have also been recent improvements to sharing of information through WHO’s online Programme Budget Portal and the May 2018 Results Report. Survey respondents most commonly viewed WHO as ‘very good’ on sharing information transparently, and interviews in AFRO region were able to describe the way that donor reporting had improved significantly in timeliness and quality.	2, 13, 14, 17, 36, 37, 38, 40, 59, 61, 70, 87
MI 6.6 Evidence confidence	High confidence
MI 6.7: Clear standards and procedures for accountability to beneficiaries implemented	Score
Overall MI Rating	Satisfactory
Overall MI score	2.33
Element 1: Explicit statement available on standards and procedures for accountability to beneficiary populations e.g. Accountability to Affected Populations	4
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
Element 6: Monitoring and evaluation procedures explicitly include the requirement to assess the extent to which procedures for accountability to beneficiaries have been addressed within the intervention	2
MI 6.7 Analysis	Source document
Strategic documentation makes important commitments to demonstrating results from a country and beneficiary perspective and these are included in the ‘triple billions’ targets of GPW13. These adopt an ambitious new standard and lens which fits well with the SDGs and Agenda 2030 and has been supported by member states in the WHA. WHO Operational Guidance on Accountability to Affected Population describe its aim to “...ensure a people centred approach to achieve better health outcomes and improve accountability by placing affected populations at the centre of decision-making... This approach ensures awareness of the different needs and capacities of women, girls, boys and men of all ages, people with disabilities, and other diverse characteristics”. How far these have been yet implemented is much less clear. The process of translating GPW13 into specific guidance for staff is underway, building on earlier work by the GER team and others which has been providing guidance to program teams supporting a beneficiary perspective and target groups for some time. Operationalizing the commitments on a country-focused approach is very much ‘work in progress’, although in one important area (WHE) the guidance and procedures are much further advanced. The new impact framework currently being developed includes some significant challenges of how to measure the results for beneficiary populations and what WHO contributes to that alongside member states.	100

Part of how WHO achieves a people-centred approach is its evaluation procedures and also in the work by cross-cutting areas such as the gender, equity and rights team. GER team has worked closely with program leads on this both in strengthening approaches to gender and for certain vulnerable groups such as those with mental health problems. The impression is of an increasingly supportive leadership at the top of WHO and a gradual and painstaking process of operationalising which cannot be achieved overnight. WHO's work with member states on health statistics and standards is central in building the infrastructure for monitoring health of beneficiaries. This is a major contribution. Within its own programs and results systems WHO is still building its mechanisms to apply these standards (e.g. gender-disaggregated data on results) consistently. The new WHO evaluation policy includes the importance of human rights, gender and 'leaving no one behind', but as in many UN and donor agencies, the process of operationalising will take time.	100
MI 6.7 Evidence confidence	High confidence
MI 6.8: Participation with national and other partners in mutual assessments of progress in implementing agreed commitments	Score
Overall MI Rating	Highly satisfactory
Overall MI score	3.4
Element 1: Evidence of participation in joint performance reviews of interventions e.g. joint assessments	4
Element 2: Evidence of participation in multi-stakeholder dialogue around joint sectoral or normative commitments	4
Element 3: Evidence of engagement in the production of joint progress statements in the implementation of commitments e.g. joint assessment reports	4
Element 4: Documentation arising from mutual progress assessments contains clear statement of the organisation's contribution, agreed by all partners	3
Element 5: Surveys or other methods applied to assess partner perception of progress	2
MI 6.8 Analysis	Source document
As already noted for other MI in this performance area, WHO actively participate in joint assessments, such as in support of the health elements of UNDAF, country level monitoring of health systems and goals, emergency response (the JEE) and in specific disease areas such as polio, malaria and non-communicable diseases. As the lead for the health cluster, it participates and often leads multi-stakeholder dialogue on joint sectoral and normative commitments. For example, following the High Level Meeting on Non-communicable Diseases, WHO participated in developing an Action Plan across a range of diseases and helped to develop indicators which are now being used jointly with partners.	25, 50, 51, 56, 61, 66

An illustrative example of how WHO works in partnership on joint programs and reviews progress is the work of the HRP special program: “With the aim of assisting parliamentarians in their efforts to end child, early and forced marriage through legislation, and in order to improve the health of children and young girls in their countries, HRP collaborated with the IPU to review legislation on child, early and forced marriage in 37 countries in the Asia-Pacific region. The review, which was published in 2016, identified both good practices and barriers to implementing laws against child, early and forced marriage. It also introduced important findings and recommendations for further advancing parliamentary engagement in efforts to end child, early and forced marriage”. The supporting documentation for the activities listed above shows that WHO is actively engaging with partners at national level and other partners to produce joint assessment reports, and this includes reasonable attempts at identifying and monitoring WHO’s contribution despite the challenges of unpicking that in certain situations. It was less clear from the documents reviewed and interviews how far WHO is using surveys or other methods to gauge partner perceptions of progress in a structured way, either at national level or otherwise, although one example was found from a recent evaluation of the PAHO Budget Policy and feedback is clearly sought in a more informal way as part of the process.	25, 50, 51, 56, 61, 66
MI 6.8 Evidence confidence	High confidence
MI 6.9: Deployment of knowledge base to support programming adjustments, policy dialogue and/or advocacy	Score
Overall MI Rating	Highly satisfactory
Overall MI score	3.67
Element 1: Statement in corporate documentation explicitly recognises the organisation’s role in knowledge production	4
Element 2: Evidence of knowledge products produced and utilised by partners to inform action	4
Element 3: Knowledge products generated and applied to inform advocacy at country, regional or global level	4
Element 4: Evidence that knowledge products generated are timely/perceived as timely by partners	3
Element 5: Evidence that knowledge products are perceived as high quality by partners	4
Element 6: Evidence that knowledge products are produced in a format that supports their utility to partners	3
MI 6.9 Analysis	Source document
WHO’s knowledge generation is a central part of its role in the global health system and has a strong reputation. In the survey, most respondents said that WHO knowledge products were excellent or very good. Almost all respondents said that they were ‘fairly good’ or better. This very positive feedback suggests that knowledge products are seen by partners as valuable, high quality and useful, justifying a highly satisfactory score on elements 2,3 and 5. Based on the documentary review, WHO knowledge products are timely and clearly presented, hence elements 4 and 6 are rated as satisfactory.	1, 2, 10, 13, 14, 26, 32, 50, 51, 52, 54, 55, 56, 70, 71

At the same time, HQ interviews explained that it can be difficult to articulate the benefits in ways which attract the necessary resources or where results can be measured. An example of how global public goods in knowledge can be undervalued is the International Classification of Diseases, with ICD 11 released recently, which is a vital part of how every health system in the world functions, but whose impact is hard to measure and is not typically listed by donors as a funding priority. WHO's knowledge work has also been central to, access to medicines and quality standards for essential medicines across the globe. It has led on many international policy developments as improving health equity and performance, Universal Health Coverage, the Framework Convention on Tobacco Control and international agreements on air pollution among many others. The Twelfth General Programme of Work 2014-19 highlights that one of the six core functions of WHO is: "shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge". Similarly, GPW13 says that "building on its normative functions, the WHO Secretariat will strengthen its role in driving policy dialogue in all Member States. As a trusted source of knowledge and data WHO will effectively support and advocate for policy actions in line with global priorities". This indicates that the organisation's role in knowledge production is very explicitly recognised in corporate documentation, element 1. A new emphasis in GPW13 is the relative greater importance attached to WHO generating knowledge with impact, focusing the normative and technical work where it can make most difference for health impact in countries and for beneficiaries. This sets the direction of travel and is yet to be fully implemented but will undoubtedly be an important part of how WHO develops and have impact on resource allocation decisions.	1, 2, 10, 13, 14, 26, 32, 50, 51, 52, 54, 55, 56, 70, 71
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: Strong and transparent results focus, explicitly geared to function	KPI score
Satisfactory	2.9

The leadership of WHO has shown a strong commitment to an organisation-wide approach to RBM. This is evident in GPW12, which represents a sustained effort over several years to strengthen results systems and implement a comprehensive programme budgeting approach. The direction of travel set out in GPW13 reinforces this commitment and seeks to take results measurement to the next level. The programme budgeting system provides a comprehensive approach so that corporate strategies and country planning processes are underpinned by a systematic approach with a sound RBM logic. There has been some progress in strengthening the linkages between the different levels from global through regional, country and project level, although this is still a challenge given the sheer range and diversity of WHO's work, which makes aggregation a challenge. The new results report is a commendable step forward in ensuring that results are captured in a clear way and fed back to the highest level. The process for setting targets is clear and includes in most cases relevant baselines and indicators. The monitoring systems are structured and well linked and generate data of satisfactory quality which then feed back into planning and priority setting through the programme budgeting process.

As recognised in the narrative around GPW13, the existing RBM system takes a particular approach to defining results, and a greater focus on outcomes at country and beneficiary level is required. Measured against this new ambition, WHO is facing a considerable challenge to develop its RBM system further. Given that outcomes measurement is still work in progress, it is not surprisingly also harder to find clear evidence that WHO is mapping fully the causal pathways determining outcomes. While indicators are in place and being used in planning, using them to drive results by focusing on outcomes and impact will have to await the new work which has been set in train in GPW13.

MI 7.1: Leadership ensures application of an organisation-wide RBM approach	Score
Overall MI Rating	Satisfactory
Overall MI score	3
Element 1: Corporate commitment to a results culture is made clear in strategic planning documents	4
Element 2: Clear requirements/incentives in place for the use of an RBM approach in planning and programming	4
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 methods	3

MI 7.1 Analysis	Source document
There were important developments in WHO's commitment to RBM and relevant systems in GPW12. This included integrating across the organisation through a unified bottom-up programme budgeting process. Creating a corporate system for tracking financial flows, outputs and some aspects of outcomes - consistently applied across the 3 levels of WHO – together with the necessary underpinning information systems was a major step. It was rolled out with guidance and training. The incentives were mainly through managerial directive, rather than specific performance incentives. In summary, WHO showed a very strong corporate commitment to RBM in its strategic planning and followed this through with clear requirements, which points to a highly satisfactory rating. The guidance provided was clear and accessible and there was clear evidence provided of training on the system at regional level, indicating a satisfactory performance on Elements 3 and 6. In terms of corporate commitment going forward, GPW13 builds on this but also seeks to take RBM to the next level, focusing on country impact and major new targets (the triple billions) in line with the SDGs and country needs. This also seeks to join up across WHO category and programme areas. HQ, regional and country level interviews indicated considerable awareness and involvement in this and intensive work is underway on operational guidance. The new Expert Working Group provides an additional high-level external expertise and scrutiny, which will help with the technical challenges. It was less clear from the evidence gathered how far WHO has progressed on ensuring that tools and methods for measuring and managing results are available, although an example from PAHO's End of Biennium Assessment was identified. The limitation here is identified in GPW13 around measuring outcomes at country level, which is the new focus and requires considerable work on implementing and operationalising the triple billions targets. WHO's own view during the commenting process was that adequate resources are not yet allocated to the RBM system itself. However, a strong team is in place at the centre leading the work on this, and it is an area of work which is obviously being given high priority by senior management. Elements 4 and 5 are therefore rated lower in this assessment. In summary, WHO has established a clear corporate commitment on RBM and has followed it through with systems, guidance and management attention. The intent of moving towards a greater focus on outcomes at country level is very clear, but requires a lot of development work on methods to measure outcomes. The system is now in transition to deliver this, with implementation just starting.	1, 13, 20, 46, 71, 155, 156, 157, 179
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	Satisfactory
Overall MI score	3
Element 1: Organisation-wide plans and strategies include results frameworks	3
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	4
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 well as deviations between planned and actual results	3

MI 7.2 Analysis	Source document
As part of GPW12, the planning and programme budgeting process sets out requirements and guidance for results frameworks to be built into plans and strategies at each level, while also incorporating them into a unified process. This represents a satisfactory performance against Element 1. The GPW and programme budget cycle means that corporate strategies are updated regularly, again satisfactory (Element 4). The position on clarity of linkages is still developing and is rated 2 on Element 2. The programme budgeting system is integrated and there have been improvements in the degree of joining up and consistency across the 3 levels of WHO, although the strength of linkages is an issue which still needs further attention. In its response to evaluation evidence on this area, in the presence of countries evaluation, WHO management commented that the system provides a good basis for assessing results but that stronger integration was required. There is a single framework and data collection and validation system which has a clear internal logic. This leads to level of consistency across WHO's different areas of work – not easy to achieve - and allows outputs and funding to be tracked across the whole organisation. However, as WHO staff noted during the interviews, there are challenges in implementing a fully linked system within WHO's decentralised structures and work is underway to improve the alignment at each level. Regarding country-level results, GPW13 emphasises linkages from country level right up to the triple billion aggregate targets, but this is work in progress rather than fully completed at the time of the assessment. The Results Report (May 2018) to the WHA is the new vehicle by which performance is reported to the governing bodies. It shows progress over time and was discussed with the WHA. Compared with earlier PB reports, there have been considerable improvements in how this information is presented. The document is both clear and comprehensive, so Element 3 is now rated as highly satisfactory. The report does not provide ratings of whether performance has been strong or not, simply presenting the numbers against targets. Progress indicators are shown on the Programme Budget Portal, and these do show deviations between planned and actual results in a clear graphical presentation. This does make it reasonably evident which areas are on track or not, even without explicit ratings. Element 5 is therefore rated as satisfactory.	1, 2, 17, 46, 70, 72, 149, 155, 158
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	Satisfactory
Overall MI score	2.75
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	3
Element 3: Development of baselines are mandatory for new interventions	3
Element 4: Results targets are regularly reviewed and adjusted when needed	3

MI 7.3 Analysis	Source document
Within the programme budgeting process and its results systems, WHO has built results frameworks and indicators in its programme and category areas. These capture at least some of the results logic required to assess progress, although they are not able to capture 'results' in the fullest sense. WHO has done this in considerable detail and although the exact approach naturally varies by type of programme, partnership and region, it is all within the framework of the programme budgeting process. The VFM toolkit and the 'bottom-up' prioritisation process are two of the elements introduced at corporate level, while at regional level there are very detailed results frameworks. In many areas there has been serious attempt to relate indicators to the relevant evidence base within the constraints of what can be measured, to ensure their relevance, and to include baselines and regular review processes. As recognised in GPW13, it focuses on resources and budgets, priorities, outputs and supporting processes, and some aspects of outcomes. It is not yet actually able to capture the full chain from interventions to outcomes that contribute to higher order objectives. One higher order objective – most important of all - is beneficiary impact at country level. WHO is the recognised source of high quality data on outcomes at country level, so it should be well positioned to strengthen the way outcomes are shown in its own internal results systems. This leads on to the approach set out in GPW13 in order to build the new impact framework. It seeks to re-orientate the systems' focus towards country level outcomes in relation to needs and to measure results for normative work in a different way. At present, however, this is work in progress. In light of the new standard in the global strategy for WHO (GPW13), the organisation is in transition. In summary, WHO has put in place relevant indicators, baselines and targets which are regularly reviewed and adjusted. This points to a satisfactory rating on Elements 2-4. It is not clear that the targets and indicators are yet adequate to capture causal pathways or how the outcomes contribute to higher order objectives. Thus, Element 1 is rated lower than the other elements in this MI to reflect the fact that this review is about progress already achieved, while recognising that this is a focus of the ongoing work in GPW13.	1, 49, 70, 155, 156
MI 7.3 Evidence confidence	High confidence
MI 7.4: Monitoring systems generate high quality and useful performance data	Score
Overall MI Rating	Satisfactory
Overall MI score	3
Element 1: The corporate monitoring system is adequately resourced	3
Element 2: Monitoring systems generate data at output and outcome level of the results chain	3
Element 3: Reporting structures are clear	3
Element 4: Reporting processes ensure timely data for key corporate reporting, and planning	4
Element 5: A system for ensuring data quality exists	3
Element 6: Data adequately captures key corporate results	2
Element 7: Adequate resources are allocated to the monitoring system	3

MI 7.4 Analysis	Source document
As discussed above the RBM system is in transition and work is underway to develop it further. As it stands, many key elements of a fully functional monitoring system are in place and in use, but it is also going through a fundamental rework. Specifically, the monitoring systems appear to be adequately resourced, although feedback from WHO during the commenting process indicates that the RBM system as a whole is not. Each of the programme areas is generating data in a timely way which is captured in a single, comprehensive and integrated system. This includes data at output and outcomes level. GPW13 intends to go to the next level on outcome and impact reporting at country level as part of the triple billions targets, which in turn suggests that there is a scope to improve how far the data captures the key corporate results as laid out in GPW13. The reporting structures are reasonably clear, from country level up to the WHA, although they are complicated by the unique governance arrangements. Formally, regions are accountable to regional assemblies and the GPG who might be the obvious focus for monitoring performance is advisory. WHO's internal systems show that performance data is captured, fed into corporate reporting and planning, and subject to validation, which is very timely for this assessment. Nonetheless, it is less clear how adequate and useful the performance data are in relation to WHO's new strategy. The data generated by the performance system are more focused on output level at country level. As such, they are no longer adequate for what WHO is setting out to achieve in GPW13. This point is recognised at the heart of GPW13's narrative and is being tackled with serious intent and high level leadership. It is too early to assess this area. HQ and regional/country interviews suggested that staff are very supportive in principle but there is not yet clarity on how this will work in practice. The challenges may be less about measuring outcomes at country level – WHO is the acknowledged expert in this area – but more about outcomes data at country level back to WHO's activities at all 3 levels (including its technical and normative work in Geneva) and measuring its contribution. Health outcomes are known to be determined by many factors, as well as impacting on others. WHO also does not achieve results on its own. On the other hand, as HQ interviewees pointed out, WHO needs to start to measure its results in ways which allow it to be 'bolder' in taking credit for its work.	157, 160, 161
MI 7.4 Evidence confidence	High confidence
MI 7.5: Performance data transparently applied in planning and decision-making	Score
Overall MI Rating	Satisfactory
Overall MI score	2.75
Element 1: Planning documents are clearly based on performance data	3
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 level	3

MI 7.5 Analysis	Source document
As noted above, the planning process – the so-called ‘bottom-up prioritisation’ within the programme budget – is clearly based around collecting data on needs and priorities and can be compared against outputs achieved and intended. In that sense performance data are clearly feeding into the planning process. This appears to drive decisions on adjusting budgets and is being reviewed regularly. The process is also moderately transparent within WHO and is now reasonably well captured in key performance reports to the WHA and other governance bodies. In specific areas – such as in WHE or in the TDR special programme – there was evidence that performance data were being used to inform decision making in terms of programme design and adjustments to interventions to improve results. However, this did not appear to be generally consistent across all areas, and it seemed more that the data were used mainly for budget setting, prioritising activities and routine monitoring. In terms of ensuring transparency, it is important to note that capturing and describing WHO’s results system clearly to communicate how it works externally is worth some attention. For the assessment team at least, it was very challenging to get a full picture of WHO’s results systems except through the recently published results report to WHA. Prior to that, the big picture does not seem to be well articulated/captured in a single accessible format, which is a goal in itself. The evidence presented in the earlier KPI on partnership also indicates that performance data are being used to support dialogue at global, regional and country level.	1
MI 7.5 Evidence confidence	High confidence
KPI 8: Evidence-based planning and programming applied	KPI score
Satisfactory	2.72
There has been considerable progress on developing the evaluation function in WHO, and this assessment rates several areas as highly satisfactory. A corporate independent evaluation function has been in place for several years and WHO has strengthened the function and the policy environment to reinforce independence, ensure good planning and coverage, follow up and use of centralised evaluations. The accountability for follow up on evaluation recommendations has been clarified, which is welcome. The systems for ensuring quality at this level are also satisfactory. The areas for further development include ensuring that the evaluation team is adequately resourced to play a wider role in supporting decentralised evaluations and wider promulgation, ownership and implementation at regional/country level of the well-developed evaluation policy. A weaker area is the indicator on mandatory demonstration of the evidence base in design of new interventions. Given WHO’s technical expertise, one would expect this to be strong in practice and evaluations are clearly being used in decision making in a broader sense. However, there was little evidence of this being reinforced by mandatory requirements in the intervention design process, nor is this supported by any specific incentives in the system. WHO is also seeking to clarify its approach to Organisational learning, which would be useful. This would help to make clearer that evaluation feeds into learning but learning itself is an Organisation wide function that needs strong leadership, separate from evaluation.	
MI 8.1: A corporate independent evaluation function exists	Score
Overall MI Rating	Highly satisfactory
Overall MI score	3.71
Element 1: The evaluation function is independent from other management functions such as planning and managing development assistance (operational independence)	4

