EVALUATION OF WHO 13TH GENERAL PROGRAMME OF WORK
Pre-publication version, December 2023

WHO/DGO/EVL/2023

Photo caption: A nurse attending to a patient in the dengue ward at Mugda Hospital in Dhaka, Bangladesh, September 2023

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<tr>
<td>ACT</td>
<td>Access to COVID-19 Tools Accelerator</td>
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<td>AFRO</td>
<td>WHO Regional Office for Africa</td>
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<td>AMRO-PAHO</td>
<td>WHO Regional Office for the Americas- Pan American Health Organization</td>
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<tr>
<td>ANACoD3</td>
<td>Analysing Mortality and Causes of Death 3</td>
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<td>ARIMA</td>
<td>Integrated Moving Average</td>
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<td>BCA</td>
<td>Biennial Cooperation Agreement</td>
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<td>CCS</td>
<td>Country Cooperation Strategy</td>
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<td>CEPI</td>
<td>Coalition for Epidemic Preparedness Innovations</td>
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<td>COVAX</td>
<td>COVID-19 Vaccine Global Access</td>
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<td>COVID-19</td>
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<td>CRVS</td>
<td>Civil Registration and Vital Statistics</td>
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<td>CSS</td>
<td>Country Strategy and Support</td>
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<td>Country Support Unit</td>
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<td>DAF</td>
<td>Director Administration and Finance</td>
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<td>DDI</td>
<td>Division of Data, Analytics and Delivery for Impact</td>
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<td>DG</td>
<td>Director General</td>
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<td>DPM</td>
<td>Director Programme Management</td>
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<td>DTP3</td>
<td>Diphtheria tetanus toxoid and pertussis</td>
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<td>ECLAC</td>
<td>United Nations Economic Commission for Latin America and the Caribbean</td>
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<td>ECOWAS</td>
<td>Economic Community of West African States</td>
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<td>EIOS</td>
<td>Epidemic Intelligence from Open Sources</td>
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<td>EMRO</td>
<td>WHO Regional Office for the Eastern Mediterranean</td>
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<td>EoB</td>
<td>End of Biennium</td>
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<td>ERG</td>
<td>Evaluation Reference Group</td>
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<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunisation</td>
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<td>GPMB</td>
<td>Global Preparedness Monitoring Board</td>
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<td>GPW 13</td>
<td>13th general programme of work</td>
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<td>GPW 14</td>
<td>14th general programme of work</td>
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<td>HALE</td>
<td>Healthy life expectancy</td>
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<td>HE</td>
<td>Health emergency</td>
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<td>Health in All Policies</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HP</td>
<td>Healthier Population</td>
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<td>Acronym</td>
<td>Full Form</td>
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<td>HQ</td>
<td>Headquarters</td>
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<td>HSSP</td>
<td>Health Sector Strategic Plan</td>
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<td>ICD</td>
<td>International Classification of Diseases</td>
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<td>ICD-11</td>
<td>International Statistical Classification of Diseases and Related Health Problems – 11th Revision</td>
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<tr>
<td>IEOAC</td>
<td>Independent Expert Oversight Advisory Committee</td>
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<td>Incident Management System</td>
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<td>Mexican Social Security Institute</td>
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<td>IsBD</td>
<td>Islamic Development Bank</td>
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<td>JEE</td>
<td>Joint External Evaluation</td>
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<td>LMIC</td>
<td>Low and Low Middle-Income Countries</td>
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<td>MCV1</td>
<td>Measles Vaccine (first dose)</td>
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<td>MDGs</td>
<td>Millenium Development Goals</td>
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<td>MMR</td>
<td>Measles, Mumps, and Rubella</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>MOPAN</td>
<td>Multilateral Organisation Performance Assessment Network</td>
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<td>MS</td>
<td>Member State</td>
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<td>Médecins Sans Frontières</td>
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<td>MTR</td>
<td>Mid-Term Review</td>
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<td>Noncommunicable diseases</td>
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<td>Neglected tropical diseases</td>
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<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<td>Programme Budget</td>
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<td>PHEIC</td>
<td>Public Health Emergency of International Concern</td>
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<td>PMNCH</td>
<td>Partnership for Maternal, Newborn &amp; Child Health</td>
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<td>PPPR</td>
<td>Pandemic Prevention, Preparedness and Response</td>
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Executive Summary
Background

WHO, since its inception in 1948, has made significant strides in public health, notably eradicating smallpox, expanding immunisation and increasing global life expectancy. To further these achievements and achieve ambitious health-related Sustainable Development Goals, WHO’s 13th General Programme of Work (GPW 13) introduced a shift to measurable impact at country level. However, halfway to 2030, countries around the world have faced significant setbacks in achieving these goals and the pandemic of coronavirus disease (COVID-19) further disrupted progress.

GPW 13 outlines how the Organization will proceed with its implementation and provides a framework to measure progress in this effort towards the health-related Sustainable Development Goals (Goal 3 (Ensure healthy lives and promote well-being for all at all ages) and other health-related indicators in other Goals). GPW 13 is relevant to all countries – low-, middle- and high-income. Health is fundamental to the Sustainable Development Goals, and WHO’s role is becoming increasingly relevant in providing global public goods that help to ensure health for all people. The Organization makes broad and sustained efforts to leave no one behind in the shared future of humankind, empowering all people to improve their health, address health determinants and respond to health challenges.

As WHO marked its 75th anniversary in April 2023 and began planning for GPW 14, it was crucial to reflect on past successes and obstacles to inform future health initiatives.

Purpose and objectives

The evaluation was intended for the Secretariat and Member States to learn from the reflection on the implementation of GPW 13, to provide critical inputs for the formulation of GPW 14 and to improve the results framework. For this, it addressed four overarching evaluation objectives.

- **Objective 1**: to assess the appropriateness of the results framework of GPW 13 in facilitating the achievement of the triple billion targets and associated organizational goals;
- **Objective 2**: to identify the areas of work in which good progress was made by countries in achieving the targets and intended outcomes of GPW 13, and in which challenges were met;
- **Objective 3**: to assess the extent to which the Organization was able to focus on the goals of GPW 13 and analyse the factors that facilitated or hindered the achievements; and
- **Objective 4**: to draw lessons from the analyses and recommendations for action, for the WHO Secretariat as well as for Member States, for sustaining results and for development and subsequent implementation of GPW 14.

Methods

To achieve the evaluation objectives, the team looked at (a) GPW 13 formulation; (b) mechanisms to cascade and steer GPW 13; and (c) implementation through Secretariat, Member States and partner structures, complemented by a data-driven decision-making framework. This approach was refined during the inception phase to ensure it was relevant to WHO’s context and for the purposes of this evaluation.

During the inception and data collection phases, the team opted for a mixed-methods approach to collect primary and secondary data. This included an extensive desktop and literature review, engagement with more than 300 internal and external stakeholders through key informant interviews (e.g. with Member State representatives with functions in governing bodies), focus-group discussions (e.g. with Member State regional groups), semi-structured questionnaires sent to all Member States and WHO country representatives, and observation of key meetings such as the 29th meeting of the WHO Programme Management Network. Available statistical data on GPW 13 indicators were used to assess Member States’ progress and achievements towards GPW 13. Six remote country “deep dives” were also conducted to review the implementation of GPW 13 at country level. Bahrain, India, Rwanda, Solomon Islands and Tajikistan were selected based on stratified random sampling to ensure a variety of country offices and geographies were represented. Sudan was later added to ensure an emergency 3 protracted crisis situation was also captured.
The evaluation team had iterative interactions with the Evaluation Reference Group, GPW 14 Secretariat, GPW 14 Steering Committee and other relevant stakeholders as required in order to share working hypotheses, early and preliminary findings, and recommendations. Two Member State information sessions were also held at the end of the inception phase and following the data collection phase.

**Key Findings**

**Objective 1: to assess the appropriateness of the results framework of GPW 13 in facilitating the achievement of the triple billion targets and associated organisational goals**

- **GPW 13 and GPW 13 theory of change**: the WHO Constitution references, but does not define, the GPW, leading to varied practices in terms of: (a) positioning GPW as a corporate strategy for the Secretariat, an institutional strategy for Member States and the Secretariat, a global health strategy for the global health ecosystem or a combination of these; (b) defining the duration of GPW; and (c) defining the level of alignment with the term of the Director-General. The evaluation found a need to ensure these choices are coherent and their implications on strategic oversight by Member States understood. The GPW 13 theory of change is implicit and at best incomplete or potentially misleading, as it focuses essentially on the Secretariat to achieve triple billion objectives.

- **Robustness of the results framework**: healthy life expectancy (HALE) is a crucial part of the GPW 13 impact measurement, effectively measuring WHO’s vision for health and well-being. Setting specific targets for HALE improvement and improving the tracking of the contributions of GPW 13 towards HALE would enhance its utility. The triple billion approach is innovative in the way it aggregates progress across three strategic priorities into a measure of impacted lives. While the approach is well documented and consulted upon, significant challenges in building the indices and making this relatable at country level have yet to be resolved. Impact is measured in terms of Sustainable Development Goals, using indicators approved by Member States and Health Assembly resolutions. The design of outcomes, outputs and indicators is, on balance, acceptable. However, there are issues concerning notably the coherence and consistency between them, the manner in which countries and regions relate to them, as well as the methodology for the Output Scorecard. Qualitative case studies are effective in communicating WHO’s work, but are time-consuming for staff to produce and do not offer a critical assessment of results. The GPW 13 results framework embeds cross-cutting issues on gender, equity and human rights and enables some disaggregation of data. The potential for GPW result disaggregation could be exploited further.

- **Results accounting and reporting**: some monitoring and evaluation activities occur, but they lack a comprehensive and integrated strategy, leading to misalignment and gaps. Data availability, currency and result reporting practices have been inconsistent throughout the GPW period and stakeholder feedback is that they are burdensome.

- **Country-level data capabilities**: efforts to improve Member States’ data capabilities under GPW 13 are ongoing, with dedicated support from the Secretariat under the Survey, Count, Optimise, Review, Enable (SCORE) programme. But substantial challenges remain and additional investment by the Secretariat and Member States is a prerequisite to enable data-driven and impact-oriented approaches.

- **Utility of results reporting**: the utility of GPW 13 reporting at the country level is dependent on alignment with country office needs and national health strategies. Despite commendable efforts by the Secretariat to improve reporting and drive towards data-based decision-making, the evaluation found that the current utility and usage of reporting primarily serve communication and advocacy objectives and marginally accountability, decision-making and learning purposes.

**Conclusion**: consistent with findings of the recent evaluation of results-based-management and internal audit of WHO result reporting, the evaluation found that the GPW 13 results framework, while ambitious and welcomed by internal
and external stakeholders, faces significant design issues, data currency problems and limitations to its utility. While useful for communication purposes, the effectiveness of reporting in supporting accountability, decision-making and learning is currently limited. Improvements within the current result architecture are favoured to maintain continuity, but the extent of challenges should not be underestimated. Substantial improvements and a clear road map for enhancement are required, integrating planning, monitoring, evaluation and reporting for results-based management.

Objective 2: to identify the areas of work in which good progress was made by countries in achieving targets and intended outcomes of GPW 13, and in which challenges were met

Member States’ achievements and challenges on GPW strategic priorities are described below.

- **Universal health coverage (UHC):** the service coverage index has stagnated globally from 2019 to 2021, with declines in some regions and countries, indicating uneven progress in health service coverage. Emerging evidence shows increased financial hardship, especially among the poorest, with an uneven recovery post-2020/2021. A notable concern is the higher public spending on national debt over health in developing countries.

- **Health emergencies:** despite progress in preparedness at various levels post-COVID-19, many systems remain inadequate or weakened, with a narrowing window for political action. The pandemic caused significant disruptions in immunisation and surveillance. Recovery has been strong but uneven globally. The continuous occurrence of acute and protracted health emergencies highlights the need for improved systems and governance, despite resource limitations.

- **Healthier populations:** progress has been made on water and sanitation, household air quality, tobacco and to a lesser extent on stunting and wasting and road safety. However, challenges persist in addressing overweight children and nutritional issues, with a significant part of the world population unable to afford a healthy diet, and millions still die annually due to inadequate water supply, sanitation and hygiene services, necessitating a significant increase in efforts to achieve universal coverage by 2030. Also the scale of the pervasive impact of environmental change on health is underestimated and not well captured in GPW 13 indicators.

Secretariat strategic and operational shifts

- **Stepping up leadership:** stakeholders acknowledged Secretariat’s leadership at global, regional and country level during the pandemic. Yet there were reservations about Secretariat effectiveness in fostering collaboration between Member States and in addressing challenges such as politicisation and financing. Some Member States question the balance between the equity/human rights agenda and WHO’s scientific/public health foundations.

- **Driving public health impact in every country:** the country-focused approach is evident, e.g. through the piloting of result-oriented approaches or the work of the Action for Results (ARG) group. But progress has been delayed and changes have yet to be institutionalised. The increase in country-level expenditure is more the result of overall budget growth than of the roll-out of a new organisational model. All in all, the satisfaction of WHO Representatives and Member States on actual effectiveness of regional offices and headquarters in supporting countries is mixed.

- **Focus global health public goods (GHPG) on impact:** the Secretariat has made strides in organising the delivery of GHPGs, through increased transparency on the pipeline of GHPGs, clearer quality assurance processes across the life cycle of technical products and some level of prioritisation. But, consistent with a recent evaluation of normative function at country level, the evaluation found that there is room for improvement in prioritisation, timely delivery of agreed GHPGs, integration between production of GHPGs and their implementation, and monitoring and evaluation of adoption at country level.
Conclusions: the analysis presents a mixed picture of progress and challenges. Member States and the Secretariat have made significant efforts and progress is observed in several areas. But overall progress towards GPW 13 goals is stagnating or even going into reverse in certain areas, and overall Member States are off-track to reach health Sustainable Development Goals targets. The pandemic exacerbated existing challenges and created new ones, affecting service coverage, financial hardship and emergency preparedness. Recovery has been uneven, and the impact on government finances and trust is significant.

Objective 3: to assess the extent to which the Organization was able to focus on the goals of GPW 13 and analyse the factors that facilitated or hindered their achievement

- **GPW 13 prioritisation challenges:** the global and comprehensive nature of GPW 13 makes prioritisation challenging. However, cascading mechanisms and planning frameworks exist. They help balance focus and flexibility in response to varying country contexts and circumstances.

- **Flexibility during the COVID-19 pandemic:** the experience of flexibility in implementing GPW 13 during the COVID-19 pandemic varied across country offices. While the Secretariat was able to reconfigure itself to respond to the most pressing needs of Member States, balancing the focus on GPW 13 with the need for emergency response flexibility, especially amidst funding constraints and organisational rigidity, proved particularly challenging. The COVID-19 pandemic and other health emergencies catalysed some progress in preparedness and demonstrated the value of integrated approaches. There are examples of opportunities seized to advance the UHC and healthier population agendas in the pandemic response. However, on balance, the shifts in focus and resources towards emergency response caused deviations from core programmatic activities and impacted overall implementation in other strategic priorities.

- **Factors affecting Member States and Secretariat achievements, deviations and challenges:** Member States' achievements and those of the Secretariat – together with the challenges they face and any departures from planned implementation – are shaped by external contingencies, the first among those being the COVID-19 pandemic. However, they are also influenced by factors that are within their control, such as governance and leadership, financing and resource allocation, collaboration and partnerships, capacity and infrastructure, communication and engagement, and finally, equity and inclusivity. These are of relevance to inform the theory of change for future GPWs, as addressing these enablers and hindrances may require targeted interventions such as those for political commitment, improved funding mechanisms, conflict resolution efforts, comprehensive public health education, and strategic resource allocation.

Conclusion: the ability of Member States and the Secretariat to effectively implement GPW 13 at the country level has been tested, particularly in the context of the COVID-19 pandemic’s flexibility demands. The findings underscore the importance of balancing strategic focus with operational flexibility, considering the diverse challenges and contexts of Member States.

The experience highlights the need for WHO in GPW 14 to more adaptively accommodate unforeseen challenges, ensuring better alignment of strategic goals with operational capabilities and resources. The role of external and internal factors, including governance, funding and organisational structures, is pivotal in shaping future successes. Moving forward, a nuanced understanding of these factors and more agile response mechanisms are crucial for the successful implementation of GPW 14 and future global health frameworks. This requires an ongoing commitment to improving governance, enhancing communication and engagement and ensuring needs-based equitable resource allocation and collaboration among all stakeholders.
Objective 4: to draw lessons from the analyses, and recommendations for action, for the WHO Secretariat as well as for Member States, for sustaining results and for development and subsequent implementation of GPW 14

General conclusions

- **Alignment and commitment need**: GPW 13 highlighted the need for better horizontal alignment between the Secretariat, Member States and partners at the country level. Although some alignment was achieved, the lack of formal commitment mechanisms on country-level objectives and on legally binding instruments such as a pandemic treaty was noted.

- **Data’s role in decision-making**: sound and timely data are crucial for guiding result-oriented actions and accountability. However, challenges in data availability and reliability need to be addressed for effective, evidence-driven decision-making at all levels.

Moving forward, a key challenge for WHO leadership and Member States will be to resolve the tensions between the following.

- **Balancing continuity and disruption**: in terms of continuity, GPW 13’s objectives are still relevant, and many positive changes have yet to be institutionalised. At the same time, the post-COVID-19 environment requires adapting to dynamics affecting global health. This includes rethinking strategies to better prioritise areas of high impact and aligning commitments across the health ecosystem.

- **Short-term and long-term focus**: in the short term, focus is required on: (a) resolving immediate pandemic impacts, most notably on immunisation, mental health and health workforce; and (b) building frameworks for future preparedness before political momentum fades. In the long term, WHO has a unique role to play to bring attention and action to address the powerful megatrends affecting global health. A more equitable, sustainable and resilient health environment is at stake.

- **Flexibility and result orientation**: a balance needs to be found between, on the one hand, required flexibility in responding to changing health circumstances and, on the other, a relentless focus on achieving specific, targeted and measurable health outcomes. Adaptive strategies need to lead to tangible and sustainable improvements in global health.

- **Aligning ambitions with means**: ambitious health goals need to be matched with sustainable and aligned financing. As WHO moves towards GPW 14, it is crucial to secure consistent funding that aligns with prioritised goals and resolve funding imbalances across different areas. Sustained resourcing of the Health Emergencies Programme is paramount but so is a rebalancing towards healthier populations, which are structurally underfunded yet a major contributor to HALE.
Recommendations

The recommended actions presented below are clustered under three overarching recommendations that are aimed at the Secretariat and Member States. They align with key evaluations questions under Objective 4 of the evaluation.

Recommendation 1. To obtain closure on COVID-19 and reset progress towards GPW 13 objectives the WHO Secretariat and Member States should prioritise the following short-term actions for the remaining period.

1.1 By latest Q2-2024, the Secretariat should seek to bridge the data gap on outcome indicators for which no recent global reporting is available. This is paramount to get a complete and coherent picture of global health post-COVID-19 and before GPW 14 implementation is initiated. Several global monitoring reports are about to be released and this data should be used. Global health estimates should also be available by then. Where no global monitoring report is forthcoming, alternative sources and approaches should be used. Particular attention needs to be paid to healthier population indicators which proved hard to analyse in a comprehensive way.

1.2 In the next two years Member States and the Secretariat need to address the immediate and most severe impacts of the COVID-19 pandemic

These include:

- immunising high-risk populations, particularly in countries with large populations and with a special emphasis to mitigate the potential resurgence of vaccine-preventable diseases and ensure comprehensive immunisation coverage;
- mental health by advocating for increased national government financial investment in services to address access and delivery challenges, supporting training programmes to strengthen human resources, focusing on enhancing the quality of services available at primary care level and ensuring availability of essential medicines; and
- health workforce strengthening: Member States should consider comprehensive mental support and incentive programmes for health care professionals tackling the pressing issue of staff burnout resulting from the COVID-19 pandemic and the loss of skilled health workforce during the pandemic. The Secretariat should provide technical assistance to Member States, where needed, to establish mechanisms for funding, development, mobilisation and retention of an effective health workforce, involving key partners.

1.3 Member States and the Secretariat need to get adequate closure on the COVID-19 pandemic before the political window to do so expires

This involves:

- prioritising leadership attention and support on finalising the pandemic treaty and adjustments to the International Health Regulations (2005);
- advancing the health emergency architecture;
- ensuring that as it morphs back to “the new normal” the WHO Health Emergencies programme can maintain and enhance its capabilities through predictable and sustained financing, and
- continued focus on enhancing preparedness at country level and sustaining improvements and capabilities developed during the COVID-19 pandemic.
Recommendation 2. WHO should build on GPW 13 and its learnings to ensure that GPW 14 will be an effective results-based strategic instrument

2.1 In formulating GPW 14 the Secretariat and Member States should ensure that it is positioned as an effective instrument to foster increased coherence and collaboration in global health

This involves the following.

- Leveraging GPW 14 as an agenda-setting instrument for Member States, the Secretariat and partners. This involves ensuring that: (a) it does not merely focus on the Secretariat; (b) the process of consultation is inclusive; and (c) mechanisms for stakeholders to commit to its implementation are considered, e.g. adoption of HALE targets at country level, Sustainable Development Goal localisation efforts at country level, and more explicit reference and efforts to align to GPW in national or partner strategies.
- Clearly differentiating between what is acknowledged as an important area of work and the 4–6 critical few narrowly defined strategic priorities which, if implemented, will make a disproportionate contribution to global health. This is where leadership attention will be provided, funding opportunities be directed and budgets scaled up. The Secretariat should also develop ways to report on the share of the budget going to these narrowly defined strategic priorities and Member States should ensure a greater share of the budget is progressively allocated to these.
- Developing an explicit, comprehensive and coherent theory of change that articulates the challenge at stake, enablers and barriers, key actions and changes required, intermediate and final outcomes, as well as the respective roles of key stakeholders. The Secretariat should pay particular attention to: (1) articulating between outputs, intermediary outcomes and final outcomes, and embedding these linkages in its results-based-management approach; and (2) articulating its specific unique and relevant contribution.
- Ensuring that GPW 14 is adaptable by having more explicit considerations of risk and contingencies that may affect its execution.
- Articulating a monitoring and evaluation strategy for GPW 14.

2.2 In formulating GPW 14, the Secretariat and the Member States should consider the following four areas as possible priorities for inclusion in GPW 14

- Building resilient health systems: long-term investment in health infrastructure, workforce development and technology is crucial. This encompasses not just physical resources, but also policies and practices that make health systems more adaptable and resilient to future crises.
- Global health equity and access: addressing inequalities in health access and outcomes should be a central focus. This includes ensuring equitable access to healthcare services and safe, effective, quality-assured health products (including, medicines, vaccines, medical devices, diagnostics, assistive products, blood and blood products, and other products of human origin), irrespective of geography, economic status or other social determinants of health.
- Climate change and health: developing strategies to mitigate and adapt to the health impacts of climate change is a critical long-term priority. This includes understanding the health risks associated with climate change and implementing measures to address these risks.
- Preventive health, chronic disease management and public health education: a critical long-term priority is to shift from reactive to preventive health care, which encompasses promoting healthy lifestyles, effective management of chronic diseases and investing in preventive measures such as screenings and vaccinations. Integral to this shift is enhancing public health education and awareness. Educating the public about health risks, preventive practices and healthy behaviours is essential for
empowering individuals to make informed health decisions and fostering a health-conscious society. This approach not only addresses immediate health concerns, but also helps in the prevention of future health issues by creating a more informed and proactive population.

2.3 The Secretariat should strengthen its results framework, accountability for results and managing for results by implementing the recommendations already formulated in the 2023 evaluation of results-based management

The Secretariat should also:

- consider targets for HALE and linking HALE to outcome indicators/triple billions;
- further align “Triple Billion” targets to the Sustainable Development Goals and implement identified improvements to indicators and indices;
- ensure results are also reported by equity dimensions;
- seek more integration and streamlining of existing: (a) results frameworks across different segments of the programme and budget; (b) planning guidance and activities initiated by different departments in headquarters; (c) workplans; and (d) key performance indicators (KPIs) used in regions and globally;
- ensure outputs are formulated in a way that countries can relate to in a meaningful way; and
- ensure sufficient consistency is preserved in results indicators in order to allow trending.

2.4 The Secretariat should ensure that reporting is useful, usable and used at the country level: for this, the Secretariat should pivot the approach to reporting from being primarily driven by corporate reporting needs to a cockpit approach that can be used at country level and clearly ties together ongoing monitoring and result reporting.

The goal should be to develop reporting templates and practices that:

- allow the user to clearly identify and allow implementation tracking against agreed country priorities, be they acceleration plans or country cooperation strategies;
- can be used as the basis for delivery stock-takes and monitoring and evaluation;
- can be an instrument with which WHO country offices can engage with national governments as part of policy dialogue, review of service delivery and accountability to Member States.

2.5 As a requisite enabler for the above, Member States and the Secretariat should get their data foundation right by focusing on improvements to data collection and data management

As WHO embraces data-driven approaches, the Secretariat should:

- further scale up its support to build Member State capacity to track and report on key health indicators;
- strengthen its own data collection and analysis capabilities, notably at country and regional levels;
- ensure any new indicators can be tracked through routines systems or country-recognised platforms; and
- set KPIs on data quality with targets for improvements on WHO core metrics in order to assess whether progress is sufficient.

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In order to improve the quality and timeliness of Member State reporting on national indicators, Member States should:

- be reminded of their obligation under Articles 61 and 62 of the WHO Constitution to share relevant data in a timely manner; and
- ensure they invest sufficiently to build up their national health information capabilities.

**Recommendation 3. The Secretariat should renew efforts to institutionalise changes underway and reap the benefits of strategic and operational shifts**

**3.1 The Secretariat should scale up, mainstream and integrate its approach to delivery of results**

For this, the Secretariat should:

- fully integrate results-based approaches and tools into programme and budget processes, manuals and instructions; over time, results-based management and what the Secretariat has called “delivery for impact” should become synonymous and be supported by proper theories of change;
- ensure alignment between Country Cooperation Strategies and acceleration plans;
- build up analytical capacity at regional and country level;
- clarify the respective roles and responsibilities of the Planning Resource Coordination and Performance Monitoring division, Country Strategy and Support division, and Data Analytics and Delivery for Impact division in planning, monitoring and reporting in order to improve coherence and avoid duplication; and,
- reposition the role of the Delivery for Impact (DFI) unit at Headquarters on: (a) development and dissemination of DFI analytical products and packages; (b) internal capacity-building; and (c) focused selective support in advancing GPW 14 strategic priorities and major acceleration scenarios.

**3.2 The Secretariat should further improve the prioritisation, production and integrated delivery of technical products:** for this, the Secretariat should implement the recommendations of the 2023 evaluation of normative function at country level including sufficient and consistent feedback mechanisms from countries and users, taking into consideration, at the country level, that these products require adaptation to local contexts. The Secretariat should start by enforcing more stringent upfront prioritisation of technical products based on strategic importance and feasibility.

**3.3 The Secretariat should further align its operating model to ensure it is fit-for-purpose to enable strategic shifts:** for this, the Secretariat should:

- empower WHO country offices and Secretariat mechanisms such as output delivery teams (ODT) through adequate: (a) administrative and technical resourcing to support the work; (b) financial allocation for the ODT/country office representative to incentivise collaboration; and (c) delegation of authority;
- align and optimise its operating model by: (a) refreshing the definition of the Secretariat’s core functions and the related division of labour between the three levels; (b) aligning resource allocation and staffing accordingly and (c) ensuring that duplication of work between each strategic priority are eliminated and that new silos are not created; and
- optimise within each level and redeploy between levels through the mobility policy and workforce planning.

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3.4 The Secretariat should ensure organisational development is deliberate, systematic, well architected and coordinated. For this, the Secretariat needs to:

- adequately resource organisational development/transformation functions and initiatives;
- articulate the change management plan underpinning GPW 14; and
- ensure a process exists to consolidate recommendations for improvements stemming from multiple oversight functions and ensure the resolution of these is effectively and efficiently channelled into change management plans.

3.5 As a prerequisite for the above, Member States and the Secretariat should renew efforts to improve the quality, predictability and alignment of financing to strategic priorities. This involves:

- implementing planned increases in assessed contributions;
- funding GPW 14;
- balancing financing among the three billion, notably regarding healthier populations.

3.6 Prior to the formulation of WHO’s fifteenth general programme of work (GPW 15), the WHO Secretariat should establish a phased strategic planning process. This process should start well in advance by an evidence-driven situation analysis, mid-term evaluation of GPW 14 and choices on the positioning of GPW 15. It should then be followed by an assessment of strategic options leading to an agreement on strategic priorities. Only then should the results framework be defined. As a last step, the implications of GPW 15 on financing needs, organisational alignment and programme and budget planning should be defined.
Introduction
Context

Background and context setting for GPW 13

Since its creation in 1948 The World Health Organization (WHO) has played a crucial role in advancing public health and improving healthcare worldwide. It has contributed to the eradication of smallpox, led major immunisation programs, controlled infectious diseases, promoted health for all and responded to global health emergencies. Also, in the last decades life expectancy has increased in many parts of the world, six million fewer children under the age of five years died in 2016 than in 1990, polio is on the verge of being eradicated, and 21 million people living with HIV are now receiving treatment. Economic and social development has lifted millions from extreme poverty, empowering numerous countries to actively engage in the global agenda. Building on these achievements and on the Sustainable Development Goals, WHO set out to define and implement its strategic objectives through the 13th General Programme of Work 2019–2023 (GPW13).

Yet as WHO marked its 75th anniversary in 2023 things have not unfolded as planned. Many achievements from the last decades have stalled or even reversed because of the COVID-19 pandemic. Even before COVID struck, the world was off track to reach GPW 13 objectives. Further progress is needed to achieve the triple billion targets towards attaining the health-related Sustainable Development Goals and meeting other health challenges.

As the Organization initiated the formulation of GPW 14 it was important to stock-take on achievements and challenges and there were important lessons to be learned from GPW 13.

GPW 13

GPW 13 outlines how the Organization will proceed with its implementation and provides a framework to measure progress in this effort towards health-related Sustainable Development Goals (SDG 3 and other health related indicators in other SDGs). GPW13 guides for each biennium stepwise progress in strategic priorities, the development of implementation plans, the programme budget, results frameworks, and operational plans.

GPW13 is based on the SDGs and is relevant to all countries – low, middle, and high income. Health is fundamental to the SDGs and WHO’s role is becoming increasingly relevant in providing global public goods that help to ensure health for all people. The Organization has broad and sustained efforts to leave no-one behind in the shared future of humankind, empowering all people to improve their health, address health determinants and respond to health challenges.

The 13th General Programme of Work (GPW) provides a vision, rooted in Article 1 of WHO’s Constitution, of: A world in which all people attain the highest possible standard of health and well-being.

It also sets out the three strategic priorities, 4 guiding principles, 3 strategics and five operational shifts that the Secretariat needs to accomplish in the period.

The three overarching Strategic priorities relate to:

- **Universal Health coverage**: This goal relates to SDG target 3.8 which aims at universal health coverage for all by 2030, at least 1 billion more people would have to have access to essential health services in each five-year period between 2015 and 2030;

- **Health emergencies**: This goal is based on SDG indicator 3.d.1 (International Health Regulations (IHR) capacity and health emergency preparedness). This goal aims to measurably increase the resilience of health systems for a population of 1 billion people and make the world better prepared for health emergencies.
• **Healthier populations**: This goal aims to achieve 1 billion more people enjoying better health and well-being. It is intended to stimulate collective action for health and to strengthen WHO’s role as a catalyst and in its rigorous monitoring to track progress.

