World Health Organization

Evaluation of the WHO Policy on Disability

Report

WHO/DGO/EVL/2025.1

Contents

List of Tables

List of Figures

Acronyms

AFRO	Regional Office for Africa
BOS	Business Operations
CRPD	Convention on the Rights of Persons with Disabilities
CO	Country office
CoP	Community of Practice
DAF	Director of Administration and Finance
DEI	Diversity, equity and inclusion
DPM	Director of Programme Management
EMRO	Regional Office for the Eastern Mediterranean
EURO	Regional Office for Europe
ERG	Evaluation Reference Group
FGD	Focus group discussion
GPW	General Global Programme of Work
GRE	Gender Equality, Human Rights and Health Equity
GRED	Department of Gender, Rights, Equity and Diversity
HRT	Human Resources and Talent Management
ICF	International Classification of Functioning, Disability and Health
IMT	Information Management and Technology
IT	Information Technology
KII	Key informant interview
KPI	Key Performance Indicators
MoU	Memorandum of Understanding
NCD	Noncommunicable diseases
OECD/DAC	The Organisation for Economic Co-operation and Development/ Development Assistance Committee
OPD	Organization of persons with disabilities
PAHO/ AMRO	Pan American Health Organization/Regional Office for the Americas
PSEAH	Prevention of sexual abuse and harassment
PRP	Department of Planning, Resource Coordination and Performance Monitoring
PRS	Prevention of and Response to Sexual Misconduct
RO	Regional office
SDG	Sustainable Development Goals

SEARO	Regional Office for South-East Asia
SHIVYAWATA	Tanzania Federation of Disabled People's Organizations
TB	Tuberculosis
ToC	Theory of Change
UHC	Universal health coverage
UNCT	United Nations Country Team
UNDIS	United Nations Disability Inclusion Strategy
UNEG	United Nations Evaluation Group
UNPRPD	UN Partnerships on the Rights of Persons with Disabilities
UN-SWAP	UN system-wide Action Plan
WPRO	Regional Office for the Western Pacific
WHA	World Health Assembly

Credit: WHO / Miguel Jeronimo

Acknowledgements

This report is issued by the WHO Evaluation Office. It is based on the independent evaluation conducted by the Evaluation Team from the Independent Evaluation Team (SDD), as detailed below. The WHO Evaluation Office would like to express its appreciation to the Team members for their dedication and excellent work. This evaluation was managed and quality controlled by the WHO Evaluation Office (please see below).

The WHO Evaluation Office is grateful for the collaboration, insights and openness of the United Nations Disability Inclusion Strategy (UNDIS) Secretariat and WHO staff at Headquarters and regional offices, and for their generous time, candid feedback and contributions, as well as for their dedicated support to the evaluation and for providing a wealth of background documentation.

The WHO Evaluation Office acknowledges and thanks several groups within WHO that provide leadership for the Organization's work on disability inclusion, and that have supported the evaluation: Embracing Disability Affinity Resource Group, the UNDIS focal point network, the UNDIS Disability Resource Group, and the Evaluation Reference Group (ERG).

The evaluation was guided by an ERG comprised of key stakeholders within WHO working on disability inclusion. The WHO Evaluation Office would like to thank all members of the ERG for their participation in fruitful discussions and input, and for sharing their valuable insights and honest perspectives to inform the evaluation and ensuring that the recommendations are relevant and actionable to support further integration of disability inclusion across WHO.