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	4
Element 4: A separate budget line (approved by the Governing Body) ensures budgetary independence	4
Element 5: The central evaluation programme is fully funded by core funds	3
Element 6: Evaluations are submitted directly for consideration at the appropriate level of decision-making pertaining to the subject of evaluation	4
Element 7: 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)	4
MI 8.1 Analysis	Source document
The evaluation office has been a separate unit since 1 August 2014. The DG Representative for Evaluation and Organizational Learning is at director level and, like internal oversight services, reports directly to the Director General in management terms and periodically to the EB and IEOAC. The first WHO evaluation policy (2012) and the Framework for Strengthening Organisational Learning and Evaluation have been instrumental in guiding evaluative work in WHO until recently, including regular reporting to the Executive Board on the work program and on completed evaluations. Following an independent review in 2017, which made recommendations on critical areas to improve, additional steps have now been taken. The new updated evaluation policy agreed in May 2018 builds on earlier decisions which helped to create structural independence for evaluation and adds clear, specific provisions to reinforce budgetary independence and others key aspects and provide a platform for discussions around adequate resourcing. Specifically, the Executive Board will now approve the budget for evaluation at the same time as the work program (para 41). The EB is to be consulted by the DG on the appointment of the head of evaluation and also before any termination of the incumbent of that office. As per the Evaluation policy (2018), the head of the Evaluation Office serves for a fixed term of four years with a possibility of reappointment only once for a further term of four years, and is barred from re-entry into the organization after the expiry of his/her term. Behavioural independence is also strong, as demonstrated by the findings of the independent review and interviews during this assessment process. Resourcing of evaluation is becoming clearer with the references in the new evaluation policy to benchmarking against typical levels for UNEG, but currently it is still a challenge. Although core funds are provided to cover priority corporate evaluations, there are important gaps in funding. The function is led by a team which is quite small compared with other large UN agencies such as FAO, WFP or UNICEF and therefore not surprisingly is stretched to cover the full range of functions, such as providing support on decentralised evaluations and implementing the evaluation policy at different levels of the Organisation, or interacting regularly with other UN evaluation functions on professional development to learn and develop methodological approaches. This is discussed in the independent review. There has clearly been strong engagement at Board/DG level on these issues. The policy recognises that adequate resourcing including for institutionalisation is essential, and refers to the benchmarks in the 2014 JIU report. It is now important that this clear intent is followed through in implementation to allow a culture of evaluation to continue to develop at all levels of WHO.	3, 5, 50, 51, 69, 70
MI 8.1 Evidence confidence	High confidence

MI 8.2: Consistent, independent evaluation of results (coverage)	Score
Overall MI Rating	Satisfactory
Overall MI score	2.8
Element 1: An evaluation policy describes the principles to ensure coverage, quality and use of findings, including in decentralised evaluations	4
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	3
Element 4: The annual evaluation plan presents a systematic and periodic coverage of the organisation's Interventions, reflecting key priorities	3
Element 5: Evidence from sample countries demonstrate that the policy is being implemented	1
MI 8.2 Analysis	Source document
The WHO evaluation policy is clear on the principles and overall framework for evaluation. The Handbook for evaluation has been an important tool for several years but is now out of date and the next task will be to set out the operational implications of the new 2018 policy in an updated manual or set of guidance. WHO has a clear evaluation plan which sets out priorities. It is agreed by the Executive Board and has strong support, but in practice there are issues around coverage and funding. An issue is that WHO's funding at Organisational level does not cover all its agreed priorities up front, although resources have been made available in practice for high priority evaluations agreed with the EB. As noted, other supporting workstreams are not funded either in financial or staffing terms, so the EVL unit has to make choices on where to focus and not surprisingly gives most attention to commissioning and managing evaluations, engaging on follow up and strengthening the policy. Part of its resource is also diverted to managing engagement on JIU reviews. The independent review of the evaluation function and interviews with regions and countries suggested awareness of WHO's evaluation policy (as opposed to the handbook) is uneven and a culture of evaluation is still emerging. While familiarity with the policy exists in some parts of HQ and among the regional focal points working on evaluation, awareness among staff at different levels and more widely across WHO of the evaluation policy is still fairly limited. Discussions with interview participants suggest it is 'there in the background' but in practice it is not directly being used as an instrument to drive decisions on resources or to implement change. In line with the above, the countries interviewed as part of the MOPAN review did not show a high level of activity or awareness of evaluation at country level. One or two regarded evaluation as part of the audit process. For this reason, element 5 is rated lower than other elements here. In summary, coverage is stronger at corporate level than at decentralised level or on workstreams around institutionalisation. Despite this, EVL has made commendable efforts to engage with regions through established networks to make progress where possible	3, 4, 51, 68, 69, 70
MI 8.2 Evidence confidence	High confidence

MI 8.3: Systems are 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	Source document
The key corporate documents for evaluation have a strong focus on quality. The new evaluation policy sets out clear principles, including reference in para 21 to UNEG norms and standards and use of independent quality assessment mechanisms. Earlier work including the evaluation practice handbook had established many of the specific requirements around quality, and the independent review found that the handbook itself was seen as useful and being applied. It now needs to be updated. The work of the central evaluation unit (EVL) is focused around ensuring quality for centralised/ corporate evaluations and in that respect, it seems to be largely successful – the evaluations presented to the Executive Board and fed into decision making at the highest levels of WHO appear to be high quality, relevant and credible. The document review for this assessment confirmed that the evaluations use appropriate methodologies for data-collection, analysis and interpretation and present the evidence in a complete and balanced way. Many of these are flagship corporate evaluations, including the very influential studies of the WHO reforms and are high quality. The independent review (2017) found that the quality and credibility of corporate evaluations had got off to a good start and had generally been done to an adequate and sometimes high standard. However, it is not clear how far systems for quality are yet applied across WHO as a whole and therefore it is also not at all clear whether all or even most WHO evaluations meet the agreed standards. For this reason, elements 1 and 5 in this area are rated as 2 rather than 3, to reflect the apparent implementation gap in EVL having the resource required for ensuring quality standards apply beyond the key corporate evaluations. EVL does not have currently have the capacity to track quality in detail, let alone to support regions in applying the policy standards. While significant evaluation activity does take place within regions (for example in PAHO this has been established for many years) the practice seems to vary and it is not obviously driven by the WHO evaluation policy framework.	3, 5, 51, 68, 69, 70, 71

In summary, the policy on quality is clear and there is evidence of good practice in application to some of WHO's evaluations, mainly at central level. The next stage should be intensive engagement to ensure quality consistent with the new policy at every level of WHO, which will require intensive engagement in: • Socialising the WHO evaluation policy standards at regional and country level, based on the new updated policy, including training and support for capacity building. • implementing the quality processes described in paragraph 20 of the 2018 policy to monitor and assure quality, strengthening the capacity to support quality at regional level through (for example) full-time regional evaluation officers as happens in other large UN agencies.	3, 5, 51, 68, 69, 70, 71
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	1.6
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	3
Element 3: There is evidence that lessons from past interventions have informed new interventions	3
Element 4: Incentives exist to apply lessons learnt to new interventions	0
Element 5: The number/share of new operations designs that draw on lessons from evaluative approaches is made public	0
MI 8.4 Analysis	Source document
Using evidence to formulate guidelines and policy advice on health to partners is central to WHO's role and yet mandatory use of the evidence base to design new interventions is harder to identify. For major policies and strategies, a feedback loop clearly does exist and the evaluations that WHO commissions are fed back to the Executive Board annually and also discussed by the GPG and senior staff. There have been in-depth, influential and relevant evaluations of the WHO reforms and on health emergencies and many other key strategic areas (e.g. staff mobility) and these in turn have informed high level discussions. In health emergencies, change in response to learning lesson has been fundamental, highly visible and has been followed up with external scrutiny of the IOAC. On a smaller scale, follow up on the independent review of the evaluation function has been clear and reflected in the new policy.	

Having said that, it is unclear if any specific mandatory requirement is in place in WHO to demonstrate how lessons have been taken into account when new interventions are being designed. The nearest equivalent to this is that CCS guidance states that all new CCS are required to document how lessons from previous CCS have been taken into account, although the extent of implementation of this is clearly partial since few CCS have been independently evaluated so far and not all countries have a CCS in place. It is also unclear if this is being tracked, let alone published i.e. the number/share of new interventions using evidence. On the supply side of evidence generation (as opposed to use of evidence), evaluations are routinely published and the proportion of evaluations that are followed up is transparent through the annual evaluation report to the EB. A welcome clarification has also recently been provided on responsibility for follow up on evaluation recommendations (see MI 8.6) which should rest with DG and not with the evaluation unit. In specific areas requirements to use lessons and evidence do exist, although they are not particularly explicit. The most important would be assessing needs in disease areas and partner strategies, in health emergencies and also in WHO's guidance on country cooperation strategies which does require (Appendix 2) that when new CCS's are formulated they should be informed by analysis of a range of sources including evaluations of the previous CCS. At the same time independent evaluation of CCSs are fairly rare, so the evidence base is not very well developed yet, although this is now the focus of an expanded effort given the new country focus of GPW13. There was no specific evidence of incentives to apply lessons in the design process for new interventions. It is was also not clear where organisational learning sits within WHO or what the overall strategy/approach is intended to be, although this was discussed in the previous reforms and the framework was in place. The issue is now clearly back on the radar of senior management, as one of the newly appointed DDGs has requested work on this since coming into office. In practice, lesson learning may still be happening and perhaps quite widespread, but not set within a structured framework other than feeding through the Executive Board and WHA on agreeing new WHA resolutions and tracking the reforms. It may for example be that WHO tends to regard use of the evidence base as so obvious as not needing to be underlined. After all many WHO staff are technical experts who would see using evidence as part of their 'bread and butter' and should not need to be reminded or rewarded for doing so. However, experience in other organisations is that feedback loops can easily end up weak unless specifically given attention.	5, 6, 31, 51, 68
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	1.75
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	1

MI 8.5 Analysis	Source document
Limited evidence was found of systems specifically labelled as intended to identify and track poorly performing interventions at the aggregate level. For this reason all elements in this MI are rated as 2 or lower. During the WHO reforms under the previous DG there were major steps forward on strengthening internal controls, including for example within AFRO. WHO's approach is to use mechanisms covered elsewhere in the assessment framework which are about risk, compliance and audit to identify and track poor performance. These are: • risk identification and management mechanisms (see MI 5.4) • internal controls including audit (see MI 4.5). • compliance risk and ethics • FENSA framework for transparency and risk management around partnerships with non-state actors • IOAC • IEOAC Tracking of evaluation recommendations is also relevant. One of the criteria for identifying evaluation priorities (such as the Ebola crisis) would be areas of poor performance and strategic/reputational risk).	
MI 8.5 Evidence confidence	Little to no confidence
MI 8.6: Clear accountability system ensures responses and follow-up to and use of evaluation recommendations	Score
Overall MI Rating	Highly satisfactory
Overall MI score	3.6
Element 1: Evaluation reports include a management response (or has one attached or associated with it)	3
Element 2: Management responses include an action plan and/or agreement clearly stating responsibilities and accountabilities	4
Element 3: A timeline for implementation of key recommendations is proposed	4
Element 4: A system exists to regularly track status of implementation	3
Element 5: An annual report on the status of use and implementation of evaluation recommendations is made public	4

MI 8.6 Analysis	Source document
The arrangements for follow-up on evaluation recommendations in WHO are fairly clear and the accountability has recently been strengthened to make them considerably more explicit. This is one key aspect of the ‘feedback loops’ (see MI 8.4) and one which is close to best practice. Specifically, the requirement for a management response is set out in the evaluation policy and also in the Evaluation Practice Handbook. Most, if not all, WHO evaluations do include management responses in practice (all that EVL is aware of and have been reported). The management responses include sections which cover key actions, responsibilities, and deadlines. Continuous tracking of progress on performance improvement following evaluations has been normal practice. In addition, the new evaluation policy (itself following up on a recommendation of the independent review) contains the following provisions on roles and responsibilities (para 45 – 47): • Each evaluation shall have an identified owner, such as the responsible officer of a cluster, programme, office or project. It is the responsibility of the owner to utilise the findings of the evaluation and develop an action plan for implementing the recommendations • The evaluation owner shall ensure that an appropriate management response is issued in a timely manner to the appropriate Deputy Director-General/Assistant Director-General at headquarters, or to the Regional Director in the regions and countries • The Director-General will establish a mechanism to ensure the effective follow-up of the implementation of evaluation recommendations in a systematic manner, coordinating efforts with the evaluation owners. Annual status reports on progress in the implementation of the recommendations will be submitted to the Executive Board through the Programme, Budget and Administration Committee. While the above sets a high standard of clarity which is welcome, the actual implementation at all levels of the organisation is work in progress, as with other areas of the evaluation policy. For example, management responses for decentralised evaluations are not as easily tracked as for corporate/centralised evaluations. The latest provisions in the new policy are of course very new and yet to be implemented, but important steps forward.	3, 4, 5, 31, 51, 52, 68, 69, 70, 71
MI 8.6 Evidence confidence	High confidence
MI 8.7: Uptake of lessons learned and best practices from evaluations	Score
Overall MI Rating	Satisfactory
Overall MI score	3
Element 1: A complete and current repository of evaluations and their recommendations is available for use	3
Element 2: A mechanism for distilling and disseminating lessons learned internally exists	3
Element 3: A dissemination mechanism to partners, peers and other stakeholders is available and employed	3
Element 4: A system is available and used to track the uptake of lessons learned	3
Element 5: Evidence is available that lessons learned and good practices are being applied	3
Element 6: A corporate policy for Disclosure of information exists and is also applied to evaluations	3

MI 8.7 Analysis	Source document
A repository of WHO evaluations exists and is held by EVL and is understood to be complete. Clearly this depends on the quality of information supplied by regions and the level of understanding of 'what is an evaluation'. EVL is not in a position to validate this directly at this stage. The Independent review mentions various steps taken to develop a systematic approach to disseminate results and lessons learned, including • Rejuvenating a global evaluation network and setting up an Organisational Learning and Change Network • Systematic presentations to staff and Member States at the conclusion of each evaluation, and making the results of evaluation publicly available • 'Evaluation matters', a quarterly newsletter on evaluation; • Discussions of recommendations from evaluations at the GPG meeting The main mechanisms for disseminating lessons are therefore: Reporting to the Board each year; publishing evaluations through the WHO website; sharing internally through the Office of the Director General, GPG meetings and directly sending to senior managers in specific areas; sharing internally through the global evaluation network (including regional and CPAN focal points on evaluation). As noted for MI 8.6, a system exists and is being used to track uptake at the level of management recommendations. It is less clear if in-depth analysis – other than self-reporting through the management response system - has yet been done on how far lessons have led to changes in behaviour and good practices are being applied. A clear exception is for health emergencies where the IOAC reports provide strong evidence of follow up. A corporate policy for disclosure of information exists and evaluation is included. (see para 48 of 2018 evaluation policy).	3, 5, 51, 68
MI 8.7 Evidence confidence	High confidence

RESULTS

Achievement of relevant, inclusive and sustainable contributions to humanitarian and development results in an efficient way

KPI 9: Achievement of development and humanitarian objectives and results e.g. at the institutional/corporate wide level, at the regional/corporate wide level and, at the regional/country level, with results contributing to normative and cross-cutting goals	KPI score
Satisfactory	2.36
In its Results Report for 2016-17, WHO summarised and presented to its governing body (the WHA) the results achieved during the latest biennium. Supporting data and indicators together with baselines and targets are published in the Programme Budget portal. Together these provide the main results reporting for WHO and were taken as the key reference for the MOPAN assessment on KPIs 9-12. The team also drew on evaluations, regional reports and other reports. The methods used to translate WHO's results data into the MOPAN assessment were as follows. 184 indicators in the PB portal were considered, of which 151 (82%) had measurable data on results and 33 did not have data available or the indicator was no being tracked due to changes in definitions. The data were analysed as follows. • First, each indicator was mapped according to its relevance for one or more KPI. In most areas it was possible to find numerous relevant indicators, although KPI 9.5 and 9.7 had relatively few. • Second, for each indicator, the team compared results achieved against the baseline and WHO target to see how far it had been achieved. • Third, for each KPI, the proportion of indicators on achieved or not achieved was estimated, with various intermediate categories such as partly achieved. • Finally, the data were used together with the narrative in the Results Report and information reported in evaluations and regional reports to reach a rating. Overall, the PB dataset showed that WHO was on target, achieving or mostly achieving its targets in 66% of the 151 indicators for which data were available. This is a satisfactory overall performance. WHO's support to national development policies and system reforms was found to be the strongest area of results and rated highly satisfactory with nearly 75% of the 80 indicators presented on track, achieved or mostly achieved. Most other areas of KPI 9 were found to be satisfactory, including in key areas such as meeting stated development goals, meeting the needs of targeted groups and supporting gender equality and the empowerment of women. Two of the seven results areas in KPI 9 are less well evidenced and were rated unsatisfactory in this assessment. They are human rights which had only 4 indicators that directly related to the MI, and environmental sustainability, where it was hard to find indicators that were directly relevant although the interviews showcased some interesting work where WHO provides leadership on the related area of how the environment impacts on health.	
MI9.1: Interventions assessed as having achieved their stated development and/or humanitarian objectives and attain expected results	Score
MI Rating	Satisfactory
MI score	2.5

MI 9.1 Analysis	Source document
For KPI 9.1 on development/humanitarian outcomes, the proportion was somewhat lower at 60%, which may partly reflect the challenges of measurement in this area. Around 71 of the indicators were mapped as relevant to this KPI and of these around 50 had usable data on results. 26% of indicators were not achieved or off track. Overall, and taking account of other information reviewed, this suggests a rating of satisfactory. The relevant benchmark agreed in the MOPAN methodology for a rating of 'satisfactory' is that more than half of indicators are achieved/on track. Key achievements on development and humanitarian results that the team noted in the PB portal include the following. Many others are described in the Results Report and at regional level. • 89% of rapid response teams from the WHO health emergencies program were deployed within 72 hours (compared with a target of 75%). • 89% of confirmed malaria cases in the public sector receiving first-line antimalarial treatment according to national policy (compared with a target of 80%). • 82 countries were supported to develop and implement strategies for improving patient safety and quality of health services at the national level within the context of universal health coverage (compared with a baseline of 47 and a target of 77). • 80.3 million people diagnosed and successfully treated for TB since the adoption of the WHO strategy. • 69 countries supported (compared with a baseline of 60 and a target of 65) to have access to tracer medicines in the public and private sector as part of increasing access to services for mental health and substance misuse. • The proportion of households without access to improved sanitation reduced to 23.8%, compared with a target of 30% and a baseline of 32%. The external PWC evaluation highlights challenges in assessing whether WHO interventions have achieved their stated results. This was primarily due to a lack of a clearly stated "articulate a clear, logical, quantifiable and compelling results-chain" and "a systematic demonstration of their contribution to the health of all". Progress on polio has been much more difficult to sustain, according to latest figures. In its independent report for 2018, the polio independent monitoring board noted that the total number of wild poliovirus cases globally has increased: 25 compared to 13 for the same period (30 October) in 2017 and concluded that progress towards interrupting polio transmission globally has stalled and may well have reversed.	17, 19, 50, 51, 52, 53, 57, 58, 60, 65, 68, 71, 148, 154
MI 9.1 Evidence confidence	High confidence
MI 9.2: Interventions assessed as having realised the expected positive benefits for target group members	Score
MI Rating	Satisfactory
MI score	2.5

MI 9.2 Analysis	Source document
For KPI 9.2, the proportion of indicators which WHO has achieved, over achieved, on track or mostly achieved was 66%. Around 70 of the indicators were mapped as relevant to this KPI and of these around 56 had usable data on results. 20% of indicators were not achieved or off track. Overall, and taking account of other information reviewed, this suggests a rating of satisfactory. The relevant benchmark agreed in the MOPAN methodology for a rating of 'satisfactory' is that more than half of indicators are achieved/on track. Interventions that have been realised the expected positive benefits for target group members that the team noted in the PB portal include the following. Many others are described in the Results Report and at regional level. • 81% of populations affected by health emergencies have access to essential life-saving health services and public health interventions (compared with a target of 75%). • 82 countries have policies, financing and human resources in place to increase access to integrated, people centred health services (compared with a target of 80%). • 69 countries with improved access to, and rational use of, safe, efficacious and quality medicines and other health technologies (compared with a target of 65). • 22 countries achieving a 25% relative reduction in the prevalence of raised blood pressure, or contain the prevalence of raised blood pressure, according to national circumstances (compared with a baseline of 40 and a target of 30). • 89% of confirmed malaria cases in the public sector receiving first-line antimalarial treatment according to national policy (compared with a baseline of 70% and a target of 80%). The Results Report also highlights that almost 1 billion cases of malaria averted since 2000.	19, 58, 59, 60, 61
MI 9.2 Evidence confidence	High confidence
MI 9.3: Interventions assessed as having contributed to significant changes in national development policies and programmes (policy and capacity impacts), or needed system reforms	Score
MI Rating	Highly satisfactory
MI score	3.5
MI 9.3 Analysis	Source document
For KPI 9.3 on the contribution of interventions to significant changes in national development policies and programs, the proportion of targets achieved, over achieved, on track or mostly achieved was 74%, which is indicative of WHO's normative role in contributing to national health policy. Around 87 of the indicators were mapped as relevant to this KPI and of these around 80 had usable data on results. Only 6% of indicators were not achieved or off track. Overall, taking account of other information reviewed, this suggests a rating of highly satisfactory. The relevant benchmark agreed in the MOPAN methodology for a rating of 'highly satisfactory' is that interventions have made a substantial contribution to either re-orienting or sustaining effective national policies and programmes in a given sector.	19, 50, 51, 53, 56, 58, 59, 60, 61, 65, 70, 71