Although the strategic priorities are presented separately, they are not mutually exclusive and thus require implementation that is mutually reinforcing. The strategic priorities require the joint effort of multiple stakeholders (Member States, WHO and other partners) to accomplish them.

GPW also sets out four **guiding principles** for the new framework for impact and accountability which will allow WHO to effectively work towards these strategic priorities. These are:

- Impact and outcome focused;
- Ensuring organisational flexibility and accountability;
- Putting countries at the centre; and
- Fostering collaboration.

With GPW 13, WHO also aimed to bring about **three strategic shifts and five organisational shifts for the Secretariat**. These shifts were identified as areas of improvement required to achieve the triple billion targets.

The three strategic shifts consist of:

- Stepping-up leadership;
- Driving public health impact in every country; and
- Focusing global public goods on impact.

The five organisational shifts are to:

- Measure impact to be accountable and manage for results;
- Reshape the operating model to drive country, regional and global impact;
- Transform partnerships, communications, and financing to resource the strategic priorities;
- Strengthen critical systems and processes to optimise organisational performance;
- Foster culture change to ensure a seamless, high performing WHO.

Acknowledging the setback that Covid-19 represented and the fact that the world was off track to reach most health-related Sustainable Development Goals by 2030, **in May 2022 Member States approved adopting resolution A75/53 which extends GPW13 (2019-2023) to 2025**. Within the GPW13 triple billion strategy, which remains fully intact and operational, five focus areas were identified:

- Promote Health: Support countries to make an urgent paradigm shift towards promoting health and well-being and preventing disease by addressing its root causes;
- Provide Health: Support a radical reorientation of health systems towards primary health care, as the foundation of universal health coverage;
- Protect Health: Urgently strengthen the systems and tools for epidemic and pandemic preparedness and response at all levels, underpinned by strong governance and financing to ignite and sustain those efforts, connected, and coordinated globally by WHO;
- Power Health: Harness the power of science, research innovation, data, and digital technologies as critical enablers of the other priorities;
- Perform for Health: Urgently strengthen WHO as the leading and directing authority on global health, at the centre of the global health architecture.
Link to Programme and Budget

GPW13 serves as the basis for resource mobilisation and for the Programme Budget (PB) for the biennium 2020–2021, 2022–2023 and 2024–2025.

The 2020–2021 budget has a base budget of US$ 3 768.7 million – a 14.7% decrease compared with 2018–2019 and had four key areas of strategic focus:

- Focus on measurable impacts to improve people’s health;
- Prioritise its work to drive public health impacts in every country and demonstrate how resources will be aligned with delivery of these impacts;
- Change from a disease-specific approach to a more integrated and health-systems-oriented approach to drive sustainable outcomes;
- Align and build synergies in delivering the work of the three levels of the Organization.

The 2022–2023 budget had a base budget of US$ 4,254 million – a 7.8% increase compared with 2020–2021 and had four key areas of strategic focus:

- Rethink health emergency preparedness and readiness and bolster response capacities to health emergencies;
- Build resilience by strengthening primary health care-oriented health systems, essential public health functions and the health security nexus;
- Get back on track and accelerate progress towards the triple billion targets and those of the sustainable development goals;
- Advance WHO’s leadership in science and data.

The Programme budget 2024–2025 is the third and last of the extended GPW13. It carries the ambitious task of getting WHO back on track to achieve the triple billion targets, while providing continuity and stability for the final phase of GPW13 implementation. It has a base budget of 4,968 US$ million and has three main overarching objectives:

- Strengthen country capacity to accelerate progress towards the triple billion targets;
- Continue the work defined by the recent revision of the Programme budget 2022–2023;
- Further strengthen accountability and transparency, incorporating guidance from the Agile Member States Task Group.
Results framework for GPW13

In designing the new framework for impact and accountability, the four guiding principles mentioned earlier namely, impact and outcome focused, ensuring organisational flexibility and accountability, putting countries at the centre, and fostering collaboration were considered. In line with the impact and outcome-focused approach of GPW13, WHO's work was organised around twelve outcomes wherein each strategic priority includes three health outcomes; one outcome for data and innovation and two outcomes related to leadership and enabling functions of the Organization. These outcomes constitute the backbone of the GPW 13 results framework and for organising the work of WHO within the programme budget.

The GPW 13 results framework is described in the graphic below. It consists of:

- An impact measurement system for tracking the triple billion targets and 46 outcome indicators (39 of which are health-related Sustainable Development Goals);
- An output scorecard to ensure that the work of the Secretariat is oriented towards the achievement of the GPW13 targets;
- Qualitative country case studies.

The results framework is used for annual reporting in the WHO Results Report.

Figure 1 GPW 13 Results Framework

The impact measurement system which is a part of the WHO results framework is a system designed to measure health impact in a way that is measurable and accountable. WHO’s impact measurement system has three layers:

- Outcomes define results that Member States with support from the Secretariat are meant to achieve through joint accountability. They are measured through a set of 46 indicators, 39 of which are SDG indicators (26 from SDG 3, 13 from other SDGs), and 7 of which relate to other WHO resolutions (polio, NCDs and health emergencies;
Each of the triple billion targets, each measured using composite indices. Tracer indicators are used to calculate average service coverage to measure universal health coverage. For the healthier population calculations, all indicators are represented on a scale of healthiness from 0 to 100, with 0% being the least healthy and 100% being the healthiest. The Health Emergencies Protection Index (HEPI) is built from three indicators that capture the scope of WHO’s health emergency activities (International Health Regulations (IHR) capacities), routine and emergency vaccination coverage, and timeliness of emergency detection and response.

Healthy life expectancy (HALE), which quantifies expected years of life in good health at a particular age. It is considered a summary measure of the overall health of populations. It is proposed to use HALE within GPW 13 as an overarching and comparable measure of the impact of the triple billion targets.

To assess the Secretariat’s contribution to outcomes, an output scorecard was introduced in the 2020–2021 Programme Budget that assesses each of the 42 outputs representing the Secretariat’s contribution to the outcomes across the three levels of the Organization against six dimensions:

- Effective delivery of technical support at the country level;
- Effective delivery of leadership in health;
- Effective delivery of the global public health goods;
- Impactful integration of gender, equity and human rights, and disability;
- Delivering value for money;
- Achieving results in ways leading to impacts.

The first three dimensions reflect GPW’s strategic shifts.

Each dimension is assessed using a standard scoring scale: 1. Emergent, 2. Developing, 3. Satisfactory, 4. Strong. Except for dimension 6, these are scored by self-assessment. The dimension 6 score is presented using the same scale, but the extent to which the indicator targets are achieved is measured first before being converted into the same standard scale.

Qualitative case studies are aimed to show the inter-relationship between outputs and outcomes at country level in a way that “tells the story “In more concrete terms than numbers and figures can. The case studies are collected from Country Offices by the Country Strategy and Support unit at HQ. At the time of writing this report, close to 200 such cases studies have been produced since 2020.
Evaluation Objectives

Background
An evaluation of the contribution of data and delivery for impact to the implementation and impact of WHO’s Thirteenth General Programme of Work, 2019–2023 (GPW 13) and WHO transformation was included in the Organization-wide evaluation workplan for 2020–2021, approved by the Executive Board at its 150th session in February 2022. During that meeting, the Board also requested an evaluation of GPW 13.

Accordingly, an evaluation of GPW 13 was commissioned to make forward-looking recommendations for the development of the fourteenth general programme of work (GPW 14). The terms of reference (ToRs) for the evaluation are provided in Appendix 1.

The evaluation was conducted by an external independent evaluation team, which undertook its main work during the period May to November 2023 and delivered the final evaluation report in December 2023.

Rationale
The evaluation took place at a time when GPW 13 has two more years to complete and preparations for the next General Programme of Work (GPW 14) were underway, and as countries around the world are facing a significant setback in achieving the GPW13 goals. Halfway to 2030, the world is off track to meet most of the SDG goals by 2030. As WHO marked its 75th anniversary in April 2023 and began planning for GPW 14, it was crucial to reflect on past successes and obstacles to inform future health initiatives.

In addition, the context in which WHO operates is continuously changing due to external factors such as the COVID-19 pandemic, natural disasters or geo-political conflicts. Given these factors, while the evaluation was expected to be largely formative and forward looking, it also covered some of the summative elements by assessing the achievements of GPW 13 to date. It sought to feed into discussions and decisions regarding GPW 14 development.

Scope
Reflecting GPW 13 result chain where outcomes are achieved by Member States with support from the Secretariat, the evaluation scope covers WHO Secretariat and Member States activities at global, regional, and national levels in implementing GPW 13, including those related to use of data to support and report on the achievements of GPW 13.

The period covered by the evaluation is 2019 to 2023. Additionally, the evaluation aimed to understand the activities intended for the extended period of the programme i.e. 2024-2025.

The evaluation paid particular attention to the impact of GPW 13 at the country level, and specifically how it has been received, how it changed WHO’s interaction with the countries, and how it helped shape the direction and contribution of its programmes.

Purpose
The evaluation aimed to serve the purpose of accountability toward Member States, donors and affected population, as well as learning. In terms of accountability, the evaluation provided evidence for the design and implementation of GPW14 and the results framework. To do so, it examined the development and formulation of the results framework and theory of change and its measurement, and the contribution of data and delivery to the implementation and impact of the GPW 13.
In terms of learning, the focus was put on regular formal and informal interactions with GPW 14 Secretariat and Steering committee, and other key stakeholders as required. We provided suggestions to make the results framework and GPW 14 more appropriate and fit-for-purpose based on findings from the evaluation. We also examined achievements and challenges related to the implementation of GPW 13 and suggested areas of work that presented opportunities for impact. These were discussed with key stakeholder groups to ensure the rationale and relevance of the findings was understood and bought in, both during the evaluation field work and during the dissemination of findings.

Objectives

There were four key objectives of the evaluation. These are as follows:

**Objective 1:** to assess the appropriateness of the results framework of GPW 13 in facilitating the achievement of the triple billion targets and associated organisational goals, including whether the application of the results framework provided:

- Accurate and timely impact measurement of progress towards the triple billion targets and health-related SDGs;
- Appropriate measure of the Secretariat’s contribution across the six dimensions of output scorecard 11;
- Evidence of the utility of the framework from experiences captured through qualitative case studies.

**Objective 2:** to identify the areas of work in which good progress was made by countries in achieving the targets and intended outcomes of GPW 13, and in which challenges were met, including WHO’s ability to effectively support countries to:

- Establish priorities based on data and evidence;
- Identify resources for acceleration;
- Implement high impact interventions against country priorities;
- Monitor public health policy and health service delivery programmes.

**Objective 3:** to assess the extent to which the Organization was able to focus on the goals of GPW 13 and analyse the factors that facilitated or hindered their achievement: by aiming for measurable impact in countries, in a holistic and seamless manner, and identifying the potential for new approaches that facilitate the achievement of GPW 13 goals.

**Objective 4:** to draw lessons from the analyses and recommendations for action, for the WHO Secretariat as well as for Member States, for sustaining results and for development and subsequent implementation of GPW 14, including identification of opportunities and areas requiring additional investment towards achievement of the triple billion targets and greater alignment and acceleration of SDGs.

In this report, objectives 1, 2 and 3 are addressed in the Findings section and objective 4 on lessons learned and recommendations are addressed in the Lessons learned & recommendations section.
**Audience**

The primary audience for this evaluation encompasses a focused and influential group, including WHO Member States, the leadership at the three levels of the Organization’s, and the Steering Committee for the upcoming 14th General Programme of Work (GPW 14). These key stakeholders are integral to the decision-making processes and strategic direction of the WHO, and they will utilise the insights from our report to guide the formulation and implementation of GPW 14.

The secondary audience, while not directly involved in these decision-making processes, is equally significant and diverse. It includes WHO staff at various levels, who will use the report to inform their daily work and long-term planning; partners and donors, who rely on such evaluations to assess the impact and effectiveness of their collaborations and contributions; and the beneficiaries of WHO’s programs, to whom WHO is also accountable and who stand to gain from any improvements and adjustments made in response to our findings. The report aims to serve as a valuable resource for this broad spectrum of stakeholders, providing them with detailed analysis, actionable insights, and a clear understanding of the impact and implications of the 13th GPW.

**Evaluation criteria and questions**

The four objectives of this evaluation have been broken down into Key Evaluation Questions (KEQ). The KEQs have been further broken down into sub evaluation questions (SEQs). Each SEQ was mapped against Organization for Economic Cooperation and Development's Development Assistance Committee (OECD-DAC) evaluation criteria with the aim to explore relevance, coherence and impact, sustainability and effectiveness, as well as cross-cutting issues such as relevant human rights, including child rights, equity and gender equality. The detailed mapping is available in appendix 2.

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<tr>
<th>Key Evaluation Question (KEQ)</th>
<th>Sub Evaluation Question (SEQ)</th>
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<tr>
<td>Objective 1: To assess the appropriateness of the results framework of GPW 13 in facilitating the achievement of the triple billion targets and associated organisational goals</td>
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<td>KEQ1: How robust was GPW 13’s theory of change and result framework?</td>
<td>What type of instrument and process is GPW 13?</td>
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<td>Is the GPW 13 theory of change comprehensive?</td>
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<td>How strong are the linkages between impact, outcomes outputs and indicators from GPW 13?</td>
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<td>How SMART is the results framework?</td>
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<td>KEQ2: How robust and effective was the accounting for results?</td>
<td>To what extent did GPW 13 address supporting monitoring and evaluation framework, reporting and plans?</td>
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<td>How often are/have results been reported? What time lag can data reporting cause? (e.g. reporting 2019 data in 2021 reporting)?</td>
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<td>Where gaps in indicators and data collection exist, how have the Secretariat and Members States worked towards bridging these gaps so that adequate GPW 13 reporting can ultimately be provided?</td>
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<td>KEQ3: To what extent is there evidence that the result framework and related reporting are used by Member States and the Secretariat to drive impact at country level?</td>
<td>To what extent have the different Member States aligned with the goals of GPW 13 and integrated them into their planning and implementation of health initiatives?</td>
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<td>Is there evidence that the results framework was used to drive decision making, prioritisation on areas and beneficiaries of greatest needs, resource allocation by Member States, the Secretariat and partners?</td>
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Objective 2: To identify the areas of work in which good progress was made by countries in achieving the targets and intended outcomes of GPW 13, and in which challenges were met
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<th>Key Evaluation Question (KEQ)</th>
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<tr>
<td>KEQ 4: To what extent were GPW 13 goals achieved by Member States, and why?</td>
<td>What results have been achieved by Member States in different areas of GPW 13, including differential results across groups? What were the deviations from these plans during the implementation period?</td>
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<td>KEQ 5: Did the Secretariat achieve the strategic and operational shifts outlined in GPW 13, and why?</td>
<td>What was the Secretariat’s relative contribution at HQ, regional and country level to each of the Triple Billion targets (UHC, HE, HP) within the Member States? What were the deviations from these plans during the implementation period?</td>
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<td>To what extent did Secretariat’s activities across the 3 levels, across regions and across programmatic areas align with and focus on implementing GPW 13? How well has the Organization worked as One WHO to harness its internal capacities to achieve results?</td>
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**Objective 3: to assess the extent to which the Organization was able to focus on the goals of GPW 13, and analyse the factors that facilitated or hindered their achievement**

| KEQ6: To what extent were Member States and the Secretariat able to focus on implementing GPW 13 at country level? | Was GPW 13 focused enough for Member States and the Secretariat to truly prioritise their resources and activities? |
| Was there sufficient flexibility built into GPW 13 and PB to accommodate these factors and changing environment and address emerging needs? | |
| Was there adequate transparency and governance around choices that may have led to deviations? Were there adequate systems in place to manage these decisions and related implications on results and resourcing? | |

| KEQ7: What external (e.g. COVID, funding) and internal (e.g. organisational issues) explanatory factors can be invoked for success and setbacks? What was their respective contribution to deviations? | What were the external and internal factors that contributed to Member States’ deviations, successes and setbacks? Do Member States have the systems, capacity and support to successfully deliver on the goals of the GPW 13? |
| What were the factors that allowed or hindered the Secretariat contribution to MS? | |

**Objective 4: to draw lessons from the analyses and recommendations for action, for the WHO Secretariat as well as for Member States, for sustaining results and for development and subsequent implementation of GPW 14**

| KEQ 8: What interventions are required to sustain results achieved to date? | Do Member States and their implementation structures have adequate capacity to sustainably carry out the goals of GPW 13? |
| KEQ 9: What are key considerations for the process of defining and implementing GPW 14? | What specific general attributes or principles should guide the definition of GPW 14 and future result framework? |
| What considerations in the strategic planning process should the Secretariat and Member States consider, e.g. cross sectoral inputs, level of consultation required use of evidence, linkages to strategy transformation processes, accountability of Member States and Secretariat, reporting? | |
| Are there specific or emerging topics of relevance for GPW 14 consideration compared to GPW 13? On the other hand, how to strengthen focus and define core areas of work? | |
| How can cross cutting aspects of gender, equity and human rights be better integrated into GPW 14? | |
| KEQ 10: What adaptations to its processes, systems, organisation and partnerships should the Secretariat consider to better support Members States to achieve GPW 14 goals moving forward? | |

**Table 1 - Key Evaluation Questions (KEQ) and Sub-Evaluation questions**
Methodological Approach

Conceptual framework for the evaluation

The evaluation mixed theory-based and empirical approaches. The empirical part aimed to review available outcome indicators to assess whether GPW 13 achieved its intended goals while the theory-based approach sought to explore and explain how and why. To achieve this, rather than a theory of change, the conceptual framework used for this evaluation consisted in a typical strategy to execution cycle complemented by a data-driven decision-making framework. It was tested with key stakeholders during the inception phase and refined to ensure it was relevant to WHO’s context and for the purpose of this evaluation. It is illustrated below.

The key evaluations questions (KEQ) were mapped to the various elements of the conceptual framework.

![Figure 2 GPW 13 Evaluation Conceptual Framework](image)

**Figure 2 GPW 13 Evaluation Conceptual Framework**

The core elements of the conceptual framework are:

- **Sustainable Development Goals (SDGs):** The SDGs form the start and endpoint of GPW 13 and the basis for the GPW 13 measurement framework. In this sense they are both an input into the strategic planning process and an output of its execution.

- **Strategy to implementation continuum:** in assessing GPW 13 and formulating recommendations for inclusion into GPW 14, the evaluation examined the three main steps of strategy to execution: starting with GPW formulation; going into strategy cascading and alignment mechanisms; and finally looking at GPW implementation in terms of delivery, operating model, and culture. Each element was evaluated either to determine whether they enabled or hindered the achievements of GPW 13 objectives, as per evaluation objectives 2 and 3.

- **Data Demand and Information Use:** given the specific focus on the adequacy and use of GPW 13 result framework and measurement in Objective 1 of this evaluation, the conceptual framework specifically embedded a component covering the link between data and decision making. It shows a virtuous cycle in which specific demand for data drives improved data collection, analysis, availability, interpretation,
and use, which continuously generates more demand for and sustained use of data, which leads to improved accountability and improved health decision making. This component is based on the DDIU in the health sector conceptual framework developed by the MEASURE Evaluation project, funded by USAID and with participation from WHO. Whilst initially targeting the national level and low resource setting, the framework is relevant to stakeholders at all levels of the health system, including to evaluate how GPW 13 result framework, data and delivery adequately supported Member States and the Secretariat.

- The drive for alignment: there needs to be strong alignment within and across each area of the strategy to implementation continuum. The evaluation paid specific attention to how GPW 13 was cascaded into (a) steering mechanisms across the three levels of the Organization, and (b) the level of alignment between GPW 13 priorities and Member States and partner strategies.

- DAC criteria: Each element of the framework is also mapped against OECD DAC criteria, i.e. relevance (I), coherence (C), effectiveness (ES), efficiency (EY), impact (I) and sustainability (S). Whilst in the early stages of strategy formulation the focus is on defining impact, ensuring relevance and coherence of the GPW, in later stages the focus is on effectiveness, efficiency and sustainability of implementation activities.

- Change management: the evaluation considered strategy and evidence-based decision making as a change management undertaking and in that vein looked at how far through this change process Members States and the Secretariat were.

Note: the evaluation team retro-documented a Theory of Change (ToC) for GPW 13 during the data analysis phase (refer finding 3). This ToC was produced as part the response to Key Evaluation Question 1, rather than as an instrument to guide the evaluation.

**Instruments and Approach**

Despite important constraints on timing and availability of data, the approach towards the evaluation was consultative, participatory, combined qualitative and quantitative tools, and used primary and secondary data sources.

The secondary data included extensive desktop and literature review of global monitoring reports, statistical information, modeling of GPW indicators, program documents, prior evaluation reports, planning and financial reports. Refer to Appendix 3 for details.

This was augmented with primary data collection primarily employing qualitative tools with various stakeholders including the three levels of the Secretariat, representatives from Member States, donors, partners and civil society organisations. All in all, more than 300 stakeholders were consulted through:

- 50 key informant interviews during the inception, data collection and data analysis phases, with Member State representatives with functions in governing bodies;
- 14 focus-group discussions, e.g. with Member State regional groups;
- Two semi-structured online questionnaires to capture the feedback from Member States and WHO Representatives respectively;
- Deep dives on six countries involving a specific desktop review, KII and FDG with Country Office management and where possible interview with the Ministry of Health. The countries were selected based on a stratified randomised sampling to ensure different types of offices across WHO regions were represented. The countries selected included: Bahrain, India, Rwanda, Solomon Islands, Sudan and Tajikistan. Selection criteria for countries are provided in Appendix 5. Sudan was later added to provide an example of a grade 3 protracted emergency.
• Observation of the 29th meeting of WHO Programme Management Network (PRG) in July 2023 and review of transcripts for the September 2023 delivery sprint workshop;
• Two Member States information sessions where Member could provide feedback on proposed approach, preliminary findings and emerging recommendations.

Refer appendix 4 for details.

The evaluation team triangulated data from the qualitative interactions, desk research and review of quantitative indicators and financial information.

The evaluation team had regular formal and informal interactions with the Evaluation Reference Group, GPW 14 Secretariat, GPW14 Steering Committee and other relevant stakeholders as required in order to share working hypothesis, early and preliminary findings, and recommendations.

**Ethics and UNEG standards**

UNEG’s four guiding ethical principles for evaluation Integrity, Accountability, Respect, and Beneficence were central to the evaluation and were integrated into the methodology.

Beyond the general guiding principles, UNEG guidance on integrating human rights and gender equality in evaluations and UNEG guidance on integrating disability inclusion in evaluations have also been referred to, consistent with article 1 of WHO’s Constitution, of: A world in which all people attain the highest possible standard of health and well-being. Questions regarding gender and social inclusion have been included in the data collection tools.

Further, all evaluators and data collectors involved in primary data collection were made aware of protocols for ensuring compliance to ethics, gender sensitivity and equity principles in data collection and management. All stakeholders and evaluation participants identified for consultations and data collection, were duly informed on the study, its intent, how the input received was proposed to be used and limits of confidentiality. Consent was sought prior to recording any data/information. All respondents were given the option to opt for anonymity and if they wished to withdraw after their consent, then were free to do so. Data collectors emphasised the voluntary nature of participation in the evaluation activities.

To ensure credibility of the evaluation the IET ran a transparent evaluation process, used inclusive approaches involving appropriate stakeholders and applied robust quality assurance during the evaluation. Evaluation results and recommendations were informed by accurate qualitative and quantitative analysis of evidence, within the limitations described hereafter.
## Limitations and mitigations

The following limitations to evaluability of GPW 13 and to the execution of the evaluation were identified and where possible mitigated:

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<thead>
<tr>
<th>Domain</th>
<th>Limitation</th>
<th>Mitigation</th>
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<tbody>
<tr>
<td><strong>Evaluability of GPW 13</strong></td>
<td>Design: The specific contribution of Member States and other actors has not been specified to a level where accountability can be assessed, making attribution difficult</td>
<td>• The accountabilities of the Secretariat were reviewed against the output scorecard&lt;br&gt;• For MS and external stakeholders, the evaluation focused on evaluating root causes to achievement and setbacks</td>
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<td></td>
<td>Context: COVID-19 represented a significant, unplanned event during the strategic period</td>
<td>• The evaluation looked at whether GPW 13 was sufficiently flexible to adapt to context&lt;br&gt;• The evaluation looked at other contributing factor and opportunities presented by COVID19 to foster GPW 13 goals</td>
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<td>Timing: The evaluation was positioned as a final evaluation of GPW 13 while GPW 13 has been extended to 2025. Most recent outcome data is often only up to reference year 2019</td>
<td>• The evaluation focused on results to date to the extend data was available to support an evaluation of results</td>
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<tr>
<td><strong>Evaluation Approach</strong></td>
<td>Limitations in budget and timing for the evaluation</td>
<td>• Increased reliance on secondary data&lt;br&gt;• Focus on areas seen as of greatest value to key stakeholders</td>
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<td>Challenge in providing timely input to GPW 14 formulation process while ensuring robustness of approach and findings</td>
<td>• Emerging and preliminary findings were shared regularly with GPW 14 Secretariat, GPW 14 Steering Committee and other relevant stakeholders&lt;br&gt;• The IET worked iteratively based on working hypothesis, with further evidence provided as they became available</td>
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<td>Balancing independence of IET with the need to engage continuously with the GPW 14 formulation process</td>
<td>• Definition of clear roles and responsibilities between IET, WHO Evaluation Office, and GPW 14 Secretariat</td>
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<td><strong>Data collection instruments</strong></td>
<td>Heavy reliance on secondary data could provide a biased view of achievement and challenges</td>
<td>• Triangulated desktop review with primary data collection and interviews. Cross check with result of questionnaires.&lt;br&gt;• Prioritised secondary evidence based on their level of independence of their author</td>
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<td>Interviews could be exploited to provide a biased picture of current state (positive or negative)</td>
<td>• Cross-checked responses from various groups to the same questions&lt;br&gt;• Introduced an element of random participant selection in interviews, FGDs and case studies&lt;br&gt;• Ensured anonymity</td>
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<td>Member States low response rate to online questionnaires meant results were not statistically meaningful and only provided “perception” insights</td>
<td>• Ensured adequate sampling and response rate through reminders&lt;br&gt;• Focused the survey on the very perception (“I feel”, “I think”), as opposed to looking for factual elements</td>
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<td>Domain</td>
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|        | Events being observed, e.g. at the 29th meeting of the Programme Management Network (PRG), may result in the event not being conducted as they would otherwise be. Also given the timeframe we could only observe events taking place in the July-Sept period. | • Cross-checked with other instruments  
• Be discrete during events under observation  
• Reviewed transcripts of events post-facto                                            |
|        | Remote meetings may not provide an adequate way to engage at regional and country levels                                                                                                                  | • Ensured adequate preparation of virtual meetings  
• Leveraged presence of regional and country staff in Geneva to organise face-to-face meetings when possible                                           |
| Potential biases | Confirmation bias amongst evaluators                                                                                                                                        | • Used a mixed methods approach using quantitative and qualitative methods and desk review has been designed for this evaluation. This allows triangulation of findings across multiple data sources  
• Further, the analysis process and findings were validated through consensus amongst evaluators to reduce personal biases |
|        | Recall bias amongst evaluation participants                                                                                                                                                                | • As the evaluation of GPW 13 is expected for the period of 2019-2023, recall bias was anticipated amongst participants. To manage this, we ensured data triangulation through multiple data sources |
|        | Recall and social desirability bias amongst internal stakeholders                                                                                                                                          | • As the evaluation was happening concurrently with formulation of GPW 14, the latter process influenced to some extent the perspectives of the participants. To mitigate this, any inference about the GPW 13 was made after due process of data triangulation including extensive review of programme documents and primary data collection from stakeholder categories beyond those involved in the formulation of GPW 14 |

Table 2 Summary of limitations
Findings
Objective 1: to assess the appropriateness of the results framework of GPW 13 in facilitating the achievement of the triple billion targets and associated organisational goals

Conclusions:

- GPW 13 and GPW 13 result framework are closely intertwined. They represent ambitious intent and shifts, which were welcomed by internal and external stakeholders.
- The result framework is however hindered by design issues and most importantly by lack of currency in data. Consequently, whilst its usefulness is currently adequate for serving communication purposes, it is limited in terms of serving accountability, decision making and learning objectives. These findings are consistent with findings from the 2023 evaluation of result-based management at WHO which for reference included the need for a clear conceptual framework for RBM, the duplication and fragmentation of RBM activities, the predominance of focus on accountability vs decision-making, a weak organisational culture on learning, a lack of focus on RBM at country offices and the need to scale up RBM capabilities and resources across the secretariat.
- The result framework is part of the transformation journey and further work should be undertaken to (a) fix the design, (b) improve the accounting and (c) ensure better utility to support country level M&E. A decision on whether to retain the current result architecture or rethink it is required. The IET is of the view that improvements within the current result architecture should be favored to ensure continuity, but the scale of challenges to improve should not be underestimated. Irrespective of the approach chosen, a clear and predictable roadmap for improvement should be defined.

Key findings:

Robustness of GPW13 theory of change and result framework

1. The WHO constitution references but does not define GPW. Observed practice has varied in terms of: (a) positioning of the GPW as a corporate strategy, an institutional strategy for the Organization (i.e. Member States and Secretariat) or a strategy for global health actors, (b) duration, and (c) level of alignment with the term of the Director General. The selection of these parameters is a strategic choice in and of itself and sets the context for a GPW theory of change and result framework.

2. Lately we have observed a movement towards aligning the duration of GPW to the term of the DG. This can have merits but the extent to which this shift is deliberate, constitutionally and strategically sound, and its implications on strategic oversight by Member States, is unclear.

3. Given the level of the ambition targeted by GPW 13, the underpinning Theory of Change should be systemic and comprehensive. The GPW 13 Theory of Change, implicit in the result framework, is at best incomplete, if not misleading.

4. HALE (healthy life expectancy) is at the top of the GPW 13 result framework. It works well as a proxy to measure the achievement of WHO’s vision of a world in which all people attain the highest possible standard of health and well-being. However, no target for improvement in HALE has been set, and the contribution of GPW 13 billion or outcome indicators to improvements in HALE is not formally tracked as part of the GPW 13 impact framework.

5. The Triple Billion approach consists in aggregating progress in each of the three strategic priorities outlined in GPW 13 and underpinning indicators into indices that are then turned into a quantity of “impacted lives”. The approach and its limitations are explicitly documented, the help of expert panels has been enlisted and the framework has been the subject of many consultations. Challenges and limitations with building the indices, although transparently recognised and communicated, remain substantial and have yet to be addressed by the Secretariat.
6. Whilst stakeholders welcome the intent and aspiration, there is a sense of unease with the triple billion targets. Few understand that the trajectories of each billion reflect historical trends, not the impact of GPW 13 and that they do not align with the number of lives improved that would be obtained by achieving SDG targets.

7. The definition of a reduced number of relevant, consistently calibrated, and measurable outcomes and outputs is inevitably a balancing act. On balance, whilst logically framed, challenges abound around the balance in scoping and levelling of outputs and outcomes, the coherence between outcomes/outputs and indicators, the consistency between GPW 13 outcome indicators and actual SDG indicators, and on the self-assessment methodology underpinning the Output Scorecard (OSC).

8. Qualitative case studies are seen as a good communication tool to bring WHO’s work “come to life”. The process of production is however seen as time consuming for the staff involved and they do not critically look at the achievements of results.

9. The GPW 13 result framework embeds cross cutting issues on Gender, Equity and Human Rights and enables some disaggregation of data. The potential for GPW result disaggregation could be exploited further.