THIS DOCUMENT IS IN ACCESSIBLE FORMAT

Independent Evaluation Team (SDD)
Jo Feather, Team Leader
Lorraine Wapling, Disability Lead
Ella Wong, Evaluation Specialist
Nilanjana Bhattacharjee, Evaluation Specialist

Evaluation Manager
Elisabetta Pegurri, Senior Evaluation Adviser, WHO Evaluation Office
Marie Bombin, Senior Evaluation Officer, WHO Evaluation Office

Evaluation Reference Group
Experts from the UNDIS Secretariat, UNDIS Working Group (including representatives from three headquarter departments), Embracing Disability Affinity Group, and from each of WHO's Regional Offices acted as the Evaluation Reference Group

Executive summary

Introduction

The UN Secretary-General launched the United Nations Disability Inclusion Strategy (UNDIS) in June 2019 to mainstream disability inclusion in all areas of the UN's work, both inside and outside the organization. Subsequently, the WHO Director-General launched the WHO Policy on Disability in December 2020. Both are implemented in WHO through the UNDIS Action Plan. In 2019, the UN established the UNDIS accountability framework with 16 common indicators for which all UN agencies report annually to the Executive Office of the UN Secretary-General. The WHO policy states that, "The WHO Evaluation Office will conduct an independent evaluation of the WHO Policy on Disability, informing its review every five years, as part of the Organization's strategic planning processes and the Global Programme of Work" (which also aligns with a requirement of Indicator 10).[1] Five years have elapsed since WHO started to implement UNDIS in 2019.

The object of this evaluation is the WHO Policy on Disability and aims to assess the implementation of disability inclusion across all three levels of WHO Headquarters, Regional, and Country Offices – spanning both operations and programmatic work. This evaluation covers the period from 2019 to 2024. It is both formative and forward looking, focusing on lessons learned and examples of good practice to guide the future of WHO's disability inclusion efforts. The evaluation draws on data from all levels of the Organization and is primarily intended for internal stakeholders, including the UNDIS Steering Committee, Secretariat, WHO Executive Board, and various departments, regions, and country offices.

Conceptual Framework

The evaluation was guided by a conceptual framework that sought to explore to what extent the WHO is both an inclusive place to work and delivers disability inclusive programmes at all three levels of operation, with three objectives:

1. The effective implementation of disability inclusion across all three levels of WHO;
2. The existence of good practice examples in mainstreaming disability inclusion and specific disability inclusion measures;
3. The existence of a sustainable foundation for the continued deliverance of the policy after 2024.

---

[1] Indicator 10 includes the need for UN agencies to conduct a "meta-analysis of evaluation findings, conclusions and recommendations relating to disability inclusion […] at least every five years".

Methodology

This non-experimental evaluation is both formative in nature and utilisation focused, with an emphasis on ensuring the findings are relevant, actionable and accessible to stakeholders. It combines both a strong participatory and human rights-based approach with a theory-based approach, grounded in the conceptual framework to explore how WHO's Policy on Disability is enhancing disability inclusion.

Central to this approach is the meaningful participation of rights-holders in the evaluation process. This was possible in particular for the operations dimension of the evaluation, primarily by engaging the WHO workforce, to ensure their voices and perspectives and experiences are central (see section on consultation and participation below for further details).

An adapted outcome-harvesting approach *(1)* a particularly useful approach for examining complex and dynamic systems of social change, was selected for this evaluation. This focus on harvesting and linking stories of change and challenges through a triangulated analysis of document review and stakeholder engagement allowed the clear identification of what worked and why, as well as conclusions to be drawn.

The evaluation used the following data collection methods:

Desk review (documents and data): The evaluators reviewed more than 40 documents sourced through the UNDIS Secretariat[2], UNDIS Disability Inclusion Strategy Information Hub, the Evaluation Manager, through key informants at the headquarters, regional and country level, and through internet searches.

Key informant interviews and focus group discussions: More than 90 respondents were interviewed through 16 key informant interviews (KIIs) and 14 focus group discussions (FGDs) conducted with a range of WHO workforce members at the three levels of the Organization. This included staff from both the Operations and Programme divisions of the Organization to ascertain how the Policy on Disability is understood and implemented (WHO, 2021).

---

[2] The UNDIS Secretariat is composed of several internal committees within the WHO Secretariat.