Key achievements on development and humanitarian results that the team noted in the PB portal include the following: • 22 global strategies and plans agreed for the management of high-threat infectious hazards (compared with a baseline of 6 and a target of 15). • 142 countries with a comprehensive national health sector policy/strategy/plan with goals and targets updated within the last five years (compared with a baseline of 103 and a target of 115). • 47 countries enabled to monitor the progress of their national health policy/strategy/plan during the biennium (compared with a baseline of 0 and a target of 25). • 82 countries supported to develop and implement strategies for improving patient safety and quality of health services at the national level within the context of universal health coverage (compared with a baseline of 47 and a target of 77). • 146 countries incorporating noncommunicable diseases in national development agenda, including in United Nations Development Assistance Frameworks, as appropriate (compared with a baseline of 62 and a target of 70). • 18 new and updated guidelines and technical documents supporting the global strategy developed and adopted in regions and countries (compared with a baseline of 3 and a target of 12). Many other achievements are described in the WHO Results Report Programme Budget 2016-2017, e.g., WHO has also developed the dedicated agenda of Health in All Policies which “combines the forces of multiple stakeholders, and aims to improve policy coherence across government”. As a result, “13 countries have developed health adaptation plans for climate change since 2015, increasing the total number of countries from 30 to 43”.	19, 50, 51, 53, 56, 58, 59, 60, 61, 65, 70, 71
MI 9.3 Evidence confidence	High confidence
MI 9.4: Interventions assessed as having helped improve gender equality and the empowerment of women	Score
MI Rating	Satisfactory
MI score	2.5
MI 9.4 Analysis	Source document
For KPI 9.4 on the contribution of interventions to improving gender equality and the empowerment of women, the proportion of targets achieved, over achieved, on track or mostly achieved was 67%. Around 22 of the indicators were mapped as relevant to this KPI and of these around 15 had usable data on results. 13% of indicators were not achieved or off track. Overall, and taking account of other information reviewed, this suggests a rating of satisfactory. The relevant benchmark agreed in the MOPAN methodology for a rating of ‘satisfactory’ is that more than half of indicators are achieved/on track. Key achievements on development and humanitarian results that the team noted in the PB portal include the following: • 61 targeted countries that have plans with targets for ending preventable maternal and neonatal deaths by 2030 (compared with a baseline of 48 and a target of 50). • 51 countries able to implement WHO strategies and interventions to cover unmet needs in family planning (compared with a baseline of 20 and a target of 40).	19, 50, 51, 56, 57, 58, 61, 62, 146

• 276 scientific publications reporting new and improved tools, solutions and strategies in sexual and reproductive health (compared with a baseline of 140 and a target of 240). • 17 WHO programme areas that have integrated gender, equity and human rights (compared with a baseline of 10 and a target of 15). WHO is also a member of the Every Women Every Child global movement and the Every Women Every Child 2017 Progress Report (2017) states “Globally, the health and well-being of women, children and adolescents are improving faster than at any point in history, even in many of the poorest nations. The transformation is due in great measure to one of the most successful global health initiatives in history: Every Woman Every Child (EWEC)”. Many other achievements are described in the WHO Results Report Programme Budget 2016-2017, e.g., “30 million more women using modern contraceptives from 2012, in countries with the greatest unmet family planning needs”.	19, 50, 51, 56, 57, 58, 61, 62, 146
MI 9.4 Evidence confidence	High confidence
MI 9.5: Interventions assessed as having helped improve environmental sustainability/helped tackle the effects of climate change	Score
MI Rating	Unsatisfactory
MI score	1.5
MI 9.5 Analysis	Source document
The proportion of targets achieved, over achieved, on track or mostly achieved was 83%. Around 9 of the indicators were mapped as relevant to this KPI and of these around 6 had usable data on results. 0% of indicators were not achieved or off track. The available indicators were inadequate to address the MI, therefore the high percentage of targets achieved was an artefact. There is some evidence that WHO’s area of work on “health and environment” has contributed to environmental sustainability and addressing climate change. While WHO’s programmatic area on health and environment has fully integrated issues on environmental sustainability and climate change, in terms of accountability systems, human and financial resource etc. this is not the case for WHO’s overall strategic plan nor the majority of programme areas outside WHO’s area of health and environment. Overall, and taking account of other information reviewed, this suggests a rating of unsatisfactory. The relevant benchmark agreed in the MOPAN methodology for a rating of ‘unsatisfactory’ is that interventions do not include planned activities or project design criteria intended to promote environmental sustainability and help tackle the effects of climate change. Key achievements on environmental sustainability and helping to tackle the effects of climate change that the team noted in the PB portal include the following: • 42 countries that have developed health adaptation plans for climate change (compared with a baseline of 28 and a target of 40). • 3 WHO norms, standards and guidelines on environmental and occupational health risks developed or updated (compared with a baseline of 0 and a target of 3). • 59.3% of the population with primary reliance on clean fuels and technology (Sustainable Development Goal indicator 7.1.2) (compared with a baseline 58.3 and a target of 59).	19, 51, 52, 53, 58, 145

The WHO Results Report Programme Budget 2016-2017 highlights WHO has also worked to address climate issues through several programmes and dialogues, including: • “(T)he BreatheLife campaign, which 40 cities globally have joined, to educate the public, encourage sharing of data and solutions, improve monitoring and help trigger alerts when air quality is dangerous”. • “The catalysing of high-level political commitment through relevant regional inter-ministerial processes, for example, the Ostrava Declaration that resulted from the Sixth Ministerial Conference on Environment and Health, held in Ostrava, Czech Republic in June 2017”. • A water project in Tajikistan which has built the capacity of the water and health sectors for water safety planning and risk based drinking-water quality surveillance, with a focus on vulnerable rural areas, strengthened of the infrastructural and personnel capacity of laboratories and closely monitored and guided pilot projects on water safety planning and risk-based surveillance. • Reducing the proportion of the population without access to improved drinking water sources from 11% in 2010 to 8% in 2015.	19, 51, 52, 53, 58, 145
MI 9.5 Evidence confidence	High confidence
MI 9.6: Interventions assessed as having helped improve good governance (as defined in 2.1.c)	Score
MI Rating	Satisfactory
MI score	2.5
MI 9.6 Analysis	Source document
For KPI 9.6 on the contribution of interventions to help improve good governance, the proportion of targets achieved, over achieved, on track or mostly achieved was 68%. Around 65 of the indicators were mapped as relevant to this KPI and of these around 57 had usable data on results. Only 9% of indicators were not achieved or off track. Overall, taking account of other information reviewed, this suggests a rating of satisfactory. The relevant benchmark agreed in the MOPAN methodology for a rating of ‘satisfactory’ is that interventions include some planned activities and project design criteria to promote or ensure good governance. Key achievements on development and humanitarian results that the team noted in the PB portal include the following: • 47 countries enabled to monitor the progress of their national health policy/strategy/plan during the biennium (compared with a baseline of 0 and a target of 25). • 158 countries having a food safety system with an appropriate legal framework and enforcement structure (compared with a baseline of 136 and a target of 148). • 18 new and updated guidelines and technical documents supporting the global strategy developed and adopted in regions and countries (compared with a baseline of 3 and a target of 12). • 5 preferred product characteristics and policy recommendations established for priority new vaccines (compared with a baseline of 3 and a target of 1). • 67 countries with core capacities independently evaluated (compared with a baseline of 22 and a target of 60). • 167 countries reporting annually on the status of implementation of the International Health Regulations (2005) (compared with a baseline of 60 and a target of 100).	50, 52, 57, 58, 60, 61, 71, 144

The WHO's work as a normative agency lends itself to several MIs including 2.1, 9.3, 12.2 and 12.3 which have considerable overlap with 9.6. In terms of improving good governance explicitly in its member states, WHO plays an active role in supporting partnerships and implementation of policies, strategies and plans. This includes encouraging alignment with the SDGs and acting "as a broker among partners and to support the government in effectively coordinating the health sector". The WHO's coordination role in countries has also seen to be increasing in recent years.	50, 52, 57, 58, 60, 61, 71, 144
MI 9.6 Evidence confidence	High confidence
MI 9.7: Interventions assessed as having helped improve human rights	Score
MI Rating	Unsatisfactory
MI score	1.5
MI 9.7 Analysis	Source document
For KPI 9.7 on the contribution of interventions assessed as having helped improve human rights, the results portal provides limited evidence and this Mi is therefore rated as unsatisfactory. Only 4 indicators could be mapped as directly relevant to this KPI. Within this limited range of indicators, the proportion of targets achieved, over achieved, on track or mostly achieved was 75%. This appears to be a significant gap in WHO's approach to measuring results. Human rights does not appear to be clearly distinguishable from gender and equity issues particularly where indicators ask if all three issues are incorporated in national plans or policies. Therefore, there is limited evidence of actual implementation of interventions explicitly improving human rights. Overall, taking account of other information reviewed, this suggests a rating of unsatisfactory since there is limited direct evidence of WHO's role in directly improving human rights. The relevant benchmark agreed in the MOPAN methodology for a rating of 'unsatisfactory' is that there is no direct indication that project or program results will not promote or ensure human rights. Key achievements on development and humanitarian results that the team noted in the PB portal include the following: • 17 WHO programme areas that have integrated gender, equity and human rights (compared with a baseline of 10 and a target of 15). • 2 evaluation processes in place to ensure gender, equity and human rights are measured in Secretariat programmes (compared with a baseline of 0 and a target of 2). • 80% of WHO country cooperation strategies developed during the biennium that are explicitly guided by the Organisation's core values and approaches based on equity, human rights, gender and social determinants (compared with a target of 61).	50, 61, 71
MI 9.7 Evidence confidence	Medium confidence

KPI 10: Relevance of interventions to the needs and priorities of partner countries and beneficiaries, and extent to which the organisation works towards results in areas within its mandate	KPI score
Satisfactory	2.5
Ensuring relevance based on health needs and priorities and targeting its work to the needs of countries and beneficiaries, within its mandate, is a key feature of how WHO works. Many of the indicators tracked by WHO as part of its results measurement system are relevant and overall the performance was found to be satisfactory in each of the 3 areas of this KPI. There is clear evidence that WHO is designing and implementing interventions that respond to the needs of countries and beneficiaries, supports national health policies and objectives and provides responses to specific identified problems. Examples of this include WHO's approach to developing country strategies and supporting national health policies and systems working with member states, strategies for meeting the needs of people in specific disease areas, support to person-centred health services, population-based health policies and health care for women and for older people. In the specific area of health emergencies, there has been a significant change during this period in how WHO responds, strengthening its approach to meet the needs of beneficiaries after criticism over Ebola.	
MI 10.1: Interventions assessed as having responded to the needs/priorities of target groups	Score
MI Rating	Satisfactory
MI score	2.5
MI 10.1 Analysis	Source document
Many of the WHO performance indicators are relevant to the needs/priorities of target groups, since many health needs require this approach. Around 90 of the indicators in the PB portal could be mapped to this part of the MOPAN assessment framework. There is some overlap with the indicators in other areas, particularly for MI 9.2 about realizing expected positive benefits for target groups. The proportion of targets achieved, over achieved, on track or mostly achieved was 66%. Of the 91 indicators that were mapped as relevant to this MI, around 73 had usable data on results. 18% of indicators were not achieved or off track. Overall, and taking account of other information reviewed, this suggests a rating of satisfactory. The relevant benchmark agreed in the MOPAN methodology for a rating of 'satisfactory' is that interventions are designed to respond to the needs/priorities of the target group. Key achievements on development and humanitarian results that the team noted in the PB portal include the following: • 81% of emergency-affected populations which have received one or more basic health services (compared with a target of 75). • 26 countries supported to deliver integrated person-centred services that respond to the needs of older women and men in low-, middle- and high-income settings (compared with a baseline of 48 and a target of 83). • 82 countries enabled to implement integrated, people centred health service strategies through different models of care delivery matched with their infrastructure, capacities and other resources (compared with a baseline of 3 and a target of 12). • 30 countries strengthening rehabilitation policies and services in collaboration with WHO (compared with a baseline of 0 and a target of 30). Many other achievements are described in the WHO Results Report Programme Budget 2016-2017, e.g., "Measles vaccination resulted in an 84% drop in measles deaths between 2000 and 2016 worldwide" and "1 billion people protected from treatable neglected tropical diseases by receiving 1.5 billion treatments in 2017".	
MI 10.1 Evidence confidence	High confidence

MI 10.2: Interventions assessed as having helped contribute to the realisation of national development goals and objectives	Score
MI Rating	Satisfactory
MI score	2.5
MI 10.2 Analysis	Source document
For KPI 10.2 on the contribution of interventions to national development goals and objectives, the proportion of targets achieved, over achieved, on track or mostly achieved was 62%. Around 75 of the indicators were mapped as relevant to this MI and of these around 66 had usable data on results. 21% of indicators were not achieved or off track. Overall, taking account of other information reviewed, this suggests a rating of satisfactory. The relevant benchmark agreed in the MOPAN methodology for a rating of 'satisfactory' is that interventions include some planned activities and project design criteria to promote or ensure good governance. Key achievements on development and humanitarian results that the team noted in the PB portal include the following. • 47 countries enabled to monitor the progress of their national health policy/strategy/plan during the biennium (compared with a baseline of 0 and a target of 25). • 142 countries with a comprehensive national health sector policy/strategy/plan with goals and targets updated within the last five years (compared with a baseline of 103 and a target of 115). • 82 countries supported to develop and implement strategies for improving patient safety and quality of health services at the national level within the context of universal health coverage (compared with a baseline of 47 and a target of 77). • 138 countries that have annual good quality public analytical reports for informing regular reviews of the health sector strategy (compared with a baseline of 85 and a target of 120). • 63 countries that have strengthened and expanded their implementation of population-based policy measures to reduce the harmful use of alcohol (compared with a baseline of 30 and a target of 60). • 87 countries able to implement WHO strategies and interventions to cover unmet needs in family planning (compared with a baseline of 54 and a target of 40) Many other achievements are described in the WHO Results Report Programme Budget 2016-2017, e.g., "33 countries introduced adequate mechanisms for preventing or mitigating risks to food safety between 2015 and 2017, increasing the total to 130" and "Countries increasingly prepared to address outbreaks and emergencies with health consequences". However, other evidence also demonstrates more mixed performance at the global level is reported on in the Evaluation of WHO's Presence in Countries (2017) within the Selected Corporate and Decentralized Evaluations (2017). This reports that "the evaluation concluded that WHO should review and clarify its role and purpose at country level . . . The added value of the different levels of WHO needs to be clarified, including making sure that WHO country presence and capacity is appropriate to country needs and consistent with the WHO global strategy".	19, 51, 52, 71, 99, 147
MI 10.2 Evidence confidence	High confidence

MI 10.3: Results assessed as having been delivered as part of a coherent response to an identified problem	Score
Overall MI Rating	Satisfactory
Overall MI score	2.5
MI 10.3 Analysis	Source document
For KPI 10.3 on results assessed as having been delivered as part of a coherent response to an identified problem, the proportion of targets achieved, over achieved, on track or mostly achieved was 60%. Around 50 of the indicators were mapped as relevant to this MI and of these around 45 had usable data on results. 22% of indicators were not achieved or off track. Overall, taking account of other information reviewed, this suggests a rating of satisfactory. The relevant benchmark agreed in the MOPAN methodology for a rating of 'satisfactory' is WHO has improved the effectiveness of its partnership relationship with partners over time and improvements are noted in evaluations. Key achievements and improvements on results that the team noted in the PB portal include the following: • 89% confirmed malaria cases in the public sector receiving first-line antimalarial treatment according to national policy (compared with a baseline of 70 and a target of 80). • 20 focus countries that have national action plans for viral hepatitis prevention and control that are in line with the global hepatitis strategy (compared with a baseline of 5 and a target of 20). • 333 institutions contributing to global expert networks and mechanisms (compared with a baseline of 253 and a target of 300). • 167 countries reporting annually on the status of implementation of the International Health Regulations (2005) (compared with a baseline of 60 and a target of 100). • 81 emergency-affected populations which have received one or more basic health services (compared with a target of 75). • 82 countries supported to develop and implement strategies for improving patient safety and quality of health services at the national level within the context of universal health coverage (compared with a baseline of 47 and a target of 77). Many other achievements are described in the WHO Results Report Programme Budget 2016-2017. Regional improvements have been seen in countries in terms of immunisation against tetanus, "all 11 countries in the South-East Asia Region achieved elimination of maternal and neonatal tetanus in 2016, making it the second WHO region to have achieved this historic milestone". This result, in part, was contributed to through the WHO's social media campaign #VaccinesWork to improve knowledge of immunisation.	1, 19, 50, 59, 60, 70, 71, 148, 149

The WHO has demonstrated achievement of across its strategic priorities but it has also been criticised for its performance in some cases. For example, it has actively promoted policy and operational coherence in global health due to the multitude of actors involved and need to delivery health services effectively and efficiently. The Evaluation of WHO Reform (2011-17) states the establishment of the International Health Partnership for UHC 2030 aims to strengthen multi-stakeholder policy dialogue and to move to a more coordinated approach to accountability for SDG. However, it has also been criticised for not always being coherent and not being specific about where it creates and delivers value. Progress on polio has been much more difficult to sustain, according to latest figures. In its independent report for 2018, the polio independent monitoring board noted that the total number of wild poliovirus cases globally has increased: 25 compared to 13 for the same period (30 October) in 2017 and concluded that progress towards interrupting polio transmission globally has stalled and may well have reversed	1, 19, 50, 59, 60, 70, 71, 148, 149
MI 10.3 Evidence confidence	Medium confidence
KPI 11: Results delivered efficiently	KPI score
Satisfactory	2.5
A significant number of WHO's performance indicators in the existing results frameworks relate to efficiency – both on resource/cost efficiency and delivering on time - and in overall terms, taken together, they show a satisfactory performance. The improvement in WHO's indicators on health emergency response underpins a highly satisfactory performance in the area of timely implementation. WHO also clearly recognises that it can strengthen its approach to resource/cost efficiency, through its new Value for Money strategy which is part of GPW13.	
MI 11.1: Interventions assessed as resource/cost efficient	Score
MI Rating	Satisfactory
MI score	2.5
MI 11.1 Analysis	Source document
For KPI 11.1 on interventions assessed as resource or cost efficient, the proportion of targets achieved, over achieved, on track or mostly achieved was 77%. Around 31 of the indicators were mapped as relevant to this KPI and of these around 26 had usable data on results. 12% of indicators were not achieved or off track. Overall, taking account of other information reviewed, this suggests a rating of satisfactory. The relevant benchmark agreed in the MOPAN methodology for a rating of 'satisfactory' is that more than half of intended objectives of interventions are achieved on time, and this level is appropriate to the context faced during implementation, particularly for humanitarian interventions. Key achievements and improvements on results that the team noted in the PB portal include the following: • 77% of the core budget available at mid-point of biennium (compared with a target of 40). • 80% of corporate risks with response plans approved and implemented (compared with a target of 50). • 97 scientific publications reporting new and improved tools, solutions and strategies in maternal, newborn, child and adolescent health within the biennium (compared with a target of 80). • 33 donors financially supporting the WHO Health Emergencies Programme through voluntary contributions of over USD 1 million per biennium (compared with a target of 22).	16, 17, 38, 50, 71, 149, 150, 151, 154, 155