Result Accounting and Reporting

10. The different layers of the GPW 13 result framework are the basis for monitoring and reporting on GPW 13 implementation. GPW 13 M&E activities are taking place but outside of a comprehensive and integrated M&E strategy and framework. Consequently, they are not necessarily aligned or sufficient.

11. GPW 13 impact reporting has been plagued with issues relating to basic data availability and currency, and with inconsistent reporting practices.

12. A substantial body of work is undertaken to support Member States in improving their data capabilities under outcome 4.1 “Strengthened country capacity in data and innovation”, with support from the Secretariat coordinated under the SCORE (survey, count, optimise, review, enable) for Health Data Technical Package. Yet despite these efforts, progress is slow, challenges remain and closing gaps in data will require a step increase in investment to strengthen MS and Secretariat data capabilities.

Usage of result reporting

13. By July 2023 an updated stream of refreshed indicator data came in for many areas which is allowing a better grasp of the global health situation post-COVID. Plans are underway to refresh other indicators.

14. Alignment between GPW 13 and national health strategies is a requisite for GPW 13 to be useful and used at country level. There is anecdotal evidence of alignment between national health strategies and GPW 13. In countries where WHO’s country office assisted in the definition of national health strategies this alignment was easier to drive and demonstrate. It should not however be inferred that this alignment is systematic nor that it is the result of a deliberate effort by Member States to implement GPW 13 at country level.

15. Actual practice on Secretariat result reporting has been too inconsistent to support accountability objectives.

16. In the current state, the utility and usage of result reporting by internal and external stakeholders essentially relates to communication and advocacy objectives rather than accountability, decision making or learning.

17. We did note however a growing and promising drive toward using outcome level indicators to support decision making and prioritisation, essentially driven out of the Division of Data, Analytics and Delivery for Impact (DFI) at headquarters, in collaboration with Planning Resource Coordination and Performance Monitoring division, Country Strategy and Support division and regional offices.
KEQ1: How robust was GPW 13’s theory of change and result framework?

**Finding 1.** The WHO constitution references but does not define GPW. Observed practice has varied in terms of: (a) positioning of the GPW as a corporate strategy, an institutional strategy for the Organization (i.e. Member States and Secretariat) or a strategy for global health actors, (b) duration, and (c) level of alignment with the term of the Director General. The selection of these parameters is a strategic choice in and of itself and sets the context for a GPW theory of change and result framework.

Article 28 of the WHO constitution states that “the function of the (Executive) Board is to […] (g) submit to the Health Assembly for consideration and approval of a general programme of work covering a specific period”.

As such all the constitution says is that it clearly positions the GPW as a document owned by Member States. It does not however define GPW further. Based on what Member States choose, a GPW could therefore consist of (a) a corporate strategy for the Secretariat, (b) an institutional strategy for the Organization (Members States and the Secretariat), and/or (c) a broader strategy Beyond Member States and Secretariat seeking to influence or commit other Global Health actors. This latter approach was for instance chosen for GPW 11. It is divided equally between a situation analysis of global health (7 pages), “A Global Health Agenda” (6 pages), what this meant for WHO as an organisation (5 pages), and what this meant for the Secretariat specifically (3 pages). The GPW was then complemented by a six-year mid-term strategic plan focusing on the Secretariat and covering three biennials. Given that there are various merits and limitations to choosing one approach over the other, the positioning of a GPW is a strategic decision in and of itself.

As far as GPW 13 is concerned, the IET sought to qualify the positioning of GPW 13 objectively by classifying each sentence of the document based on whether it describes the actions or commitments of the Secretariat, joint commitments with or expectations towards WHO Member States, or global health trends/expectations towards partners. This mapping, available in Appendix 6, shows that besides setting an ambition to improve 3 billion lives and reach the underpinning health SDG targets described in a few paragraphs and visuals, the rest of the GPW 13 document is overwhelmingly an inward focused document describing what the Secretariat will do, i.e. a corporate strategy.

Based on the constitution, the other key parameters for defining the GPW are the duration of a GPW which is a function of whether Member States are opting for a mid-term or longer-term strategy; and the extent to which a GPW duration should align with the tenure of the Director General. The practice up until GPW 6, 7 and 8 were six years long and broadly aligned with the term of the Director General. Since then, the practice has varied, with GPW10 covering only four years yet spanning two DGs, GPW11 covering 10 years and spanning 3 DGs, and GPW12 coming back to the six-year period and largely executed under one DG.

**Finding 2.** Lately we have observed a movement towards aligning the duration of GPW to the term of the DG. This can have merits. However the extent to which this shift is deliberate, constitutionally and strategically sound, and its implications on strategic oversight by Member States, is unclear.

Lately we have observed a movement towards aligning the duration of GPW closer to the tenure of the Director General. GPW12 was sunset shortly after the election of the current Director General, a first in the history of WHO. The 2028 targeted end-date for GPW 14 - shortest period of all GPWs – is close to the expiry of his mandate in June 2027. This shortened period is in line with observed strategy trends and can allow more adaptability to a fast-changing environment. Shorter strategies may also bring coherence between a candidate platform for election (or re-election) and the means provided to them to implement the vision for which they were elected. It may also allow MS to place
increased accountability on the Director General. The downsides should however not be underestimated. This may place more emphasis on implementing a person’s vision than driving the definition of a GPW based on evidence, limit the ability to position GPW as more than a corporate strategy for the Secretariat, limit ownership of GPW implementation by Member States and other elected officials (regional directors), and create a bias toward continuity in the second GPW in a DG two term tenure, i.e. a GPW that is more akin to a strategy refresh than a comprehensive strategic reflection. Also the extent to which this shift is deliberate, constitutionally and strategically sound, and its implications on strategic oversight by Member States is unclear.

Finding 3. Given the level of the ambition targeted by GPW 13, the underpinning Theory of Change should be systemic and comprehensive. The GPW 13 Theory of Change, implicit in the result framework, is at best incomplete, if not misleading.

Given the magnitude of the ambition targeted by GPW 13, the underpinning Theory of Change should be systemic and comprehensive. In this respect by describing the work it will undertake under each billion and by outlining the three strategic and five operational shifts for the Secretariat, the document spells out what the Secretariat will do in ways that in principle support evaluaibility. This was welcomed by multiple Member States interviewed and surveyed, chief among them donor countries, as they see this as a major step toward holding the Secretariat accountable and promoting a culture of result orientation.

However, GPW 13 is succinct on the situation analysis (1 page) and does not spell out what the contribution of Members States and partners should be to achieve the triple billion targets and health SDG. Other elements of a properly articulated Theory of Change are missing, notably key assumptions, risks, barriers, enablers, and intermediary outcomes in the period. This contrasts for instance with the Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP), which has an explicit Theory of Change that includes 19 documented barriers and risks and four key assumptions.

The focus on the Secretariat, whilst understandable, creates important limitations on: (a) placing accountability for impact and outcome where it primarily belongs, (b) attributing results, and (c) evaluating whether MS and other actor’s accountabilities were met since these are not clearly defined. This results in an implicit theory of change that is at best incomplete, if not misleading, in the sense that it can be understood as inferring that merely improving the workings of the Secretariat will result in MS achieving GPW 13 billions and outcomes, or in other terms that MS achievements are essentially merely the result of actions by the Secretariat.

We sought to reconstruct what a comprehensive Theory of Change would look like for GPW 13, based on insights gathered during interviews, surveys, and country deep dives. The result is provided below and could serve as a basis for GPW 14 to document the ToC for the upcoming GPW. It highlights how critical success factors, constraints, and risks to achieve the triple billion agenda would need to be considered.

Of relevance is the gap between Secretariat outputs and health outcomes achieved by Member States and their partners. In the reconstructed Theory of Change we call these “intermediary” or conditions for success at country level. Our view is that more explicitly defining these system outcomes would enhance the clarity of linkages of the GPW theory of change, allowing the Secretariat to better explain its unique contribution, and better delineating between Secretariat specific accountability (outputs), joint accountability of MS, partners and MS (intermediary outcomes), country level results (Health Outcomes) achieved by Member States and impact on populations as measured through healthy life expectancy (HALE).
Figure 3 GPW 13 Theory of Change (reconstructed)
We review below each component of the GPW 13 result framework and their linkages. Issues relating to availability of data, timeliness and use of reporting are dealt with in the following sub-evaluation question.

Finding 4. HALE (healthy life expectancy) is at the top of the GPW 13 result framework. It works well as a proxy to measure the achievement of WHO’s vision of a world in which all people attain the highest possible standard of health and well-being. However, no target for improvement in HALE has been set, and the contribution of GPW 13 billion or outcome indicators to improvements in HALE is not formally tracked as part of the GPW 13 impact framework.

The metric calculates the average remaining number of years that a person can expect to live in “full health” at a certain age by considering years lived in less than full health due to disease, injury or disability. HALE is reported for each country and is disaggregated by sex, age, location, and socio-economic conditions.

It is a good approximation of mortality and morbidity linked to risk factors. In that sense it is very well aligned as an overall impact measure of WHO’s vision of a world in which all people attain the highest possible level of health, and WHO’s mission to promote health, keep the world safe and serve the vulnerable, with measurable impact for people at country level.

We note that whilst HALE is the ultimate impact measure of GPW 13, no target improvement to HALE has been set. Doing so might alleviate some of the challenges and limitations encountered in counting the billions. It would also align well with the direction taken by some MS to set target improvements in HALE, such as the mention in UK’s levelling up agenda of a goal to increase HALE by 5 years by 2035, Saudi Arabia’s goal to increase HALE by 6 years by 2030 or the Chinese government’s goal to increase HALE to 79 years by 2030. In the Africa region, country profiles on healthy life expectancy are now complete for all countries in the WHO African Region. This would enhance the alignment between global and country level reporting of impact.

Also, despite existing work by the Secretariat and other institutions on disaggregation of contributing factors to changes in HALE, the contribution of GPW 13 billions or outcome indicators to improvements in HALE is not formally tracked as part of the GPW 13 impact framework. This is a possible area of strengthening the impact framework and enhancing evaluability since the decomposition of changes in HALE over time into the contribution of diseases and injuries in general, and of the 46 GPW 13 indicators in particular, has the potential to help better understand the changes in population health, and to provide evidence on the relevance of WHO priorities and effectiveness of its strategies. Improvements in some outcome indicators are reflected in a relatively short time into HALE (e.g. reduction in under 5 mortality), while others only materialise in the longer term (e.g. tobacco prevention). This constrains, but does not invalidate, its relevance as an indicator for short-term decision making and impact measurement.

Finding 5. The Triple Billion approach consists of aggregating progress in each of the three strategic priorities outlined in GPW 13 and underpinning indicators into indices that are then turned into a quantity of “impacted lives”. The approach and its limitations are explicitly documented, the help of expert panels has been enlisted and the framework has been the subject of many consultations. Challenges and limitations with building the indices, although transparently recognised and communicated, remain substantial and have yet to be addressed by the Secretariat.

The Triple Billion approach consists of aggregating progress in each of the outcome indicators underpinning three strategic priorities outlined in GPW 13, and then turning these indices into a quantitative measure of “impacted lives” based on data from the UN Population Division of the UN Department of Economic and Social Affairs (UN DESA).

The Universal Health Coverage index is based on 2 outcome indicators. First, the average service coverage is itself an index based on geometric mean of 14 tracers of essential health services which have been calibrated on a scale of 0
to 1 prior to being aggregated. Second, financial hardship/catastrophic spending i.e. the proportion of population with out-of-pocket health spending exceeding 10% of household expenditures or income. The result is an index measuring the probability expressed as a percentage that someone will have access to essential services without incurring health related financial hardship. The UHC “billion” is then calculated by taking change in this percentage between the 2018 baseline for this index and the current period and applying them to the population in the current period.

The Health Emergency index is based on 3 indices as follows:

- The Emergency Prepare index measures the level to which a country is ready to identify and respond to a range of emergency situations. It does so by averaging the results of MS responses to IHR State Party Self-Assessment Annual Reporting (SPAR) tool on 13 IHR capacities. This results in a %. We note that whilst potential bias in self-assessment is monitored through Joint External Evaluation (JEE), the index takes unadjusted values.
- The Emergency Prevent index measures a country’s effort to prevent a pandemic through vaccination coverage. The indices calculate the percentage of a country’s relevant population vaccinated against selected diseases: Polio and Measles (applicable to all countries), yellow fever (in 40 selected countries), Meningitis (in 26 selected countries) and Cholera (in 47 selected countries).
- The Emergency Detect and Respond index measures the timeliness of surveillance and detection efforts for IHR notifiable events and serious public health events as defined under IHR 2005. For each event, the time to detect, time to report, and time to respond are scored on a 1-5 scale defined based on available timing for the 2014-18 period. The score is then averaged for this event and scaled to correspond to 0–100-point scale. The index for a country is the average score for all events for that country. The contribution to Health Emergency "billion" will be based on a comparison with a rolling average (3-5 years) of timeliness value. However, given that this is a new indicator with no baseline data for 2018 to compare against, a theoretical contribution to the Health Emergency "billion" was defined based on the country average score (from 5% of country population for an average score of 5 to 0% for an average score of 0) as a workaround.

The combined health Emergency indicator is an average of the scores for each of the three above indices. The contribution to the “billions” is based on applying the percentage of change in the period to the overall population.

The Healthier Population “billion” is calculated based on a selection of 16 indicators reflecting environmental, societal/health risk factors across water and sanitation, air pollution, road safety, alcohol and tobacco consumption, nutrition, and home conditions. They mix indicators of prevalence and indicators of risk factors which are transformed to allow aggregation whilst not requiring additional data collection by Member States. The change of prevalence across the 16 indicators are apportioned to the relevant population to quantify the improvement in lives for that indicator. Numbers are then added to get the contribution to the Healthier population “Billion”. To limit double counting an elimination is performed using a simplified statistical elimination.

The above approaches and their limitations are well and explicitly documented. They have been discussed, reviewed, and endorsed through multiple expert meetings and Member State consultations throughout 2018 and to this day. They meet the falsifiability criteria. We also understand that there is still work in progress to improve the definition of results and their reporting in the context of GPW 14 formulation.

The challenges and limitations with building the indices, although transparently recognised and communicated, remain however substantial and have yet to be fully addressed by the Secretariat. They include notably:

- Indicators are not weighted. This results in skewed indices, e.g. on UHC where HIV and hyper-tension explain 2/3rd of the progress observed or on healthier population where the indices are heavily influenced by sanitation indicators. Whilst weighting indicators would technically be feasible, the likelihood is that it would result in lower reported achievements.
• So far only absolute values have been used, creating a perception in some MS and country office staff in smaller countries that their efforts do not matter. Even for larger countries such as India, there was a reluctance to be singled out as a key contributor to the triple billion. This resulted in the country featuring as a targeted country for most programme strategies to improve specific indicators, which is contrary to the notion of focusing WHO priorities at country level.

Finding 6. Whilst stakeholders welcome the intent and aspiration there is a sense of unease with the triple billions. Few understand that the trajectories of each billion reflect historical trends, not the impact of GPW 13 and that they do not align with the number of lives improved that would be obtained by achieving SDG targets.

All in all, we noted an ambiguity in the MS, donors and WHO staff who participated in the evaluation about the status of the triple billion objective. Many mentioned this was - and should still be – an aspirational slogan with no direct applicability to the work of the Secretariat and that it was not meant to be used as an accountability tool. The method, although described as simple and straightforward in technical documents, does present a level of complexity that proves challenging for most non-statisticians to comprehend. This results in two opposite tendencies identified in our interviews, FGDs and surveys. On the one hand it leads to a perception of rigor and robustness, and as a result a tendency to take the framework and results reported at face value without taking the limitations into account. To illustrate, there was an acknowledgment in the MS survey that GPW 13 had articulated causal pathways and included measurable indicators in its results framework, which are considered as being important aspects of a robust framework. On the other hand, multiple stakeholders voiced concerns and even cynicism about the approach chosen and the relevance and integrity of the reporting produced.

There is ambiguity in what the billion indices mean and consequently what the quantification in billion lives impacted also mean, e.g. a 10% improvement in the emergency preparedness index may be understood to mean a population is 10% better prepared, rather than 10% more people are fully prepared. Likewise, a 5% improvement to the UHC service coverage indicator could mean that 5% additional people have full access to the services they need, while the rest saw no improvement, or that the entire population saw a 5% improvement in their access to essential health services. This has vastly different implications on policy and equity. Further, the same person might be affected by each triple billion, thereby resulting in double if not triple counting, and within each billion the methods used to eliminate double counting are basic.

In that respect we note that the method described above is a method of accounting, not a method of setting a target. Evidence suggests that the billion mark was chosen for its global appeal and simplicity and is not the result of a bottom-up quantification of the improvements that would be achieved by implementing WHO priorities or reaching SDG targets. As a case in point:

• The initial projections that served as a basis for the billions were based on historical data up to 2019. Limited adjustment are made as more recent data becomes available. They do not reflect the impact WHO’s actions or GPW 13 shifts would have on the trends. This means that trajectories of each billion reflect historical trends, not the impact of GPW 13.

• Already back in 2018 the Reference Group on the General Programme of Work Interim Report voiced reservations about WHO’s ability to meet the UHC target. Likewise, the overachieving on healthier population was foreseen by the expert panel from the onset. Yet targets of 1 billion were retained. Regarding the emergency triple billion, whilst the expert panel could not foresee the COVID-19 pandemic, reporting that 690 million [591 - 784 M] more people were expected to be protected from health emergencies by 2023 compared to 2018 is hard to relate to the experience the world went through during the COVID-19 pandemic.

• If the triple billion method had been used to quantify the number of lives improved that would be obtained by achieving SDG targets, the “billion” targets for 2023 and overall trajectories would have
looked quite different, as illustrated by the graph below. The graph shows that the ambition set out in GPW 13, despite looking ambitious when expressed in “billions” is below what it would take to achieve SDG targets. Whilst this disconnect is not visible when billion targets are presented for 2023 or 2025, it will become more apparent as 2030 approaches. The approaches will need to be synchronised in GPW 14. In that light the rate of improvement in each of the three billion will need to be much steeper than in GPW 13 for 2030 SDG targets to be achieved.

Figure 4 Global contributions for each Triple Billion (Source: WHO division of Data Analytics and Delivery for impact)

- The actual contribution of regions or countries to the triple billion can be calculated based on the methodology outlined above. However, expected regional or country contributions, which are a function of country population, baseline and target level of indicators, have not been determined or communicated, despite what was initially planned. Likewise, the expected contribution of each indicator to the triple billion (as opposed to the SDGs) is not defined. This does not make it possible to assess on a country by country or on an indicator-by-indicator basis whether objectives are met, exceeded, or not met. Such a process would require a negotiation with each Member State which may prove lengthy and contentious. Feedback from country offices in the HWCO survey and the country deep dives however mentioned that for COS and their MS counterparts to better relate and align with the triple billion agenda, they would require an ability to choose and define targets at country level and understand their expected contribution to the triple billion. We note that as part of the Member States consultation to formulate GPW 14 the Secretariat has produced country contribution relative to their population size.

Good practice - Localisation of health SDGs in Sudan

Sudan offers a good example of how global and country-level health targets could be aligned. Sudan has endorsed the 2030 Agenda for Sustainable Development and is a signatory of UHC2030 partnership and Salalah Declaration 2018, that promotes the collaborative working in countries and globally on health systems strengthening and advocacy to increase political commitment to universal health coverage (UHC) and facilitate accountability and knowledge sharing.

The strategic shift because of SDGs, has put considerable responsibility on the government and development partners not only to address the unmet agenda of MDGs, but also a more focused approach for more comprehensive SDGs.

The SDG localisation assessment included quantitative and qualitative approaches following serial methodological steps. Two outputs were produced: a comprehensive list of indicators at country level with baselines (2000 and 2005), status, milestones and targets; and highlighted quality and gaps in Health Information Systems with reference to SDG3 targets.

A framework was developed along with key actions for local adaptation using the outputs from document reviews and stakeholder analysis and a comprehensive list of localised indicators. Gaps in the health information systems were
highlighted, with specific reference to targets and indicators for SDG3. This report provided a working document to the Federal Ministry of Health and partners to finalise the milestone and targets at national level which will also be used for monitoring purposes in future. This data was also used to define an action plan.

The ongoing crisis in Sudan, however, has had a devastating impact on the country’s health system, endangering a reversal in hard-won gains over the years.

Finding 7. The definition of a reduced number of relevant, consistently calibrated, and measurable outcomes and outputs is inevitably a balancing act. On balance, whilst logically framed, challenges abound around the balance in scoping and levelling of outputs and outcomes, the coherence between outcomes/outputs and indicators, the consistency between GPW 13 outcome indicators and actual SDG indicators, and on the self-assessment methodology underpinning the Output Scorecard (OSC).

Twelve outcomes are defined and grouped under each strategic priority. The outcomes define results that Member States with support from the Secretariat are meant to achieve through joint accountability. They are measured through a set of 46 indicators, 39 of which are SDG indicators (26 from SDG 3, 13 from other SDGs), and 7 of which relate to other WHO resolutions (polio, NCDs and health emergencies).

Outcomes are the basis against which Member States’ progress is assessed, against which the Secretariat defines its outputs, and against which the Programme and Budget is reported.

The definition of a reduced number of relevant, consistently calibrated, and measurable outcomes is inevitably a balancing act. In the case of GPW 13 this exercise was further constrained by the fact that the set of outcomes defined had to accommodate a rather large set of pre-defined health related SDG indicators, complemented by additional indicators linked to previous WHA resolutions.

We found that despite the above constraint, on balance, the outcomes were logically framed.

We however noted challenges relating to:

- Some imbalances in the scoping of outcomes, with some outcomes being very broad, e.g. Outcome 1.1 (improved access to quality essential health services) has 18 indicators and a budget of USD 1.4B for 2022-23 vs outcome 1.2 (reduced number of people suffering from financial hardship) with only 2 indicators and budgets of USD 100M (14 times less than outcome 1.1) and USD 306M respectively.
- The nature of outcome 4.1, 4.2 and 4.3 under the “More effective and efficient WHO providing better support to countries” strategic priority, which are put on the same level as other outcomes but are of a different nature since relating to the Secretariat. We also note the absence of outcome indicator for these three outcomes.
- Coherence between outcome and outcome indicators, linked to the fact that 46 indicators were “retrofitted” against outcomes so that these indicators could be featured in the result framework, as opposed to selected because they represented the best proxy to measure each specific outcome. As a case in point, some indicators were shifted from one outcome to another between different biennia. Output 3.1 (Safe and equitable societies through addressing health determinants) had 15 indicators in 2020-2021 whilst 3.3 (Healthy environments to promote health and sustainable societies) had none. In 2022-23 seven indicators of outcome 3.1 were shifted to 3.3 and one to 1.1. Whilst this reflects a drive by the Secretariat to continuously improve the result framework, it does question the strength of linkages between outcome and outcome indicators.
- SDG based outcome indicators can span immediate outputs (ex. Number of health workers per 1000 population), to medium- (ex. Vaccination for immunisation rate) and long-term outcomes (ex. End the epidemics of tuberculosis).
Some subtle but important to note differences between SDG targets and outcome indicators in PB 2024-2025. Whilst for the most part they are clarifications of definitions, in some cases they are different indicators e.g. SDG indicator Hepatitis B incidence per 100 000 population, replaced by Hepatitis B surface antigen (HBsAg) prevalence among children under 5 years old (%), Percentage of bloodstream infections due to antimicrobial-resistant organisms replaced by Percentage of member countries and areas reporting on bloodstream infections due to antimicrobial resistant organisms, or Proportion of the target population covered by all vaccines included in their national programme replaced by Diphtheria-tetanus-pertussis (three-dose) immunisation coverage among one-year-olds (%).

As mentioned earlier in this section, the completeness of the result chain, given that only the Secretariat expected outputs are described despite outcomes being the joint responsibility of MS, their partners and the Secretariat.

The twelve GPW 13 outcomes are underpinned by 42 outputs and supporting output indicators. The delivery of outputs is the Secretariat’s accountability. Outputs are the basis for operational planning and budgeting and for reporting the Secretariat’s activity and results.

For GPW 13 a deliberate choice was made to promote integrated delivery and define outputs that cut across organisational silos. This results in promoting more horizontal approaches compared to the more vertical/disease specific approaches used in previous GPWs. Whilst this resonates well with some country offices which do not have the critical mass to specialise staff by disease, this creates a difficulty to link the outputs to the organisational structure and a perception by some that the work of specific teams is diluted or abstracted, a situation that is resented by some donors and staff, notably at headquarter and regional levels. This also makes it harder to assign accountability for results given the cross-cutting nature of outputs.

The 42 Outputs are measured through:

- Leading indicators: a set of 130 output indicators were defined for the Programme Budget 2020-2021, 116 for PB 2022-2023 and 152 for PB 2024-2025. Most of these indicators seek to measure the effect the Secretariat is having at country level. They are often framed in terms of “number of countries that” or “number of countries with”. In that sense output indicators do seek to measure the contribution WHO’s Secretariat at country level.
- An output scorecard (OSC) methodology agreed with Member States in line with resolution WHA72.1 (2019) on the Programme budget 2020–2021, whereby each budget center self-assesses its performances in reaching the technical or enabling outputs it works on across six dimensions, Including: (1) Effective delivery of technical support at the country level; (2) Effective delivery of leadership in health; (3) Effective delivery of the global public health goods; (4) Impactful integration of gender, equity and human rights, and disability; (5) Delivering value for money; (6) Achieving results in ways leading to impacts. These dimensions are assessed using a scoring scale ranging from 1. “Emergent” to 4.” Strong”. Except for dimension 6, these dimensions are scored by self-assessment. Dimension 6 score is presented using the same scale but the extent to which the indicator targets are achieved are measured first before being converted into the same standard scale.

In addition to the above, the regional offices for the Eastern Mediterranean region, South East Asian region and African region have defined specific indicators that are tracked by the regional office. Overall, this results in a set of 95 additional or adapted indicators. Whilst these are mapped to the outcomes, this results in added complexity and the level of alignment or duplication with PB output indicators defined at the global level is unclear. Some regions also provide specific Topline Accountability Reports (TAR), focusing on business operations and budgetary reporting. Some programmes sitting outside the base segment budget, e.g. OCR or PMNCH, also have specific outputs and output indicators which are tracked and reported separately.
Just as mentioned already regarding the development of outcomes, the definition of a reduced number of relevant, consistently calibrated, and measurable outputs that adequately represent the breadth and depth of what the Secretariat does is challenging. Likewise, the selection of a limited set of indicators to measure each output is inevitably introducing some bias in what is reported.

We found that despite the above constraint, on balance, the overall set of output is logically framed and if reported against can support Secretariat accountability. We, however, noted a number of challenges relating to the design of output, output indicators and output scorecard. These include:

**Output definition:**

- Given their cross-cutting nature, outputs cut across the organisational structure. This does not make it easy to assign accountability for achieving the results to specific departments or divisions. Output Delivery Teams (ODTs) were meant to take on this responsibility. But feedback from internal stakeholders is that they were not empowered in terms of authority and resource allocation to effectively be held accountable for results.
- Internal stakeholders also mentioned that because of how broad, high level and integrated outputs are, the allocation of areas of work under a specific output can be left to interpretation or can based on personal preferences, e.g. based on how working under a specific output can facilitate access to donors and funding. Across PB 2020-2021 and 2022-2023 some areas of work were moved from one output to another which incurred a level of disruption as the composition of ODT teams changed and new connections had to be established.
- Logical linkages and coherence can be improved in some areas, e.g. some outputs belonging to different strategic priorities seem to overlap, e.g. 1.1.3 (Countries enabled to strengthen their health systems to address population-specific health needs and barriers to equity across the life course) and 2.3.(Essential health services and systems maintained and strengthened in fragile, conflict-affected and vulnerable settings). Also, some outputs such as 1.1.2. (Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results) regroup a wide scope of WHO activities and budget relating to vertical diseases. Finally, some outputs are inputs into other outputs, e.g. 1.3.1 (Provision of authoritative guidance and standards on quality, safety and efficacy of health products, essential medicines and diagnostics lists) could be considered as an input into 1.3.2 (Improved and more equitable access to health products through global market shaping and supporting countries to monitor and ensure efficient and transparent procurement and supply systems) but it is considered a distinct output in the result framework.

**Output indicators and output scorecard:**

- The measurement philosophy adopted is consistent with the drive to achieve measurable impact at country level through Member States adoption of global goods and adequate country level strategies and plans. However, the level of control over the Secretariat’s ability to obtain these results is unclear since Member States set their own priorities. In that sense the outputs are as much the responsibility of Secretariat as they are of MS. Also, the target setting based on “number of countries” is not by itself a guaranty that changes are targeted on themes or in countries where they are most needed to drive the triple billion targets.
- We noted that output indicators changed between biennia and even between the beginning and end of a biennium. For technical outputs consistency was maintained in 59 out of 78 indicators (76%) between 2020-2021 and 2024-2025, and for enabling outputs consistency was maintained in 21 out of 42 indicators (50%) across the GPW duration. Whilst this can be illustrative of a continuous improvement mindset, this makes it hard to apply trend analysis and see continuity between biennia.
- In terms of consistency, whilst most output indicators demonstrate MS results, e.g. “Number of countries that have a comprehensive national health sector policy/strategy/plan with goals and targets
that have been updated within the last five years”, some still focus on measuring the Secretariat throughput, e.g. “Number of products prequalified annually” or “Coordination of activities on scientific advice across the Organization”. One outcome indicator for 1.3 and one output indicator (1.3.1) were the same (proportion of health facilities with essential medicines available and affordable on a sustainable basis);

- Governance around the setting of targets for output indicators is left to the ODTs. ODTs propose indicators and set targets. Whilst the definition of indicators is reviewed, challenged and harmonised by the Planning Resource Coordination and Performance Monitoring division (PRP), we understand there is no challenge of the targets to ensure they are stretch yet achievable.

- Several regions have defined regional KPIs that COs report against. The link between these regional KPIs, output and output indicators, is unclear. This may impact strategic alignment and it adds to the burden on country offices.

- OSC: Output scorecard uses a six-dimensional self-assessment approach, three of which should allow for the measurement of strategic shifts by the Secretariat. With evidence needing to be provided in the OSC tool, the self-assessment method used may be prone to facilitate organisational learning if used in practice. The reporting capabilities exist to visualise results by OSC dimension, by output, and by regions. However, without a level of independent review and validation of the self-assessments its effectiveness as an accountability tool is limited.

- The above is valid for base segment reporting. Separate results frameworks are used for other segments of the budgets, e.g. PMNCH, polio and OCR. What is “off balance sheet” may seem trivial, but it represents a bigger budget than what is reported against as part of outputs of the base segment.

Finding 8. Qualitative case studies are seen as a good communication tool to bring WHO’s work “come to life”. The process of production is however seen as time-consuming for the staff involved and case studies do not critically look at the results achieved.

The last layer of the GPW 13 result framework consists of qualitative case studies, also called “health impact stories”, which aim to showcase country-level results and achievements on the ground. The three-level stories are co-developed by technical counterparts in WCOs and ROs along with regional CSU Network colleagues. Each case study is mapped against a specific outcome.

There is an overall appreciation that case studies are a good way to bring WHO’s work “come to life” in more vivid ways compared to a purely numerical approach, and that case studies therefore play an important role in communicating the work of the Organization.

However, feedback from the HWCO survey and interviews showed that the process is seen as rather heavy, the production of each case study being time-consuming for the staff involved. Also, there is a general agreement that for all their worth as a communication tool, they do not represent a balanced assessment of performance per say, do not support decision making or course correction and should not be considered part of the Monitoring and Evaluation framework of the Organization.