Evaluation Findings

***Evaluation Question 1:** To what extent is disability inclusion effectively implemented across all three levels of WHO?*

The WHO Policy on Disability together with the UNDIS have provided a strong mandate for integrating disability inclusion into all aspects of programmatic work and business operations. Disability inclusion also benefits from the underpinning of the UN-wide commitment to the ‘Leave no one behind’ principle, and the WHO commitment to ‘Health for All’, which include a strong focus on persons with disabilities, and with which staff are very familiar and personally committed to. Coherence is mostly identifiable at Headquarters’ level, which is expected given that this work is at an early stage. The overlap between the policy and UNDIS means that lines of accountability and responsibility could be clearer, and a stronger, strategic focus on disability inclusion could support increased coherence through to regional and country levels. Disability inclusion is considered a cross-cutting issue relevant to both programme technical work and business operations. However, further efforts are needed to enhance its implementation across the Organization and ensure clearer alignment with other cross-cutting initiatives to ensure disability inclusion is a priority issue.

A number of mechanisms are supporting disability inclusion across the Organization, including UNDIS structures (Steering Committee, Secretariat and Working Group) and the WHO UNDIS Action Plan, all of which are backed by strong leadership commitment. Staff groups have been helpful in raising awareness and driving conversations. Country offices are seeking more practical guidance, tools, and training to mainstream disability inclusion in their work. While global planning and reporting frameworks could improve accountability, their effectiveness is mixed, and there are no mandatory disability-specific indicators in place.

The flexible funding allocated to support the UNDIS Action Plan has been crucial in resourcing and implementing key disability inclusion initiatives. These funds have helped integrate disability inclusion into core processes, while also supporting stand-alone activities. This funding mechanism highlights the importance of flexible resources in starting and mainstreaming priority areas like disability inclusion. However, resource gaps still exist, which should be addressed to ensure the continued implementation of the Action Plan and the sustainable embedding of disability inclusion across all operational and programmatic areas.

Considerable progress has been made in fostering an inclusive culture within WHO. However, some barriers to disability inclusion appear to be systemic, with opportunities to further raise awareness and improve the implementation of policies and guidance across all levels of the Organization. Additionally, there is a perception that some of the challenges are rooted in a biomedical approach to disability, which is understood as a health condition by some of the technical units outside of the disability programme, suggesting a need for broader perspectives in programming.

Evaluation Question 2: *Are specific disability inclusion measures in place at each level of the Organization – and what examples of good practice exist?*

There is a range of examples of disability inclusion at all three levels of WHO, some which appear to be part of a more strategic approach, but many are standalone activities with limited sustainable or transformative impact. Common challenges identified include issues of centralized decision-making and insufficient data on disability, gaps in the communication and promotion of existing resources, and challenges in distinguishing disability-specific programming from disability inclusion.

Evaluation Question 3: *To what extent has WHO created a sustainable foundation on which to continue to deliver on the policy after 2024?*

There are positive foundations in place to support disability inclusive practices and mechanisms, particularly at the Headquarters' level, and there has been progress on integrating disability inclusion into corporate and programme practices, along with improvements in reporting, governance, and accountability mechanisms. There has been a notable shift in how disability is discussed across all levels of the Organization, with increased confidence in using rights-based language and acknowledging the need for further sensitization and capacity building. Partnerships, particularly with organizations of persons with disabilities (OPDs), are recognized as crucial for driving sustainability and embedding disability inclusion, although these collaborations are still in their early stages.

Conclusions

Conclusion 1. Alignment of the WHO Policy on Disability and UNDIS

The alignment of the WHO Policy on Disability to the UNDIS has been worthwhile with regards to raising the profile of disability inclusion across the Organization and this has given WHO a strong mandate to promote disability inclusion across the Organization and its programmes to meet UN-wide commitments. There is an opportunity for WHO to further adapt and contextualize the UNDIS specifically for itself, tailoring it to better align with the Organization's unique operational framework. This would enhance WHO's strategic and sustainable impact for the future. Currently, the WHO UNDIS guidance provided does not fully capture WHO's processes and priorities, so clearer, practical directives that identify measurable changes are needed. Addressing this gap could shift the focus from stand-alone actions within the current plan towards more integrated, evidence-based interventions, embedding disability inclusion more deeply into WHO's core strategies, and fostering greater collaboration and long-term impact across its initiatives.