• 53 of countries monitoring and reporting their progress in financial protection (compared with a baseline of 24 and a target of 50). The lack of evidence regarding the extent to which WHO interventions were assessed as being cost efficient has been highlighted by the WHO Reform: Better Value, Better Health: Strategy and Implementation Plan for Value for Money in WHO (2018), which states that “Although WHO already has some value-for-money processes, they are not applied uniformly or systematically, and are not always well documented or appropriately evaluated”. However, WHO is seen to be improving as a “more cost-conscious Organisation”. The Investing in the World’s Health Organisation; Taking Steps Towards a Fully Funded Programme Budget (2016-17) states that, “We [WHO] have made significant savings in staff costs, which have fallen from 47% to 41% of expenditure over the past three years”. This continued commitment to delivering value for money has been adopted by the DG as a part of the GPW13 whereby a “comprehensive, value-for-money approach to all actions undertaken by the Secretariat” was launched.	16, 17, 38, 50, 71, 149, 150, 151, 154, 155
MI 11.1 Evidence confidence	Medium 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	2.5
MI 11.2 Analysis	Source document
For KPI 11.2 on implementation and results assessed as having been achieved on time, the proportion of targets achieved, over achieved, on track or mostly achieved was 84%. Around 31 of the indicators were mapped as relevant to this KPI and of these around 26 had usable data on results. 12% of indicators were not achieved or off track. Overall, and taking account of other information reviewed, this suggests a rating of satisfactory. The relevant benchmark agreed in the MOPAN methodology for a rating of ‘highly satisfactory’ is that all or nearly all objectives of interventions are achieved on time or, in the case of humanitarian programming, a legitimate explanation for delays in the achievement of some outputs/outcomes. Key achievements and improvements on results that the team noted in the PB portal include the following: • 22 global strategies and plans agreed for the management of high-threat infectious hazards (for example, by means of influenza vaccines, antivirals, yellow fever vaccine and cholera vaccine) (compared with a baseline of 6 and a target of 15). • 86% of all graded emergencies which activate an Incident Management System at country level within 72 hours (compared with a target of 70). • 167 countries reporting annually on the status of implementation of the International Health Regulations (2005) (compared with a baseline of 60 a target of 100). • 100 detected events of public health importance for which health related risks are assessed and communicated (compared with a target of 100). • 86 of newly graded events for which a strategic response plan is developed with partners within 30 days (compared with a target of 80).	17, 54, 63
MI 11.2 Evidence confidence	High confidence

KPI 12: Sustainability of results	KPI score
Satisfactory	2.17
Many aspects of WHO's work relate to building capacity of national health systems and strengthening the enabling environment, including at global and regional level. These are the areas which would be expected to underpin progress in achieving sustainable results. Numerous indicators in the results portal can be mapped to MIs 12.2 and 12.3 in this KPI. In this assessment there was only limited evidence from available evaluations showing that WHO has delivered benefits that are continuing, leading to a lower rating on MI 12.1. Overall, the KPI is rated as satisfactory but there is scope for WHO to improve the evidence around sustainable results.	
MI 12.1: Benefits assessed as continuing or likely to continue after project or program completion or there are effective measures to link the humanitarian relief operations to recovery, to resilience and eventually to longer-term developmental results	Score
MI Rating	Unsatisfactory
MI score	1.5
MI 12.1 Analysis	Source document
For KPI 12.1 for benefits assessed as continuing or likely to continue after project, the proportion of targets achieved, over achieved, on track or mostly achieved was 64%. Around 48 of the indicators were mapped as relevant to this KPI and of these around 39 had usable data on results. 21% of indicators were not achieved or off track. The relevant benchmark agreed in the MOPAN methodology for a rating of 'satisfactory' is that evaluations assess as likely that the intervention will result in continued benefits for the target group after completion. However, based on the documentary review, it was not possible to identify evaluative evidence which directly shows that benefits assessed continue or are likely to continue after project or programme completion. For this reason, and notwithstanding the fact that the majority of the relevant performance indicators are on track this element is assessed as (2.0) unsatisfactory. Key achievements and continued benefits that the team noted in the PB portal include the following: • 156 countries and territories in which use of oral poliovirus vaccine type 2 in routine immunisation has been stopped (compared with a baseline of 49 and a target of 156). • 82 countries supported to develop and implement strategies for improving patient safety and quality of health services at the national level within the context of universal health coverage (compared with a baseline of 47 and a target of 77). • 169 countries that have produced a comprehensive health situation and trends assessment during 2016–2017 (compared with a baseline of 119 and a target of 80). • 61 targeted countries that have plans with targets for ending preventable maternal and neonatal deaths by 2030 (compared with a baseline of 48 and a target of 50). • 51 countries able to implement WHO strategies and interventions to cover unmet needs in family planning (compared with a baseline of 21 and a target of 40). As is discussed in MI 12.2 below, there are many examples of where WHO's interventions have been assessed as having built sufficient institutional capacity and/or been absorbed by government. Given that the nature of WHO's normative work (e.g. providing guidelines and strategies) and technical support is conducted with the aim of enabling countries to carry out work with sustainable impacts, rather than WHO conducting the work directly, there is an overlap between MI's 12.1 and 12.2.	

17, 58, 59, 60, 61, 152, 153

Despite the lack of evaluation evidence focused specifically on sustainability of results, the document review did identify a number of examples of projects/programmes where WHO's work has achieved results which appear likely to have continuing benefit. An obvious example is where WHO has supported disease elimination e.g. "the WHO Region of the Americas became the first region in the world to have eliminated measles" and helps to ensure that a disease does not recur.	17, 58, 59, 60, 61, 152, 153
MI 12.1 Evidence confidence	Medium confidence
MI 12.2: Interventions assessed as having built sufficient institutional and/or community capacity for sustainability, or have been absorbed by government	Score
MI Rating	Satisfactory
MI score	2.5
MI 12.2 Analysis	Source document
For KPI 12.2 for interventions assessed as having built sufficient institutional and/or community capacity for sustainability, or have been absorbed by government, the proportion of targets achieved, over achieved, on track or mostly achieved was 78%. Around 54 of the indicators were mapped as relevant to this KPI and of these around 49 had usable data on results. 8% of indicators were not achieved or off track. Overall, and taking account of other information reviewed, this suggests a rating of satisfactory. The relevant benchmark agreed in the MOPAN methodology for a rating of 'satisfactory' is that interventions may have contributed to strengthening institutional and/or community capacity but with limited success. Key achievements and institutional strengthening that the team noted in the PB portal include the following: • 30 most vulnerable countries supported by WHO which have demonstrated progress in critical capacities for health emergencies, in line with the International Health Regulations (2005) and the Sendai Framework for Disaster Risk Reduction 2015–2030 (compared with a baseline of 0 and a target of 30). • 82 countries implementing integrated services (compared with a baseline of 65 and a target of 80). • 82 countries enabled to implement integrated, people centred health service strategies through different models of care delivery matched with their infrastructure, capacities and other resources (compared with a baseline of 48 and a target of 83). • 142 countries with a comprehensive national health sector policy/strategy/plan with goals and targets updated within the last five years (compared with a baseline of 103 and a target of 115). • 47 countries enabled to monitor the progress of their national health policy/strategy/plan during the biennium (compared with a baseline of 0 and a target of 25). • 138 countries that have annual good quality public analytical reports for informing regular reviews of the health sector strategy (compared with a baseline of 85 and a target of 120). There is widespread evidence to suggest that WHO interventions have been assessed as having built the capacity of in-country health systems, and have been absorbed by government. Positive performance against this MI is available from several evaluation reports and interventions. WHO has also encouraged and supported countries to adopt the International Health Regulations (IHR) (2005). The WHO Results Report also goes on to note key achievements, "100 countries have an operational policy, strategy or plan to reduce physical inactivity" and "46 countries have adopted legislation in line with WHO guidelines on safe drinking water quality".	19, 50, 51, 53, 56, 57, 58, 59, 60, 61, 65, 70, 71
MI 12.2 Evidence confidence	High confidence

MI 12.3: Interventions assessed as having strengthened the enabling environment for development	Score
Overall MI Rating	Satisfactory
Overall MI score	2.5
MI 12.3 Analysis	Source document
For KPI 12.3 for interventions assessed as having strengthened the enabling environment for development, the proportion of targets achieved, over achieved, on track or mostly achieved was 68%. Around 65 of the indicators were mapped as relevant to this KPI and of these around 60 had usable data on results. 13% of indicators were not achieved or off track. Overall, and taking account of other information reviewed, this suggests a rating of satisfactory. The relevant benchmark agreed in the MOPAN methodology for a rating of 'satisfactory' is that interventions have made a notable contribution to changes in the enabling environment for development. Key achievements in strengthening the enabling environment for development that the team noted in the PB portal include the following: • 67 countries with core capacities independently evaluated (compared with a baseline of 22 and a target of 60). • 64 emergency medical teams verified and/or mentored at global level (compared with a baseline of 25 and a target of 40). • 82 countries enabled to implement integrated, people centred health service strategies through different models of care delivery matched with their infrastructure, capacities and other resources (compared with a baseline of 48 and a target of 83). • 82 countries supported to develop and implement strategies for improving patient safety and quality of health services at the national level within the context of universal health coverage compared with a baseline of 47 and a target of 77). • 169 countries that have produced a comprehensive health situation and trends assessment during 2016–2017 (compared with a baseline of 119 and a target of 156). • 5 preferred product characteristics and policy recommendations established for priority new vaccines (compared with a baseline of 1 and a target of 3). There is an overlap in the evidence relating to MI's 9.3 and 12.3, as evidence that the WHO has contributed to significant changes and system reforms in national health policy can also be interpreted as evidence of having strengthened the enabling environment for development. The presentation of evidence for this MI puts a greater emphasis on the WHO strengthening coordination in the health sector and improving capacity of relevant countries/actors as in MI 12.2. The WHO Results Report also goes on to note key achievements, "health situation assessment and trends analysed in 37 more countries in 2016–2017, providing important data and evidence for policy-making", "better hand hygiene in hospitals in 29 countries through the African Partnership for Patient Safety", and "countries increasingly prepared to address outbreaks and emergencies with health consequences".	19, 50, 51, 60, 71, 99, 144
MI 12.3 Evidence confidence	High confidence

Annex 2. List of documents

All document listed below are WHO publications or official open access documents, unless indicated otherwise.

1. WHO (2014), *Twelfth General Programme of Work 2014-19*, World Health Organization, Geneva.
2. WHO (2016), *Programme Budget 2016-17*, World Health Organization, Geneva.
3. WHO (2011), *WHO evaluation policy*, World Health Organization, Geneva.
4. WHO (2016), *Evaluation: update and proposed workplan for 2016-2017*, World Health Organization, Geneva.
5. WHO (2014), *WHO evaluation practice handbook*, World Health Organization, Geneva.
6. WHO (2016), *Human resources: annual report*, World Health Organization, Geneva.
7. WHO (2017), *Code of Ethics and Professional Conduct*, World Health Organization, Geneva.
8. WHO (2016), *WHO staff regulations and staff rules*, World Health Organization, Geneva.
9. WHO (2016), *Global strategy on human resources for health: Workforce 2030*, World Health Organization, Geneva.
10. WHO (2017), *WHO Strategic Communications Framework*, World Health Organization, Geneva.
11. WHO (2015), *Revised Human Resources Strategy 2015*, World Health Organization, Geneva.
12. WHO (2015), *WHO Whistleblowing and protection against retaliation 2015*, World Health Organization, Geneva.
13. WHO (2015), *WHO Accountability Framework 2015*, World Health Organization, Geneva.
14. WHO (2016), *WHO's Framework of Engagement with Non-State Actors (FENSA) 2016*, World Health Organization, Geneva.
15. WHO (2014), *WHO Financial Rules and Regulations*, World Health Organization, Geneva.
16. WHO (2016), *Investing in the World's Health Organisation; Taking steps towards a fully funded Programme Budget 2016-17*, World Health Organization, Geneva.
17. WHO (2016), *WHO mid-term programmatic and financial report for 2016-2017*, including audited financial statements for 2016, World Health Organization, Geneva.
18. WHO (2013), *Internal Control Framework 2013*, World Health Organization, Geneva.
19. WHO (2018), *WHO Results Report Programme Budget 2016-2017*, World Health Organization, Geneva.
20. WHO (n.d.), *Draft Concept Note towards WHO's 13th General Programme of Work 2019-23*, World Health Organization, Geneva.
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22. WHO (2013), *WHO reform Financing of WHO*, World Health Organization, Geneva.
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25. WHO (2017), *The Work of WHO in the African Region: Biennial Report of the Regional Director*, World Health Organization, Geneva, World Health Organization, Geneva.
26. WHO (2017), *Implementation of the Transformation Agenda: Progress Report*, World Health Organization, Geneva.
27. WHO (2017), *Regional Matters Arising from Reports of the WHO Internal and External Audits*, World Health Organization, Geneva, World Health Organization, Geneva.
28. WHO (2016), *Collaboration within the United Nations system and with other intergovernmental Organisations*, World Health Organization, Geneva.
29. WHO (2016), *Health in the 2030 Agenda for Sustainable Development*, World Health Organization, Geneva.
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31. WHO (2016), *WHO Country Cooperation Strategy*, World Health Organization, Geneva.
32. WHO (2016), *Rapid Independent Review of the International Health Partnership 2016*, World Health Organization, Geneva.
33. WHO (2014), *WHO workplan on climate change and health aims and objectives: 2014-2019*, World Health Organization, Geneva.

34. WHO (2018), *WHO Transformation Plan and Architecture*, World Health Organization, Geneva.
35. WHO (2015), *Performance Management and Development Framework*, World Health Organization, Geneva.
36. WHO (2016), *WHO delivering for results: Changing ways of working for effective and efficient delivery, 2017*, World Health Organization, Geneva.
37. WHO (2017), *Costing of results (outputs) for the Programme budget 2018-2019*, World Health Organization, Geneva.
38. WHO (2016), *A proposal for increasing the assessed contribution: Ensuring sustainable financing for WHO*, World Health Organization, Geneva.
39. WHO (2013), *Corporate risk register; Organisation wide strategic risk management in WHO*, World Health Organization, Geneva.
40. WHO (2017), *Compliance, risk management and ethics: annual report*, World Health Organization, Geneva.
41. WHO (2017), *Report of the External Auditor 2017*, World Health Organization, Geneva.
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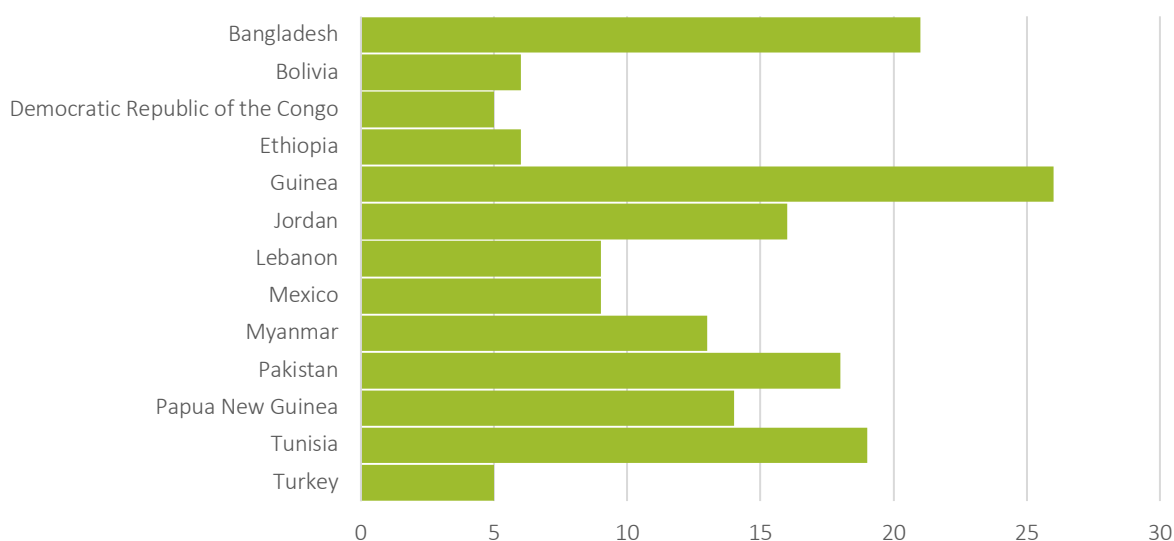
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Annex 3. Results of Mopan's Partner Survey

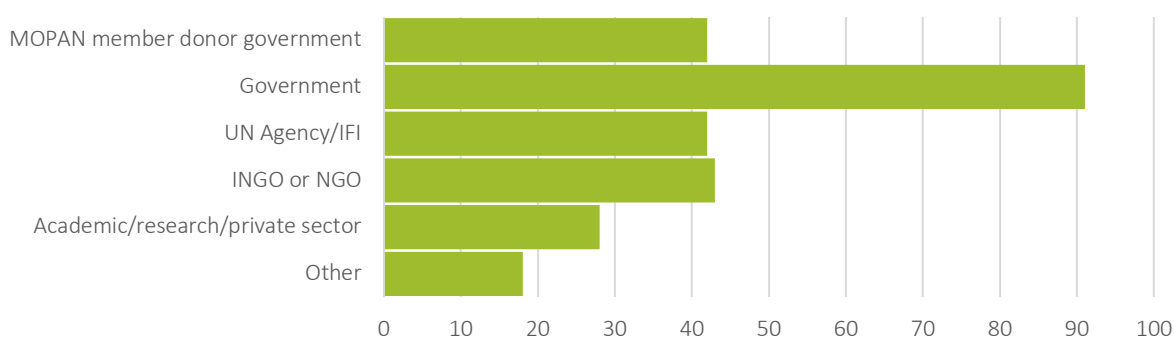
Response profile

Number of survey responses: 264

Number of survey responses by country:

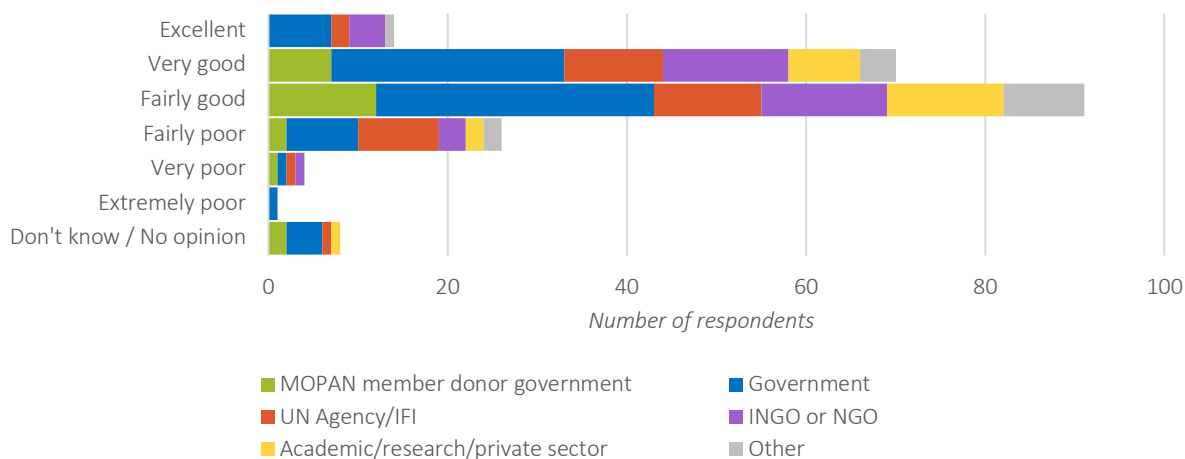


Respondent type:

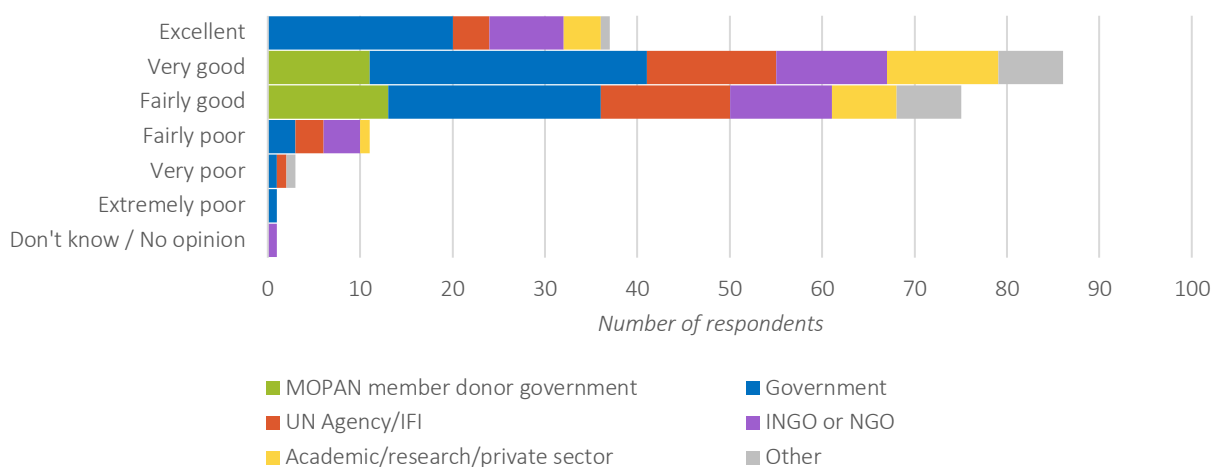


Staffing

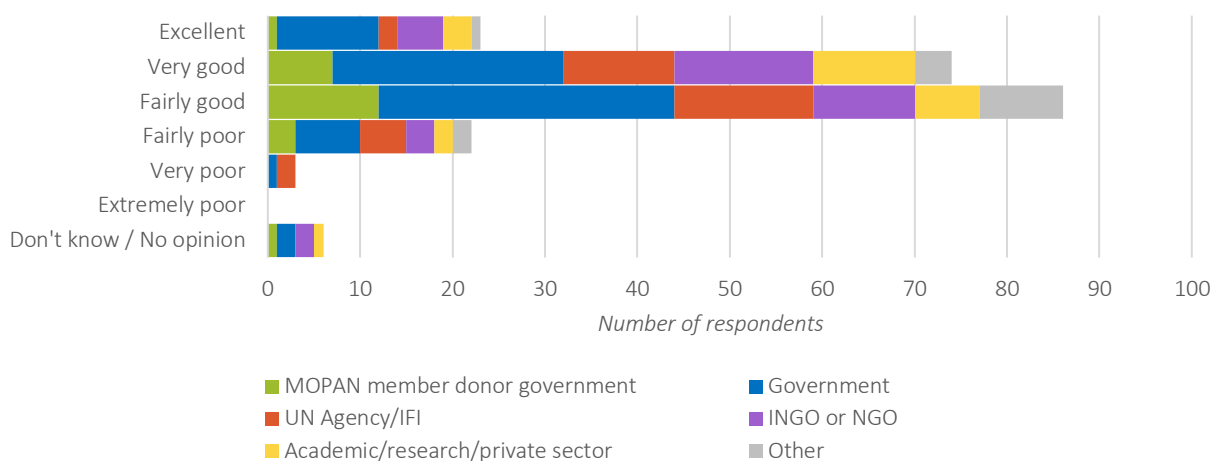
WHO has sufficient staffing to deliver results