Finding 9. The GPW 13 result framework embeds cross cutting issues on Gender, Equity and Human Rights and enables some disaggregation of data. The potential for GPW result disaggregation could be exploited further.

Consistent with the WHO mandate, GPW13 strategically integrates gender, equity, and human rights into WHO’s work, viewing it as crucial for attaining the triple billion goals and for Leaving No One Behind in the achievement of the health-related SDGs.
Equity in health was considered as a cross-cutting theme of the GPW 13 and it was envisaged to monitor the progress across equity in health different levels of the result framework, as well as provide disaggregated data by key inequality dimensions and priority subgroups.

Specific outcome indicators cover gender, equity and human rights, e.g.:

- Proportion of women (aged 15–49) having need for family planning satisfied with modern methods (%);
- Proportion of population with large household expenditures on health (>10% of total household expenditure or income) (%);
- Proportion of population with large household expenditures on health (>25% of total household expenditure or income) (%);
- Proportion of health facilities with essential medicines available and affordable on a sustainable basis (%);
- Proportion of women (aged 15–49) subjected to violence by current or former intimate partner (%);
- Proportion of women (aged 15–49) who make their own decisions regarding sexual relations, contraceptive use, and reproductive health care (%).

Disaggregated data by inequality dimensions is also available for HALE and for 38 out of 46 outcome indicators, usually age, sex, economic status or place of residence, although not all dimensions are available for all 38 indicators. In addition, one of the six dimensions of the Output Scorecard (OSC) covers the integration of gender, equity, and human rights into WHO programming. Disaggregated analysis is usually done in global monitoring reports for these indicators. However, the reporting on result framework does not provide such a disaggregation, e.g. progress on the triple billions or indices for each strategic priority is not reported by gender or economic status.
Finding 10. The different layers of the GPW 13 result framework are the basis for monitoring and reporting on GPW 13 implementation. GPW 13 M&E activities are taking place but outside of a comprehensive and integrated M&E strategy and framework. Consequently, they are not necessarily aligned or sufficient.

The different layers of the GPW 13 result framework described in the previous section are the basis for monitoring GPW 13 implementation. Extensive efforts were conducted to document the GPW 13 methods for impact measurement and meta-data for impact measurement. A result hierarchy is also maintained along an output indicator report that keeps track of output indicator baseline, Medium Term and End of Biennium targets, Medium Term and End of Biennium actuals, as well as sources and validation process for indicators. The methodology for the Output Scorecard (OSC) is also documented.

In practice and regarding monitoring, the various elements are monitored through different instruments such as:

- For HALE: the publication of global health estimates;
- For Billion indices and trajectory: the triple billion dashboard;
- For outcome level indicators: annual WHO World Health Observatory, world health statistics publications, and Global reports on thematic areas, e.g. Universal Health Coverage, as well as Programme and Budget Mid-Term and End of Biennium result reporting by the Secretariat;
- For outcome, output indicators and country impact stories: Programme and Budget Mid-Term and End of Biennium result reporting by the Secretariat;
- Programme level and country level implementation monitoring practices such as those in place in regional offices using regional KPIs, which can vary in terms of rigor and are not systematically linked to GPW 13. These usually take place on a monthly and six-monthly basis.

There was however no formal Monitoring and Evaluation plan supporting GPW 13 from the onset. In the absence of a comprehensive Theory of Change (refer to earlier section) this would have proved difficult to formalise.

Regarding evaluation, a biennial workplan is developed by the WHO Evaluation Office in consultation with WHO management across the Organisation. It is reviewed by the Independent Expert Oversight Advisory Committee (IEOAC) and approved by the Executive Board. It includes corporate/centralised evaluations to be managed, commissioned or conducted by the Evaluation Office (programmatic, thematic and office-specific evaluations).

The plan is not explicitly aligned to GPW 13 but does cover areas of relevance to GPW 13, e.g. since 2020 the following evaluations have been produced:

- Joint Evaluability Assessment of the Global Action Plan for Healthy Lives and Well-being for All (2020);
- Evaluation of WHO transformation (2021);
- Evaluation of the integration of gender, equity and human rights in the work of the World Health Organization (2021);
- Evaluation of Results Based Framework (2022);
- Normative function at country level (2023);
- Joint evaluation of Global Action Plan for Healthy Lives and Well-being for All (2023, underway at the time writing this report).

The Evaluation Office also managed and supported several inter-agency health emergencies evaluations in Somalia, Sudan, Syria, Ukraine, South Soudan, and Yemen. It also conducted evaluations of WHO’s work at country level in Myanmar (2021) and Kyrgyzstan (2020).

Overall, however, we note that the evaluability of the GPW 13 was not assessed and that no interim and final evaluation of GPW 13 were planned. The present evaluation was requested by Member States and not planned as part
of the evaluation office programme of work. It was also performed concurrently with GPW 14 formulation, creating limitations in its execution and challenges in ensuring its utility to embed learnings into GPW 14 formulation.

Finding 11. GPW 13 impact reporting has been plagued with issues relating to basic data availability and currency, and with inconsistent reporting practices.

**HALE**

HALE is meant to be published for each country as part of the Global Health Estimates (GHE) refresh cycle. However, the production of HALE depends on several inputs, most notably national vital registration systems that record death and their causes, as well as national health examination systems on the prevalence of diseases, injuries and disabilities. This makes the production of HALE a rather complex operational process for Member States and the Secretariat which constraints the ability to provide more frequent updates.

The production of HALE was disrupted by COVID-19, and the latest update dates back from 2020 based on data up to reference year 2019. A process of consultation is underway at the time of writing this report and HALE is expected to be next published in May 2024 ahead of the 77th World Health Assembly based on data up to reference year 2021. This means WHO has been unable to assess whether there has been an improvement in HALE in the GPW 13 period.

**Triple Billion dashboard, billion indices and outcome indicators**

Initial projections for the tracer indicators underpinning each billion have been done to 2030 essentially based on constant or Integrated Moving Average (ARIMA) modelling strategies and based on data up to reference year 2019.

We understand there is no specific frequency of update on triple billion trajectory and underpinning outcome indicators. In May 2023, the projections have been adjusted for disruption due to the COVID-19 pandemic based on data available for 2020-2021. Data was available for 12 indicators, and only 4 tracer indicators relating to immunisation required an update of the projections: DPT3 Immunisation coverage, TB treatment coverage, polio routine and Measles (MCV1) Routine.

Monitoring health-related SDGs and reporting on the WHO impact framework requires functioning data systems in each country, including household and other-population-based surveys, surveillance systems, regular harmonised health facility assessments and administrative data, civil registration and vital statistics, and other sources that may be outside of the health sector. Reporting on the impact framework suffers from the lack of timely data, which substantially constrains the quality, timeliness and as a result the usefulness of impact reporting.

The first challenge relates to the **availability of outcome data**. The tables in the next page illustrate what is referred to as “data density” for GPW 13 outcome indicators, i.e. the number of countries for which data is available for each year and each indicator. It shows as of May 2023 the most recent year where data was available in sufficient density was 2019, i.e. the first year of GPW 13. For some indicators, e.g. obesity, the most recent data is from 2017, whilst for others, e.g. meningitis or yellow fever there was no baseline data to date.

The second challenge relates to the **availability of current and accurate census and cause of death data**. Census data provides benchmark population data for many health statistics. As mentioned in the 2020 Global report on health data systems and capacity “with less than 50% of countries conducting post-enumeration surveys, there is legitimate concern about the quality of census data”. The quality of cause-of-death data could also be an issue. Only 28% of countries have less than 10% ill-defined cause-of-death codes. The remaining 72% either do not record cause of-death data using International Classification of Diseases (ICD) codes or have more than 10% ill-defined cause-of-death codes.

UN members are meant to conduct regular censuses every 10 years, or equivalent population registries that provide information on population and socioeconomic characteristics by small geographical area, conducted in line with
United Nations Department of Economic and Social Affairs (UNDESA) standards. Whilst in 2018-20 86% of countries reported having run a census in the last 10 years, some regions were lagging, e.g. in the Eastern Mediterranean region only 55% had a census that was less than 10 years old, and in the Africa region only 77%. Only 51% of countries had disaggregated population projections.

**Civil registration and vital statistics** (CRVS) that record life events such as birth, marriage, death and cause of death are also holding reporting back. As far as death registration and causes of death are concerned, 40% of deaths are not recorded and in low-income countries only 8% of reported deaths show cause of death.

The above is further compounded by some Member States' lack of willingness to communicate data, or to communicate it in a timely manner, despite their constitutional obligation to do so as per articles 63 and 64 of the WHO constitution.

To account for the above gaps or lag in data, uncertainty margins have been introduced in the May 2023 version of the triple billion dashboard. The graphs now take into account both the uncertainty relating to historical data and the uncertainty linked to the projection models used.

Whilst the above situation constraints the feasibility, timeliness and ultimately utility of reporting, it is not in any way a reason for the Secretariat to forgo close monitoring and assessment using impact measurement.
Maturity of SCORE capabilities critical to support triple billion reporting (based on survey of 133 countries in 2018-20)
The tables below present the baseline assessment for selected SCORE capabilities that are of relevance to support SDG and GPW 13 impact reporting.

Data density Challenges to report on Outcome and Triple Billion achievements
The tables below show how many countries have provided data for each indicator and year as of August 2023, i.e. in bright green more than 180 countries have reported data for that indicator that year, and red less than 20 countries have reported data for that indicator that year. It shows a significant lag in data availability which limits the accuracy and usefulness of outcome and triple billion reporting.

Figure 5 Maturity of SCORE capability and data density challenges
Finding 12. A substantial body of work is undertaken to support Member States in improving their data capabilities under outcome 4.1 “Strengthened country capacity in data and innovation”, with support from the Secretariat coordinated under the SCORE (survey, count, optimise, review, enable) for Health Data Technical Package. Yet despite these efforts, progress is slow, challenges remain and closing gaps in data will require a step increase in investment to strengthen MS and Secretariat data capabilities.

**A substantial body of work is undertaken to support Member States** in improving their data capabilities under outcome 4.1 “Strengthened country capacity in data and innovation” and notably output 4.1.1 “Countries enabled to strengthen data, analytics and health information systems to inform policy and deliver impact” and 4.1.2. “GPW 13 impacts and outcomes, global and regional health trends, Sustainable Development Goals indicators, health inequalities and disaggregated data monitored”.

**The work is coordinated under the SCORE (survey, count, optimise, review, enable) for Health Data Technical Package.** SCORE was developed by WHO and partners to assist Member States in strengthening country data systems and capacity to monitor progress towards the health-related SDGs, Triple Billion targets, and other national and subnational health priorities. It brings together a set of 90 of the most effective interventions and tools for addressing critical data gaps and strengthening country health data for monitoring health priorities and inform planning.

An initial assessment of the maturity of country health information systems against each of the five SCORE capabilities was conducted by WHO between 2018 and 2020. It provided a sound **baseline of the health information systems of 133 countries covering 87% of the world's population.** The findings were consolidated into a global report on health data systems and capacity 2020 published in 2021. Refer to the right part of Figure 5 for key results.

This baseline assessment has been used to tailor the technical assistance provided to countries based on the identification of where the gaps are and capacity building on relevant SCORE instruments such as:

- World Health Survey Plus (WHS+), a household survey instrument that has been used in more than 100 countries. 29 of Health-Related SDG targets rely on nationally representative household surveys;
- The WHO Civil Registration and Vital Statistics (CRVS) Strategic Implementation Plan 2021-2025 aims to empower Member States to more effectively mobilise their health sector to lead, or contribute to, CRVS system strengthening efforts. The Implementation Plan avails detailed guidelines that outline how this might happen in practice and what Member States need to consider when implementing health related CRVS strengthening activities. Technical assistance was provided at mid-term of Programme Budget 2022-2023 to Kenya, Malawi, Nepal, Pakistan and the Philippines in workshops and joint missions with other United Nations agencies to strengthen (CRVS) systems.
- International Statistical Classification of Diseases and Related Health Problems – Eleventh Revision (ICD-11) and related implementation tools. In 2022-23 ICD-11 was being implemented across 70 low- and middle-income countries, with use of DHIS2 as the national health information system. Training in use of the ANACOD3 tool was conducted for 50 countries in the African, Americas and Eastern Mediterranean regions. Training in the South-East Asia Region focused on improving birth and death registration by all countries.

In the Africa region, country profiles on healthy life expectancy are now complete for all countries in the region. Health Atlas profiles were also developed for all 47 countries, which show trends in health impact and health outcomes using Sustainable Development Goal (SDG) indicators. Several countries have also developed generic profiles and state of health reports, notably Burundi, Mozambique and Niger.

**Yet for all the above efforts, progress is slow, and challenges remain.** By 2022, 164 countries have conducted the SCORE assessment and validated the data, an additional 31 compared to 2020. The population – weighted average score of country CRVS system performance has improved from 61% in 2019 to 68% in 2022. Overall, the percentage of
global population that is covered with recent data for at least 75% of the targets of the health-related Sustainable Development Goals reported in World Health Statistics remains at 62% in 2022.

**Closing gaps in data will require a steep increase in investment by MS and the Secretariat in data capabilities.** At USD 67M as of Sept 2023 the overall amounts expensed for the biennium remain modest in comparison to the challenge and the importance of this issue, notably considering that only USD 20M went to Regional Office and USD 22M to Country Office level. On output 4.1.2 only USD 3.3M were expensed in countries as of 31 September 2023 vs a planned budget of 9.2m for the biennium.

Finding 13. By July 2023 an updated stream of refreshed indicator data came in for many areas which is allowing a better grasp of the global health situation post-COVID. Plans are underway to refresh other indicators.

The later part of 2023 has seen a steady improvement in the currency of many indicators. This should allow us to critically revise the state of global health in the aftermath of COVID-19 and understand MS achievements and setbacks during GPW 13.

The table below summarises some of the recent or upcoming updates:

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<th>Topic/Report</th>
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**Table 3 Recent or upcoming updates on GPW 13 indicators**
KEQ3: To what extent is there evidence that the result framework and related reporting are used by Member States and the Secretariat to drive impact at country level?

**Finding 14.** Alignment between GPW 13 and national health strategies is a requisite for GPW 13 to be useful and used at country level. There is anecdotal evidence of alignment between national health strategies and GPW 13. In countries where WHO’s country office assisted in the definition of national health strategies this alignment was easier to drive and demonstrate. It should not however be inferred that this alignment is systematic nor that it is the result of a deliberate effort by Member States to implement GPW 13 at country level.

We asked Member States in the online consultation whether there is alignment between the goals set forth in WHO’s GPW 13 and their country’s health priorities, policies, and strategies. **Out of 16 Member State responses collected, 19% of the respondents strongly agreed that there is an alignment between the goals set forth in WHO’s GPW 13 and their country’s health priorities, policies and strategies; 50% somewhat agreed; 25% neither agreed nor disagreed and 6% strongly disagreed.**

When reviewing national health strategies(s) and priorities during the six country deep dives, we found that:

- **Bahrain:** GPW 13’s first and third goals align significantly with Bahrain’s National Health Policy 2016-2025. The focus on universal access to high quality healthcare, echoed in the policy’s background, aligns with the GPW 13’s goal one. Similarly, the emphasis on well-prepared health services during emergencies in Bahrain’s policy resonates with GPW 13’s third goal. Deeper alignment is observed with GPW 13’s third goal, emphasising healthy populations. Bahrain’s policy underscores this alignment by prioritising investment in prevention and promoting health lifestyles, reflecting a concordance with GPW 13. This resonance is further supported by primary data indicating that the country’s health sector strategies prioritise preventive aspects, reinforcing the synergy between global and national objectives.

- **India’s GPW13** aligns with the National Health Policy (2017), emphasising elements of UHC and emergency case in disaster preparedness. Section 8’s focus on creating healthy populations is crucial. Additionally, India’s approach to mental health is integrated, while separate policies address diverse indicators such as sanitation (Swachh Bharat Mission), clean cooking fuels (Ujjwala Yojana), clean water access, and (Nal Jal Yojana) and road safety (National Road Safety Policy). This comprehensive strategy reflects a multifaceted commitment to public health.

- **Rwanda:** The goals of GPW 13 align largely with Rwanda’s Fourth Health Sector Strategic Plan July 2018 – June 2024. The policy reflects UHC through coverage of essential health interventions (section 6), emergency preparedness through assuring health security (section 7) and healthier populations through health promotion, prevention, and environmental health (section 6.3).

- **Solomon Islands:** The goals of GPW 13 are in complete alignment with the National Health Strategic Plan 2016 – 2020 for Solomon Islands. Achieving UHC through improved service coverage is one of the strategic goals. Improving preparedness and responsiveness for emergency and disaster outbreaks has been included as an outcome statement. Healthier populations have been considered throughout the document with a lot of focus on healthy villages, healthy families, healthy schools, healthy markets, healthy workplaces, healthy towns, and healthy cities.

- **Sudan:** GPW 13 aligns significantly with Sudan’s National Health Policy (2017-2030). The commitment for achieving UHC is reflected in both the GPW’13 first goal and Sudan’s first objective. The Policy’s dedication to supporting healthy living across the life course, with an emphasis on promotion interventions, resonated with GPW 13’s goals one and three. Sudan’s National health recovery and Reform Strategy Plan (2022-2024) further reinforces this alignment. The strategy, focusing on optimising available resources, enhancing primary healthcare services, and strengthening emergency care and preparedness, aligns with GPW 13’s goals one and two. The mobilisation of additional resources and capacity building within the health system underscores a shared commitment.
- **Tajikistan**: The goals of GPW 13 are largely in alignment with the National Health Strategy of the Republic of Tajikistan 2010-2020 which mentions improving access to health care under UHC, health determinants and forming of a healthy lifestyle for healthier populations, and implementation of the 'Action Plan on Disaster Preparedness In The Health System Of RT" with the aim of ensuring better medical supply, prevention for response to emergency situations.

There is anecdotal evidence of alignment between national health strategies and GPW 13. In countries where WHO’s country office assisted in the definition of national health strategies this alignment was easier to drive and demonstrate.

**Good practice – Aligning GPW and national strategies**

The example below, from the Seychelles 2022-26 National Strategic Plan is a good illustration of strong alignment between GPW 13 and a national priority. 3 of the six priorities (in green) mirror the GPW 13 strategic priorities whilst the others can easily be mapped to the outcome 4.1, 4.2 and 4.3 in GPW 13.

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Figure 6 Good practice – Aligning GPW and national strategies

It should not however be inferred that this alignment is systematic nor that it is the result of a deliberate effort by Member States to implement GPW 13 at country level. This was strongly revealed in a number of interviews, notably those led by country office representatives. Interviewees challenged the narrative that Member States implement a GPW. They notably mentioned that:

- Several Member States national strategies, although aligned with GPW 13, pre-date the definition of GPW 13 and have not been revised since;
- Translating GPW 13 at national level would require that political leaders and MoH leadership grasped GPW 13 and committed to it. Whilst this is true in many situations, feedback was that political instability and turnover at the MoH meant that basic understanding of GPW 13 priorities was often missing at country level and that a significant level of effort was dedicated by regional and country office staff to merely explain GPW 13;
- GPW 13 is so broad that by design anything can be reported under one of the triple billions or 12 outcomes and alignment be claimed. Member States’ strategies and priorities would have been the same had GPW 13 not existed.

As one HWCO highlighted: “GPW is an umbrella. In our country, the government has its own national plan. Whatever they achieve is aligned with the national plan. It is aligned with the GPW 13 because GPW is very broad. It is also aligned with the SDGs because they are very broad. Many things in this country would have been achieved without the GPW 13. The
discussion is a bit upside down. We are fishing for results as part of the GPW 13 but in reality, these results have more to do with the national plan than the GPW itself. I doubt that the country would have adjusted its national plan according to the GPW. We give GPW credits for things that would have happened anyway. GPW is presented as if GPW pushes an agenda that wouldn’t have been pushed. This is wrong. There wouldn’t be much difference without GPW.”

Finding 15. Actual practice on Secretariat result reporting has been too inconsistent to support accountability objectives.

Output level monitoring and reporting are based on the biennial Programme & Budget cycle. In principle output indicators are redefined at the beginning of each biennium, along with baselines, medium term targets and end of biennium targets. Results are then reported yearly in Mid-Term Review (MTR) and End of Biennium (EOB) reports. Over the years these reports have been placed onto online platforms and have become more sophisticated, providing increasing levels of detail.

It took time for the Secretariat to truly implement the above principles:

- The 2020-2021 biennium output indicators were defined in the course of biennium, not at its onset;
- At the beginning of the 2022-2023 output indicators were defined but baseline values were not available;
- We understand that for the 2024-2025 biennium output indicators, both baseline and target values will be available for most indicators.
- **Substantial changes in indicators between biennia and even between the beginning and the end of a biennium** mentioned earlier in this section do not make it easy to monitor performance as they result in gaps in baseline data availability and limit WHO’s ability to trend performance over time. For technical outputs 59 of 78 (76%) indicators in the Programme Budget 2024-2025 were already there in 2020-2021. For enabling outputs only 21 indicators out of 42 (50%) in the Programme Budget 2024-2025 were already there in 2020-2021.

The OSC section of MTR and EoB reports are produced by aggregating the self-assessments done in a dedicated online tool by departments at HQ and divisions in regional offices for each output they contribute to, along with supporting documentation and narrative. Results by output are then rolled up at Budget Center, Major Office and global level, with the possibility for supervisors, major office ODT leads and global ODT lead to adjust scores and supporting narrative every step of the way. For the 2020-2021 EOB period three regions (Americas, Europe and Western Pacific) did not assess the results dimension of the output scorecard (the extent to which the output leading indicators were being achieved) at the country and regional levels, whilst others only assessed a portion of the 121 indicators for that PB (80 for the Africa Regional Office, 77 for the Eastern Mediterranean Regional Office, and 43 for the South-East Asia Regional Office).

Country Offices follow a different process that has varied over time and by region. For the 2020-2021 end of biennium reporting, the global guidance was that each country should assess itself against up to 5 outputs. In some regions COs assessed themselves against all outputs which created an important burden whilst in other s the assessment was not done. In the end what was published in the EoB report ranged from a country office self-assessment against the dimensions of the technical and enabling output scorecards (but not against specific outputs) to a scorecard that did not include the result dimension (e.g. Samoa, Cambodia) to simply no report for some countries (e.g. Columbia, North Macedonia). This is a weakness given the emphasis placed on measurable impact at country level.

Instead of reporting on the OSC, country offices focus on documenting case studies. Since 2020, 198 impact stories have been documented that illustrate WHO’s achievements at the country level: 78 for the 2020-2021 MTR, 61 for the 2020-2021 EoB, 59 for the 2022-2023 MT. We understand that an additional 70 are currently being developed for the 2022-2023 EoB report. These narratives are presented as integral components of the mid- and end-of-biennium results
reports, as well as in ancillary publications available on the WHO website. The latest publication, "WHO Country Stories: Delivering for All," was released in October 2023. It comprises 59 unique stories that illustrate WHO's commitment to achieving the triple billion targets. Each story is mapped to a specific outcome.

Finding 16. In the current state, the utility and usage of result reporting by internal and external stakeholders essentially relates to communication and advocacy objectives rather than accountability, decision making or learning.

Result reporting can be used for the following purposes:

- Accountability;
- Decision making;
- Learning;
- Communication.

We sought to assess the extent to which result reporting was used by the Secretariat, Member States and Partners, and for which of the above possible purposes.

**Partners & Donors**

Partners and donors are primarily interested in result reporting for communication and accountability purposes.

**Partners interviewed had uneven familiarity with GPW 13 and its result framework.** GPW 13 awareness was found to be good at senior levels but somehow limited at more operational levels. GPW 13 reporting does not appear as a feature or be aligned prominently in their own M&E activities. We noted for instance that the SDG3 GAP monitoring framework does not consider the triple billion dashboard as a good source to measure the additionality that GAP seeks to monitor: "WHO tracks data through its triple billion dashboard which includes a business-as-usual projection which could be used to assess whether acceleration has occurred. Another advantage of using data from this source is that the triple billions provide a way of aggregating and weighting different health-related SDGs. The main disadvantage of this data source is that this is seen as specific to WHO and may not be accepted by other agencies. In addition, assessing progress towards the triple billion's targets might be seen as only assessing progress towards the SDGs indirectly." Also, GAP3 focuses on measuring country level improvements, which the triple billion dashboard and outcome indicators presented to date in aggregated form do not support.

**Donors mentioned they welcomed the result framework** as it signaled a move from the Secretariat towards a more result-based orientation. They appreciated the attempt to link the Secretariat's work to impact and see the result framework as a key step towards holding the Secretariat accountable. **They were however more reserved on the practical utility of result reporting to meet their needs.** Donors who practice strong earmarking of grants mentioned that the result framework does not match the way they approach their programming and plan their grant portfolios, hence they rely on specific grant level KPIs to assess performance, and plan to continue doing so in the future. This was primarily linked to the difficulty they find in using reporting that is based on cross-cutting outcomes and outputs that do not match the organisational structure. It does not in their eyes sufficiently identify the specific contributions of each level of the Organization, and in the absence of strong performance management systems in the Secretariat, they seek to be precise on who/what they fund. As for using impact level reporting (triple dashboard and outcome indicators) to support their programming or resource allocation decisions, they mentioned that the triple billion concept is a good way to communicate but voiced skepticism about the trustworthiness of triple billion and impact reporting. They mentioned that they rely on alternative sources such as the Institute of Health Metrics (IHME) and research firms.

Likewise, donors with a practice of non-earmarking, although they welcome the attempt to measure performance through the result framework, stressed that the focus is too dominated by the 3 billion which cannot be attributed
solely to WHO action and that further development is needed to ensure WHO is capturing and accounting for its contribution to global health. They found the framework complex to navigate, mentioned it was difficult to assess what progress is being made at different levels of the organisation and requested more clarity on how the framework is applied at country and regional levels. In their view strengthening WHO’s reporting on data and progress at the output level – linking this to outcomes – is needed to better assess WHO’s performance and clearly articulate its contribution.

**Secretariat & Member States**

Result reporting has been used to support all four purposes, albeit to varying degrees and with mixed success.

**Member States are primarily seeking to use the result framework to hold the Secretariat accountable** through the Programme and Budget mid-term and biennial reporting to Member States. Feedback from the Member States consultation was generally positive on the robustness of the result framework and what it seeks to achieve. Several MS did however mention the usefulness of the framework was diminished by the lack of up-to-date data, some challenges in navigating through results and most of all the difficulty to obtain relevant regional and country level views of the results.

Feedback from Member States in the online survey was overall positive on the various aspects of the result framework including robustness, adequacy, usefulness, gathering of evidence and frequency of reporting. Refer Figure 7 for details. This suggests that the result framework provides in the eyes of Member States a solid base moving forward.

![Figure 7 Member State level of satisfaction with GPW 13 Result Framework and reporting on GPW 13](image)

Q7: Based on your feedback above, overall, how would you rate your government’s overall satisfaction with how WHO has worked with your government throughout the formulation of the results framework of GPW 13, its implementation and reporting?
In terms of using result reporting for accountability purposes, there was however an overall acknowledgement in interviews and focus group discussions that given all the limitations outlined in the earlier sections, more needs to be done to really bring accountability through the result framework:

- There is no accountability for the Triple billion and Outcome indicators since (a) they are beyond the influence of the Secretariat, (b) Member States have not formally committed to pursuing these results in their country and (c) regional or country level contributions have not been defined;
- Accountability for outputs also remains a work in progress given that they cut across the organisational structure and overall responsibility for output delivery rests with Output Delivery Teams that do not have the authority and decision-making ability to realistically take on this responsibility. The fact that country level results are not rolled up into the OSC and the lack of country level result dashboard is also a limitation.

Outside of the Secretariat’s assistance, Member States do not appear to make substantial use of the result framework at country level. In the MS state consultation, the main reasons cited for not using WHO’s result data and reporting were that MS already have the data (6/18 responses), the lack of awareness that the data is available and not knowing how to access the data (6/18 responses), data not sufficiently disaggregated to meet national needs (3/18 responses) and data too old to be relevant (2/18 responses). Key informant interviews and the review of selected country level presentations showed that the level of detail of the indicators provided, which were selected and designed to allow comparability at global level, is just not detailed and relevant enough to fully inform national policy dialogue and planning beyond high level contextual analysis. This is further compounded by the data availability issues outlined earlier.

Stakeholders consider the result framework in its current state more as a communication and advocacy instrument. There is evidence that is the case, e.g.:

- Outcome indicators reporting is used to frame High level policy discussions at global level, e.g. during governing body meetings or Global reports informing strategy dialogue, e.g. the production of the UHC global report ahead of the UN global meeting on UHC in September 2023; and
- The country case studies/ impact stories are used to explain and promote the work of the Organization.

In terms of use of the result framework to support learning and decisions making, the picture is also mixed. At country level there is a difference between the metrics used for monthly and six-monthly monitoring and the GPW 13 output indicators reported for the MTR and EoB. In addition, given how output scorecard and output reporting were rolled up at global level for each output, it is not possible to obtain reliable regional or country view of results. This limits its usefulness for regional and country leadership. In the various focus group discussions, there was widespread skepticism from country leadership on the relevance and usefulness of the output scorecard to the work they do. Stakeholders at various levels were not able to describe how output reporting fed back into course correction activities. The lack of a feedback loop based on reporting was also mentioned. This weakness was also identified in a 2022 internal audit of 2020-2021 result recording.

Conversely there was important criticism of how time-consuming reporting was and the lack of attention paid to the quality of data that is reported. Overall feedback from interviews with Secretariat staff, focus group discussions with selected ODT teams, regional teams and HWCO survey consistently point to an imbalance between the time consumed by output reporting and the actual value derived by this reporting. Whilst the original intent of the OSC was to support organisational learning, participants saw the process as a compliance overhead and we did not obtain evidence that this reporting was used by ODTs to course correct or programmatic make decisions. This is consistent with findings of the 2022 evaluation of Result Based Management where just over half (56%) of respondents to a staff survey for that evaluation agreed or strongly agreed that existing institutional measurement systems and tools in WHO, for example the OSC, provide the right incentives to foster a culture of achieving results.
Finding 17. We did note however a growing and promising drive toward using outcome level indicators to support decision making and prioritisation, essentially driven out of the Division of Data Analytics and Delivery for Impact (DDI) at headquarters, in collaboration with PRP, CSS and regions.

This is exemplified by:

- **The organisation of global delivery stock takes and thematic deep dives:** the approach started with a review by Secretariat senior management in late 2020 of the Healthier Population billion, including trajectory, related challenges and call to action. This was followed by the identification of specific programmes (tobacco, obesity and climate/air quality and later road safety) for which deep dives with senior management were organised and countries that could benefit from acceleration (28 front runner countries for obesity, 6 for improved air quality and already existing ones on reducing tobacco prevalence). Leadership attention and sponsorship was obtained to engage with regional and country staff to drive this acceleration, with periodic review of progress against agreed delivery milestones. At the time of writing this report we understand 10 such global delivery stock takes have taken place to date in each of the three strategic priority areas. For Obesity an acceleration plan was defined that includes proven, consolidated and prioritised policy interventions including impact-modelling estimates, as well as 28 front runner countries which will be receiving combined technical and delivery support from WHO until 2030 with the expectation that the process of test and learn will generate evidence and expertise for scaling up the approach to other countries.