Conclusion 2. Alignment and leadership of disability inclusion work

The leadership and governance framework established through the UNDIS Steering Committee, involving senior management and the UNDIS Secretariat, has been key to advancing disability inclusion within the Organization. This structure offers an opportunity to ensure the sustainability of disability inclusion as part of a broader organizational change. As the UNDIS Secretariat and the Disability Programme are responsible for driving the implementation of the Policy on Disability along with the delivery of the UNDIS Indicators, they would seem to have a role in supporting greater synergies across different initiatives. To strengthen commitment to this agenda, it is important to address the current reliance on UNDIS structures and resources for implementation of the Policy on Disability, which are not sufficient to effect the organizational change process required for disability inclusion to become fully embedded within WHO. Stronger alignment and collaboration between departments working on health equity, such as gender equality, human rights and health equity, alongside the UNDIS Secretariat, is essential for strategic coherence. Raising staff awareness of their roles and key contacts will help foster a more cohesive and inclusive approach.

Conclusion 3. The role and identification of the focal point for disability inclusion

The focal point structure is an effective way to promote a coordinated approach to disability inclusion across WHO programmes and operations, but it requires more resources to ensure focal points have the necessary expertise. Providing adequate training and support will enable focal points to effectively lead and advocate for disability inclusion, reinforcing its priority within the Organization. Strengthening this system will help cultivate a strong network of champions who can drive meaningful progress and foster an inclusive culture throughout the Organization.

Conclusion 4. Awareness-raising and definitions

The strong commitment to human rights and the ‘Leave no one behind’ agenda, along with WHO staff’s personal dedication to the ‘Health for all’ mandate, provides a solid foundation for further embedding disability inclusion work across the Organization. However, to enhance the impact of these efforts, more consistent messaging and awareness-raising are needed. Empowering staff with the right language and tools is crucial for planning and delivering disability-inclusive programmes. The UNDIS Secretariat and Disability Programme play a key role in building capacity and fostering a culture where disability inclusion is embraced as a core value, rather than just a reporting obligation under UNDIS.

Conclusion 5. What gets measured gets done

Country offices interviewed in the context of this evaluation were more aware of the accountability requirements under the UNDIS reporting processes coordinated by the UN Country Teams (UNCTs) than they are with any WHO specific requirements related to the WHO Policy on Disability and accompanying Action Plan. The absence of a mandatory reporting system (specific for disability inclusion) for WHO programmes to provide information and data makes it difficult to identify examples of evidence-based good practice to support institutional learning and accountability. Neither the WHO Results Framework, nor the Output Scorecard, is detailed enough to help WHO assess its progress against the Policy on Disability. There is no organization-wide tracking of inclusion of persons with disabilities and the impact of that inclusion. Understanding who accesses services and is employed by WHO is essential, but without disaggregated data, it is difficult to assess the Policy on Disability's effectiveness or its overall impact on organizational coherence.

Conclusion 6. Flexible funds mechanism

The flexible funds mechanism to support the UNDIS Action Plan has provided crucial resources and support to kickstart a number of initiatives at Headquarters to ensure disability inclusion. While there have been challenges with the funding allocation and spending processes, which have primarily impacted the distribution of resources to regional and country offices, there is a significant opportunity to enhance the impact of this mechanism and catalyse efforts towards greater disability inclusion for the remaining period that these funds are available. To maximize the catalytic impact and sustain the momentum on disability inclusion, dedicated human resources and a supportive organizational infrastructure and enabling environment are needed to strengthen the overall resourcing and capacity needed to deliver on this ambitious agenda.