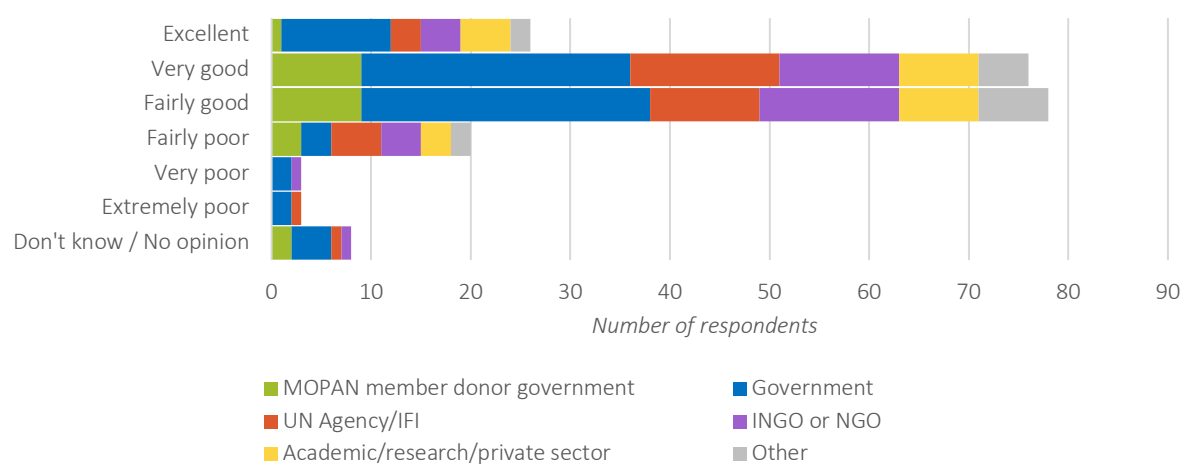
WHO has sufficiently skilled and experienced staff



WHO has sufficient continuity of staff to build relationships

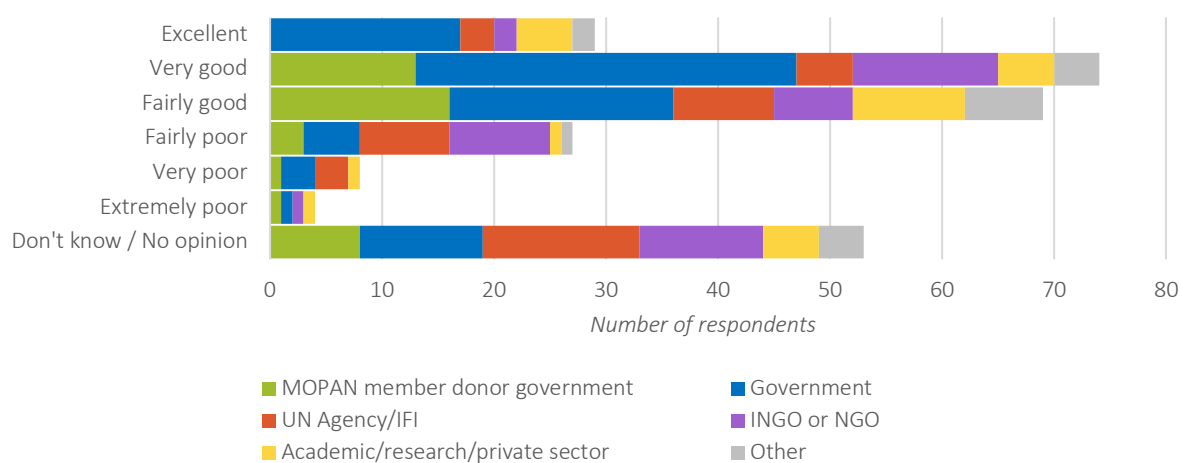


WHO staff can make critical strategic and programming decisions locally

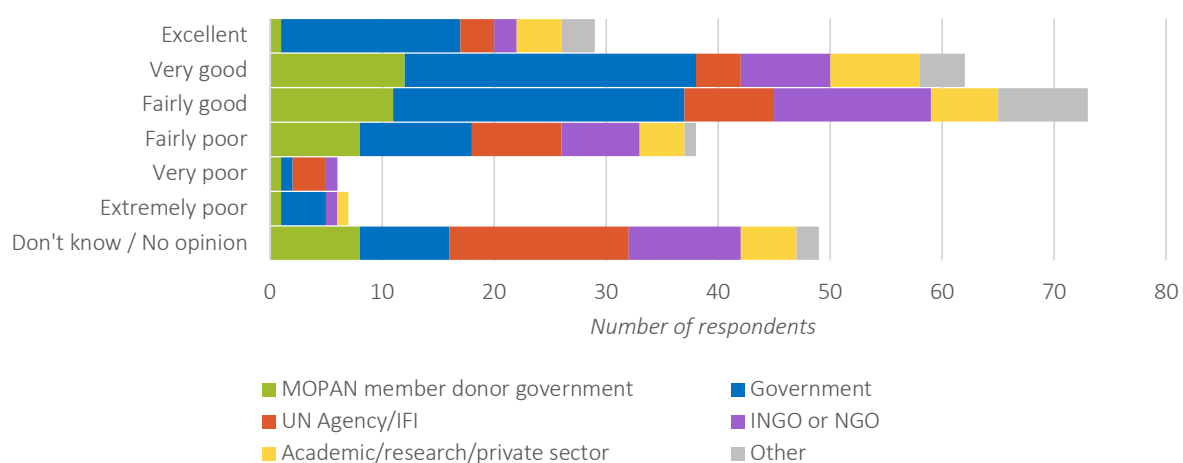


Managing financial resources

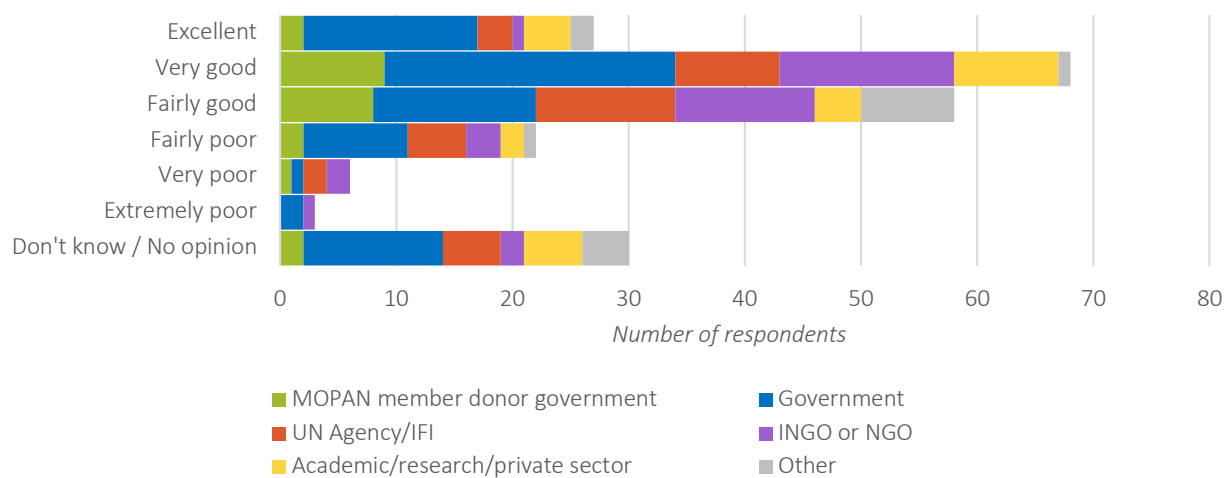
WHO provides transparent criteria for financial resource allocation



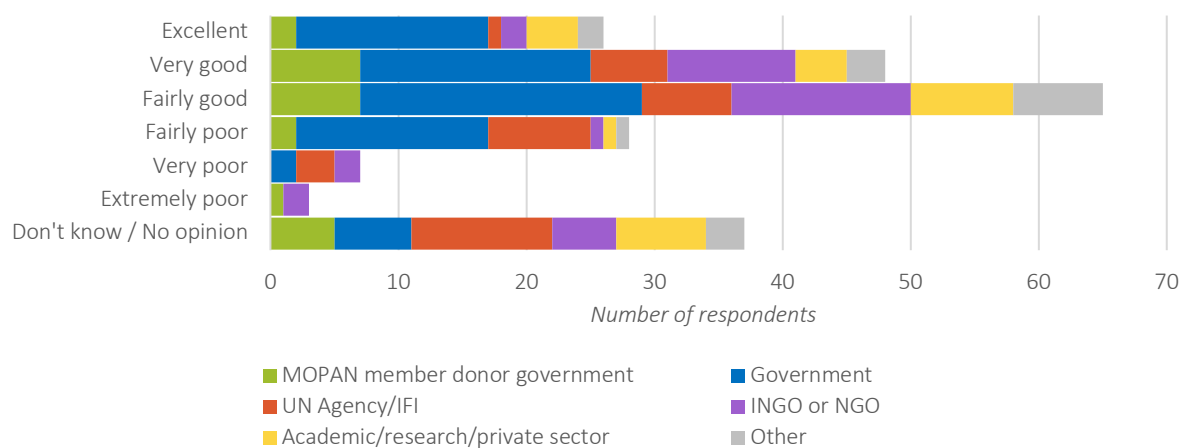
WHO provides predictable financial allocations and disbursements



WHO financial cooperation is coherent/not fragmented

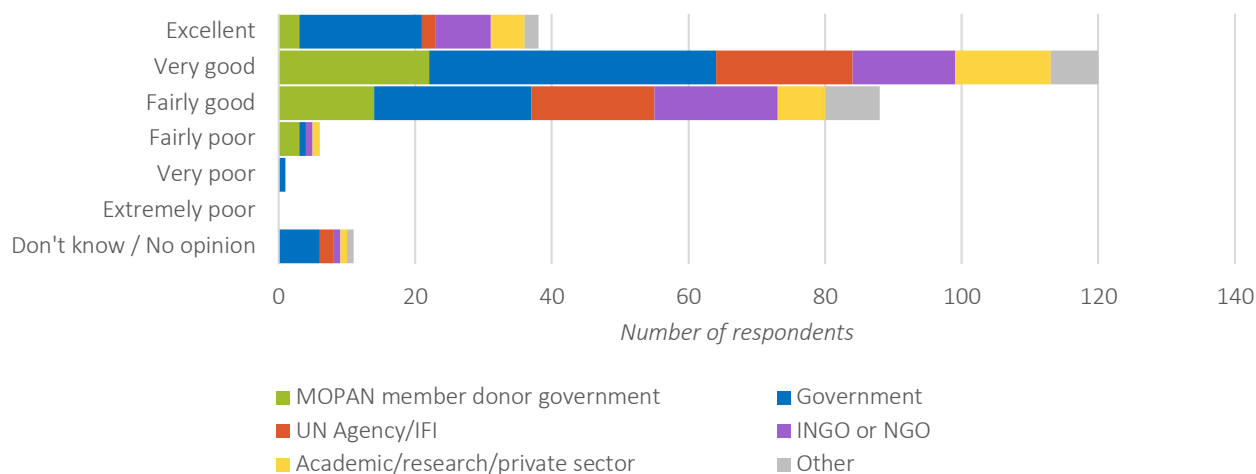


WHO has flexible resources

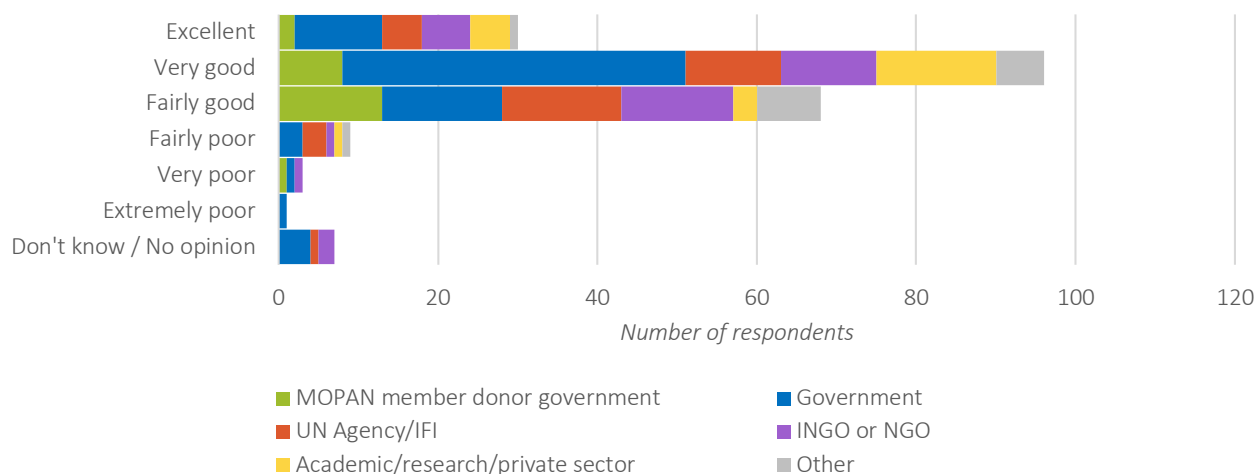


Interventions (programmes, projects, normative work)

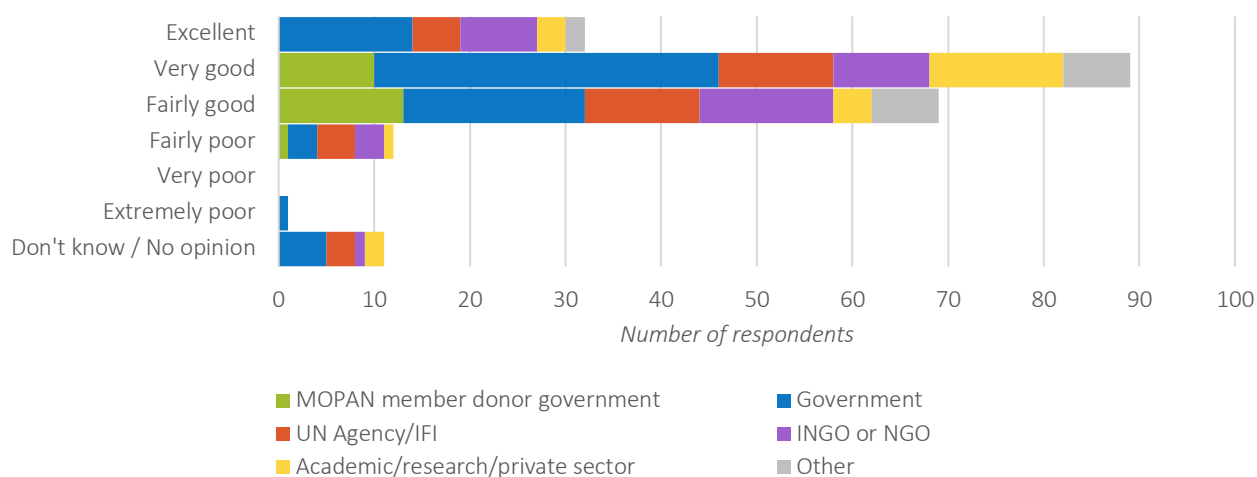
WHO interventions are fit national programmes and results of partner countries



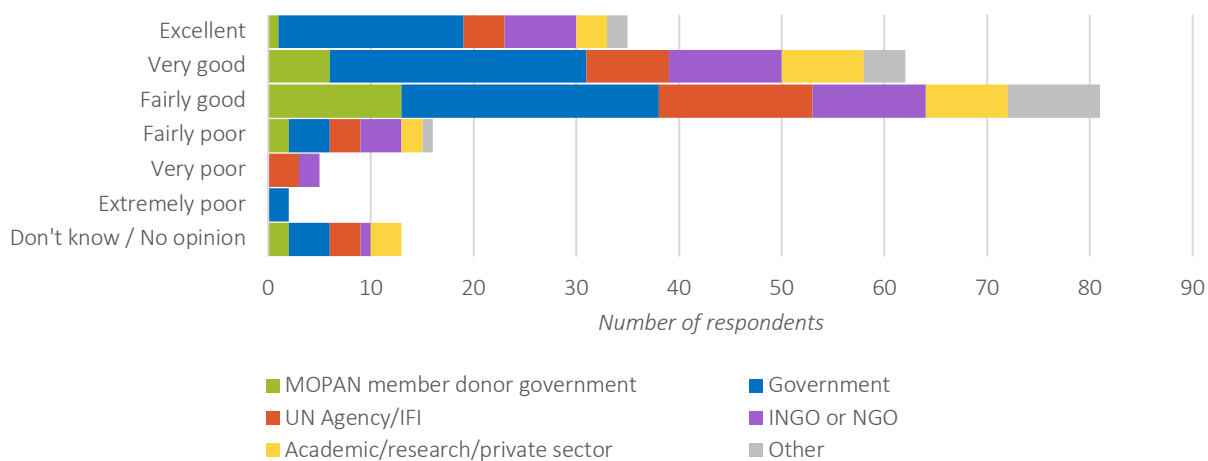
WHO interventions are tailored to the needs of the local context



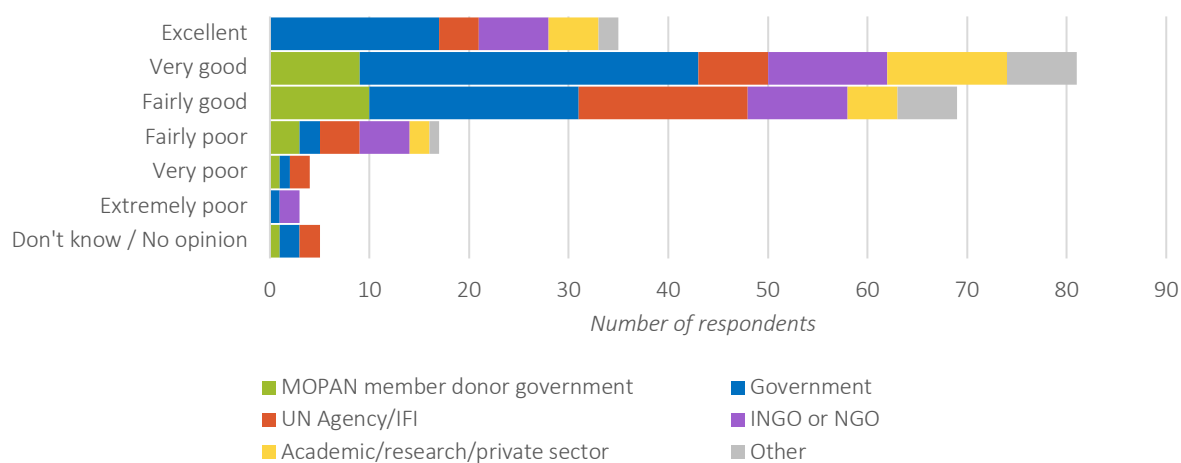
WHO interventions are based on a clear understanding of comparative advantage