- **The organisation of country level 100-day challenge, delivery sprint, and country level delivery stock - takes:** from October 2022 to February 2023 a 100-day country challenge for piloting an end-to-end planning process was organised based on a methodology developed by UAE Government Accelerators. Nine frontrunner WCOs were nominated by their respective ROs and proceeded with a stock take of current data on GPW 13 outcome indicators, identification of priority areas for action, development of specific indicators, targets and acceleration scenarios that could be used to track progress over time, as well as clearly defined deliverables for WHO support. At the conclusion of the pilot in February 2023, all nine countries had identified one to six priority areas for accelerated action to improve positive health impact. This was followed by a delivery sprint from May to September 2023 which focused on further developing and building on the achievements of the initial 100-day challenge. Front runner countries who participated in the 100-day challenge pilot, were supported to apply “Delivery for Impact” tools and templates, with the objective of enhancing operational plans for the 2024/25 biennium to have a clear linkage to measurable results and impact.

- **Event driven dissemination of “data packs” to regional and country office:** “Triple billion data packages”, data-based presentations drawing on output indicators and global burden of disease data have been produced and delivered to more than 50 country offices since 2020, e.g. when specific Country Cooperation Strategies or biennial cooperation agreements in the Europe region are being renewed, ahead of the prioritisation stage of the 2024-25 Programme and Budget, or for operational planning. In 2021 and 2022 regional benchmarking data including outcome indicators, trends and comparisons to regional averages have been produced to help regional and country teams plan for the programme and budget and operational planning processes. These tools allow country offices to assess country-level gaps and expected progress to guide decisions on the outputs and interventions to include in operational plans or CCSSs. They also allow programme officers in Regional Offices to compare countries against regional averages and identify countries with low baseline or worsening trends so that regional support can be prioritised.

The country offices engaged in the 100-day challenge found the process of setting up health goals to be beneficial for planning, monitoring and evaluation within a defined timeframe. FGD participants that took part in 100 challenge and...
delivery sprints mentioned that these approaches have yet to be mainstreamed and articulated with institutional planning and prioritisation processes, notably country cooperation strategies, programme and budget, and resource allocation processes. The conditions for their applicability and scaling-up have also yet to be fully articulated, e.g. their applicability to protracted and acute emergency settings have not been tested, there is insufficient capacity to support a scaling-up, and government requisites to deploy such an approach should not be under-estimated. The effectiveness of these data-driven approaches is currently constrained by data quality issues mentioned earlier. They represent, however, a path towards increased strategic alignment, focus and strategic implementation at country level. They also signal the importance of the cultural shift underway.

Two of six countries selected for deep dive were involved in delivery of impact pilots.

**Bahrain**

Bahrain was among six participating countries in the 100-day challenge. The country office and MoH engaged voluntarily in the initiative. Through bimonthly spring sessions, priorities were set at the 100-Day Challenge’s outset by Bahrain. The second phase involved a “delivery Sprint”, which focused on the development of a healthy cities network. A key element consisted in a literature review and production of a theory of change. The efforts is supported by the introduction of a delivery dashboard which is actively updated by the country office and will be used an integral of planning, monitoring and evaluation processes moving forward.

Bahrain recognises the initiative’s value, enhancing technical staff capacity for effective on the ground implementation. The initiative also directed attention to strengthening the country office and enhancing its capacity. The bi-monthly sessions, particularly with the introduction of new tools and approaches, were deemed formative in shaping the initiative.

**Rwanda**

Rwanda’s strategic approach to strengthening its national statistical systems (NSDS-II 2014-18 and NSDS-III 2019-24) includes the phased integration of SDG indicators, emphasising the crucial role of key health information systems. A notable achievement by the Ministry of Health and Partners is the successful digitisation of healthcare, underscoring their commitment to robust monitoring and evaluation of health-related SDGs.

The WHO Rwanda country office embarked on a **100-day challenge** with backing from the Ministry of Health. Capacity building sessions were conducted to enhance reporting progress and results indicators and using GPW 13 dashboards. Leveraging the dashboard, 16 national priorities were identified, addressing challenges such as stagnation in health outcomes, issues in urban areas like alcohol, and concerns related to water and sanitation. While stakeholders appreciated the innovative technology highlighted with the use of dashboard, they noted that there are certain aspects of the overall structure that need to be translated at country level.
Objective 2: to identify the areas of work in which good progress was made by countries in achieving the targets and intended outcomes of GPW 13, and in which challenges were met

Conclusions
A comparison between available recent statistical information and qualitative data paints a picture where (a) much is being done by Member States and the Secretariat, (b) progress is observed in several areas, but (c) overall progress is stagnating if not being reversed and (d) Member States are off-track to meet SDGs targets. Being systematic or conclusive on MS achievements to date is however challenging in the absence of comprehensive recent data on GPW 13 indicators.

Challenges in progress towards SDGs, already present before the COVID-19, were exacerbated during the pandemic: UHC service coverage is stagnating, and financial hardship has worsened; gaps persist in emergency preparedness; there is insufficient focus on the healthier billion goal notably health prevention and promotion, which was already lagging prior to COVID-19, and climate change which is not well captured in the GPW 13 result framework.

COVID-19 effects are still present. Post-COVID recovery has been uneven between outcomes and inequitable between countries and populations. The pandemic has had lasting effects on government finances and on trust. In many ways there has not been closure on COVID-19.

Moving forward a two-pronged strategy is required:

- A short-term strategic agenda to obtain closure on COVID-19: This should consist in (a) targeted actions to offset setback on specific indicators which deterioration has potential immediate effects, such as immunisation, mental health and health workforce; and (b) bridging gaps in global preparedness notably through the finalisation of the pandemic treaty and update to IHR.
- A medium-long term agenda for global health that reflects trends affecting the post-COVID world, and where approaches to achieving the SDGs will need to be revised.

There is evidence that COVID-19’s effects on the Secretariat were mixed. On the one hand leadership of the Secretariat was manifest during the pandemic. On the other hand, progress on other strategic and operational shifts has been limited, delayed and has not resulted in tangible results to date. Much remains to be done to reap the benefits of these shifts, and institutionalise and sustain changes.

Key findings

**GPW 13 goals achievement by Member States**

18. The Service Coverage Index stagnated globally between 2019 and 2021, while sub-regional and country-level decreases were observed in some dimensions of the SCI.

19. There is emerging evidence of a worsening of financial hardship in 2020/2021 in the general population and for the poorest, and of uneven recovery. A growing number of developing countries are spending more public resources on servicing their national debt than on health.

20. Progress has been made in the aftermath of COVID-19 to improve preparedness at national, regional and global levels. However, many capacities are still not adequate, some have weakened and the political “window of opportunity” on preparedness is closing fast.

21. The COVID-19 pandemic led to setbacks in surveillance and immunisation efforts. The suspension of immunisation services and declines in immunisation rates and surveillance across the globe left millions vulnerable. Recovery has been overall strong but is uneven.
22. The rate of acute and protracted health emergencies continues unabated. Whilst systems and governance around detection and response are improving, resources are falling critically short of needs.

23. Progress has been made on a healthy environment, notably on water and sanitation, and household air quality. The scale of the pervasive impact of environmental change on health is however underestimated and not well captured in GPW 13 indicators.

24. Progress on risks factors during the period has been uneven and hard to evaluate precisely. Member States continue to make advances in the fight against tobacco. Fragile improvements have been observed in wasting and stunting. Data on alcohol and obesity is lacking but available evidence shows limited improvement or signs of deterioration.

25. Data is lacking to assess Member States progress on health determinants during GPW 13. This is an area of concern as available evidence points to a steady rise in mental health and domestic violence during the COVID-19 pandemic.

**Strategic and operational shifts by the Secretariat**

26. Leadership by the Secretariat at global, regional and country level, and across strategic priorities has been evident. The influence of WHO and the Director General has been protected if not enhanced through the pandemic.

27. Member States are more reserved on the leadership role of the Secretariat in fostering collaboration and coordination between Member States. The feedback suggests the potential for further improvements in future implementations and highlights the need to address challenges such as politicisation, financing, and disparities in commitment.

28. Whilst the Secretariat’s leadership on equity is acknowledged, some Member States challenge the balance between the equity and human rights agenda and the need to ensure WHO remains solid in its scientific and public health foundations.

29. The mantra of country focus is visible and the drive for impact is palatable. Progress has however been delayed and feedback from HWCOs and Member States is mixed.

30. A wealth of global public health goods has been delivered with increased efforts to prioritise based on needs and facilitate country adoption. Effectiveness can be further improved by more aligned and realistic prioritisation of TPs, broader involvement at various levels, and better monitoring and integration of feedback.

31. Operational shifts have been initiated but much remains to be done. The transformation of WHO is seen as an unfinished business.
KEQ 4: To what extent were GPW 13 goals achieved by Member States?

Given the factors outlined in the previous chapter it is difficult to assess with precision and through the result framework what has and what has not been achieved at the time of writing this document. It is however no surprise that on balance, GPW 13 goals, as defined under the triple billion objectives, have overall seen mixed achievements. The section summarises the situation on each billion, in quantitative terms when this is possible and qualitative terms based on primary and secondary data. Where possible and within the constraint of remaining succinct, we seek to depart from the global average by focusing on outliers (areas with comparatively better or lower achievements compared to averages) to identify root causes of successes and challenges.

Universal Health Coverage

Finding 18. The Service Coverage Index stagnated globally between 2019 and 2021, while sub-regional and country-level decreases were observed in some dimensions of the SCI.

Achievements and challenges of UHC are captured in the 2023 UHC global monitoring report jointly published by WHO and the World Bank. Whilst the report trends UHC since 2000, it does contain several data points for the 2019-2021 period which can be used as a proxy to assess progress on UHC during GPW 13.

Despite the extension of GPW 13 to 2025, the world is still far short of the goal of 1 billion additional people covered by UHC by the end of GPW 13. For 2023, 434 to 524 million additional people are estimated to be covered by UHC relative to 2018, with an expected value of 477 million. This range is forecasted to rise to 586 to 696 million people in 2025, with an expected value of 643 million.

While most countries saw improvements in health service coverage since 2000, since 2015 progress in health service coverage has stalled, and more people are facing devastating out-of-pocket (OOP) health costs. Low and lower-middle-income countries (LICs and LMICs), which had seen major UHC service coverage improvements since 2000 experienced the highest rise in catastrophic OOP health expenditures. In 2019, 1.3 billion people incurred impoverishing health spending at the relative poverty lines and 344 million people faced impoverishing OOP health spending at the extreme poverty line, i.e. almost half of the global population living in extreme poverty in 2019.

Available evidence suggests that the situation has not improved, and to some extent worsened in the early years of GPW 13.

The Service Coverage Index stagnated globally between 2019 and 2021, while sub-regional and country-level decreases were observed in some dimensions of the SCI, alongside significant acute disruptions in delivering health services not captured by the annual SCI at the global level. The disruptions occurred through a mix of demand and supply factors and the diversion of significant health system resources to COVID-19-related services. The combined macroeconomic, fiscal, and health impacts of the pandemic, and emerging evidence on rising poverty, led to the weakening of financial protection globally, with higher rates of forgone care due to financial barriers and more people incurring financial hardship due to catastrophic and impoverishing OOP health spending.

Across the 194 Member States, the SCI scores varied (see Fig. 1.5), ranging from 28 to 91 in 2021, with a global average of 68. The population-weighted regional index scores were highest in the European Region (81) and the Region of the Americas (80), followed by the Western Pacific (79), South-East Asia (62), Eastern Mediterranean (57), and African (44) Regions. While SCI sub-indexes remained relatively stable between 2019 and 2021 the NCD indicator improved in all regions, access and capacity reduced in the Africa region and RMNCH decreased in the South-East Asia and Americas regions.

In terms of inequality the Gini coefficient of the SCI indicates that between-country inequality decreased globally and across all WHO regions from 2000 through 2015 (see Fig. 1.10), but that after 2015, between-country inequality
continued to decrease in the South-East Asia and African Regions but increased in all other regions.

**Finding 19.** There is emerging evidence of a worsening of financial hardship in 2020/2021 in the general population and for the poorest, and of uneven recovery. A growing number of developing countries are spending more public resources on servicing their national debt than on health.

Data on financial hardship for the 2019-23 period is sparse. Available evidence based on estimates for countries that continued their household survey programmes despite the pandemic and evidence on financial access barriers based on phone surveys that took place in 2020–2022 indicate that catastrophic and impoverishing health spending at the extreme poverty line worsened during the pandemic, while impoverishing health spending at the relative poverty line was unaffected. Other data sources support the emerging evidence of a worsening of financial hardship in 2020/2021 in the general population and for the poorest and point to uneven recovery. Evidence from nationally representative phone surveys in LMICs indicate a low share of households forgoing needed care during the pandemic, but among those with forgone care, the prevalence of financial barriers to accessing health services is high.

**Country examples**

**Iraq**

Iraq represents a good example of progress made on UHC, even in a fragile context, when political will, internal support and resourcing are available.

Since 2019, Iraq has made commendable progress in enhancing access to essential health services. Key achievements include the expansion of primary health care delivery system, updating evidence-based guidelines for primary healthcare, strengthening of healthcare infrastructure, deployment of skilled healthcare professionals throughout the country, and bolstering health insurance schemes by expanding its coverage. These efforts have collectively contributed to improved access to quality healthcare services for the people of Iraq. Additionally, The Health Resources and Services Availability Monitoring System (HeRAMS) has played a vital role in effective resource allocation, has bridged gaps in service provision, and ensured more equitable access to quality health care. Similarly, the provision of additional diagnostic tools and vaccines for COVID-19 during the pandemic, coupled with the approval of the social security law, has been instrumental in enhancing the delivery of primary healthcare services and improving overall essential healthcare services. These initiatives are reported to have had a significant positive impact on the healthcare landscape.

Despite efforts in ensuring UHC for all its citizens, it has not adequately translated in improvement of health indicators of women and vulnerable groups. Hence, WHO can support Iraq in addressing and enhancing various social determinants of health which can positively affect health outcomes among the vulnerable population.

**Solomon Islands**

In the Solomon Islands the positive trend in child mortality rates with a modest decrease from 22.7/1,000 (2015) to 19.4/1,000 (2020) (National Health Strategic Plan 2022-2031) is outweighed with an above-average maternal mortality rate. Main challenges in connection with RMNCH are limited talent pool of professionals and limited medical resources (i.e., vaccines, medical tools, equipment). To enhance services provided in connection with RMNCH, the country engages in common projects with international donors such as the UN Joint Program om RMNCAH in Kiribati, Solomon Islands and Vanuatu 2015-2019 and Strengthening the RMNCAH Service Delivery Capacity in Guadalcanal Province, Solomon Islands 2015-2020 (joint project with KOICA).

**Tajikistan**

With the support of WHO, Tajikistan has enhanced its leadership in the health industry by preparing the National Health Strategy 2030 (2021-2030), which focuses on increasing health financing to raise well-being and health of the
population. The priorities set within the program are directly aligned with the triple billion goals of ensuring universal health coverage, health emergencies protection, and better health and well-being. Among other goals, the strategy sets objectives in health financing with an emphasis on improving mobilisation of resources, promoting equity in allocation of resources, and improving public purchasing of healthcare services. Such initiatives as Basic Benefit Package and health support of refugees allowed the country to advance in achieving the goal of universal health coverage and health equity. WHO has consulted Tajikistan in drafting multisectoral strategies to ensure cooperation between industries towards improving well-being of population (e.g., National Action Plan to Tackle Antimicrobial Resistance that involves the joint work of health, animal health and agricultural institutions of the country).

**Health Emergencies**

Finding 20. Progress has been made in the aftermath of COVID-19 to improve preparedness at national, regional and global levels. However, many capacities are still not adequate, some have weakened and the political “window of opportunity” on preparedness is closing fast.

The COVID-19 pandemic provided a clearer picture of the most critical points of system failure and what to do about them. The 2023 Report on the State of the World’s Preparedness by the Global Preparedness Monitoring Board (GPMB) provides the most current and comprehensive overview of the state of preparedness. The graphic next page, based on the GPMB monitoring framework, summarises the state of play as of 2023.

Sixteen out of thirty indicators have improved in the 2023 update, showing that some progress has been made in the aftermath of COVID-19.

Indicators for global information platforms, community engagement, and international regulatory instruments, independent monitoring and regional laboratory capacity show that good/partial capacities are in place.

However, none of the capacities assessed in the report are considered adequate, and many remain insufficient or poor. The GPMB’s analysis finds that the weakest and deteriorating areas of PPPR relate to:

- Global common good financing;
- Global management of misinformation and disinformation, with currently no global mechanism to effectively address health-related misinformation and disinformation.

Other weak and deteriorating capacities include:

- Financing effectiveness of preparedness funding and financing of WHO and other institutions;
- Inclusion of low- and middle-income countries and involvement of relevant actors in multisectoral coordination;
- Weaknesses in global coordination of pandemic-related R&D and limited national and regional R&D capacities leave countries dependent on a global system that cannot ensure innovation is focused where it matters and delivered equitably.

Community engagement capacities, whilst more mature, are also seen as eroding.
Figure 8 State of play as of 2023 based on the GPMB monitoring framework

Overall important investments and progress made during COVID-19 are being lost in these areas. A WHO country representative mentioned in our interviews how the case management of the country that had been digitised during the COVID-19 pandemic has now returned to paper based.

Many national governments, international organisations, civil society, private sector and research actors have developed tools, programmes and initiatives directed towards better and more sustainable PPPR. While there are signs of improvement in some aspects of global preparedness, and significant global and regional initiatives are under development to enhance collective action, the world lacks a commonly agreed framework for PPPR that is comprehensive in scope, based on shared goals and targets, and able to facilitate planning, implementation, monitoring, and resource mobilisation. The focus for strengthening PPPR is now on the negotiation of a convention, agreement or other international instrument, under the WHO constitution. The Intergovernmental Negotiating Body (INB) established for this purpose by the special session of the World Health Assembly in December 2021 will present its outcomes to the World Health Assembly in May 2024. However, progress has been slow and at the time of writing this report differences remain in several key areas of the proposed Pandemic Agreement. While independent
monitoring has been assessed as having a degree of capacity in place, the GPMB report stresses that monitoring and accountability has been insufficiently resourced and institutionalised and that there is a need for independent monitoring to complement self-assessment and peer review, at all levels, nationally, regionally and globally. The GPMB is also concerned with the lack of inclusion of independent monitoring in key international instruments including the Political Declaration from the United Nations General Assembly High-Level Meeting on Pandemic Prevention, Preparedness and Response, the draft WHO Pandemic Agreement, and in the proposed amendments to the IHR (2005).

The emergency footing that countries were on at the height of the COVID-19 pandemic has abated, countries have integrated responses into routine public health efforts and COVID-19 ceased to be a Public Health Emergency of International Concern (PHEIC) in May 2023. The GPMB report notes that this has led countries to become complacent, despite risk of a new surge or of the emergence of viral variants that can evade the protections of vaccines and natural immunity.

The above findings are consistent with the evolution of IHR capacities between 2018, before GPW 13 started, and the latest available data from 2022. Improvements have taken place on most capacities with an average global score across capacities moving from 61 in 2018 to 66 in 2022. The strongest capacities relate to surveillance (83% in 2022, + 11 points between 2018 and 2022), health service provision (74, + 14 pt since 2018), laboratory (74%, + 4 point since 2018), and Health emergency management (72%, + 13points since 2018). Progress is not necessarily continuous: HR capacity increased in 2020 but since then has weakened and in 2022 was at 60%, 3 points lower than in 2018, and Policy, Legal and normative Instruments to implement IHR are 6 points down from 2018.

Also, most capacities are below 70% and significant regional differences remain. In 2022 the overall IHR score for the Africa region was 52% vs 75% and 72% for the Europe and Western Pacific regions respectively.
WHO and UNICEF produce yearly estimates of national immunisation coverage of 13 diseases given through regular health systems. The data for 2022 was released in July 2023. With 183 out of 195 reports from Member States collected, the data can be considered as robust.

The COVID-19 and the strain it put on health systems in 2020 and 2021 had a dramatic impact on immunisation of children. 25 million children missed out on basic vaccines through routine immunisation services in 2021. This included 18 million that missed out on any vaccination, was 6 million more than before the start of the pandemic in 2019 and was the highest number since 2006.

“DTP3” – or coverage with a third dose of the basic diphtheria-tetanus-pertussis vaccine – is often used as a proxy for the overall performance of a country’s health system in consistently reaching children with immunisation. Almost all zero-dose children – those never vaccinated with even a first dose of DTP-containing vaccine – live in low- and middle-income countries, especially in the Africa and South-East Asia regions. The South-East Asia region was most affected by the COVID-19 pandemic and related disruptions in DTP vaccines with a drop of 9 percentage points over two years, whilst the Western Pacific, Americas and Africa regions all experienced 4 percentage points, Eastern Mediterranean region 3 percentage points and Europe region limited the impact to 1 percentage point.

Coverage of a first dose of a vaccine protecting against measles (MCV-1) dropped to 81% in 2021, the lowest level since 2008, leaving 7 million children vulnerable whilst a further 14.7 million children received only the first of two required doses.

192 Member States introduced Covid-19 vaccines in 2020 and 2021 but 17 vaccine introductions were reported in 2020 and 26 in 2021.

Countries have since stepped up their efforts to recover this historical lost ground. Global immunisation services reached 4 million more children in 2022 compared to 2021. The average coverage of the full set of essential WHO recommended vaccines against 11 key diseases – polio, measles, rubella, diphtheria, tetanus, pertussis, hepatitis B, haemophilus influenzae type B ( Hib), pneumococcus, rotavirus and HPV – has increased by 5 percentage points to 56%. Among the 57 lower-income countries DTP3 coverage increased to 81 per cent in 2022 - a considerable increase from 78% in 2021. 46% are at or above 2019 levels, with 54% yet to return to pre-pandemic coverage levels. Countries immunised roughly the same number of children in 2022 (61.1 million) as in 2019 (61.6 million). The number of zero-dose children who receive no basic vaccines also dropped by 2 million in these countries. 47 new vaccine introductions (other than COVID) were done in 2022. The number of cases of wild Poliovirus (WPV) essentially located in Afghanistan and Pakistan, fluctuated from 33 cases in 2018 to 178 in 2019, 148 in 2020, an all-time low of 6 in 2021, 30 in 2022 and 10 as of 2 November in 2023.

The recovery is, however, uneven. The 2022 increase in DTP3 coverage in Gavi-implementing countries is concentrated in lower-middle income countries, with low-income countries not yet increasing coverage – indicating the work remaining to help the most vulnerable health systems rebuild. Although half of the top 10 lower-income countries showing the greatest increases in DTP3 coverage in 2022 are in Africa, the Region is still 6 percent below 2019 levels. Fragile and conflict afflicted countries showed recovery, with DTP3 coverage rising 2 percentage points in 2022, and nearing pre-pandemic levels. But 4 of the 6 countries with the lowest DTP3 rates in the world also fall into this category – Central African Republic, Papua New Guinea, Somalia, and the Syrian Arab Republic.

Also, vaccination against measles - one of the most infectious pathogens - has not recovered as well as other vaccines, putting an additional 35.2 million children at risk of measles infection. First dose measles coverage increased to 83 per cent in 2012 from 81 per cent in 2021 but remained lower than the 86 per cent achieved in 2019. As a result, in 2022
21.9 million children missed the routine measles vaccination in their first year of life - 2.7 million more than in 2019 - while an additional 13.3 million did not receive their second dose, placing children in under-vaccinated communities at risk of outbreaks. While recovery seems well under way in the South-East Asia, Western Pacific, and Eastern Mediterranean regions, the Africa and Europe regions continue to lose momentum as far as Measles Containing Vaccine coverage is concerned. Despite the recovery in global coverage, many countries have still not attained pre-pandemic levels, and many countries have worsened in every Region. The WHO European Region is experiencing an alarming rise in measles cases. Over 30,000 measles cases were reported by 40 of the Region’s 53 Member States between January and October 2023.

**Finding 22.** The rate of acute and protracted health emergencies continues unabated. Whilst systems and governance around detection and response are improving, resources are falling critically short of needs.

**Overall, between the years 2019 and 2023, WHO had to deal with 120 distinct health emergencies, out of which 24 reached Grade 3/Protracted 3, 72 reached Grade 2/Protracted 2 and 24 reached Grade 1/Protracted 1 statuses.**

The table below shows the evolution of graded emergencies since 2017. As of 30 November 2023, 43 emergencies were underway, including seven grade 3 and seven protracted level 3.

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<tr>
<th>Grade</th>
<th>2017</th>
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<td>2022-G013 Greater Horn of Africa Drought and Food Insecurity</td>
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<td>Protracted 2</td>
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<td>2013-G001 Syrian Arab Republic Complex Emergencies</td>
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<td>2014-G001 South Sudan Humanitarian Crisis</td>
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<td>2020-G001 COVID-19</td>
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**Table 4:** Progression of emergencies by grade per year (2017-2023). Emergencies shown refer to Grade 3 and Protracted 3 active in 2023.

**Note:** total number of emergencies for 2023 is 49, however by the 30th of November 2023, 6 have been resolved leaving 43 active ones.

The August 2023 update on the response to major ongoing health emergencies from the Standing Committee on Health Emergency Prevention, Preparedness and Response (SHEPPR) mentions that overarching trend is a steep increase in humanitarian health needs on a global scale, driven by intensifying, overlapping and interacting aggravating factors, including accelerating climate change, increased conflict and insecurity, increasing food insecurity, weakened health systems in the wake of the COVID-19 pandemic, and new infectious disease outbreaks. All WHO regions are affected by health emergencies, with the WHO African Region accounting for the highest number of
current health emergencies. The report stressed that the situation puts an important strain on the WHE programme and its finances. As of August 2023, the base segment of the WHO Health Emergencies Programme budget had a funding gap of 40% – double the WHO-wide funding gap of 20% for the biennium 2022-2023 – and the emergency operations and appeals segment had a funding gap of 25%.

The issue is not restricted to WHO. In the global preparedness report, the GPMB mentions that the creation of a Pandemic Fund has been a welcome addition, but its available funding is far short of the US $10 billion originally proposed for such a fund. The total value of country proposals for funding exceeded by 23 times the amount allocated in the Fund’s first round of grants in May 2023. Other global mechanisms to finance preparedness and pandemic countermeasures, such as the Coalition for Epidemic Preparedness Innovations (CEPI) and the Global Alliance for Vaccines and Immunisation (GAVI), have also struggled to meet their recent replenishment goals. Also, countries increasingly struggle to make investments in PPPR due to shrinking budgetary spaces. In 2019-21 45 developing countries spent more public resources on servicing their national debt than on health, up from 36 in 2010-12 (UN Global Crisis Response Group calculations based on IMF World Economic Outlook April 2023, IMF Investment and capital stock database and World Bank World Development Indicators database).

<table>
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<tr>
<th>Benefits of Integrated Approach to UHC and Health Emergencies</th>
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<tr>
<td>To achieve Universal Health Coverage (UHC) and enhance health system resilience, it is crucial to expand and maintain fiscal space for health. This involves establishing resilient health financing structures capable of responding to future health emergencies, as underscored by the lessons learned from the COVID-19 pandemic. To address this, countries should commit to UHC financing mechanisms that enable swift mobilisation of fiscal resources, ensuring effective response and recovery during health crises.</td>
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<td>A resilient health financing strategy for UHC incorporates key elements such as prioritising marginalised communities, emphasising resilience and public revenues to minimise out-of-pocket expenses, and ensuring ample, adaptable public financing. Successful UHC implementation enhances sustainability and equity in health service delivery and financing models.</td>
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This approach proves vital in health emergencies, guaranteeing that everyone, particularly vulnerable populations, receives adequate healthcare. For example, during the pandemic, India was able to draw funds from the State Disaster Response Fund, state contingency funds and through the Post Devolution Revenue Deficit Grant to augment the COVID-19 emergency response package. This was only possible with resilient health financing which gives space for emergency situations. Further, the country’s national health insurance policy covered under ‘Ayushman Bharat’ aims to protect the people through covering not only non-communicable diseases but also communicable diseases such as TB which are often spread during epidemics.

Sudan serves as a compelling case of effective health emergency management and fragility when collaborative efforts are employed. Despite enduring long-running conflict and facing infrastructure gaps, including limited access to clean water and sanitation, Sudan grapples with recurrent large-scale diseases outbreaks. Collaborating with WHO, the country engages in cross-border discussions to enhance preparedness and response planning, aiming to bolster public health security in the sub-region. However, Sudan encounters challenges in health financing, particularly with overreliance on out-of-pocket payments, hindering access for the poor despite recent efforts to provide free and subsidised care for vulnerable populations. Moreover, skewed spending toward curative services instead of prioritising primary healthcare complicates rapid fund mobilisation during emergencies.
**Healthier Populations**

The healthier population triple billion covers a wide range of health issues grouped under three GPW 13 outcomes:

- **Healthy environments** to promote health and sustainable societies: this regroups notably objectives relating to air pollution and water and sanitation (WASH);
- Supportive and empowering societies through addressing **health risk factors**: this regroups notably objectives relating to tobacco, alcohol and nutrition;
- Safe and equitable societies through addressing **health determinants**: this regroups objectives relating to road traffic injuries, domestic violence and mental health.

The delineation of work and allocation of indicators between these outcomes has varied during the GPW period and indicators do not reflect the breadth of activities and programmes falling under this strategic priority. Also, this strategic priority is lacking up to date data which makes it difficult to assess Member States progress during GPW 13 and the effect of the COVID pandemic in a systematic way.

**Figure 10 Allocation of indicators between outcomes**

Overall, the understanding is that the world is on track to reach the billion targets for Healthier Population but that the rate of progress is only a third of what it should be for related SDGs targets to be achieved.
Finding 23. Progress has been made on a healthy environment, notably on water and sanitation and household air quality. The scale of the pervasive impact of environmental change on health is however underestimated and not well captured in GPW 13 indicators.

Member States have achieved major progress on WASH and WASH has been a key contributor to improvements to the healthier population billion. The 2030 Agenda for Sustainable Development called for “ensuring availability and sustainable management of water and sanitation for all” under SDG6 and established ambitious new indicators for WASH services under targets 6.1 and 6.2. A joint monitoring report on household drinking water, sanitation and hygiene was released by WHO and UNICEF in July 2023. Progress observed since 2000 on access to safely managed water has continued during GPW 13: the number of people lacking at least basic level of safe water decreased from 844 to 588 million people between 2018 and 2022. Southeast Asia and Western Pacific saw the steepest progress in access to safely managed water (increase of 6.9 and 5.9 percentage points respectively) with more moderate progress in Africa (+1.1%). The number of people lacking basic sanitation services has decreased from 2.3 billion in 2018 to 1.5 billion in 2022 with important progress in the Southeast Asia and Africa regions (improvement of 2.8 and 1% percentage point in the population covered). A slight decrease was observed in the regions of the Americas and Europe (-0.9%). Opportunities for further progress are still sizeable: 2.2 billion people still lack adequate access to safely managed water; 3.5 billion people are without basic sanitation services. Likewise, since 2015, 250 million people in rural areas have gained access to basic hygiene service, but 2 billion people still lack these services in 2022. 3.5 million people still die each year due to inadequate water supply, sanitation, and hygiene. Rates of progress would need to double for the world to achieve universal coverage with basic drinking water services by 2030 and there needs to be a 6-fold progression increase to achieve universal safely managed services.

Over 2 billion people live in water-stressed countries, which is expected to be exacerbated in some regions as result of climate change and population growth. Options for water sources will continue to evolve, with an increasing reliance on groundwater and alternative sources, including wastewater.