Conclusion 7. Operational guidance and training

In the five years since the UNDIS Action Plan was introduced, it has successfully identified practical actions to advance the strategy, mainly at the Headquarters' level. However, further implementation is needed at regional and country levels. To promote disability inclusion effectively, practical training for the workforce on how to deliver on WHO's disability-inclusive commitments and to empower them to support others in this approach, is essential. The following are needed to enhance the action plan and strengthen delivery: a communication strategy, increased human resources, and targeted training for interview panels and hiring committees to ensure they understand and implement disability-inclusive practices confidently.

Conclusion 8. Working with OPDs and networks of persons with disabilities

The evaluation has identified promising examples of partnerships between WHO and organizations of persons with disabilities (OPDs), along with efforts to integrate guidance on consulting with these groups into WHO programmes. While these collaborations are currently limited in number, they represent a valuable starting point for enhancing engagement with OPDs. Meaningful involvement of OPDs is not only essential for fulfilling international commitments under the UN Convention on the Rights of Persons with Disabilities (CRPD) and UNDIS, but it also plays a crucial role in enhancing programme outcomes. To strengthen these partnerships, investment is needed to build OPD capacity to better engage in the health sector and develop a comprehensive WHO engagement strategy. This strategy should include long-term investments in capacity building, as well as funding dedicated to supporting both organizational growth and programming initiatives. By fostering stronger, more sustainable partnerships with OPDs, WHO can enhance its efforts towards inclusivity and ensure that the voices of persons with disabilities are integral to its work.

Recommendations

The following recommendations have emerged from the findings and conclusions of the evaluation and were validated by the UNDIS Secretariat, Steering Committee and the Evaluation Reference Group in a series of validation workshops and meetings.

Strategic recommendations

Recommendation 1

Update the WHO Policy on Disability in the next phase of implementation to better reflect the unique operational situation of WHO, in particular its decentralized structure. This should include a clearer specification of roles and responsibilities for all disability inclusion work and the following actions:

External:

- Organize a consultation process with UN peers to understand how others have utilised UNDIS in their organizational policies and reporting systems.

Internal:

- Organize a consultative process to ensure that different parts of WHO gain buy-in for the Policy on Disability;
- Establish a process for adapting and tailor the Policy setting out clear timeframe, resourcing, monitoring and oversight;
- Conduct a comprehensive mapping of how disability inclusion is integrated across a range of departments and programmes working on health equity issues.

Recommendation 2

Enhance engagement with different departments around the UNDIS indicators, to support greater integration of disability inclusion across WHO both in programmes and operations. This could be done through supporting greater synergies across different initiatives and clarifying the scope of work of individual teams and oversight of organizational initiatives to promote disability inclusion:

- Strengthen the linkages between different departments and teams working on disability inclusion to ensure these initiatives can be more aligned, including the collaboration between GRE and UNDIS Secretariat and Disability Programme;
- Develop a clear strategy for how to utilise collaboration and synergies with other cross-cutting initiatives to make disability inclusion more visible and more effective;
- Establish clear roles and responsibilities across the different departments working on aspects of integrating disability inclusion into their work to improve collaboration,

streamline workflows and ensure staff understand how to apply disability inclusion practically.

Recommendation 3

Strengthen the focal point structure established to promote a coordinated approach to integrating disability inclusion by articulating the roles and responsibilities of focal persons who steer offices, teams and departments towards mainstreaming disability inclusion in the longer term:

- Ensure there is a clear expectation and dedicated time within the job descriptions of those with focal point responsibilities and that they have the technical knowledge to support colleagues in implementing inclusive actions;
- Ensure Terms of Reference are updated and shared with all focal points;
- Identify clear time commitments for focal points to fulfil these requirements;
- Encourage individuals to not take on too many focal point responsibilities to avoid them spreading themselves too thinly;
- Ensure focal persons receive regular mandatory learning and development opportunities so that they can keep abreast of current good practice and WHO developments in disability inclusion mainstreaming;
- Consider developing a succession plan to manage turnover among focal persons at different levels.