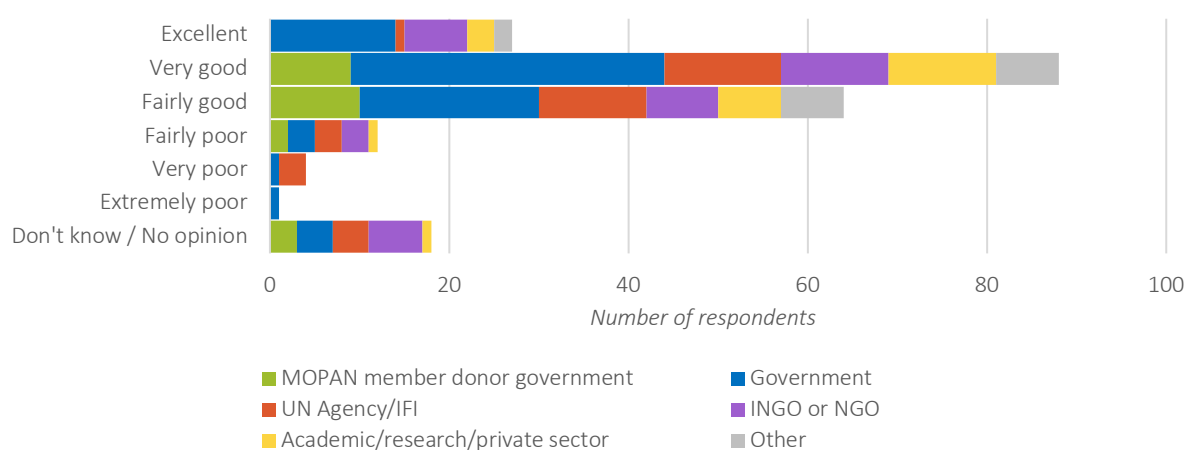
WHO can adapt or amend interventions to changes in context



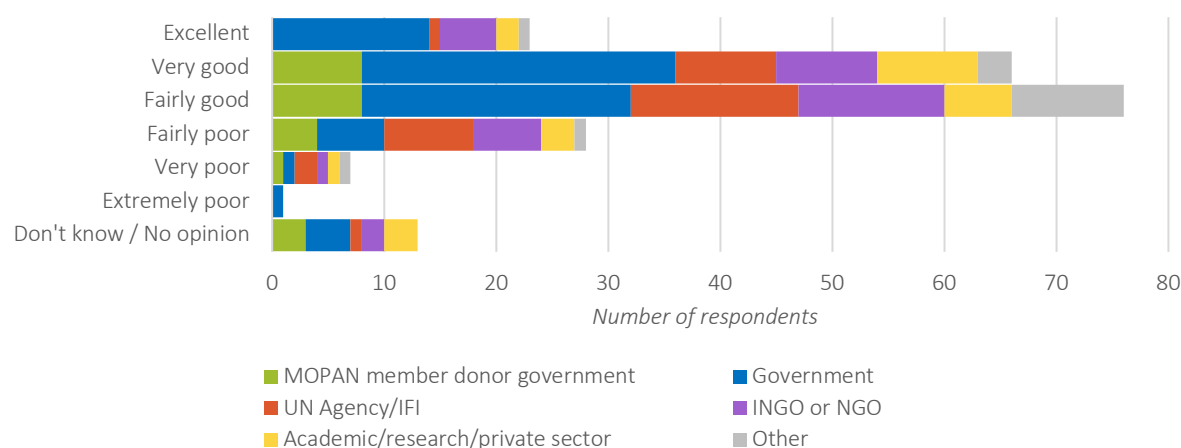
WHO interventions take in to account realistic assessments of national/regional capacities



WHO interventions appropriately manage risk in a given context

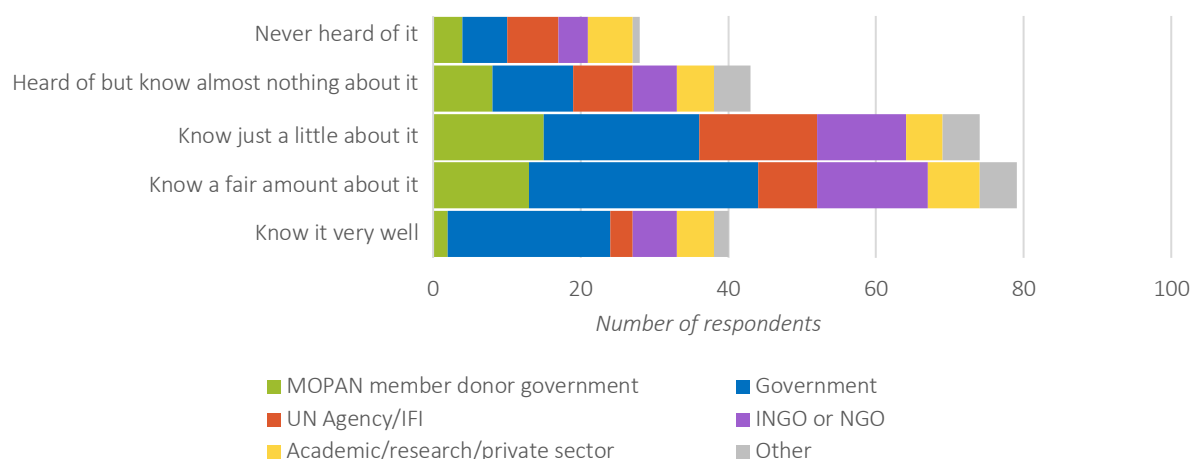


WHO designs and implements its interventions to sustain effect and impact over time

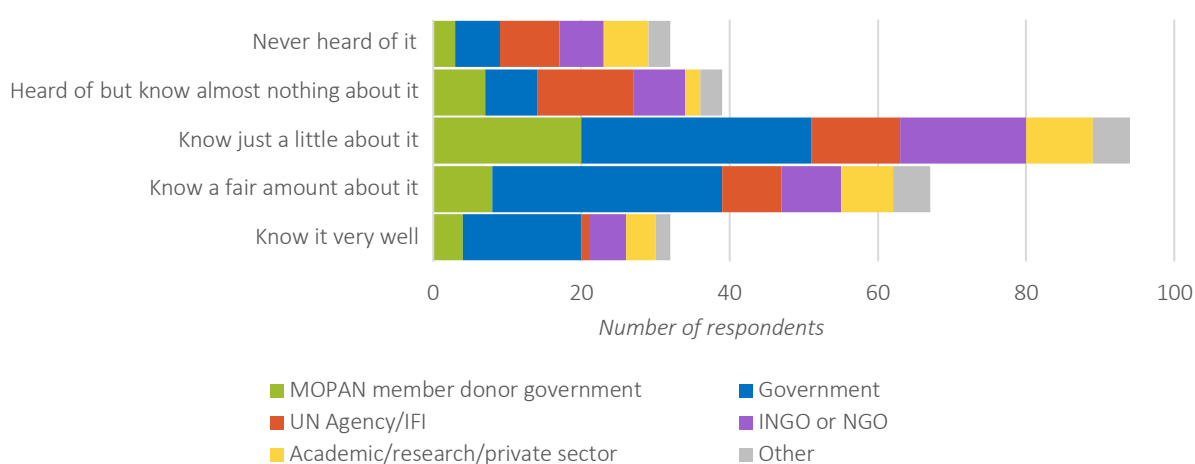


Interventions (cross-cutting issues)

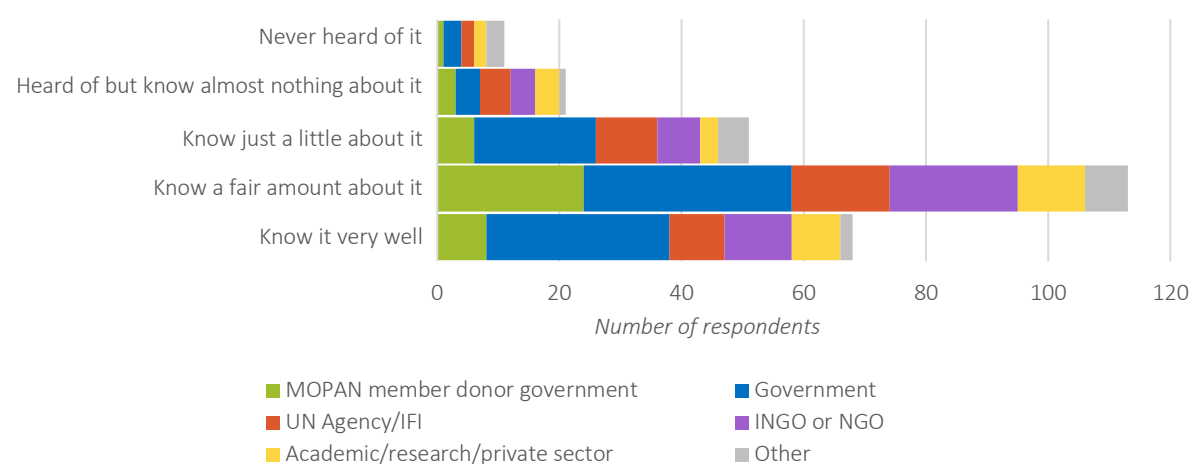
Familiarity with gender strategy of WHO



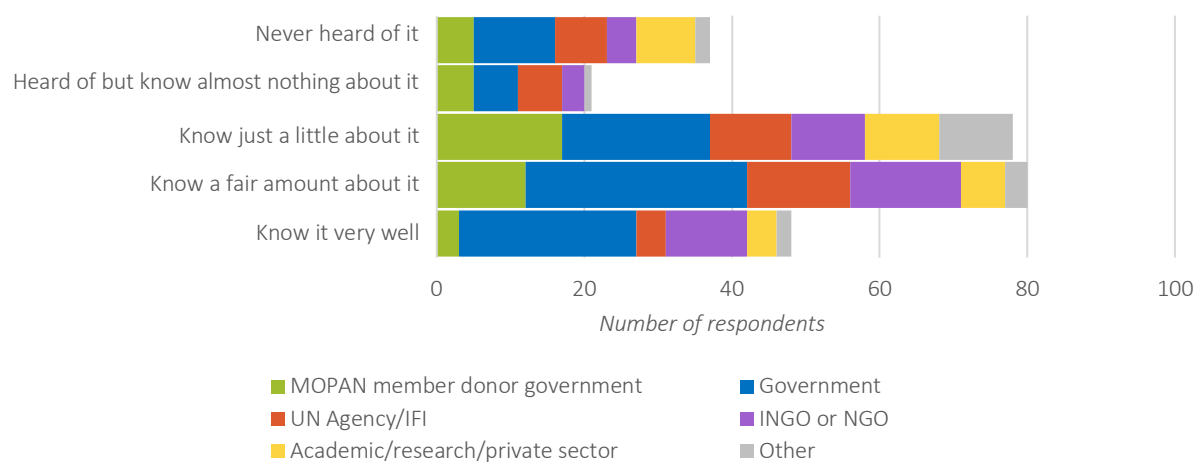
Familiarity with environmental sustainability strategy of WHO, including addressing climate change



Familiarity with strategy for setting out how WHO intends to engage with good governance

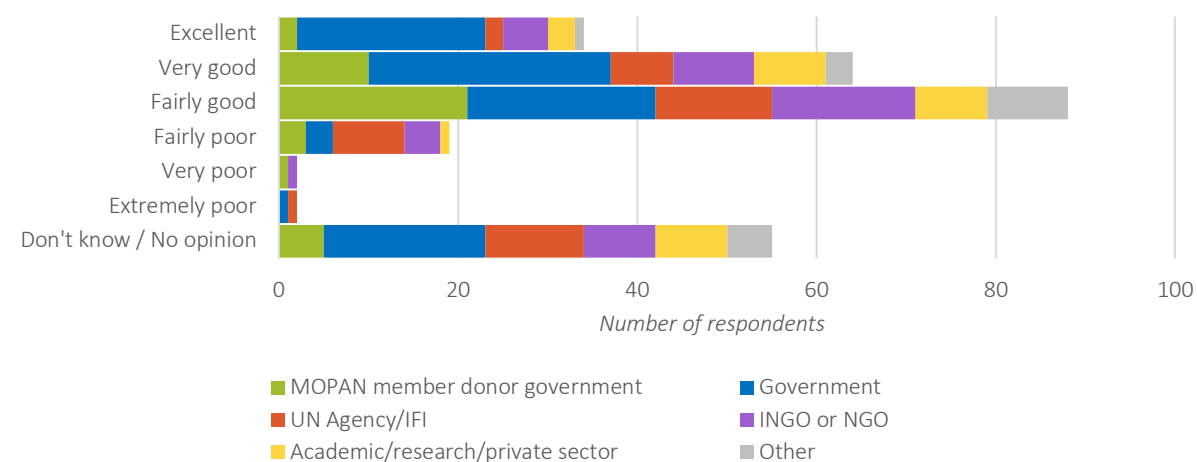


Familiarity with strategy for how WHO intends to take forward its policy commitment on human rights

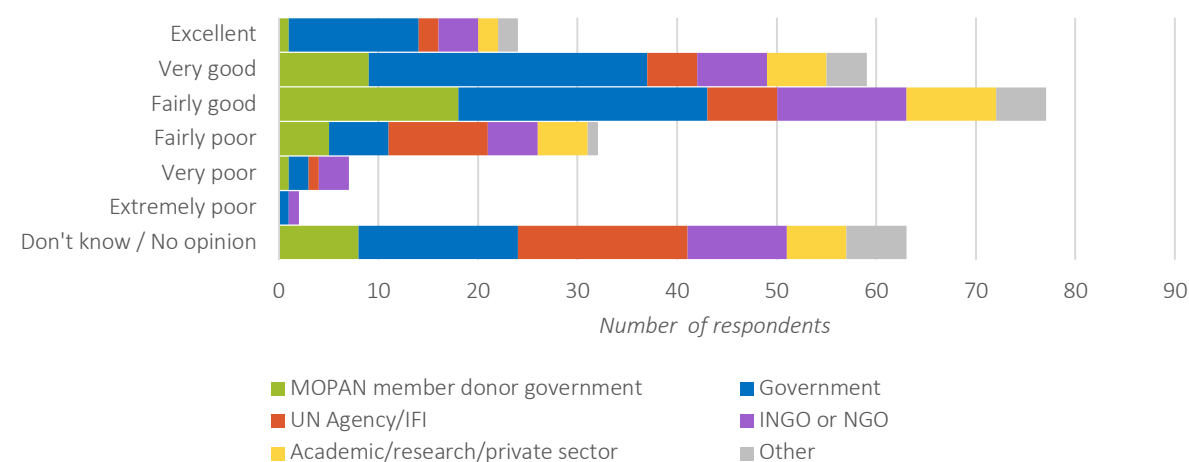


Interventions (cross-cutting issues, organisational performance)

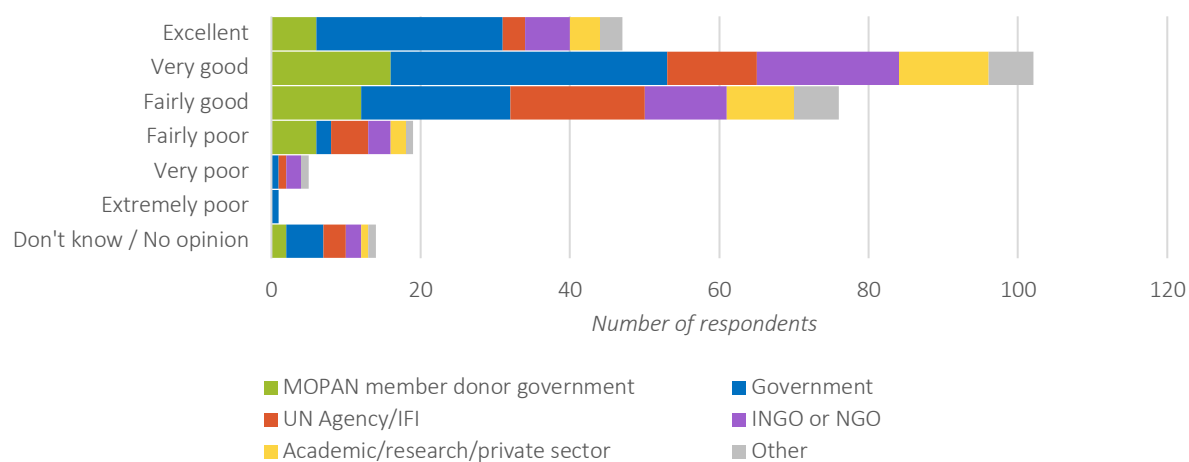
WHO promotes gender equality



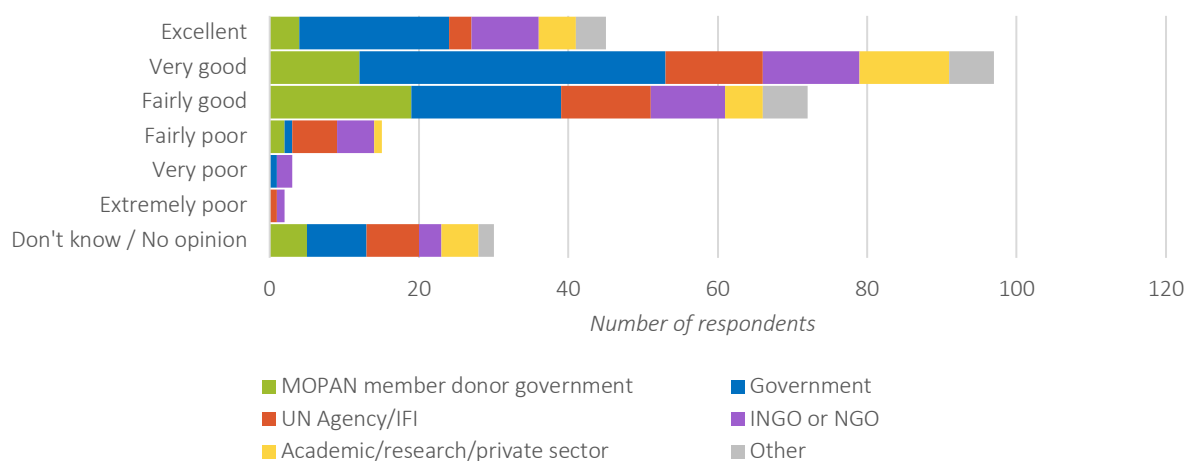
WHO promotes environmental sustainability/addresses climate change