Air quality is one of the greatest environmental risks to health, both in itself and due to its link with climate change. Air pollution is the second highest risk factor for noncommunicable diseases and 99% of the world’s population live in places where air pollution levels exceed WHO guideline limits. Ambient (outdoor) air pollution was estimated to have caused 4.2 million premature deaths worldwide in 2019. Member States achievement during GPW 13 are difficult to assess in the absence of recent consolidated data on exposure to fine particulate matter (PM2.5). Available data for OECD and Europe shows that despite some progress, exposure to fine particulate matter (PM2.5) remains high. Mean
population exposure to PM2.5 across the OECD has generally decreased, however in 2020 exposure remained above the WHO guideline of 5 µg/m³ in most members. Similarly, data available for Europe shows that fine particular matter emissions decreased from 1,443 micrograms per cubic meter to 1276 in 2020 – one the rare positive effects of COVID – and 1304 in 2021, i.e. a reduction of 9.6%. Between 2005 and 2021, the number of deaths in the EU attributed to PM2.5 fell by 41%. Yet in 2021 293,000 deaths were attributable to exposure to PM2.5 concentrations above WHO’s guideline level of 5 µg/m³. We were not in a position to assess recent trends in other regions. Analysis of enabling legislation on Ambient Air Quality Standards (AAQS) by UNEP in 2021 shows that AAQS in most national laws do not comply with the WHO air quality guidelines, and that overall, the global picture of national air quality laws is one of heterogeneity. Household air pollution generated from the use of polluting cooking fuels and technologies is a major source of disease and environmental degradation in low- and middle-income countries, and disproportionately affects women. The most recent data on household air pollution dates from 2021. It is estimated that approximately 71% of the global population were primarily using clean fuels and technologies for cooking in 2021, up from one half (49% [UI 45 to 53]) in 2000. In all WHO regions, urban populations have systematically had greater access to clean fuels and technologies for cooking in the past two decades. The biggest improvement was in the South-East Asia Region, which experienced a seven-fold increase in coverage in its rural areas and a doubling in its urban areas. Coverage in the rural areas of the Western Pacific Region more than doubled between 2000 and 2021. Coverage has remained lowest in the African Region: only 6.8% of its rural population and 40.5% of its urban population could rely primarily on clean fuels and technologies for cooking in 2021. Large discrepancies exist in access to cleaner cooking alternatives between urban and rural areas: in 2020, only 14% of people in urban areas relied on polluting fuels and technologies, compared with 52% of the global rural population.

The above indicators, although showing welcome improvements, do not adequately reflect the scale of the health challenges caused by environmental degradation and climate change. Available evidence, e.g. that presented in the 2023 Lancet report on the mounting effects of climate change on health, shows the pervasive effect of climate change on health including, but not restricted to:

- **Increased exposure to heat** that disproportionately affects vulnerable populations (infants and adults over 65), reduces physical activity and labour capacity, and is projected to dramatically increase annual health mortality of people older than 65 (85% increase in heat related mortality in 2013-22 compared to 1991-2000, +370% forecasted in 2041-60 compared to 1995-2014);
- **Increased exposure to extreme weather events**, including drought, floods and wildfires, with impact on communicable diseases (28% increase in dengue transmission potential between 1951-60 and 2013-22), food security and undernutrition (127M more people in 2021 experiencing moderate of severe food insecurity compared to 1981-2010 and mental health.

In light of the above health adaptation efforts implemented by Member States are showing some results as showed by improvements in preparedness and climate risk assessments, a decrease in the lethality of storms in high and very high HDI and a 37% decrease in Aedes borne disease between 1990 and 2021. But overall efforts are still not commensurate to the risk, notably funding for adaptation continue to be insufficient (205M of Green Climate Fund is dedicated to project with potential health benefits) and few countries have developed or up to date national adaptation plans for health (4 out of 64 countries making COP 26 commitments). This leaves Member States exposed. Malaria offers a good case in point. Hopes were high linked to the Malaria-free certification of Azerbaijan, Tajikistan and Belize, a 13% drop in child deaths in areas where the first Malaria vaccine has been administered, and the validation in 2022 of a second vaccine. However overall cases have increased from 233M in 2019 to 249M in 2022, and Malaria deaths from 576,000 to 608,000, partly as a result of favourable conditions for mosquitoes created by rising temperatures and disruptions linked to extreme flooding in countries such as Nigeria and Pakistan.
Member States efforts on climate change mitigations are overall lagging, including in the health sector which is responsible for 4.6% of global greenhouse emissions and an estimated 4M of disability adjusted life years (DALYs) annually are lost due to ozone emissions from the healthcare sector.

Finding 24. Progress on risks factors during the period has been uneven and hard to evaluate precisely. Member States continue to make advances in the fight against tobacco. Fragile improvements have been observed in wasting and stunting. Data on alcohol and obesity is lacking but available evidence shows limited improvement or signs of deterioration.

Tobacco is one of the world’s largest preventable causes of premature death, accounting for more than 8 million deaths and costing the global economy US$ 1.4 trillion each year. GPW 13 includes a target for reducing the global prevalence of tobacco use (smoked and smokeless tobacco) by 30% by the year 2025 relative to 2010. The global prevalence of smoking has reduced in just the past 12 years from 22.8% in 2007 to 17% in 2019. Data on tobacco prevalence is available for 2020. Many countries continue to make progress in the fight against tobacco, but efforts must be accelerated to protect people from the harms of tobacco and second-hand smoke. The WHO Framework Convention on Tobacco Control (WHO FCTC) was introduced in 2003 and its implementation in the country is supported by MPOWER, a technical package. The WHO report on the global tobacco epidemic released in July 2023 highlights that the number of countries that have adopted at least one MPOWER measure at the highest level of achievement has grown from 140 in 2018 to 151 in 2022. 5.6 billion people, i.e 71% of the world population, are now protected by at least one MPOWER measure, i.e. 300M more than in 2018. Over one quarter of the world’s population is now covered by comprehensive smoke-free laws. 121 countries have adopted measures addressing electronic nicotine delivery systems (ENDS) through ban the sale of ENDS (34 countries) by fully or partially adopting one or more measures to regulate them (87 countries). Whilst significant progress has been achieved and continues despite the effects of COVID-19, with 44 countries still unprotected by any of the MPOWER measures, there is an urgent need to accelerate efforts.

Member States progress on reducing the harmful use of alcohol during GPW 13 is hard to ascertain due to complex specific data collection and review processes. With development and ratification of the Framework Convention on Tobacco Control, alcohol remains the only psychoactive and dependence-producing substance with significant global impact on population health that is not controlled at the international level by legally-binding regulatory frameworks. The last available Global status report on alcohol and health dates from 2018, with a new report expected to be released in December 2023 with data up to 2020 and in some cases 2021. In 2018 total alcohol per capita consumption in the world was forecasted to amount to 6.6 litres in 2020 and 7.0 litres in 2025 unless projected increasing trends in alcohol consumption in the Region of Americas and the South-East Asia and Western Pacific Regions were stopped and reversed. The most recent available evidence suggests that the total alcohol per capita consumption has decreased by 5-10% during the COVID-19 pandemic. This unattended positive effect of the pandemic is not expected to last, with alcohol consumption forecasted globally to grow back to pre-COVID levels or slightly lower levels by 2025, with some important variations in regions and countries.

Progress on obesity and overweight is similarly hard to determine due to lack of recent data for the adult population. Based on 2023 State of Food Security and Nutrition in the World Report the number of people able to afford a healthy diet has slightly improved between 2020 and 2021, with 42.2% of the world population not being able to afford a healthy diet in 2021 compared to 43.3% in 2020. However, this progress is fragile, with food prices that continue to climb (3.51 PPP dollars per person per day in 2020 to 3.66 in 2021), pushing the average cost of a healthy diet globally and increasing the intake of energy dense foods that are high in fat and sugars. All in all, 37M children (5.5%) under the age of 5 were overweight in 2022, a number that is stable compared to 2012 and 2020 but an increase of 4 million compared to 2000. Variations between countries are notable, with the highest rate of increase in Melanesia and Australia New Zealand. No recent data is available on adults. Even fewer countries are expected to achieve the 2030
target of 3 per cent prevalence for overweight, with just 1 in 6 countries currently ‘on track’. Gaps in the available data in some regions make it challenging to accurately assess progress towards global targets.

Member States progress on physical activity is mixed. The 2022 Global Status Report on Physical Activity from 2022 mentions an increase in countries reporting national guidelines on physical activity, rising from 40% in 2019 to 46% in 2021. 86% of the Member States report having a national NCD policy that includes physical activity and 47% a standalone national policy. However, improvements are still possible: only 67% and 38% report these policies as operational, a decrease from 72% and 39% in 2019, respectively. 28% of Member States remain unprotected by any operational national NCD policy or standalone policy (up from 21% since 2019).

The steady decline in stunting observed over the last decade has continued during GPW 13, with 148.1 million, or 22.3 per cent of children under age 5 worldwide affected in 2022, compared to 169 million (24.5%) in 2015. Nearly all children affected lived in Asia (52% of the global share) and Africa (43% of the global share). All regions have seen a decrease except for countries in the Pacific and Melanesia. The biggest decline was observed in the South-East Asia region from 36.1% in 2015 to 31.8 in 2022 and 30.1% in 2022, followed by the Africa and Eastern Mediterranean regions. Progress on wasting has also continued, albeit at a smaller pace. In 2022, an estimated 45 million children under 5 (6.8 per cent) were affected by wasting, of which 13.6 million (2.1 per cent) were suffering from severe wasting. More than three quarters of all children with severe wasting live in Asia and another 22 per cent live in Africa. Despite this commendable progress the Joint Child Malnutrition Estimates (JME) released in 2023 stresses that insufficient progress to reach the 2025 World Health Assembly (WHA) global nutrition targets and SDG target 2.2. Only about one third of all countries are ‘on track’ to halve the number of children affected by stunting by 2030, and assessment of progress to date is not being possible for about one quarter of countries.

Finding 25. Data is lacking to assess Member States progress on health determinants during GPW 13. This is an area of concern as available evidence points to a steady rise in mental health and domestic violence during the COVID-19 pandemic.

In 2021 road traffic injury was the leading cause of death for children and young people aged 5–29 years and the 12th leading cause of death when all ages are considered. GPW 13 included a target to halve the number of deaths and injuries from road traffic accidents by 2020 compared to 2010, consistent with the target set by the Decade of Action for Road safety 2011–2020 and embedded in SDG target 3.6.1. At the end of 2021, only 10 countries from four different regions had achieved this target while reductions of 30–49% were observed in 35 additional countries. The target was reset to 2030 with the adoption in 2020 at the UN General Assembly of resolution A/74/299 on Improving Global Road safety, including a) provisions for the establishment of a Second Decade of Action for Road Safety 2021-2030 and b) a goal to reduce road deaths and injuries by 50 per cent by 2030 compared to 2021. Against this backdrop Member States have achieved moderate progress during the GPW 13 period. As of 2022, 140 countries have legislation meeting WHO best practice for at least one of the five key risk factors, but only six countries have legislation on all five that meet WHO best practice criteria. Since the Global status report on road safety 2018, 23 countries have modified their laws to align with WHO best practice in at least one of five key risk factors: 8 (total of 54 countries meeting best practice) for speed, 3 (total of 48) for drink driving, 11 (total of 116) for seat-belt, 5 (total of 54) for helmet and 4 (total of 37) for child restraints systems. Producing a global morbidity figure for road traffic crashes is challenging, with important discrepancies between road fatalities reported by Member State, and changes in statistical methods over time. There were an estimated 1.19 million road traffic deaths in 2021 vs 1.21 million in 2016, the previously available year. This corresponds to a rate of 15 road traffic deaths per 100 000 population vs 17 in 2018. COVID-19 had a positive effect on road safety, e.g. with a 16-18% drop in the number of road deaths in 2020 compared to the 2017–19 baseline in the European Region, as a consequence of rapid government COVID-19 restrictions. The potential for further progress remains substantial. Nearly 80% of the roads assessed do not meet a minimum 3-star rating for pedestrian safety and just 0.2% of the roads assessed have cycle lanes. Of particular concern, many new roads being built in low-
and middle-income countries fail to meet recognised safety standards. Important inequity persists, with 92% of deaths occurring in low- and middle-income countries. The risk of death is three times higher in low-income countries than high-income countries despite these countries having less than 1% of all motor vehicles. Road traffic deaths also disproportionately impact men, with an overall female-to-male fatality ratio of 1 to 3.

The collection of regular, systematic data from a wide range of countries on the prevalence of violence against women and violence against children is challenging, notably given the stigma around the topic, many different forms of violence and a lack of agreed-upon definitions for the different forms. Globally about 1 in 3 (30%) women worldwide have been subjected to either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime, most of this violence being intimate partner violence. In 2019 an estimated one out of two children aged 2–17 years suffer some form of violence each year and close to 300 million children aged 2–4 years regularly experience violent discipline by their caregivers. Intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women were last published in 2018. The Global status report on preventing violence against children (VAC) was last published in 2020 based on data collected from mid-2018 to mid-2019, ie before or at the beginning of the GPW 13 period. Different nationally representative surveys, covering different forms of violence exist but these are generally sporadic. The Violence against Children and Youth Survey is a comprehensive survey covering all forms of violence but has so far been conducted in only 23 countries. We could therefore not assess Member States’ progress during GPW 13. Plans exist to implement more systematic approaches to produce national, regional, and global estimates for past year and lifetime physical, sexual, and emotional violence. We could therefore not assess Member States’ progress during GPW 13.

Available evidence shows that children living in rural areas, those whose mothers have no education and those living in households in the poorest quintile are less likely to be children developmentally on track. There is however currently no global indicator for tracking early childhood development (ECD) and assess the evolution of ECD in Member States during the GPW 13 period. Data for child development 24 to 59 months is essentially based on UNICEF’s Early Childhood Development Index 2030 - ECDI2030 and recent updates are available for 12 countries only. Initiatives are underway to bridge this gap in data, e.g. the Global Scales for Early Development (GSED) which was launched by WHO in February 2023 to measure ECD under 36 months for population level and programmatic evaluation, or work by the Child Health Accountability Tracking (CHAT) Technical Advisory Group which is preparing recommendations for a set of validated indicators for responsive caregiving, early learning and safety and security.

Mental health trends globally have been significantly influenced by both pre-existing factors and the impact of the COVID-19 pandemic. Prior to the pandemic, there was an ongoing increase in mental health conditions. In 2019, it was estimated that 970 million people worldwide were living with a mental disorder, with a steady prevalence rate of about 13% due to population growth. 82% of these individuals were in low- and middle-income countries (LMICs). Anxiety and depressive disorders were particularly prevalent, affecting 301 million and 280 million people respectively. The COVID-19 pandemic substantially exacerbated these mental health issues. The pandemic’s stressors, including health concerns, social restrictions, economic instability, and misinformation, led to a significant rise in mental health problems. A global burden of disease analysis reported a 25-27% increase in depression and anxiety cases in the first year of the pandemic alone. This effect was more pronounced in certain demographics, with younger people, women, and individuals with pre-existing mental health conditions being more adversely affected. Suicide rates also varied, with an estimated 703,000 suicides globally in 2019, predominantly in LMICs. While global suicide rates had decreased by 36% since 2000, the Americas saw a 17% increase over the same period. The pandemic’s impact on suicide rates has been mixed, with some studies indicating increases and others showing stable or declining rates. Efforts to mitigate these mental health impacts have been diverse. Many countries incorporated mental health and psychosocial support (MHPSS) into their national COVID-19 response plans. Digital interventions, relaxation training, and guided crisis interventions were some measures adopted, especially for healthcare workers and COVID-19 patients. However, by the end of 2021, over a third of countries still had not allocated additional funding for MHPSS.
Below is a snapshot of a few achievements made regarding work done on healthier populations from a country perspective.

**India**

India has made significant strides in access to basic sanitation, clean water and clean household fuels, thanks to interventions such as the Swachh Bharat Mission, Nal Jal Yojana and Ujjwala Yojana. This addresses the environmental determinants of health which impact health outcomes of a country.

Further, the government is actively enhancing mental health and neurological services at the primary level, addressing gaps through increased investment. This includes strengthening the capacities of the community mental health workforce, ensuring access to medications, addressing disabilities, and supporting essential elements for the treatment of mental health and substance use disorders. Implementation of the Mental Health care Act 2007 is a pivotal step in safeguarding the rights of individuals with mental health conditions.

India shows stagnating progress in health and nutrition status among its population, especially the vulnerable groups such as adolescent girls, pregnant women, nursing mothers, and young children.

Road safety continues to be a major developmental issue, a public health concern and a leading cause of death and injury. According to WHO at least one out of 10 people killed on roads across the world is from India. WHO has been supporting India in initiatives such as “Road Safety Week Campaign”.

**Solomon Islands**

Fresh water supply and sanitation are the biggest concern of the Solomon Islands where only 35% of population use at least basic sanitation services and 67% use at least basic drinking water services. Generally, the rural WASH1 sector in the Solomon Islands is characterised by challenging logistics, poor access to supply lines, limited financial resources and limited technical skills at the community level. This factor reflects on health delivery services poorly by increasing the pace of diseases spreading and slowing down speed of recovery. To address this issue, in 2014 the Ministry of Health and Medical Services of Solomon Islands has developed and implemented the Rural Water Supply, Sanitation and Hygiene policy (RWASH) focusing on developing, updating and enforcing standards for WASH infrastructure and community preparation package. Following the RWASH policy, Solomon Islands together with EU introduced a National Indicative Programme for 2014 – 2020. Currently, focus on the RWASH initiatives is introduced through the third main objective of National Health Strategic Plan for 2022-2031 (NHSP).

**Tajikistan**

To increase children’s access to treatment for severe acute malnutrition and reduce wasting, Tajikistan implemented the national Integrated Management of Acute Malnutrition Protocol. Within the country strategic plan (2023-2026) with World Food Programme Tajikistan is focusing on achieving food security and broadening access to good-quality nutrition. Together with WHO Tajikistan participates in the Childhood Obesity Surveillance Initiative (COSI).
**KEQ 5: Did the Secretariat achieve the strategic and operational shifts outlined in GPW 13?**

**Finding 26. Leadership by the Secretariat at global, regional and country level, and across strategic priorities has been evident. The influence of WHO and the Director General has been protected if not enhanced through the pandemic.**

Feedback from Member States and external stakeholders is that leadership by the Secretariat has been welcome and evident during the COVID-19 pandemic and that WHO leadership on health equity has been essential, even if not completely successful.

This is most evident at global level where:

- There was frequent mention by external and internal stakeholders of the positive impact the Director General had in raising the voice and visibility of WHO;
- The Secretariat played a leading role during and after the COVID-19 pandemic, e.g. in setting up the COVID-19 Tools (ACT) Accelerator or more recently in convening and facilitating of the Intergovernmental Negotiating Body (INB) to draft and negotiate a WHO convention, agreement or other international instruments on pandemic prevention, preparedness and response;
- WHO played a prominent role in agenda setting for intergovernmental forums such as the three High Level Meetings on UHC, health emergencies and Tuberculosis that took place at the UN General Assembly September 2023 or in the promotion of the health agenda at G20 meetings;
- The Secretariat increased and diversified partnerships and engagement with UN agencies (e.g. through setting up the Global Action Plan for Healthy Lives and Well-being for All, SDG3 GAP), civil society (e.g. through the creation of the WHO Civil Society Commission in 2023 of new partnerships organisations such as FIFA) and the private sector (e.g. through the creation of the WHO Foundation).

Leadership at regional level, although more often manifested through the country office, is also evidenced through specific regional offices initiatives or actions e.g.:

- The definition of regional frameworks, e.g. in September 2022 following close collaboration by the WHO Secretariat Member States in WHO’s European Region adopted The European Framework for Action on Alcohol 2022-2025 with established Member State focal points on alcohol and civil society organisations. Likewise in Western Pacific region the WHO regional office facilitated the definition of the Asia Pacific Health Security Action Framework, and in 2021 in the Americas region with the Action framework for developing and implementing public food procurement and service policies for a healthy diet was adopted.
- Convening, e.g. through Secretariat support to the Asia-Pacific Parliamentarian Forum on Global Health, a platform for parliamentarians, 30 countries comprising the Member States of the WHO Western Pacific Region and the Association of Southeast Asian Nations (ASEAN) to exchange ideas, build political will, strengthen capacity, and foster collaboration towards sustainable action for health. Similarly, just in November 2023, the regional office for Africa, in collaboration with the Inter-Parliamentary Union (IPU) jointly convened a African High-level Parliamentary Conference on Achieving UHC & Health Security Preparedness, whilst the regional office for Europe is hosting the Europe’s Regions for Health Network (RHN) 28th annual meeting.
- Coordinating and leading during the COVID-19 pandemic: in PAHO, a 2023 independent evaluation of PAHO response to COVID-19 found that PAHO was the only regional organisation with the mandate, institutional capacity, and technical expertise to encourage a regional response at the highest political level, and that although essential public health decisions by some Member States were not always aligned with the scientific evidence offered by PAHO, in managing the WHO MoHs adopted most PAHO recommendations. Similarly, in the Western Pacific region, the WHO regional office facilitated the Asia Pacific Health Security Framework that incorporates APSED’s achievements, approaches, and regional
experiences, particularly in responding to public health emergencies spanning in the last two decades. **Advocating for health and equity:** In pursuit of health equity, WHO is fostering collaboration between regions and countries to share best practices and innovative approaches. This includes supporting initiatives that focus on vulnerable populations, ensuring that their unique health needs are addressed comprehensively. Eg in Sudan, the National Multi Hazard Health Emergencies Preparedness and Response Plan 2022, a collaborative effort between the Ministry of Health, WHO and UNICEF, is a key component of a broader initiative to strengthen emergency preparedness and response in the region. This comprehensive strategy is designed to address a spectrum of sudden onset disasters, ranging from conflicts and floods to disaster outbreaks. The plan’s objective is to ensure health resilience at various levels and implement inclusive approaches to effectively respond to and prepare for these diverse emergencies. Similarly, in South-East Asia region, Nepal demonstrated effective leadership during COVID-19 response, engaging at the highest political level and showcasing multisectoral action for the establishment of a regional health emergency council. The involvement of parliamentarians and advocacy to the office of the Prime Minister contributed to the successful conduct of IHR, JEE in December 2022 emphasising preparedness and response to public health emergencies.

**Overall, external stakeholders interviewed mentioned that the standing of the Organization has improved throughout COVID-19.** Whilst some survey done in the immediate aftermath of COVID-19 found that public trust in WHO was decreasing, in a 2023 survey of 32’000 participants in 28 countries, the Edelman Trust Barometer found that WHO remains the most trusted multilateral organisation. Whilst trust in the United Nation has decreased in 21 out of 28 countries surveyed between 2022 and 2023, trust in WHO has increased in 15 out of those 28 and sits at 67% vs 59% for the UN and 56% for the European Union. In a world marked by a global recess in trust in institutions and given the importance trusts play in fighting dis-misinformation, this is a fragile but commendable accomplishment.

**Finding 27.** **Member States are more reserved on the leadership role of the Secretariat in fostering collaboration and coordination between Member States.** The feedback suggests the potential for further improvements in future implementations and highlights the need to address challenges such as politicisation, financing, and disparities in commitment.

Member States were asked in the online survey about the extent to which the Secretariat, through GPW 13, facilitated collaboration and coordination among Member States and other stakeholders in addressing global health issues. Respondents conveyed that while the Secretariat demonstrated commitment to fostering global health collaboration through GPW 13, the outcomes were mixed. Some acknowledged the central and political role played by the Secretariat under GPW 13. Positive collaborations were reported under GPW 13, with WHO’s leadership in global health being recognised. The collaboration and coordination among Member States were viewed as satisfactory under the circumstances, with regional offices playing a key role in adhering to and promoting common goals. Some expressed appreciation for the WHO’s partnership, emphasising the Organization’s role in facilitating frequent engagement sessions and information sharing on global health issues. The Secretariat’s efforts in organising briefings and facilitating resource exchanges were also noted.

On the other hand, some respondents mentioned the challenges stemming from competing interests of different political blocs. They mentioned that the situation during the COVID-19 pandemic elevated WHO’s status but also led to increased politicisation, necessitating a more defined voice for the Organization. The impact of GPW 13 on collaboration was perceived differently across regions and Member States. Some respondents felt that GPW 13 was not a significant driver in facilitating collaboration, especially for many developed countries. They noted that the global health architecture remained fragmented and issues such as non-sustainable financing remained. Some also called for more support at the sub-national level, and some respondents perceived a decrease in the effectiveness of facilitation.
All in all, although the Secretariat’s role in collaboration was seen as essential, it was unclear if the successes could be solely attributed to GPW 13. The feedback suggests the potential for further improvements in future implementations and highlights the need to address challenges such as politicisation, financing, and disparities in commitment.

Finding 28. Whilst the Secretariat’s leadership on equity is acknowledged, some Member States challenge the balance between the equity and human rights agenda and the need to ensure WHO remains solid in its scientific and public health foundations.

Some Member States mentioned the need for WHO to strike a balance between addressing political considerations and advancing human rights on the one hand and ensuring that its primary goal of improving public health is not compromised on the other hand. This balance is seen as crucial for WHO to effectively fulfill its mandate.

In that light some Member States respondents saw these factors are diverting the organisation's focus away from its core mission of promoting and safeguarding the health and well-being of populations around the world. They mentioned that some Member States expect WHO to prioritise the advancement of a human rights agenda to the detriment of its primary mission of improving public health. Further, they perceive that this has successfully passed to the Secretariat, which they see at times overly committed to this agenda, potentially at the expense of addressing health-related issues. Reference was made to the impact this stance has on hiring practices where a perception that candidates with "holistic visions" are given priority over those with strong medical expertise. This shift in hiring priorities can have implications for the Organization’s effectiveness. While a holistic vision or other disciplines can bring valuable perspectives and considerations to public health issues, it may also lead to a situation where professionals are chosen for their broader, interdisciplinary perspectives at the expense of their core medical skills and clinical expertise. This could hinder the WHO’s ability to provide timely and evidence-based guidance on complex medical and public health issues, throughout the various programmes of the Organization. They urge the Secretariat to ensure that most experts have deep medical knowledge and clinical experience.

The above contrasts with statements by some HWCOs in the survey who mentioned the need to ensure an equity and human rights lens is maintained if not strengthened in GPW 14.

There is an opportunity in the formulation of GPW 14 to consult and seek Member States guidance on this factor of importance in the positioning of the Organization.
Stepping up leadership: diplomacy & advocacy; gender, equality, equity, human rights; multi-sectoral action; finance

Select examples within this strategic shift are provided below:

**Sudan**

In the output scorecard, the WHO Country Office in Sudan scored highest on the leadership dimension amongst all the dimension scores. During the COVID-19 pandemic, the Country Office served as technical lead for guiding most COVID-19 intervention pillars. More broadly, WHO demonstrated leadership by playing a coordinating role, and successfully encouraged the Ministry of Health and other partners to adopt a “one plan” approach to ensure complementarity and avoid duplication of activities. The Country Office was able to position health high on the national agenda by helping to strengthen Government leadership.

Further, the country office facilitated an initiative with York University, United Kingdom, to assess gender-specific patient needs and barriers in the design of gender-responsive service delivery. There is no special programme for people with disabilities at the Ministry of Health, and WHO is advocating for an increase in their inclusion.

**India**

WHO has been able to enhance India’s global leadership in health by providing support to the country’s efforts to improve global access to, and the regulation and safety monitoring of, medicines, medical devices and diagnostics made in India; share innovations in health practices and technologies invented in India with the rest of the world; and become a leader in digital health technology. Enhancing India’s global leadership in health has also been identified as one of the strategic priority in the country cooperation strategy (CCS) jointly developed with MoHFW.

Further, the India CSS has a focus on poor and vulnerable populations and aims to significantly increase public spending on health which will reduce individual OOP expenditure.

**Solomon Islands**

With limited medical workforce and supplies allocation to health facilities, health service delivery in the Solomon Islands is suffering. To step up the country’s leadership in health, WHO supported the Ministry of Health and Medical Services of Solomon Islands in developing the National Health Strategic Plan 2022-2031 (NHSP). This Plan focuses on three strategic objectives aligned with the WHO’s triple billion goals: (i) Better governance of the health sector, (ii) Our systems and resources meet our needs and are responsibly managed, (iii) All Solomon Islanders have equitable access to fully implemented, quality health care programs. NHSP puts emphasis on improving mobilisation of resources, coordination between partners and various stakeholders, increasing staffing to support provision of sustainable financing to country’s health system, and as result ensuring smooth, cooperative and efficient provision of health services to the population.

Within NHSP focus on combatting gender-based violence, on integration of disabled people into the society, achieving universal access to specific diseases prevention services all add to approaching the objective of gender equality, health equity and human rights. Further, in this domain, with the guidelines from WHO MHMS has developed and launched the National Disability Inclusiveness Development Policy 2022-2031, Rehabilitation Strategic Plan 2022-2031 and National Mental Health Policy. Alignment of these policies with the third objective of NHSP strengthens the delivery of these health services in a sustainable way. Together the three policies allow to increase health and well-being of individuals as well as ensure inclusive participation of each individual in the development of the country.
Finding 29. The mantra of country focus is visible and the drive for impact is palatable. Progress has however been delayed and feedback from HWCOs and Member States is mixed.

GPW 13’s second strategic shift is based on two of WHO’s core functions: articulating ethical and evidence-based policy options; and providing technical support, catalysing change and building sustainable institutional capacity. GPW 13 envisaged the strengthening and tailoring of Secretariat’s work at country level to ensure relevance to context and better impact.

The two main levers relate to:

- **The strengthening of country offices.** Different instruments or mechanisms were meant to bring this country focus including fit-for-purpose models of engagement with countries, adequate staffing structure, appropriate delegation of authority, and business processes that facilitate effectiveness and efficiency at country level;
- Improved alignment and support from regions and headquarters to country offices and Member States.

**Strengthening of country offices has taken place through improved resourcing at country level.** Between the 2018-19 PB and 2022-23 the level of expenditures at country office level increased 50% from USD 3 billion to USD 4.5B. Most of this growth relates to emergencies, with expenditures doubling from OCR going from USD 1.1B to 2.2B, but expenditures under the base budget also saw an increase from USD 1.1B to 1.5B, i.e. 36%. For the 24-25 however, the situation does not look promising. The planned budget of USD 2.4B for country offices for the base segment in 2024-25, which now includes the budget for Polio eradication, represents only an 8% increase compared to the combined base and polio eradication segments in 2018-19.

Implementation rates at country level for the base segment of the budget have fallen to 77% and 67% in 2020-2021 and 2022-2023, compared to an average implementation rate at country level of 78% during GPW12. This is partially due to COVID-19 pandemic and the reconfiguring of the Secretariat has had to perform to address the pandemic.

In 2020, the guidance on Country Cooperation Strategies was updated to align with the objective of implementing the GPW 13 and driving impact in every country. The document reaffirms the centrality of Country Cooperation Strategies and the input they provide to the process of formulating key elements of WHO’s operational instruments such as the Country Support Plans (CSPs) and Joint working team for UHC and PHC.

Other than that, limited results have been achieved to date on the strengthening of country offices. This was also a conclusion of the 2021 evaluation of the WHO transformation. Most recently in 2023 the Action for Result Group (ARG), a taskforce of six HWCOs created at the initiative of the Director General, has produced an action plan to better position country offices to drive impact in every country. Working with support from the CSS and DFI division at HQ, the ARG produced a typology of country offices broadly aligned with the above-mentioned engagement models mentioned in GPW 13. The group also allocated each country office to a type.