Operational recommendations

Recommendation 4

Strengthen awareness and understanding of disability inclusion and implement a comprehensive, organization-wide capacity-building initiative that includes targeted training and practical technical guidance and advice in order to enhance skills across the workforce and foster a culture of continuous learning and self-reflection:

- Ensure the technical guidance notes that have been developed under UNDIS are widely circulated and promoted across the organization;
- Continue to develop, finalize and share widely simple, practical, best practice guidance on how to mainstream disability inclusion, that is adapted for WHO’s specific context;
- Develop a clear training strategy, supported by inclusion champions who have the confidence to nudge people away from biomedical thinking;
- Support the Disability Programme to provide a more flexible, on-demand internal ‘Helpdesk-type’ approach to provide capacity strengthening support across the workforce, including access to evidence-based research, information and guidance tailored to their specific needs;

- Integrate disability inclusion into the mandatory 2-3 day induction training at the regional office level for new staff delivered every quarter which currently includes Prevention of and Response to Sexual Misconduct (PRS) as a core topic for induction;
- Encourage consultants employed by WHO on long-term contracts to participate in the induction training as a requirement for their contract;
- Continue to offer the programme of webinars and awareness raising events to raise the profile of disability inclusion across the Organization, and improve socialisation of the issues, and ensuring that advice remains relevant and up to date;
- Establish peer learning opportunities to explore how disability inclusion is being considered and taken forward in these areas.

Recommendation 5

Sustain and enhance efforts to become a disability-inclusive employer with a proactive and structured approach to inclusive hiring practices and ensuring that barriers to employment for persons with disabilities are identified and removed to address underrepresentation of persons with disabilities in the workforce:

- Provide mandatory training for hiring managers and HR personnel on disability awareness, unconscious bias, and inclusive hiring practices;
- Ensure reasonable accommodations are clearly offered and communicated during the hiring process, not just once in post;
- Offer flexible application and interview arrangements, including accepting alternative application formats, virtual interviews etc.;
- Monitor recruitment data, retention rates and employee satisfaction to evaluate the success of inclusive hiring practices and make adjustments based on real-time data;
- Conduct a review of reasonable accommodations and compensation packages available across the workforce to ensure they adequately address the needs of employees and consultants with disabilities.

Recommendation 6

Strengthen the Organization’s monitoring, evaluation and reporting systems to systematically track and report disability-specific activities, outcomes, and expenditure with an emphasis on improving data collection related to persons with disabilities:

- Develop a Theory of Change and results framework to articulate results for the WHO Policy on Disability Inclusion;
- Collect data on disability that is relevant to each of its own organizational priorities. The measurement process should reflect the policy area (team priorities) rather than being entirely analogous to UNDIS. WHO should consider separating the reporting system from UNDIS reporting requirements and making it internal to WHO;

- Explore the requirements to make reporting against the Disability Inclusion Marker mandatory, and similar to reporting against the Gender Equality Marker and UN system-wide Action Plan (UN-SWAP) indicators;
- Develop an enhanced system for tracking how resources are used for disability inclusion efforts specifically, ensuring spending and programmatic outputs are monitored on an ongoing basis. This will help improve the prioritisation of resource allocation;
- Implement a confidential system for collecting data on the disability status of the workforce to support inclusive practices. This could be an annual survey or an optional equality and diversity monitoring form, in which confidentiality and voluntary participation is assured;
- Conduct organizational-wide awareness raising to encourage voluntary disclosures among the workforce to ensure accessibility and accommodation needs are addressed;
- Ensure guidance on how to collect disaggregated data safely and appropriately at strategic planning and population level is made widely available and communicated to staff at country level in particular;
- Document good practice examples from country offices who are already working with national governments to strengthen health systems and health management information systems, so as to capture this information and thereby share learning widely across the Organization.