WHO promotes principles of good governance

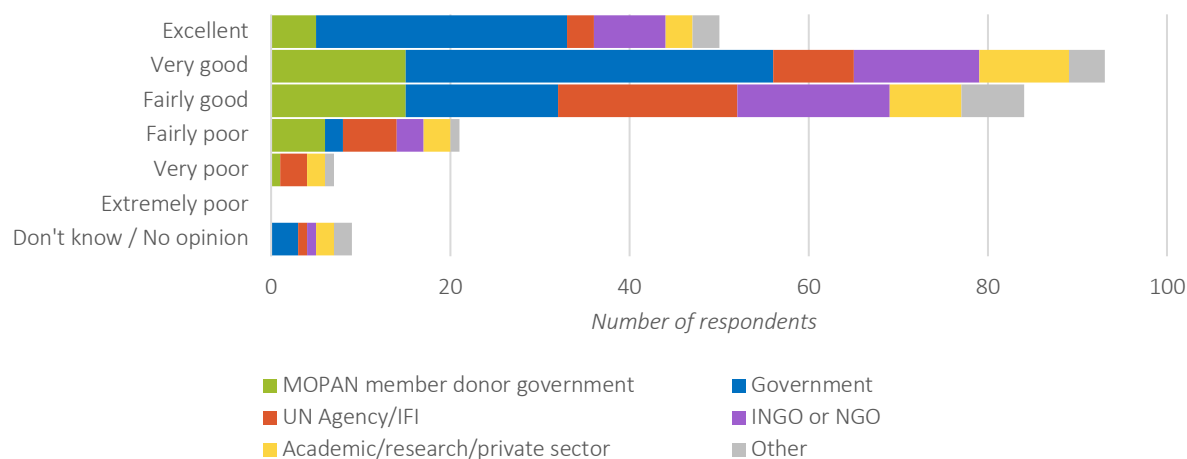


WHO promotes human rights

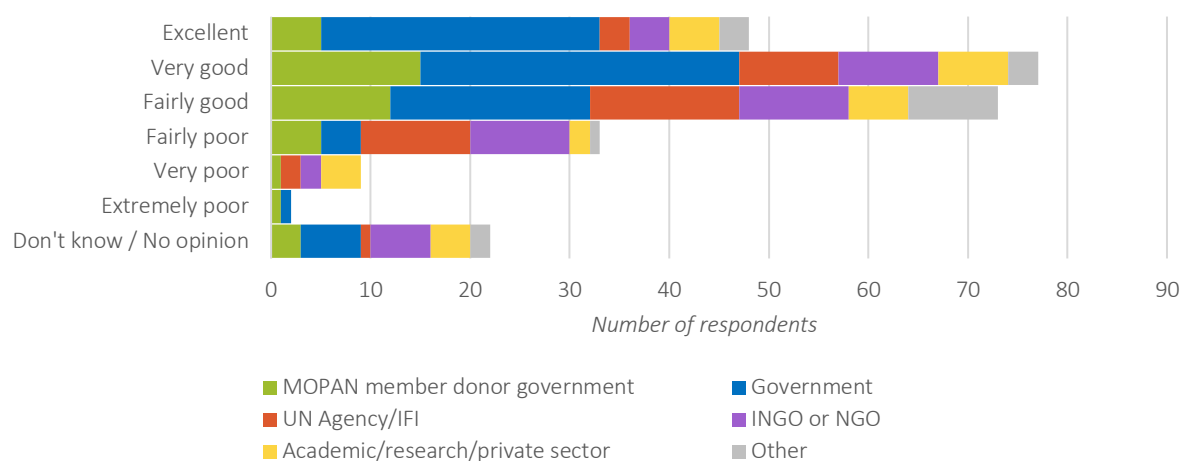


Managing relationships

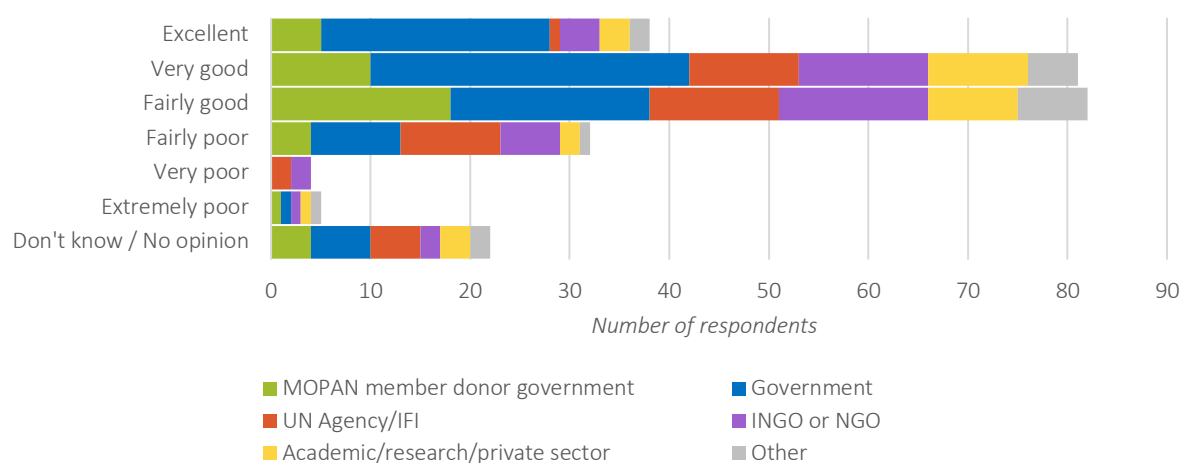
WHO prioritises working in synergy/partnerships



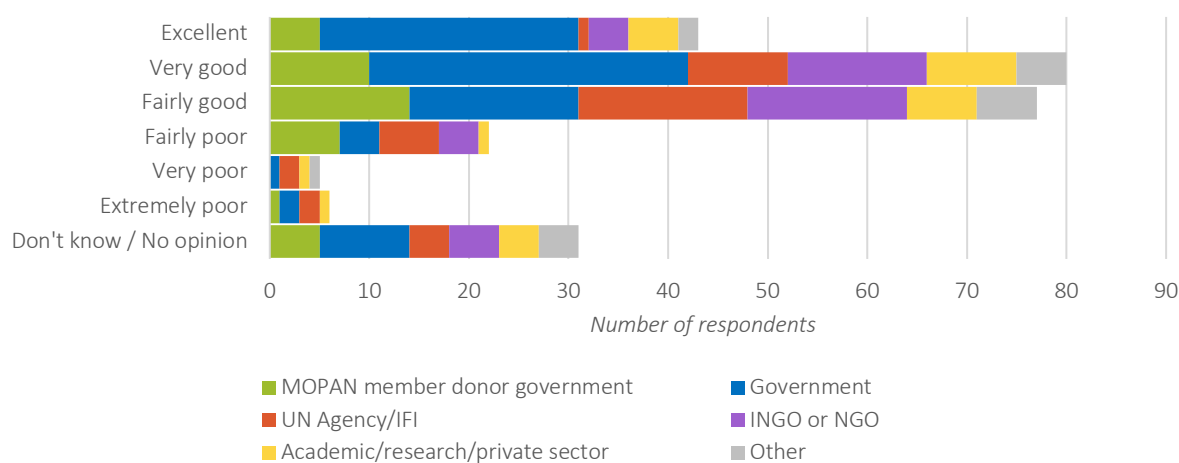
WHO shares key information with partners on an ongoing basis



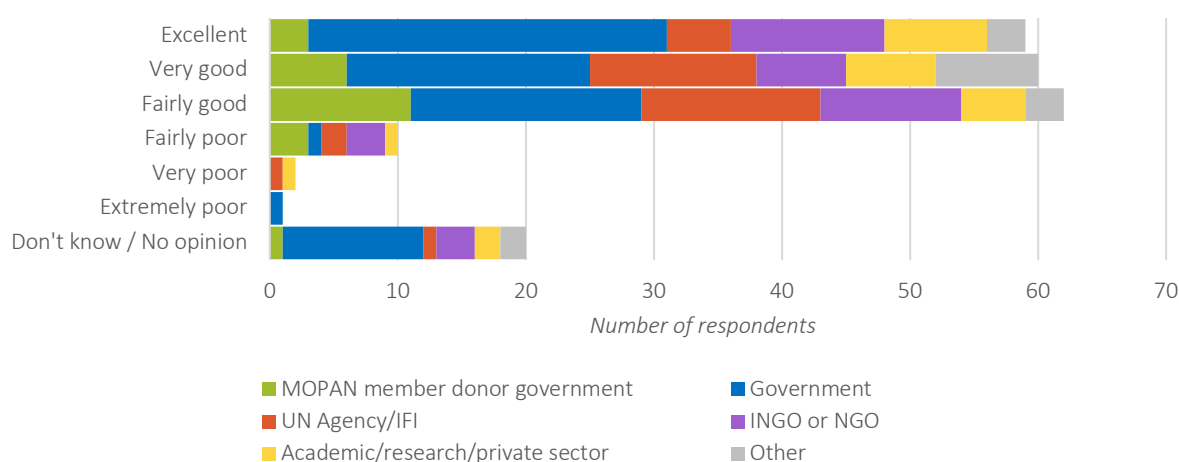
WHO uses regular review points with partners to identify challenges



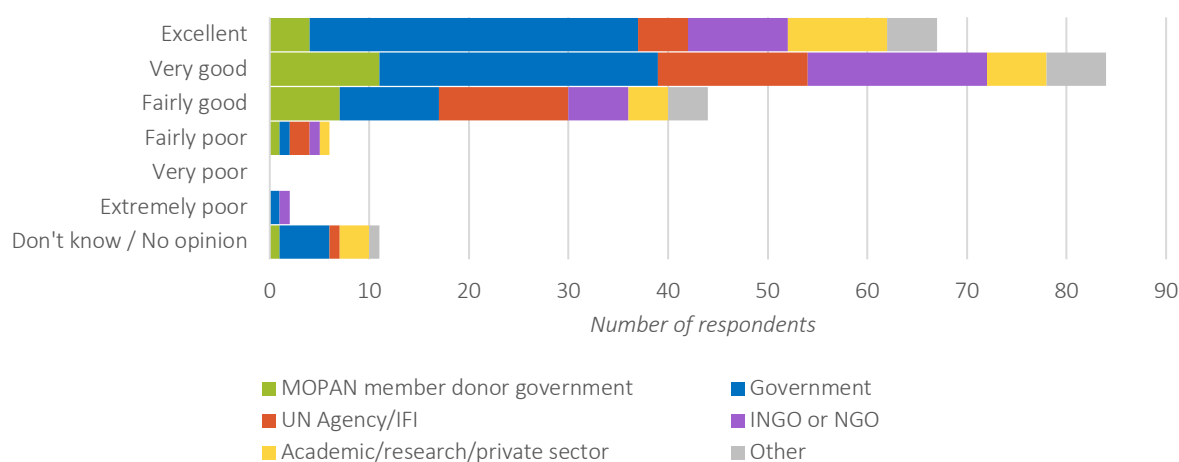
WHO organisational procedures are synergised with partners



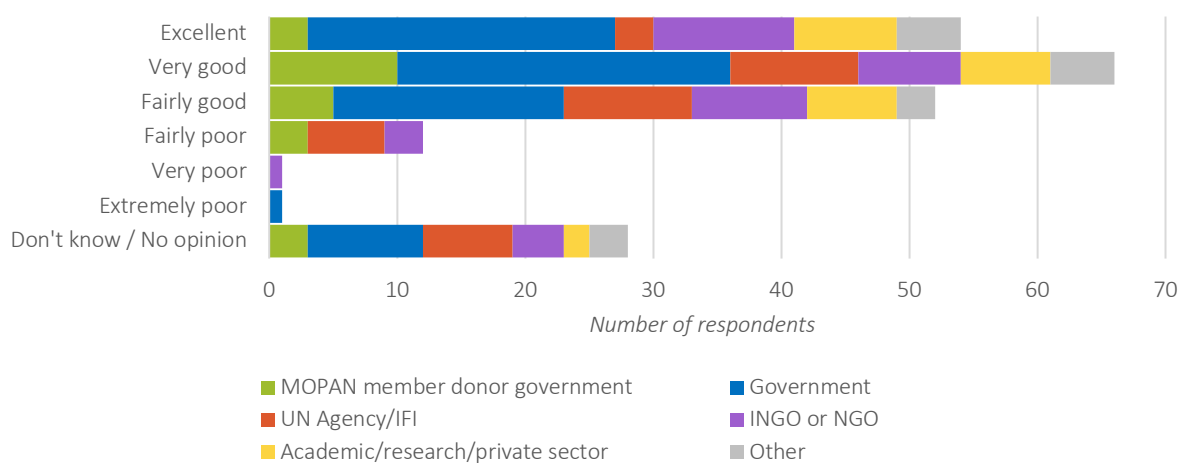
WHO provides high quality inputs to country dialogue



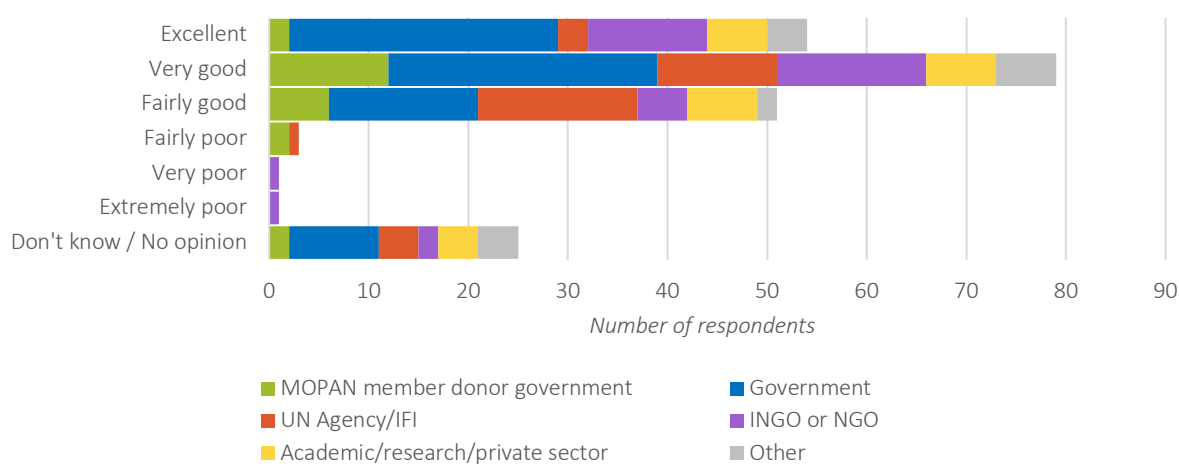
WHO views are well respected in country policy dialogue



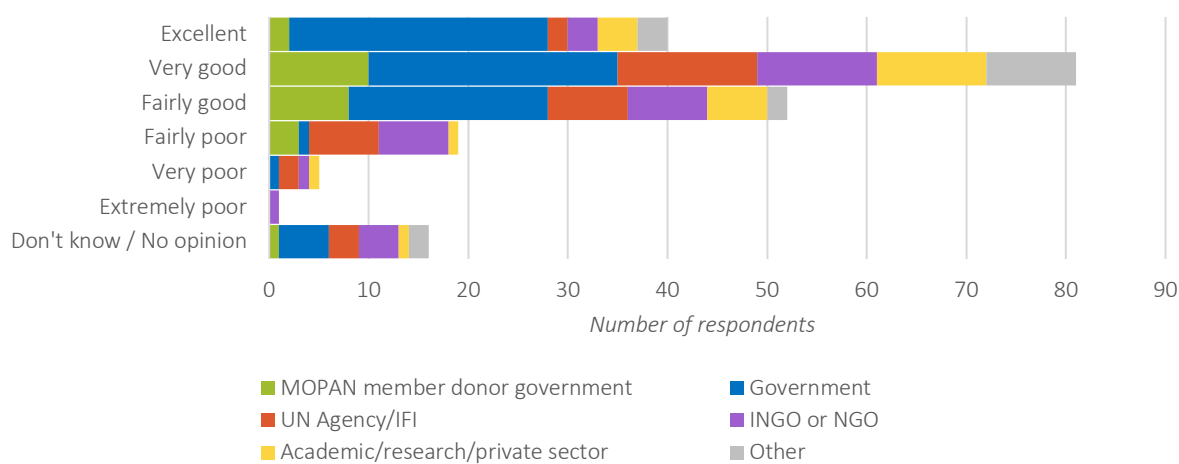
WHO provides high quality input to regional dialogue



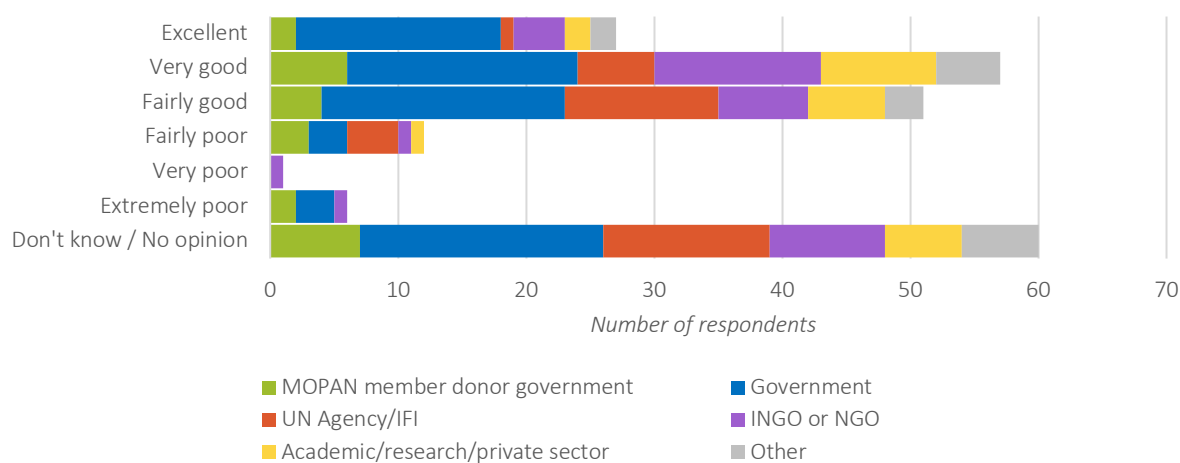
WHO views are well respected in regional policy dialogue



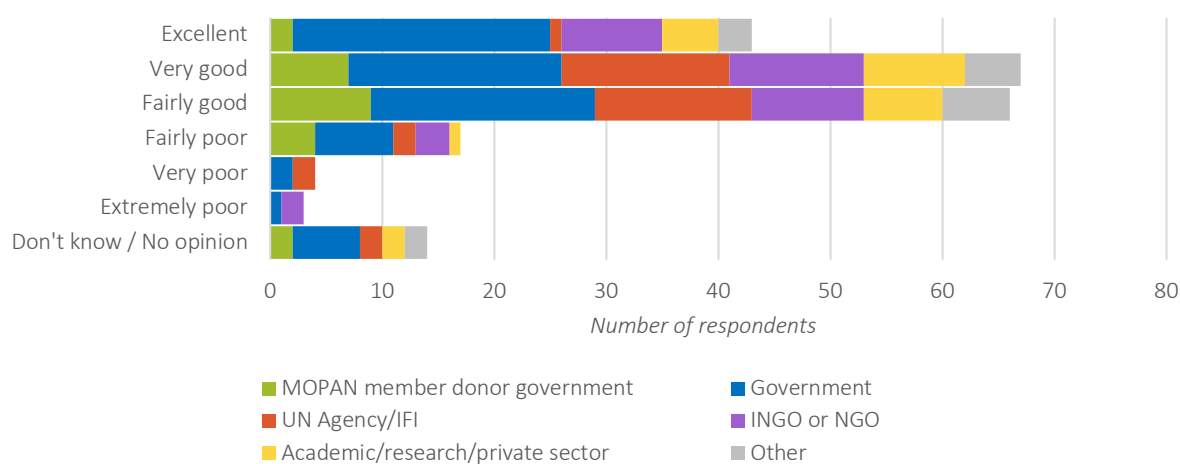
WHO conducts mutual assessments of progress with national/regional partners



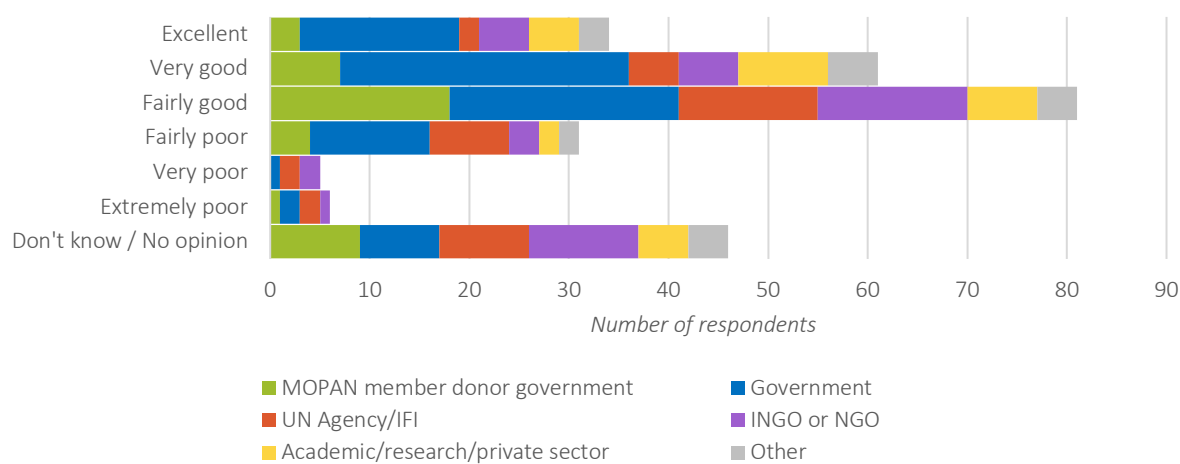
WHO channels resources through country systems as the default option



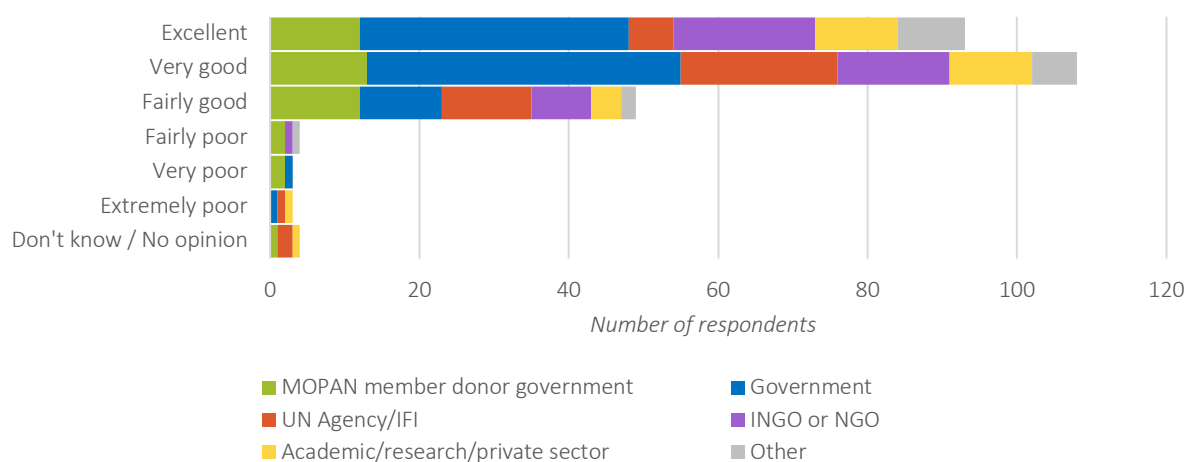
WHO builds capacity in countries where systems are not up to the required standard