The proposals contained in the ARG action plan are grouped under six categories and include actions such as:

- The definition of a strengthened and funded core country presence based the country typology: this typology is the basis for a conversation ongoing at the time of reporting on Core Predictable Country Presence (CPCP), i.e. the minimum sizing of country offices which should be funded with predictable, non-earmarked contributions;
- Improvement in country leadership and HR practices;
- Simplification and unification of planning instruments;
- Increased delegation of authority of HWCOs, which was validated in 2023.
Several proposals such as increasing the delegation of authority of HWCOs have already been accepted and are in the process of being implemented.

**The other lever for improved country impact relates to the alignment and support of regional offices and headquarters.** This support is driven through Output Delivery Teams (ODTs) and Technical Expert Networks (TENs) who define Country Support Plans (CSP) in alignment with country priorities. CSPs are two-year plans defined as part of the programme budget and planning that precise how, when and at which level (HQ, RO or CO) WHO support will be provided to a given country based on the priorities that have been articulated by the country in CSSs or PB prioritisation activities. As such CSPs indicate how all three levels of the Organization can contribute towards clearly defined priority outcomes and targets defined at country level. They are key instruments to promote a coherent “One WHO” approach.

The approach has also been complemented by the piloting of more data driven approaches to define country acceleration plans and identify priority countries for impact, as already described in Objective 1, finding 17.

In interviews and focus group discussions with selected Output Delivery Teams and at different levels of the Organization there was genuine appreciation for the shift underway in placing country impact at the center.

**However, feedback from Member States and HWCOs is that results appear to be mixed so far.** Respondents to the online survey about WHO Secretariat support reported diverse impacts, including improvements in national health information systems, and managing COVID-19 healthcare services and technical assistance in various domains. WHO also aided in implementing international health coding systems and developing strategies for healthy aging. Its role in global health crisis response and supporting health-related events was noted. Achievements in national health strategies, cancer control, and digital health initiatives reflected WHO’s broad influence. However, responses varied, with some noting unclear outcomes and challenges such as resource constraints. Overall, WHO’s assistance was substantial in health initiatives, but effective resource allocation and implementation remain key areas for improvement.

Moreover, only 11 out of 19 Member State respondents to the online survey strongly or somewhat agreed that WHO Secretariat has been working effectively as One WHO to help them achieve results. Others did not agree (2) or were not in a position to answer (6). Likewise, only 2 of 17 respondents strongly agreed that the Secretariat has helped improve the capacity and effectiveness of their national health system in responding to the public health challenges they face vs 7 that somewhat agreed, 7 that could not comment and 1 that did not agree.

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**Exhibit 1  Satisfaction with Secretariat effectiveness to work as One WHO**

*Member State survey Q20: The WHO Secretariat has been working effectively as One WHO to help you achieve these results. (Indicate your opinion based on extent to which you disagree or agree with the statement).*

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**Exhibit 2 Improvement of the capacity and effectiveness of national health systems with Secretariat help**
Member State survey Q21: The Secretariat has helped improve the capacity and effectiveness of your national health system in responding to the public health challenges you face. (Indicate your opinion based on extent to which you disagree or agree with the statement)

Similarly in the HWCO survey, when asked to rate their overall satisfaction with support from global and regional levels to their country office for the formulation, implementation, monitoring and reporting and course correction for GPW 13, HWCOs provided overall positive ratings, but substantial progress is still possible notably on a) implementation (capacity building, human resource, leveraging partnerships with stakeholders), b) support where only 2/3rd are somewhat or extremely satisfied, and c) monitoring (identification of KPIs, monitoring framework development) where only a slight majority of HWCO respondents are satisfied.

Exhibit 3 Overall satisfaction with WHO secretariat’s support (global and regional levels) to the country office

HWCO survey Q8: How would you rate your overall satisfaction with WHO secretariat’s support (global and regional levels) to the country office for the formulation, implementation, monitoring and reporting and course correction for GPW 13?
**Strategic Shift: Driving public health impact in every country**

This transformative shift underscores the need for innovative strategies, collaboration, and a renewed commitment to fostering health equity. In this evolving landscape, the dynamics of driving public health impact in every country demands strategic foresight, adaptive policies, and collaborative efforts to create a resilient and healthier future for all.

Following are the select examples within this strategic shift:

**Bahrain**

The Bahrain Country Office is working with the UN Country Team to facilitate access to vaccination services for migrants and other vulnerable populations. The goal is to achieve inclusivity, leaving no one behind. This involves implementing activities particularly addressing the healthcare needs of persons with disabilities, promoting essential health services for a comprehensive and equitable approach. Further, WHO is supporting the development and dissemination of guidelines and tools for preventive, diagnostic, curative, palliative and rehabilitative care for noncommunicable disease and surveillance of risk factors to address the growing burden of these diseases and guiding development of food, nutrition, and health policies and programmes in line with the food-based dietary guidelines to improve population health and well-being.

**Rwanda**

WHO Rwanda delivers on its five strategic priorities by supporting the Ministry of Health (MOH) and Rwanda Biomedical Centre (RBC) to coordinate health partners, develop and implement evidence-based policies, strategies, and guidelines, set, and monitor public health standards, build institutional capacity for public health, and monitor the health situation in the country. WHO has negotiated and agreed with the Government of Rwanda to deliver five strategic priorities which are: strengthening the health system to improve access to health services, improving access to diagnostic and treatment facilities for communicable and non-communicable diseases, supporting activities aimed at reducing maternal, new-born, child and adolescent morbidity and mortality through the improved access to immunisation and family planning services. This is formalised through the CCS which focuses on supporting the country to domesticate the Sustainable Development Goals (SDGs) and strengthen its health system towards attainment of Universal Health Coverage (UHC).

**Tajikistan**

WHO has been able to provide country-tailored advocacy to address country-specific issues (ex. TB, HIV, poliovirus, malnutrition, etc.) and empower the WHO country office in Tajikistan to increase the quality of work delivered on the ground. With the support of WHO, Tajikistan launched several strategic programs on prevention and control of infectious diseases such as TB (2018-2022), HIV (2016-2020), malaria (2019-2023), soil-transmitted helminths (2018-2022), as well as the National Action Plan to Tackle Antimicrobial Resistance in the Republic of Tajikistan (2018-2022).
Finding 30. A wealth of global public health goods has been delivered with increased efforts to prioritise based on needs and facilitate country adoption. Effectiveness can be further improved by more aligned and realistic prioritisation of TPs, broader involvement at various levels, and better monitoring and integration of feedback.

The secretariat’s work on Global Public Health Goods (GPHG) or Technical Products (TP) encompasses work on norms and standards, data and innovation. TPs are products that are applicable to multiple countries and developed through processes at global, regional and country level to drive impact. After an initial round of planning for the Global Public Health Goods for the Programme Budget 2020-2021, lessons were drawn up and a process for TPs was formalised in April 2021 in a Guide on alignment of Technical Products (TPs). The guide provides guidance on each phase of the lifecycle of TPs from selection through to development, quality assurance, implementation, measurement and monitoring for the Programme Budget 2022-2023 and onwards. It also outlines the link with planning and budget processes. The process is also supported by a tracking tool called Tulip where proposed TPs are recorded, assessed, approved and tracked.

Overall, the process and supporting Tulip tool bring more transparency to the list of TPs that are proposed to be developed during each biennium. It should also result in more focus and integration in the delivery and implementation of technical products.

Interviews with Secretariat staff outlined however 3 main challenges:

- **Prioritisation**: for 2020-2021 the list of TPs to be developed included 348 products, 186 approved for delivery in 2020-2021. For 2022-2023 the list of TPs to be developed included 862 products, including 713 approved for delivery in 2022-2023., i.e. around 1 TP for every 5 staff of the Professional (P) category. The list for 2024-2025 currently includes 828 TPs pending including 729 TPs for HQ alone. Only 28% are considered to be country facing. This raises questions about the Secretariat’s ability to ensure the production and quality assurance of so many products, and in the ability of implementing structures at country office and Member State levels to absorb so much. Feedback was that leadership of ADGs on the selection of TPs based on utility and feasibility needs to be stronger. The role of regional offices in confirming priorities also needs to be reinforced.

- **Delivery**: there is a low implementation rate for TPs. In 2020-2021 only 70% of greenlighted TPs were delivered. For 2022-2023, as of mid-August 2023, out of 713 approved TPs, only 116 (16%) had been completed, 87 (12%) had been cancelled and 343 (48%) had not started the QA process. Given the low delivery rate the capacity of the Quality Norms and Standards division at HQ to absorb this volume has not been tested, and many TPs (e.g. data products and translations) will not require QA. It is however unlikely that quality procedures and implementation would not be able to absorb such a volume of TPs to quality-assure should they eventually be submitted before the end of the biennium.

- **Implementation tracking and M&E**: a team within the QNS division is looking at implementation and monitoring. Feedback was that monitoring and evaluation of actual implementation was not consistently done across programmes and therefore the overall impact of TPs is difficult to assess in any systematic way. Some programmes notably in the communicable disease area, are used to producing implementation plans for their TPs and measuring the uptake of their products, whilst in other areas it is proving to be less consistent.

**Normative work** encompasses work on constitutional normative products, scientific and technical normative products, and health trend assessments. This is an area where the external stakeholders interviewed place a lot of reliance on WHO’s role which they see as unique and distinctive.

GPW 13 was meant to result in improved prioritisation of normative products, strengthened guiding principles and quality assurance procedures, standardised and streamlined systems and plans for monitoring and evaluation, and a
focus on documenting impact rather than just assessing the quality of normative products and their recommendations.

An independent evaluation of WHO’s normative function at country level was finalised in 2023. It confirms the observations made above on TPs. It found that WHO’s role in developing global normative products was highly valued by Member States for their global perspective and evidence base, that the selection of these products increasingly aligned with the priorities of Member States and that at the country level these products are widely used. The evaluation found however the implementation of this prioritisation process to be inconsistent, with the development of these products predominantly carried out at WHO’s headquarters, with limited involvement from regional offices and even less from country offices beyond the initial prioritisation phase. The process lacks sufficient and consistent feedback mechanisms from countries and users. Furthermore, at the country level, these products require adaptation to local contexts.

In terms of dissemination and adoption of these products at country level the evaluation highlighted a misconception that national governments will apply WHO guidance independently; in reality, a broader range of actors is needed for effective implementation. Additionally, WHO’s functions at the country level go beyond simply disseminating and adopting global normative products. There is a lack of integration of these products into overall country planning and a misalignment of resources with WHO’s ambitions in its normative role.

Finally, while there was evidence that these products contribute to health goals, the evaluation found that the systematic monitoring of the use of WHO normative products is notably absent and that there’s limited proof of their impact on health equity, gender equality, or discrimination reduction. The evaluation underscored the need for improved processes, broader involvement at various levels, and better monitoring and integration of feedback to enhance the effectiveness of WHO’s normative products.

On data, GPW 13 outlines the Secretariat role in terms of:

- Set data collection standards and provide tools and support for diverse data collection platforms that are needed by Member States;
- Support Member States in strengthening national statistical capacity at all levels to ensure good-quality, accessible, timely, reliable, and disaggregated health data, including through, where appropriate, the Health Data Collaborative;
- Support Member States to improve capacity for the systematic and transparent translation of evidence to inform policy and national decision-making;
- Promote open reporting of health data by Member States’ and the Secretariat and support Member States’ creation of transparent data warehouses for these data;
- Promote strategic disaggregation of data through collection, analysis and reporting to better inform programmes;
- Work with relevant institutions, including academic institutions and networks, non-State actors and think tanks in the collection, analysis and strategic use of health information;
- Ensure itself of the availability of data and metrics to support strategic management and agile learning for the Organization;
- Catalyse investments by donor agencies, development banks and national governments in filling critical data gaps.

Substantial momentum on data has been built by the Secretariat through the result framework, delivery for impact team and SCORE programme. New capacity has been implemented at Headquarters. These come in addition, not in replacement of the work the Secretariat has historically been doing. Member State’s interest in data has been manifest, as illustrated by the fact that output 4.1 was number 3 in the PB 2024-2025 prioritisation by Member States with 66% seeing this as a high priority. This participates in a virtuous circle where demand for data generates
improved data collection which in turn increases the demand for data. Refer findings under Objective 1 of the evaluation for our assessment of achievements and challenges relating to data.

The third area relating to Global Public Health Good relates to research and innovation. GPW 13 objectives on research and innovation were for the Secretariat to shape, scale and amplify innovation. This objective was supported by the creation of the Science Division in HQ in 2019 under WHO’s Chief Scientist. The team took a prominent role during the pandemic, notably in terms of coordinating the research agenda therapies, diagnostics, and vaccines and ensuring development and access to those is equitable. The Science Division has been instrumental in making WHO a trusted source of scientific evidence about COVID-19, its treatment and prevention, and in fighting the infodemic.

A key instrument to shape the research agenda is the R&D Blueprint. The R&D Blueprint is a global strategy and preparedness plan that allows the rapid activation of R&D activities during epidemics. It aims to fast-track the availability of effective tests, vaccines and medicines that can be used to save lives and avert large scale crisis. As part of WHO’s response to COVID-19 a R&D Blueprint for COVID was activated to accelerate diagnostics, vaccines and therapeutics for this novel coronavirus. The GPMB noted in their 2023 report on preparedness that although the global R&D Blueprint was convened in timely fashion at the beginning of the COVID-19 pandemic, it was not convened thereafter and has limited leverage in directing research priorities or investment. Much indeed remains to be done.

Data from the AdisInsight Springer Nature database that tracks various health products such as medicines, vaccines and diagnostics from discovery to market launch for all diseases shows that as of July 2023, of the 63,000 unique products in the pipeline only 3% target R&D Blueprint pathogens, and less than 0.5% of active products target a neglected tropical disease.

### Research and innovation at the heart of COVID-19 response

The development of effective COVID-19 vaccines, treatments and public health interventions has been a key area of focus for pre-qualification and research. Achievements have been tracked and reported regularly. A COVID research and innovation achievements update published in February 2022 listed achievements in the following areas:

- SARS-CoV-2 at the human-animal interface;
- Epidemiology of COVID-19 focusing on past and current trends, drivers of transmission and severity, and epidemiological research gaps;
- WHO Hub for Pandemic and Epidemic Intelligence;
- Research on public health and social measures and their impact;
- Progressing on the public health research agenda for managing infodemics;
- Vaccines: Research and development priorities;
- Outbreak research response centred around the patient;
- Research and development for treatments of hospitalised patients;
- Critical needs for outpatients and for the design of outpatient therapeutic trials;
- Global consultation on community centred approaches to health emergencies;
- Effectiveness and cost effectiveness study of IPC interventions aimed at reducing transmission of SARS-CoV-2 among HCWs;
- Regulatory science and convergence between national regulatory authorities;
- The 1st WHO International Standard for SARS-CoV-2 RNA was established by the WHO ECBS.

With 12 Vaccine products and 38 In Vitro Diagnostics (IVD) products for COVID-19 reviewed and listed in emergency use listing procedure (EUL), the WHO prequalification programme can also be listed as a key WHO contribution.
The Secretariat also defined an **Innovation Scaling Framework and four initiatives to support innovation**: a WHO internal innovation programme, an innovation space at WHO Headquarter, a global innovation capacity building programme for WHO staff, Member States and partners, and an innovation network. Given the constrained in timing of the evaluation we did not assess innovation in more detail.

Progress has also been made on digital health. These initiatives include development of digital health strategies, promotion of digital health literacy and expansion of telemedicine services. In India, WHO provided technical support for the development and implementation of a web-enabled near real-time electronic information system called the Integrated Health Information Platform which is an essential part of India's National Digital Health Plan. WHO also formulated regional strategies for each WHO region which collated the region's approach and initiatives under digital health.

Some respondents to the HWCO and Member State surveys suggested that digital initiatives in some Member States were in accelerated phase requiring the Secretariat to scale up its technical capabilities in order to provide relevant technical support requested by these Member States. The Global Strategy on Digital Health 2020-2025 and Global initiative on Digital Health (GIDH) are steps in the right direction. They provide a roadmap to link the latest development in innovations in digital health for improving health outcomes, focusing on scaling up digital health innovations by systematically linking needs of the countries with available digital health innovations. This includes development of guidelines and standards of digital health, improvement of data systems and overall digital health infrastructure in the countries.

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**Strategic Shift: Focusing global public goods on impact:** This transformative strategic shift emphasises the interconnectedness of challenges that transcend national borders. Impact on a global scale requires collaborative efforts, innovative solutions, and a shared responsibility to foster the well-being of humanity. As nations navigate complex issues ranging from health crises to environmental sustainability, this strategic shift holds a new era of international collaboration.

**Select examples within this strategic shift from the country deep dives are provided below:**

**Rwanda**

WHO played a crucial role in developing a community-based health insurance sustainability plan for 2021-2030, making it the country's largest health insurance provider and advancing universal health coverage. The country office assisted in assessing sustainability issues, modelling required resources, and implementing efficiency measures for long term viability. Aligning with WHO’s 2021-2030 roadmap, there is a commitment to foster country ownership by building expertise and capacity building in the region. Notably, WHO welcomes a $140 million investment from the BMGF to combat Neglected Tropical Diseases (NDTs) and Malaria in the Africa region.

**Sudan**

The fourth strategic shift identified for Sudan in its CCS is developing a consolidated disease surveillance and early preparedness, including early warning system and response to emergencies and humanitarian needs which includes amongst others strengthening the epidemiological surveillance system, and facilitate the incorporation of the existing different surveillance activities into a comprehensive national surveillance system and strengthen the public health laboratory network as part of the communicable diseases surveillance and control system at federal and state level.

**Solomon Islands**

The WHO office supported the National Referral Hospital (NRH) Molecular Laboratory, laboratory services in the provinces, the recruitment of personnel, the improvement and development of standard operating procedures, the establishment of an information sharing mechanism and the procurement of relevant COVID-19 testing equipment, reagents, kits, and consumables. This resulted in strengthened laboratory capacity and local capacity for diagnosis and testing of SARS CoV-2, established procedures and, eventually, COVID-19 being tested locally.
Finding 31. **Operational shifts** have been initiated but much remains to be done. The transformation of WHO is seen as an unfinished business.

GPW 13 strategic shifts for the Secretariat were meant to be enabled by five operational shifts:

- Measure impact to be accountable and manage for results;
- Reshape the operating model to drive country, regional and global impact;
- Transform partnerships, communications, and financing to resource the strategic priorities;
- Strengthen critical systems and processes to optimise organisational performance;
- Foster culture change to ensure a seamless, high performing WHO.

These shifts were meant to be achieved through a transformation initiative initiated in 2017. This initiative was evaluated in 2021. At the time the key findings were that as an ambitious and complex change management endeavor the transformation addressed both “hard wiring” (structural, process, and policy refinements) and “soft wiring” (cultural change) in a comprehensive way. The evaluation found substantial progress had been made in implementing most workstreams, but the rollout was taking longer than initially envisioned. It concluded that the transformation had led to positive changes in organisational structure, strategic planning, results focus, and more, but that fostering a motivated workforce and reducing administrative burdens had been less pronounced, and that the transformation’s impact at the country level remained limited. Challenges included resourcing country offices, increasing staff mobility, and addressing the top-heavy nature of staffing. Additionally, there was a lack of clear metrics for measuring outcome-level results, making it difficult to assess the transformation’s overall effectiveness.

Some of the main developments that have taken place since this exercise have been:

- The **COVID-19 pandemic has forced the Secretariat to reconfigure and work in more agile ways**. As part of this, procurement and HR processes were simplified, staff were redirected to work in areas of highest need and new ways of working were mainstreamed e.g. remote working. Feedback from external stakeholders was that although perfectible they perceived this shift and nimbleness of the Secretariat as a real achievement during the pandemic, and that they now expect this to become “the new normal”.
- The progressive **ramp-up and piloting of result-based approaches**, as already mentioned earlier, which foster increased impact orientation;
- As mentioned earlier, the creation in 2023 by the Director General of an Action for Result Group (ARG);
- **Further development of partnerships**, after those developed for the SDG GAP in 2019 and the launch of the WHO foundation in 2020. This includes for instance the UHC Partnership’s programme, one of WHO’s largest platforms for international cooperation on universal health coverage (UHC) and primary health care (PHC), Quadripartite Alliance on One Health created in 2022 between WHO, FAO, UNEP and WOAH. Also the first Steering Committee of WHO Civil Society Commission took place in August 2023.
- The **decision in May 2022 by the WHA to gradually increase assessed contribution to represent 50% of WHO’s core budget**. It is intended that the gradual increase to assessed contributions will start with WHO’s 2024–25 budget, with a proposed 20% increase over the assessed contributions in the approved 2022–23 base budget. The aim is to reach 50% of WHO’s budget by 2028–2029 if possible, and by 2030–31 at the latest, up from the current 16% in 2020–21. This would mean that by 2028–2029, WHO would see an increase of roughly US$ 600 million a year in the part of its income that comes from the most sustainable and predictable sources.
We conclude however that the mixed conclusions from the 2021 evaluation of WHO transformation remains largely valid. Feedback in several focus group discussions was that staff expected closure on the WHO transformation but did not get it, leaving the impression of an unfinished business. There was also feedback at country level that despite the welcome definition of a broader delegation of authority to heads of WHO offices, administrative procedures remained burdensome and had yet to reflect the new delegation of authority.

In term of effectiveness of key partnerships, the fourth annual progress report of the Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP) evaluates the initiative’s performance since its inception in 2019. The report highlights that despite advancements, the world remains significantly behind in major health-related indicators, exacerbated by COVID-19, economic challenges, and other global crises. While some interim milestones set for 2023 by SDG3 GAP signatory agencies have been achieved or partially achieved, others remain unmet. Successful aspects of the SDG3 GAP include the establishment of a continuous improvement cycle in multilateral health system functioning, supportive structures for collaboration across sectors impacting health, and promising country-specific and thematic approaches. However, challenges persist, such as inconsistent translation of SDG3 GAP commitments into action at the country level, limited engagement of civil society and communities, and insufficient incentives for collaboration. The report emphasizes the need for enhanced collaboration within the multilateral system, innovative approaches in data, delivery, and financing, and stronger incentives for cooperation to accelerate progress towards the Sustainable Development Goals.

There was unanimous feedback in interviews and FGDs that a mindset shift is taking place around delivering impact at country level. In the HWCO survey 34 out of 52 respondents mentioned they were extremely or somewhat satisfied with WHO secretariat’s support (global and regional levels) to the country office for GPW 13 implementation support (capacity building, human resource, leveraging partnerships with stakeholders), vs 5 neither satisfied nor dissatisfied and 13 somewhat or extremely dissatisfied. However internal stakeholders mentioned that although some structural adjustments have taken place, this was mostly at HQ and to a much lesser extent at regional and country office level. They also mention that there is still some level of duplication in administrative and technical activities.

In addition, many of the actions recommended by ARG have yet to take effect. We reconciled the action plan proposed by the ARG group to the initiatives contained in the 2011-16 WHO reform and found a very high level of commonality. This is an indication that reform and transformation have yet to materialise in concrete changes at country office level. During FGDs it was also suggested that there was absence of a clear and unified approach within the system that hindered the ability of country offices to effectively communicate their achievements and failures with regional offices and headquarters.

Finally, looking at the evolution of WHO actual expenditures, overall the weight of country office in overall expenditures has not changed since the 2018-19 biennium. To the extent that country offices were strengthened this was achieved by through the overall increase of WHO’s budget rather than the implementation of a new organisational model.

![Figure 12 Evolution of expenditures 2014 to 2023 by level of the Organization](image-url)
Evaluation participants suggested that **improvements in communication and alignment of Secretariat's activities across the 3 levels, across regions and across programmatic areas have contributed to programmatic success.** It was also suggested that GPW 13 has broken down silos and promoted information sharing which acted as an enabler. Stakeholders cautioned however about the **risk of new silos appearing as teams organise around strategic priorities and outputs.** Specific mention was made of the need to deduplicate and limit overlaps between teams working on each of the three strategic priorities.

The evaluation also highlights that **significant resources, efforts and management time are taken up by restoring trust and implementing remedial actions relating to breach of compliance and ethics**, and more largely to implementation of recommendations stemming from oversight bodies and oversight activities.

Prevention and Response to Sexual Exploitation and Abuse (PRSEA) has occupied most of the GPW 13 period. In response to the serious allegations of sexual exploitation and abuse (SEA) during the 10th Ebola outbreak in the Democratic Republic of the Congo, the World Health Organization (WHO) took unprecedented steps to address the issue. An Independent Commission was appointed in October 2020 to investigate the allegations and make recommendations. The Commission's report, released in September 2021 provided eight key recommendations for WHO, which were promptly accepted. A Management Response Plan was developed to implement these recommendations and additional measures to strengthen the prevention and response to sexual misconduct.

Progress has been made in various areas, including policy revision, incident management systems, awareness-raising, training, investigation processes, victim assistance, and DNA testing. There's also an emphasis on continuous improvement and transparency, with initiatives such as the establishment of a Survivor Assistance Fund and the appointment of specialised personnel for investigations. The Secretariat has also developed a 3-year strategy focusing on a zero-tolerance approach to sexual misconduct, victim-centered policies, and institutional culture change, demonstrating a commitment to address and prevent sexual misconduct comprehensively.

**More generally, every year a wealth of remedial actions stemming from audits, evaluations and other oversight activities are generated.** A secretariat improvement plan exists that contains 96 recommendations, 70% of which had been closed by September 2023. However a consolidation of the overall body of recommended actions since 2015 is underway, which leads to a much higher number – circa 5000 - of actions being formulated. This shows that there is still a lot of potential for improvement in effectiveness, efficiency and compliance.

**The impact on resource and management attention in order to address these recommendations is substantial.** Also the high level of overlap in the recommendations indicates some level or redundancy in oversight activities and the fact that similar recommendations are being formulated over time despite earlier recommendations being marked as completed is an indication that the root causes of issues have not been fully addressed.
Objective 3: to assess the extent to which the Organization was able to focus on the goals of GPW 13, and analyse the factors that facilitated or hindered their achievement

Conclusions

- The ability of Member States and the Secretariat to effectively implement GPW 13 at the country level has been tested, particularly in the context of the COVID-19 pandemic’s flexibility demands. The findings underscore the importance of balancing strategic focus with operational flexibility, considering the diverse challenges and contexts of Member States.
- The experience highlights the need for WHO in GPW 14 to accommodate unforeseen challenges more adaptively, ensuring better alignment of strategic goals with operational capabilities and resources. The role of external and internal factors, including governance, funding, and organisational structures, is pivotal in shaping future successes.
- Moving forward, a nuanced understanding of these factors and a more agile response mechanism are crucial for the successful implementation of GPW 14 and future global health frameworks. This requires an ongoing commitment to improving governance, enhancing communication and engagement, and ensuring equitable resource allocation and collaboration among all stakeholders.

Key findings

**Ability of Member States and the Secretariat to focus on implementing GPW 13 at country level and flexibility of GPW 13 to accommodate changing environment and address emerging needs**

32. GPW13 global and comprehensive nature makes prioritisation a challenge, but cascading mechanisms and frameworks exist to balance focus and flexibility to respond to country context and circumstances.

33. The actual experience of flexibility during the pandemic varied across different country offices. Balancing focus on implementation of GPW 13 at country level and the need for flexibility in emergency response proved challenging, notably given funding constraints and organisational rigidities. In GPW 14 WHO needs to accommodate unforeseen challenges more adaptively.

**External and explanatory factors for achievements, deviations and challenges for Member States and the Secretariat**

34. Member States and Secretariat’s achievements, deviations and challenges in implementing GPW 13 are rooted in contingencies first among them the COVID-19 pandemic, but also on factors that are within the control of Member States and the Secretariat such as governance and leadership, financing and resource allocation, collaboration and partnerships, capacity and infrastructure, communication and engagement, and finally equity and inclusivity. These are of relevance to inform the theory of change for future GPWs as addressing these enablers and hindrances may require targeted interventions such as seeking political commitment, improved funding mechanisms, conflict resolution efforts, comprehensive public health education, and strategic resource allocation.
KEQ6: To what extent were Member States and the Secretariat able to focus on implementing GPW 13 at country level?

Finding 32. GPW13 global and comprehensive nature makes prioritisation a challenge, but cascading mechanisms and frameworks exist to balance focus and flexibility to respond to country context and circumstances.

Managing the inherent tension between clear, focused priorities and flexibility to adapt to changing circumstances is paramount to successfully achieve any strategy. Focus allows us to clearly align financial and human resources with priorities and to drive coherent implementation. Flexibility allows to ensure objectives remain relevant to context and that implementation is responsive to changes in the external and internal environment. Whilst details about country focus are discussed under finding 29, we sought to understand how WHO managed the tension between focus and flexibility.

GPW 13 outlines the body of work that the Secretariat will undertake under each of the three strategic priorities, as well as implementing the three strategic and five operational shifts. This results in a rather comprehensive description of activities. Strategic priorities were seen by internal and external stakeholders as effective in grouping activities in a way that can be communicated, but they are not a limited set of narrowly delineated areas of focus. So, whilst at a higher level GPW 13 priorities seem clear, the document does not clearly prioritise activities by the Secretariat and Member States. Likewise in terms of flexibility the broad scope of work described and the strategic shift relating to country impact allow flexibility in implementation. However, the GPW 13 did not outline the conditions under which it could realistically be implemented and what would need to happen if these conditions were not in place.

Prioritisation and adaptation of resources and activities happens through different instruments including:

- **Programme budget (PB)**, which is defined at output level and presented to Member States by outcome. Over time greater emphasis has been placed on engaging Member States at country level around the definition of a more focused set of priorities for Secretariat assistance, with a goal to have 80% of WHO assistance focused on a maximum of five areas of work. An extensive prioritisation exercise between country offices and Member States notably took place as part of PB 2024-2025. These are aligned with GPW 13 in the sense that they used GPW 13 output structure as a basis and that increased efforts were made to share GPW 13 outcome indicators with regional and country offices to jump start this planning. PB 2024-2025 also makes a more deliberate effort to sharpen priority interventions, e.g. on UHC it points to the opportunity to focus on 25 out of the 92 countries where UHC progress has stalled, and explicitly names four high impact interventions and the impact they could have on meeting the 1 billion targets for UHC. Likewise, on healthier populations the PB 2024-2025 clearly spells out the impact several interventions would have on the healthier population billion.

- **Regional strategies or flagship programmes** defined at regional level, which are more narrowly defined objectives and activities of relevance to regional context. The flagship programs create prioritisation, a sense of urgency, tangible goals, and greater scope for alignment with national and regional priorities, making it appealing to local political leaders and incentivising further investment. In the South-East Asia region this led to the validation of 21 specific disease elimination programmes which in most cases were seen as national achievements by the respective heads of state.

- **Country cooperation strategies (CCS) and biennial collaboration agreement (BCAs)** in the Europe region: a CCS is a negotiated instrument between WHO and a Member State that frames WHO’s technical cooperation with that Member State in support of the country’s national health policy, strategy, or plan. CCSs are also key to frame WHO’s collaboration with other United Nations bodies and development partners at the country level. CCSs vary in duration to align with national cycles and processes. Renewal efforts are made to align WHO’s assistance to GPW 13 strategic priorities.
All in all, the instruments to bring focus exist and are applied to balance focus and flexibility on the most impactful priorities at global, regional, and country level. However, more needs to be done to increase focus whilst also ensuring adaptability:

- **Looking across the duration of GPW12 and 13 there is still a significant inertia in WHO’s budget and imbalance in the financing of the three strategic priorities.** Figure 13 shows how budgets for the base segment have evolved between 2014-2015 and 2024-2025. Except for the rise in the Emergency budget whose weight in the overall base segment has doubled since 2014-2015. It shows the shifts are happening slowly and the funding of each strategic priority is not balanced.