Partnership and resourcing recommendations

Recommendation 7

Strengthen partnerships with organizations of persons with disabilities (OPDs), developing Memoranda of Understanding where appropriate, and prioritize supporting their long-term capacity so as to strengthen their ability to influence health-related policy, monitor health service provision, and ensure that governments meet their obligations under disability rights frameworks:

- Emphasize to donors the need to invest in strengthening the capacity of OPDs to better engage in the health sector, in particular committing to long-term, sustainable funding arrangements to enable OPDs to focus on advocacy work and deliver for their members without being hindered by short-term, activity-based funding cycles;
- Build on nascent examples of good practice working with OPDs at country and regional level to develop and formalise an organizational process for working with OPDs to strengthen systemic engagement;

- Maximize the opportunities for Regional Offices and Country Offices to ensure that persons with disabilities are able to participate and engage in mainstream programmes, for example ensuring they are involved in evaluation processes and programme advisory groups etc.;
- Explore opportunities for developing Memorandums of Understanding with OPDs to formalize partnerships to strengthen the meaningful engagement of persons with disabilities across WHO's work.

Recommendation 8

Prioritize resources for spending on disability inclusion to sustain the momentum and strong progress achieved to date:

- Encourage programmes to add one disability inclusion action in their workplans over the next three years;
- Continue to ensure that disability inclusion is embedded in the Organization's operational budget planning and resource allocation processes, so it becomes a core consideration across all funding decisions, through ongoing advocacy with custodian departments and budget centre managers;
- Advise donors of the need to ensure disability inclusion is built into all projects/programmes and not just to fund standalone disability projects; make this a requirement for all requests for proposals, in the same way that gender and safeguarding are now included.

I. Introduction and context

The UN Secretary-General launched the United Nations Disability Inclusion Strategy (UNDIS) in June 2019 to mainstream disability inclusion in all areas of the UN's work, both inside and outside of the organization. Subsequently, the Director-General launched the WHO Policy on Disability in December 2020. Both are implemented in WHO through the UNDIS Action Plan. In 2019, the UN established the UNDIS accountability framework with 16 common indicators for which all UN agencies report annually to the Executive Office of the UN Secretary-General. The WHO policy states that, "The WHO Evaluation Office will conduct an independent evaluation of the WHO Policy on Disability, informing its review every five years, as part of the Organization's strategic planning processes and the Global Programme of Work" (which also aligns with a requirement of Indicator 10)[3] . Five years have elapsed since WHO started to implement UNDIS in 2019.

Between January and October 2024, WHO conducted an independent evaluation to review the extent to which disability inclusion is effectively implemented across all three levels of WHO. The evaluation covers the period from 2019, which coincides with the launch of the United Nations Disability Inclusion Strategy, to the present.

1.1 Background and context

In line with the UN Convention on the Rights of Persons with Disabilities (CRPD), WHO refers to disability as the interaction between a person's impairment and/or health conditions and attitudinal, institutional and environmental barriers that can hinder full and effective participation on an equal basis with others. Persons with disabilities are a diverse population, including children, working age and older adults of all genders, race and sexual orientation with an equally diverse range of intellectual, mental, sensory and physical impairments.

Persons with disabilities face a varied range of barriers, including negative attitudes and beliefs to low expectations; discriminatory legislation and regulations; a lack of accessibility to buildings, transport, information and communication; and segregation in access to public services such as health and education.

Around 1.3 billion people experience significant disability, representing 16% of the global population. In the past 10 years alone there has been a global increase of more than 270 million persons with disabilities, partly as a result of ageing populations and general increases in the numbers of those living with noncommunicable diseases, but also as a consequence of health emergencies, including infectious disease outbreaks, natural disasters and conflict (2). Almost 80% of people experiencing disability live in low- and

---

[3] Indicator 10 includes the need for UN agencies to conduct a "meta-analysis of evaluation findings, conclusions and recommendations relating to disability inclusion […] at least every five years".

middle-income countries, although the highest prevalence rates are found in higher-income contexts such as Europe (20%) and the Americas (19.4%). Rates also vary by age group with around one in three older adults (60 years and older) experiencing functional limitations compared with just below 6% in those under 15 years *(3)*.