WHO organisational procedures do not cause delays for implementing partners

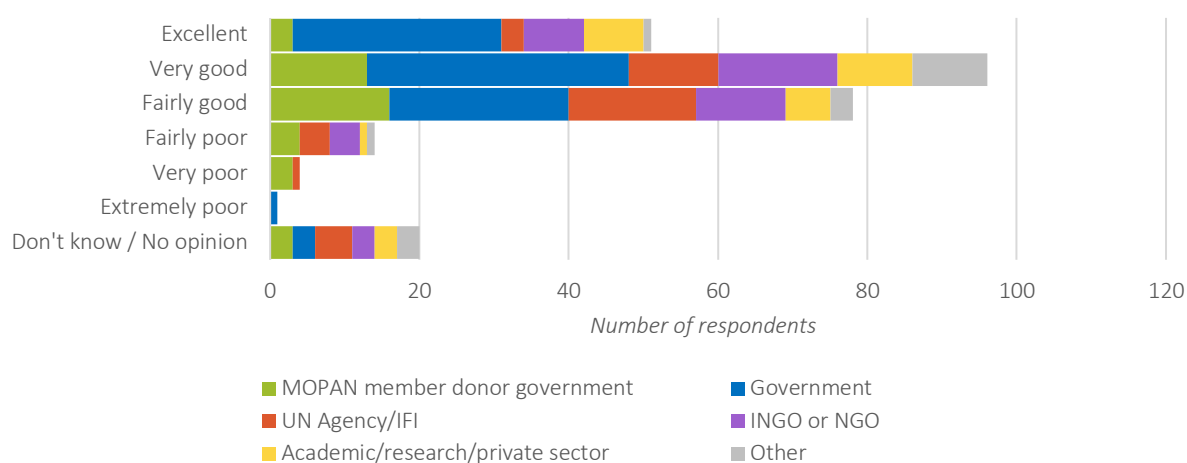


WHO knowledge products are useful for my work

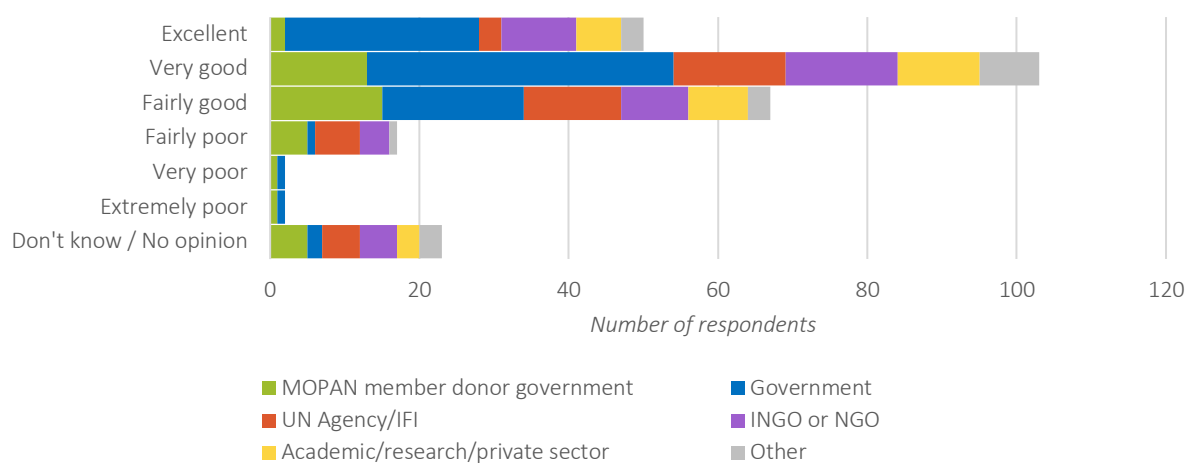


Performance management

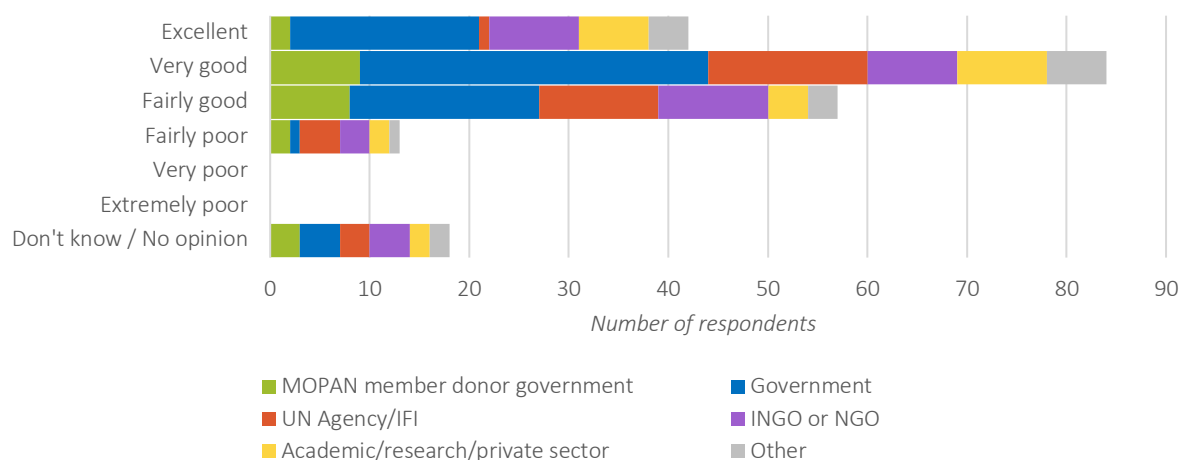
WHO prioritises as results-based approach



WHO uses robust performance data when designing and implementing interventions

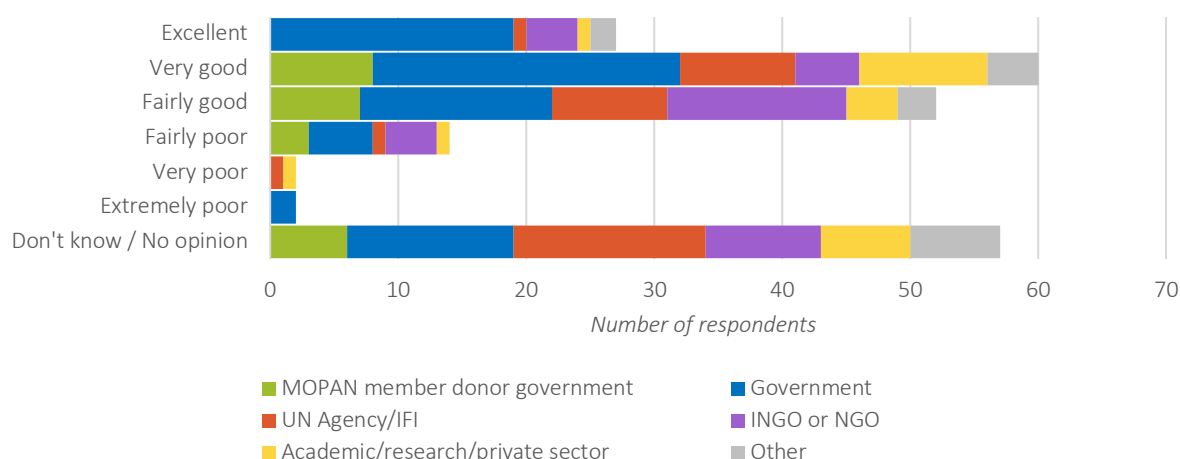


WHO bases its policy and strategy decisions on robust performance data

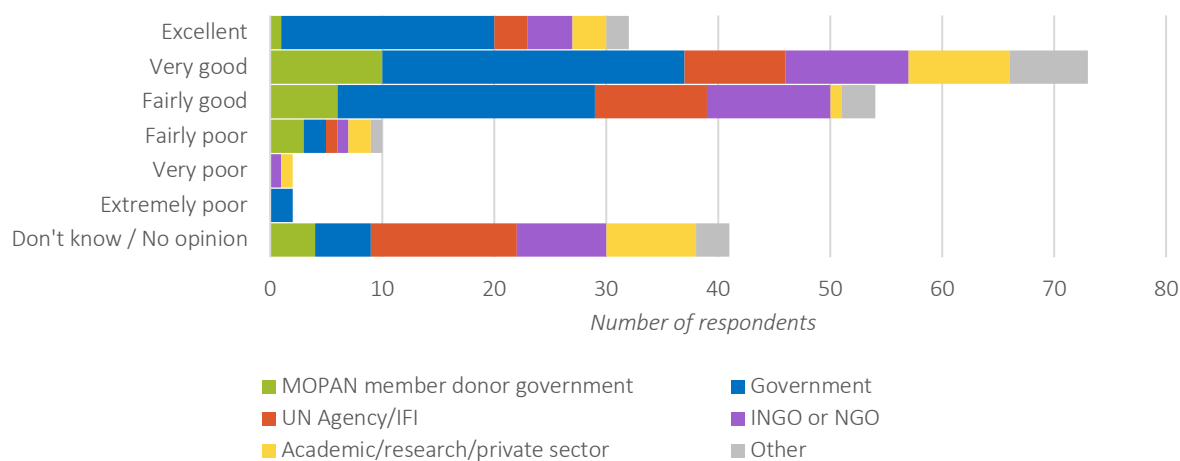


Evidence base for planning and programming

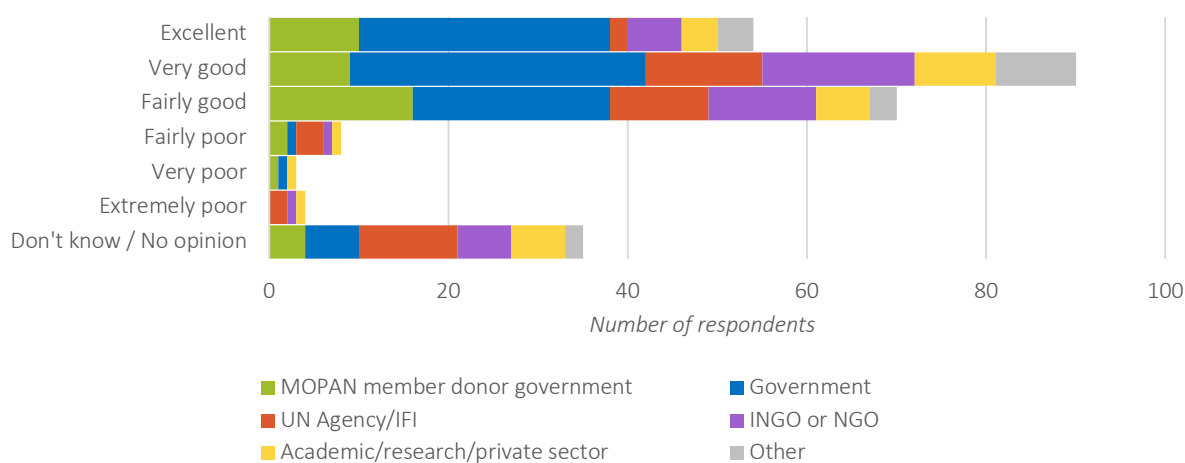
WHO has a clear statement on which of its interventions must be evaluated



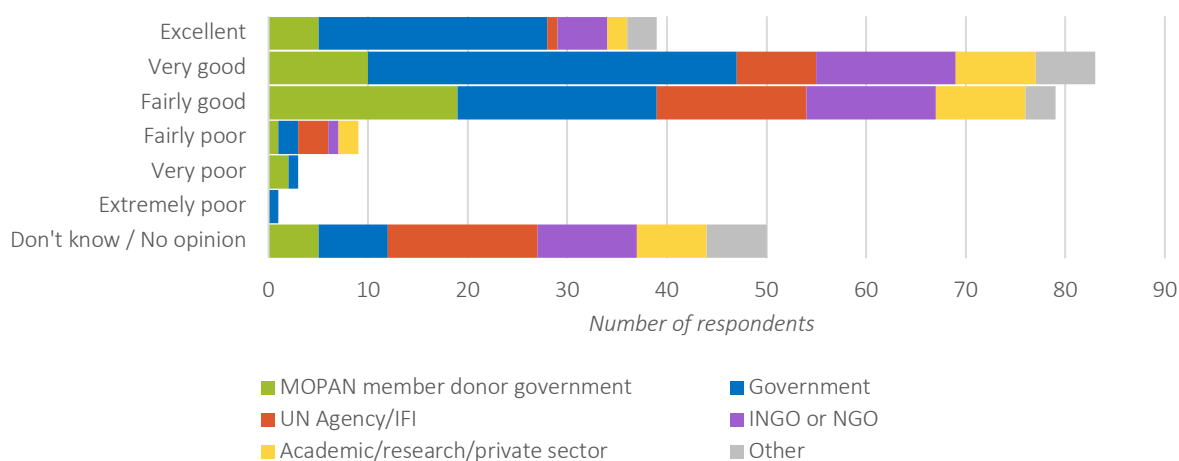
Where required, WHO ensures that evaluations are carried out



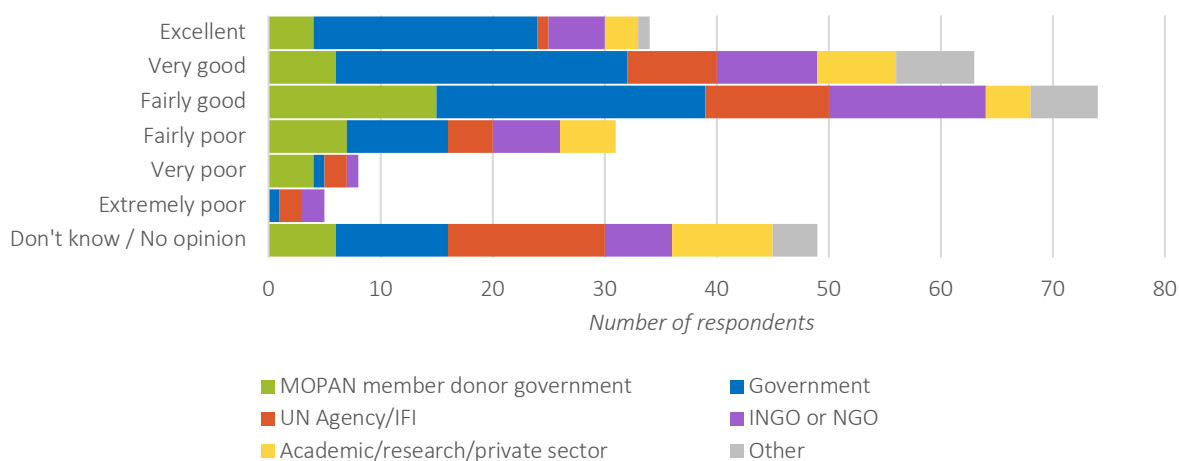
WHO participates in joint evaluations at the country/regional level



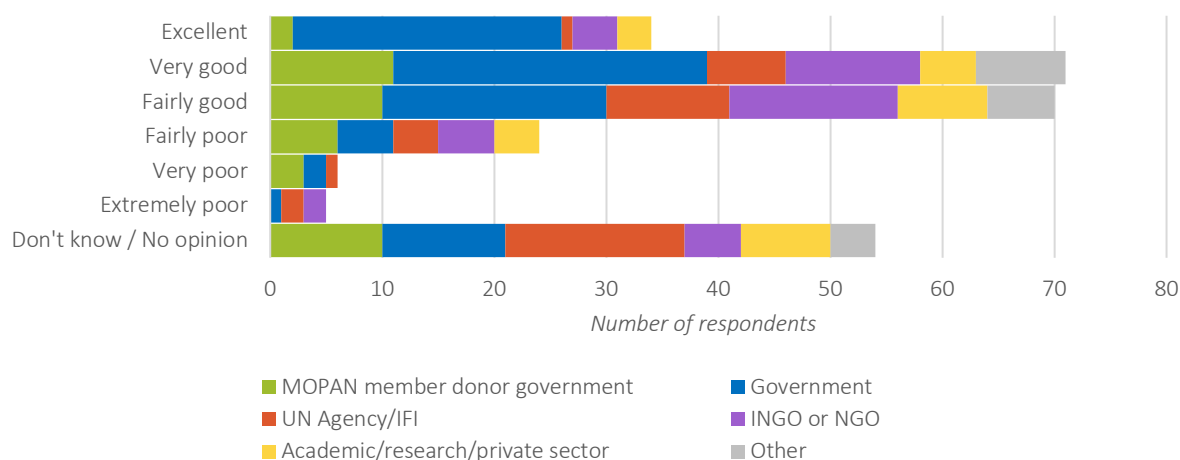
WHO intervention designs contain a statement of the evidence base



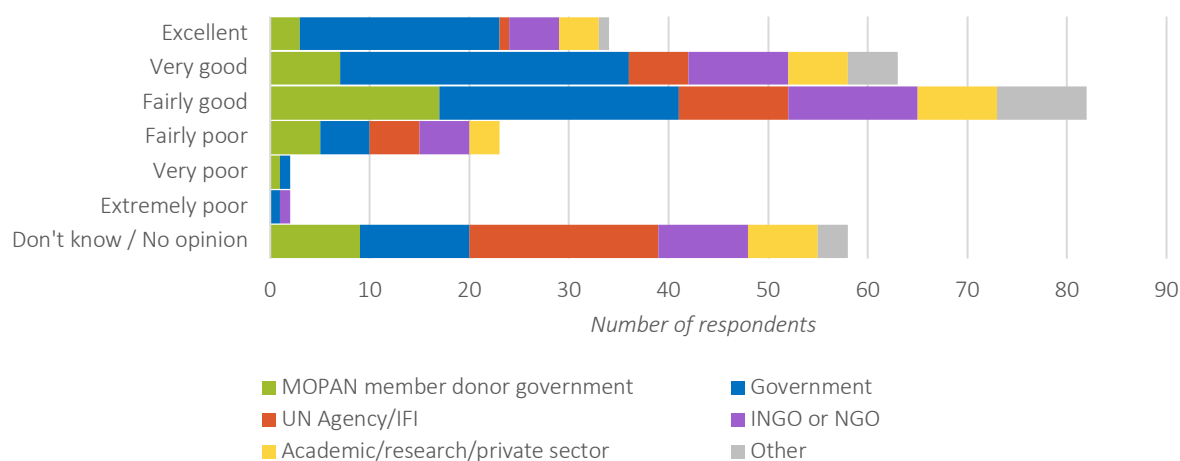
WHO identifies under-performing interventions



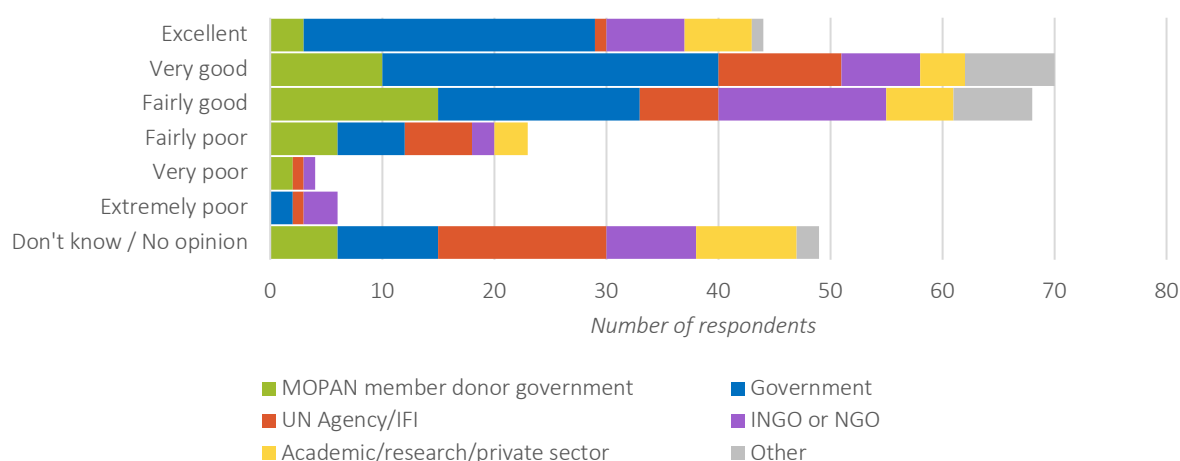
WHO addresses any areas of intervention under-performance



WHO follows up evaluation recommendations systematically



WHO learns lessons from experience rather than repeating the same mistakes





For any questions or comments, please contact:

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