![Figure 13](image)

**Figure 13 Evolution of the structure of WHO’s budget 2014 to 2025, by Strategic Priority**

- **Regional Strategies are not necessarily aligned to GPW 13 and required resources for priority programmes are not systematically costed,** e.g. AMR, the first flagship program in the South-East Asia region had a ministerial declaration and commitment from the countries of that region but did not see significant resources allocated until the programme was fully costed. Leprosy and most neglected tropical diseases (NTD) programmes have not been costed. On the contrary, the resources of HIV swelled after the first resource need study came before the UN General Assembly special session on AIDS backed up by advocacy by the affected people. Similarly, the success of resource mobilisation for TB (from 500 million to 1.2 billion USD) came from combining the highest level of advocacy with resource gap analysis.

- **Country Cooperation Strategy is not always aligned, current or simply does not exist.** Not all countries have a CCS. In the six countries selected for deep dive, India, Rwanda and Sudan CCSs have been refreshed during the GPW 13 period and showed good alignment with GPW 13. Bahrain and Solomon Islands had not and consequently alignment was only partial. In Tajikistan, most of its activities are provided by the technical and expert support under the Biennium Collaborative Agreement (BCA) made between the Ministry of Health of Tajikistan and the World Health Organization. The strategic priorities outline in the CCS/BCA show significant alignment with the objectives set forth in the national health priorities.
Country | CCS (Y/N) | Updated When | Aligned with GPW 13 triple billion targets | Triple B 1 | Triple B 2 | Triple B 3
--- | --- | --- | --- | --- | --- | ---
India | Y | 2019 | | Yes | Yes | Yes
Bahrain | Y | 2016 | | Yes | Partly | Yes
Rwanda | Y | 2021 | | Yes | Yes | Yes
Solomon Islands | Y | 2018 | | Yes | Partly | Yes
Sudan | Y | 2022 | | Yes | Yes | Yes
Tajikistan | Y | 2022 | Yes | Yes | Yes

Table 5 Snapshot of CCS from Country Deep Dives

Finding 33. The actual experience of flexibility during the pandemic varied across different country offices. Balancing focus on implementation of GPW 13 at country level and the need for flexibility in emergency response proved challenging, notably given funding constraints and organisational rigidities. In GPW 14 WHO needs to accommodate unforeseen challenges more adaptively.

GPW 13 and WHO’s flexibility was put to the test during the COVID-19 pandemic. In responses from country representatives (HWCOs) to the online survey there was a nuanced view of the General Programme of Work (GPW) 13’s flexibility during the COVID-19 pandemic. On the favorable side, the HWCOs reported that WHO demonstrated an agile response at the outset of the pandemic, that COs were able to adjust their workplans and reallocate resources as needed to swiftly provide guidance and maintain essential health services. They noted that strategic areas identified for inclusion in the Programme Budget were aligned with the Organization’s overarching goals, which allowed for integration with minimal deviation from planned activities. The HWCOs also mentioned some donor reporting requirements offered leeway during the pandemic, aiding the flexible use of funds. Additionally, the priority put on emergencies in GPW 13 and WHO’s emergency response framework was praised for the ability it gave the Secretariat to quickly activate plans. At the programme implementation level, HWCOs felt there was a degree of flexibility that enabled countries to combat COVID-19 while keeping other health services active. 2/3rd of HWCO respondents agreed that there was sufficient flexibility built into GPW 13.

Exhibit 4 GPW 13 and PB flexibility

HWCOs conveyed however that flexibility was not without limitations. They expressed concerns about the majority of funding being specified, which restricted the ability of country offices to prioritise projects according to needs or priorities. Some HWCOs found the Output prioritisation tool – a key tool to ensure WHO resources are focused so they can have impact - to be too restrictive, as it forced them to select only a few high-priority outputs without considering the inflexible nature of funding. A sentiment of structural rigidity was also evident in the responses, with a belief that the GPW 13 did not significantly empower the country offices, which are critical for on-the-ground implementation.
They pointed out the challenges in budget justification and the repetitive nature of reporting that did not necessarily align with dynamic field needs or changes. Lastly, despite some flexibility during the COVID-19 emergency, some HWCOs observed that GPW 13 did not have in place continuity of essential WHO services when designed and was therefore not in a position of strength to adapt its implementation during Covid-19. They indicate that true flexibility would still have allowed the Secretariat to achieve stated objectives despite unplanned/unforeseen country requests, or to reset objectives by taking context into account. Several mentioned that the deliverables set prior to the pandemic were not adequately adjusted, suggesting a need for a more adaptive planning approach in the future to accommodate unforeseen challenges without compromising the integrity of the initial goals and objectives.

In their reflections, the HWCOs acknowledged that while the GPW 13 facilitated certain strategic and programmatic adaptations, particularly in emergency response, it was simultaneously hindered by funding constraints and structural inflexibilities that limited overall agility. They indicated that for future iterations, a more integrated approach to flexibility—encompassing both funding and structural policies—would be essential to manage unforeseen events effectively.

As a representative from one Member State put it: “A robust framework should be flexible enough to adapt to changing circumstances, emerging health threats, and evolving priorities. It should allow for adjustments as needed to address new challenges. The GPW 13 proved not fit for purpose, in the moment that was profoundly affected by the COVID-19 pandemic. The fact that it had to be delayed/extended, recognising “gap years” with the pandemic, paints a very poor picture on the ability to adapt to (even the direst) circumstances.”
KEQ7: What external (e.g., COVID, funding) and internal (e.g., organisational issues) explanatory factors can be invoked for success and setbacks? What was their respective contribution to deviations?

Finding 34. Member States and Secretariat’s achievements, deviations and challenges in implementing GPW 13 are rooted in contingencies first among them the COVID-19 pandemic, but also on factors that are within their control such as governance and leadership, financing and resource allocation, collaboration and partnerships, capacity and infrastructure, communication and engagement, and finally equity and inclusivity. These are of relevance to inform the theory of change for future GPWs as addressing these enablers and hindrances may require targeted interventions such as seeking political commitment, improved funding mechanisms, conflict resolution efforts, comprehensive public health education, and strategic resource allocation.

Root causes for achievements and challenges are outlined in available global monitoring reports for each of the areas reviewed earlier under objective 2. We also asked stakeholders what were the enablers and hindrances to achievements. They are summarised below:

**Figure 14 Root causes for achievements and challenges**

They are summarised below:

**Health Emergencies and other contingencies**

Unplanned adverse events are a primary reason for deviations identified in GPW 13. They place significant stress on available human resources of the Member State but also of the Secretariat, and divert attention and resources away from other programmatic activities.

At Member State level COVID-19 and its impact on health systems had a major impact on country’s progress towards SDGs and GPW13 objectives. Although available evidence shows that in low and lower-middle income countries with fully disaggregated data by disease for 2019 and 2020, COVID-19 health spending did not appear to reduce spending on other diseases in 2020, the pandemic overwhelmed the health infrastructure in countries thereby affecting provision of essential health services. Similarly, the pandemic had significant economic impact on Member States and put a strain on funding for other health emergencies. Positive side effects identified in Objective 2, e.g. reductions in air pollution, traffic injuries or alcohol consumption were not enough to offset the negative effects of the COVID-19 pandemic and are not expected to be sustained over time.

Interviewees and survey respondents however mentioned that to some extent COVID-19 did catalyse some progress notably in preparedness. Improvements in laboratory capacity in many countries, digitisation of case surveillance or enhanced community engagement in many settings were determinant in the success of response to natural and man-made disasters. Related security risks were also mentioned as causing significant disruption in continuity of care, policy implementation and progress towards SDGs, shifting focus to short term rather than implementation of
sustainable capacities. Whilst country deep dives such as Sudan showed how a resilient health system can to some extent absorb these external shocks, there was widespread feedback that these types of externalities impact on availability of health professionals, access to and financing of health systems.

The work of the Secretariat is also heavily influenced by natural and man-made disasters. Health emergencies such as COVID-19 led to repurposing existing staff for public health emergency response. Interviewees and survey respondents mentioned that to some extent COVID-19 did catalyse some progress notably in increasing the global recognition and visibility of the Organization – and the importance of protection from health emergencies which is a critical part of GPW 13. It also contributed to a closer collaboration between Secretariat and Member States. Similarly, it strengthened WHO’s surveillance system to better prepare and respond to future health crises. However the pandemic led to a reduction and deviation in funding and other resources, resulting in delays and reduced availability of funding for other GPW 13 programmes. Numerous programmes including immunisation, non-communicable diseases screening and vector borne disease control also experienced disruptions and deviations to workplans. Where natural disasters happened, they took resources and focus away from agreed country cooperation priorities, especially in middle-income countries. In addressing these emergencies, the immediate focus shifted to providing humanitarian aid, medical assistance, and relief efforts and GPW 13’s regular health programmes were temporarily reconfigured to address the urgent needs. Natural disasters exacerbated public health risks such as water borne diseases and mental health issues.

Governance and Leadership

Political will and commitment to health at the highest level of state were mentioned as the most critical success factors by stakeholders where progress was observed at the country level. This was reiterated by Member States themselves in the survey and notably in relation to progress in UHC and strengthening of surveillance systems. Support to invest in the health system specific cross sectoral coordination and the definition of conducive policy framework to tackle risk factors were highlighted. The level of political commitment from the country, as well as support from national government, played a crucial role in building the MS system and capacity for successful implementation of GPW 13. For example, in Rwanda the 100 days delivery sprint was used as an opportunity to identify the health priorities in the country and generate a higher level of political commitment from Rwanda as the participation in the sprint was voluntary. Further, the alignment of the country’s national priorities with the goals of GPW 13 was a key factor to secure political commitment.

On the contrary, geopolitical fragmentation at the international level, political instability at the national level and lack of good governance were seen as key hindrances, causing disruptions to collaboration, constraining the availability of resources, resulting in ineffective management practices and increasing the potential for corruption, especially in emergency settings.

At Secretariat level, the political will and stability of Member States political and administrative leadership were seen by HWCOs as the most important enabler for WHO’s work at country level. Frequent resetting of the dialogue with Member States following turnover at ministerial level was notably mentioned a hindrance to progress. As mentioned earlier in this report, interviewees and survey respondents also mentioned WHO’s leadership heightened the Organization’s role in global health security. The role and profile of WHO leadership at global, regional and country level during the pandemic contributed to improved collaboration between Secretariat and Member States. Effective leadership and consistent communication were cited as key enablers for the implementation of GPW 13. In contrast, factors such as delays in decision making, the increasing politicalisation of WHO governing bodies, prolonged gaps in key positions at HQ, regional and country level normalised deviations and created a lack of continuity in implementation.

The evaluation also highlights the importance of aligning governance cycles, e.g. between biennium workplans, government financial fiscal year, donor reporting timelines, Secretariat election cycles at regional and HQ level, as
they prove to have a significant impact on coherence and alignment. Improving the alignment between these different governance timelines is essential for aligned and effective programme implementation.

**Financing and resource allocation**

The 2023 Global health expenditure report shows that 2021 saw a record level of spending on health by countries. It suggests that countries prioritised public health during the pandemic even as economies and societies were being disrupted. Capital investments increased in all income groups during the pandemic: 40-50% in low- and lower-middle income countries, and 8-9% in upper-middle and high-income countries. The report also shows the importance external aid had in supporting government spending in low and lower-middle income countries. The sharpest rises in external aid in 2021 were in lower-middle income countries. The capacity to raise resources for health and the availability of domestic and international funding to support health policy, priorities and initiatives were mentioned as a key success factors to achieve results across GPW 13 priorities. Stakeholders consulted during the evaluation emphasised that although Member States have increasingly recognised the importance of financing the health sector, this perspective has not adequately translated into increased government spending on health for system strengthening. Hence, constraints such as lack of financial resources sometimes hindered the pace of various initiatives. In the context of tightening fiscal space, a key challenge for countries will be to continue prioritising government spending on health. Global monitoring reports and stakeholders interviewed were consistent in stressing that financing is a growing concern across all the three GPW 14 strategic priorities.

As far as the Secretariat is concerned respondents suggested that GPW 13 had led to an increase in financial allocation at secretariat level, from Member States and donors. However, the lack of sustainable, predictable and stable funding manifests at all levels of the Organisation and is strongly felt at the country level. Additionally, earmarked funding based on donor agendas rather than the programme priorities, low implementation rates notably at country level, and challenges in disbursements of funds in a timely manner that resulted in unutilised or underutilised funds, ultimately contributed to deviations between GPW 13 priorities and actual implementation by the Secretariat.

**Collaboration and partnerships**

Achieving GPW13 goals necessitated collaboration among diverse stakeholders, such as government, national and local authorities, civil society organisations, international partners, and communities, as for instance the UHC partnership is doing in 125 countries. This also included the ability to enlist and leverage international support in terms of technical assistance and resource availability, and collaboration between UN agencies at global and country level. For example, to manage global and transnational health threats at the human-animal-environment interface, with the recent launch of One Health Consortium, India has taken a step to initiate cross-cutting collaborations between animal, human and wildlife health professionals for integrated and unifying response to health emergencies.

Respondents to the Member States survey however cautioned that the COVID-19 pandemic exposed a significant shortcoming in international cooperation highlighting the challenges during complex and rapidly evolving crisis, which the Secretariat leadership could only partially mitigate.

Feedback from some key informant was also that the Secretariat does not sufficiently tap into UN resident coordination mechanisms at country level, and that although partnerships have been expanded at global level the collaboration with civil society organisations at country level was not at the level is should be.

**Capacity and infrastructure**

The scale, distribution and maturity of national, sub-national and community level health capacity and infrastructure also play an important role in achievements. Fragmentation within health systems, lack of sufficient and adequately trained health personnel, and uneven distribution of health infrastructure, notably between urban and rural areas are
cited as a key hindrance to GPW 13 achievement to universal health coverage more specifically. Gaps in data collection systems and more generally in access to technology were also mentioned. The evaluation highlights the differential capacity of MS for implementation of the goals of GPW13.

Further, Member States stressed the importance of robust and reliable data for effective policy dialogue and decision making for implementation of GPW13. As mentioned in Objective 1 data quality and reporting at the country level in the context of GPW13 faced many challenges with weak data availability and reliability due to use of multiple systems and inconsistencies in reporting practices. Some GPW13 indicators lacked updated primary data making it difficult for countries to collect and account for progress (for example HBV and HCV incidences and deaths).

As far as the Secretariat was concerned, respondents suggested the importance of alignment of staff size and expertise in accordance with the new areas of work taken up by the Organisation to ensure programmatic success and avoid staff burnout and attrition. Similarly, maintaining institutional knowledge, especially in critical fields such as health emergencies during events such as COVID-19 can be enablers for ensuring operational efficiency and decision-making in future emergencies. Limitations in staffing, particularly in certain programmes, delays in appointing qualified personnel and repurposing existing staff for public health emergencies were mentioned as a key hindrance for the Secretariat.

**Communication and engagement**

Strong, frequent, and transparent communication, leveraging evidence-based data sources, behavioral science, and community engagement, played a role in pandemic response and are also cited as a key enabler for healthier populations and emergencies. Stakeholders suggested the role of communication and engagement with the community playing a critical role in the success of health initiatives, e.g. in global polio eradication efforts.

On the contrary, infodemic and disinformation particularly evident during COVID-19 pandemic acted as an important hindering factor for promotion of evidence-based public health measures and increased vaccine hesitancy. This is perceived as an area which was not well foreseen in GPW 13. It took pre-eminence during the pandemic and is here to stay. Stakeholders commented on the risk this poses to public health in general and to trust in WHO in particular.

**Equity and inclusivity**

Respondents have observed a significant push towards equity and inclusivity in health over the last half-decade, with national policies increasingly focusing on these values and some governments issuing detailed equity reports. However, a critical point of contention has been the evident disparity in access to health resources, not just between countries but within them as well. The COVID-19 pandemic particularly highlighted this issue, as the initial distribution of vaccines and medical technologies largely favored wealthier regions, both internationally and domestically. The concentration of research and development in affluent areas has led to a profound breach of trust, underscoring the urgent need for equitable health solutions that transcend borders and penetrate all levels of society.

Incidentally, as already discussed under objective 2 regarding Secretariat strategic shifts, respondents noted that the Secretariat has continued to emphasise the importance of health equity, pushing for more inclusive health systems and responses that address the needs of vulnerable populations.
Lessons learned and recommendations for the WHO Secretariat and for Member States
General Conclusions

In its drive to generate measurable impact at country level, GPW 13 constituted a shift compared to previous GPWs with important implications on how WHO approaches its role and its work. This represented a disruption that was acknowledged and embraced by the Secretariat, Member States, and partners. But results have yet to materialise and much remains to be done for changes to the soft and hard wiring of the Organization to be fully aligned with a result on focus and institutionalised.

Less understood is the fact GPW 13’s drive to generate measurable impact at country level also has implications for Member States in terms of the need for better horizontal alignment at country level between Secretariat, MS strategies and partners, and the need for clearer national commitments. Whilst we found anecdotal evidence that some alignment took place, formal commitment mechanisms (e.g. HALE objectives at country level, SDG localisation) and even legally binding instruments (e.g. pandemic treaty) are missing.

COVID-19 introduced further disruption on an already disruptive strategic agenda. Setbacks due to COVID-19 are manifest despite commendable efforts and anecdotal progress by Member States and the Secretariat, with slippage or stalled progress across most outcomes and output indicators, and uneven and unequitable recovery to this day. In many ways COVID-19 was a stress test for (a) the relevance of GPW 13’s strategic priorities and their integrated nature, (b) the ability and agility of the Secretariat to rise to the moment whilst keeping focus on GPW 13 objectives, and (c) the cohesion between Member States and their commitment to GPW 13’s equity principle. Whilst COVID-19 validated the importance and mutually reinforcing benefit of focusing on emergency and universal health coverage, it also resulted in a reconfiguring of national health systems, global financing, and Secretariat’s work toward emergency response, which despite efforts to maintain some level of focus and progress on GPW 13 has resulted in compounding the pre-existing lack of focus on the healthier population and health promotion agenda.

Data plays a fundamental role in steering result orientation and accountability. Important challenges remain and need to be addressed for evidence-driven priorities to be set at country, regional and global level. The data foundation in Member States and the Secretariat has yet to catch up with the ever-increasing demand for timely and reliable information, and monitoring and evaluation practices need to be strengthened and more strategically aligned to the result management cycle.

Moving forward WHO leadership and Member States’ challenge will be to resolve the tensions between:

- **Continuity and disruption:** in terms of continuity, the objectives and shifts outlined in GPW 13 are relevant but still largely underway, and the time for stakeholders and systems to adapt and embed new ways of working cannot be compressed. At the same time the environment in which WHO operates is different than before COVID-19. Mega-trends of influence on health are accelerating and the effect of COVID-19 on trust, equity and the global economic outlook introduce new constraints and imperatives. Also, the setback on SDGs, which were already in the making prior to COVID-19, require WHO and partners to think differently, e.g. through better prioritisation on areas of highest impact and clearer commitment and alignment across the health ecosystem.

- **Short-term and Medium-Long term focus:** in the short term, focus is required on: (a) resolving immediate pandemic impacts, most notably on immunisation, mental health and health workforce; and (b) building frameworks for future preparedness before political momentum fades. In the long term, WHO has a unique role to play to bring attention and action to address the powerful megatrends affecting global health (e.g. demographic shifts, rapid urbanisation, climate change and resource scarcity, technological disruption, political fragmentation) and create a more equitable, sustainable, and
resilient global health environment, capable of facing future challenges while improving health outcomes.

- **Flexibility and Result Orientation**: a balance needs to be found between, on the one hand, required flexibility in responding to changing health circumstances and, on the other hand, a relentless focus on achieving specific, targeted and measurable health outcomes. Adaptive strategies need to lead to tangible and sustainable improvements in global health.

- **Ambitions and Means**: ambitious health goals need to be matched with sustainable and aligned financing. As WHO moves towards GPW 14, it is crucial to secure consistent funding that aligns with prioritised goals and resolve funding imbalances across different areas. Sustained resourcing of the Health Emergencies Programme is paramount but so is a rebalancing towards healthier populations, which are structurally underfunded yet a major contributor to HALE.
Recommendations

Recommendations directly follow from the evaluation key questions, findings and conclusions. They were socialised and discussed during a series of meetings and presentations with the Evaluation Reference Group, GPW 14 Steering Committee and other internal stakeholders. Additional details on possibilities of implementation of some recommendations were also provided separately, e.g. on positioning of GPW 14 and GPW 14 theory of change.

In addition, early findings and emerging recommendations were shared in the Member States information sessions held in July and November 2023.

The recommended actions presented below are clustered under three overarching recommendations that are aimed at the Secretariat and Member States. They align with key evaluations questions under Objective 4 of the evaluation:

- Recommendations in relation to short-term priorities for the remaining part of GPW 13 to accelerate results;
- Recommendations in relation to the process of defining and implementing GPW 14;
- Recommendations in relation to strengthen mechanisms and instruments to better support Member States to achieve GPW goals moving forward.
Recommendation 1. To obtain closure on COVID-19 and reset progress towards GPW 13 objectives the WHO Secretariat and Member States should prioritise the following short-term actions for the remaining period.

1.1 By latest Q2-2024, the Secretariat should seek to bridge the data gap on outcome indicators for which no recent global reporting is available. This is paramount to get a complete and coherent picture of global health post-COVID-19 and before GPW 14 implementation is initiated. Several global monitoring reports are about to be released and this data should be used. Global health estimates should also be available by then. Where no global monitoring report is forthcoming, alternative sources and approaches should be used. Particular attention needs to be paid to healthier population indicators which proved hard to analyse in a comprehensive way.

1.2 In the next two years Member States and the Secretariat need to address the immediate and most severe impacts of the COVID-19 pandemic

These include:

- immunising high-risk populations, particularly in countries with large populations and with a special emphasis to mitigate the potential resurgence of vaccine-preventable diseases and ensure comprehensive immunisation coverage;
- mental health by advocating for increased national government financial investment in services to address access and delivery challenges, supporting training programmes to strengthen human resources, focusing on enhancing the quality of services available at primary care level and ensuring availability of essential medicines; and
- health workforce strengthening: Member States should consider comprehensive mental support and incentive programmes for health care professionals tackling the pressing issue of staff burnout resulting from the COVID-19 pandemic and the loss of skilled health workforce during the pandemic. The Secretariat should provide technical assistance to Member States, where needed, to establish mechanisms for funding, development, mobilisation and retention of an effective health workforce, involving key partners.

1.3 Member States and the Secretariat need to get adequate closure on the COVID-19 pandemic before the political window to do so expires

This involves:

- prioritising leadership attention and support on finalising the pandemic treaty and adjustments to the International Health Regulations (2005);
- advancing the health emergency architecture;
- ensuring that as it morphs back to “the new normal” the WHO Health Emergencies programme can maintain and enhance its capabilities through predictable and sustained financing; and
- continued focus on enhancing preparedness at country level and sustaining improvements and capabilities developed during the COVID-19 pandemic.
KEQ 9: What are key considerations for the process of defining and implementing GPW 14?

Recommendation 2. WHO should build on GPW 13 and its learnings to ensure that GPW 14 will be an effective results-based strategic instrument

2.1 In formulating GPW 14 the Secretariat and Member States should ensure that it is positioned as an effective instrument to foster increased coherence and collaboration in global health

This involves the following.

- Leveraging GPW 14 as an agenda-setting instrument for Member States, the Secretariat and partners. This involves ensuring that: (a) it does not merely focus on the Secretariat; (b) the process of consultation is inclusive; and (c) mechanisms for stakeholders to commit to its implementation are considered, e.g. adoption of HALE targets at country level, Sustainable Development Goal localization efforts at country level, and more explicit reference and efforts to align to GPW in national or partner strategies.

- Clearly differentiating between what is acknowledged as an important area of work and the 4–6 critical few narrowly defined strategic priorities which, if implemented, will make a disproportionate contribution to global health. This is where leadership attention will be provided, funding opportunities be directed and budgets scaled up. The Secretariat should also develop ways to report on the share of the budget going to these narrowly defined strategic priorities and Member States should ensure a greater share of the budget is progressively allocated to these.

- Developing an explicit, comprehensive and coherent theory of change that articulates the challenge at stake, enablers and barriers, key actions and changes required, intermediate and final outcomes, as well as the respective roles of key stakeholders. The Secretariat should pay particular attention to: (1) articulating between outputs, intermediary outcomes and final outcomes, and embedding these linkages in its results-based-management approach; and (2) articulating its specific unique and relevant contribution.

- Ensuring that GPW 14 is adaptable by having more explicit considerations of risk and contingencies that may affect its execution.

- Articulating a monitoring and evaluation strategy for GPW 14.

2.2 In formulating GPW 14, the Secretariat and the Member States should consider the following four areas as possible priorities for inclusion in GPW 14

- Building resilient health systems: long-term investment in health infrastructure, workforce development and technology is crucial. This encompasses not just physical resources, but also policies and practices that make health systems more adaptable and resilient to future crises.

- Global health equity and access: addressing inequalities in health access and outcomes should be a central focus. This includes ensuring equitable access to healthcare services and safe, effective, quality-assured health products (including, medicines, vaccines, medical devices, diagnostics, assistive products, blood and blood products, and other products of human origin), irrespective of geography, economic status or other social determinants of health.

- Climate change and health: developing strategies to mitigate and adapt to the health impacts of climate change is a critical long-term priority. This includes understanding the health risks associated with climate change and implementing measures to address these risks.

- Preventive health, chronic disease management and public health education: a critical long-term priority is to shift from reactive to preventive health care, which encompasses promoting healthy lifestyles, effective management of chronic diseases and investing in preventive measures such as
screenings and vaccinations. Integral to this shift is enhancing public health education and awareness. Educating the public about health risks, preventive practices and healthy behaviours is essential for empowering individuals to make informed health decisions and fostering a health-conscious society. This approach not only addresses immediate health concerns, but also helps in the prevention of future health issues by creating a more informed and proactive population.

2.3 The Secretariat should strengthen its results framework, accountability for results and managing for results by implementing the recommendations already formulated in the 2023 evaluation of results-based management

The Secretariat should also:

- consider targets for HALE and linking HALE to outcome indicators/triple billions;
- further align "Triple Billion" targets to the Sustainable Development Goals and implement identified improvements to indicators and indices;
- ensure results are also reported by equity dimensions;
- seek more integration and streamlining of existing: (a) results frameworks across different segments of the programme and budget; (b) planning guidance and activities initiated by different departments in headquarters; (c) workplans; and (d) key performance indicators (KPIs) used in regions and globally;
- ensure outputs are formulated in a way that countries can relate to in a meaningful way; and
- ensure sufficient consistency is preserved in results indicators in order to allow trending.

2.4 The Secretariat should ensure that reporting is useful, usable and used at the country level: for this, the Secretariat should pivot the approach to reporting from being primarily driven by corporate reporting needs to a cockpit approach that can be used at country level and clearly ties together ongoing monitoring and result reporting. The goal should be to develop reporting templates and practices that:

- allow the user to clearly identify and allow implementation tracking against agreed country priorities, be they acceleration plans or country cooperation strategies;
- can be used as the basis for delivery stock-takes and monitoring and evaluation;
- can be an instrument with which WHO country offices can engage with national governments as part of policy dialogue, review of service delivery and accountability to Member States.

2.5 As a requisite enabler for the above, Member States and the Secretariat should get their data foundation right by focusing on improvements to data collection and data management

As WHO embraces data-driven approaches, the Secretariat should:

- further scale up its support to build Member State capacity to track and report on key health indicators;
- strengthen its own data collection and analysis capabilities, notably at country and regional levels;
- ensure any new indicators can be tracked through routines systems or country-recognised platforms; and
- set KPIs on data quality with targets for improvements on WHO core metrics in order to assess whether progress is sufficient.

In order to improve the quality and timeliness of Member State reporting on national indicators, Member States should:

- be reminded of their obligation under Articles 61 and 62 of the WHO Constitution to share relevant data in a timely manner; and
- ensure they invest sufficiently to build up their national health information capabilities.
KEQ 10: What adaptations to its processes, systems, organisation and partnerships should the Secretariat consider to better support Members States to achieve GPW 14 goals moving forward?

Recommendation 3. The Secretariat should renew efforts to institutionalise changes underway and reap the benefits of strategic and operational shifts

3.1 The Secretariat should scale up, mainstream and integrate its approach to delivery of results

For this, the Secretariat should:

- fully integrate results-based approaches and tools into programme and budget processes, manuals and instructions; over time, results-based-management and what the Secretariat has called “delivery for impact” should become synonymous and be supported by proper theories of change;
- Ensure alignment between Country Cooperation Strategies and acceleration plans;
- build up analytical capacity at regional and country level;
- clarify the respective roles and responsibilities of the Planning Resource Coordination and Performance Monitoring division, Country Strategy and Support division, and Data Analytics and Delivery for Impact division in planning, monitoring and reporting in order to improve coherence and avoid duplication; and,
- reposition the role of the Delivery for Impact (DFI) unit at Headquarter on: (a) development and dissemination of DFI analytical products and packages; (b) internal capacity-building; and (c) focused selective support in advancing GPW 14 strategic priorities and major acceleration scenarios.

3.2 The Secretariat should further improve the prioritisation, production and integrated delivery of technical products: for this, the Secretariat should implement the recommendations of the 2023 evaluation of normative function at country level including sufficient and consistent feedback mechanisms from countries and users, taking into consideration, at the country level, that these products require adaptation to local contexts. The Secretariat should start by enforcing more stringent upfront prioritisation of technical products based on strategic importance and feasibility.

3.3 The Secretariat should further align its operating model to ensure it is fit-for-purpose to enable strategic shifts: for this, the Secretariat should:

- empower WHO country offices and Secretariat mechanisms such as output delivery teams (ODT) through adequate: (a) administrative and technical resourcing to support the work; (b) financial allocation for the ODT/country office representative to incentivise collaboration; and (c) delegation of authority;
- align and optimise its operating model by: (a) refreshing the definition of the Secretariat’s core functions and the related division of labour between the three levels; (b) aligning resource allocation and staffing accordingly; and (c) ensuring that duplication of work between each strategic priority are eliminated and that new silos are not created; and
- optimise within each level and redeploy between levels through the mobility policy and workforce planning.

3.4 The Secretariat should ensure organisational development is deliberate, systematic, well architected and coordinated.

For this, the Secretariat needs to:

- adequately resource organisational development/transformation functions and initiatives;
- articulate the change management plan underpinning GPW 14; and
- ensure a process exists to consolidate recommendations for improvements stemming from multiple oversight functions and ensure the resolution of these is effectively and efficiently channeled into change management plans.
3.5 As a prerequisite for the above, Member States and the Secretariat should renew efforts to improve the quality, predictability and alignment of financing to strategic priorities. This involves:

- implementing planned increases in assessed contributions;
- funding GPW 14;
- balancing financing among the three billion, notably regarding healthier populations.

3.6 Prior to the formulation of WHO’s fifteenth general programme of work (GPW 15), the WHO Secretariat should establish a phased strategic planning process. This process should start well in advance by an evidence-driven situation analysis, mid-term evaluation of GPW 14 and choices on the positioning of GPW 15. It should then be followed by an assessment of strategic options leading to an agreement on strategic priorities. Only then should the results framework be defined. As a last step, the implications of GPW 15 on financing needs, organisational alignment and programme and budget planning should be defined.