The increased availability of quality data is helping to highlight how health inequities experienced by persons with disabilities and can significantly impact on health outcomes. Persons with disabilities have a 2.4-fold higher mortality rate than people without disabilities, resulting in a 10- to 20-year lower life expectancy. Recent studies have shown that they face poorer health outcomes across all indicators under Sustainable Development Goal (SDG) 3 to ensure good health and well-being for all, *(4)* but most of these outcomes are not related to underlying health conditions or impairments alone. Rather, many of the drivers for health inequity result from structural factors affecting access to health care *(5)*. People with disabilities are more likely to live in poverty, with poorer quality housing and lower levels of education and employment. These factors are compounded by ableist attitudes and social norms creating significant barriers to healthcare.

The operational mandate of WHO has always been relevant to persons with disabilities. The WHO constitution has a set of principles and obligations stating that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction”. The WHO created the International Classification of Functioning, Disability and Health (ICF) in 2002 in response to the need to understand the impact a health condition and/or impairment can have on an individual’s capacity to function within a given context. The ICF consolidated the understanding of disability as the result of an interaction between health conditions and social and personal factors, now referred to as the biopsychosocial model of disability *(6)*. This represented a fundamental shift in the way disability had been regarded and is now central to a rights-based approach to disability across all sectors.

In response to the findings of the World Report on Disability 2011, the 66th World Health Assembly in 2013 requested that the WHO Director-General prepare a comprehensive action plan to address the recommendations raised by the report, which resulted in the development of the WHO Global Disability Action Plan 2014-2021 (WHO, 2015).

A key international development since WHO’s 2014-2021 Disability Action Plan was the publication of the UN Disability Inclusion Strategy (UNDIS). This was launched in 2019 due to the need to strengthen and coordinate a system-wide approach to disability, including in relation to accountability. The aim of UNDIS is to ensure for the first time that the whole UN system embeds the rights of persons with disabilities into its work both internally (as inclusive places to work) and externally (through inclusive and targeted programmes). The strategy itself focuses on four core areas:

- Leadership, strategic planning and management
- Inclusiveness
- Programming
- Organizational culture

Across the four areas there are a total of 15 common-system indicators (graded on a four-point scale of missing, approaching, meeting and exceeding requirements) against which the UN system as a whole and each of its entities has a reporting facility. This accountability framework has purposefully been created to ensure that disability inclusion is the responsibility of all UN staff, with disability units and focal points playing a catalytic role. It is very much a strategy designed to ensure that the UN becomes fully disability-inclusive at all levels.

The current WHO Policy on Disability *(7)* builds on many decades of experience in working on targeted programmes that bring specific benefits to persons with disabilities as well as a growing experience of disability inclusion. This latest policy reiterates that WHO is approaching disability from a human rights perspective and that disability inclusion is a key development issue because of the strong links between poverty and disability.

The UNDIS and its underlying ambition would appear to have fundamentally influenced WHO in the formulation of the 2021 Policy on Disability. During the Seventy-Fourth World Health Assembly held in 2021, resolution WHA74.8 requested the Director-General to fully implement the UNDIS across all levels of WHO, and the current policy and the UNDIS are completely aligned. The aim of the policy is broad-reaching in its intention to “support an organization-wide disability-inclusive culture” (p.5), which ranges from Headquarters to country offices and covers both business operations and programming. The policy is operationalized through a costed Action Plan (2021-2024), structured using the four core areas outlined in the UNDIS (leadership, strategic planning and management; inclusiveness; programming; and organizational culture), which are further broken down into the 15 common-system indicators used by UNDIS. Each indicator has custodian departments with responsibility for implementing and reporting on activities and coordinating with regions, and across related departments. Therefore, the WHO Policy on Disability is completely aligned with the UNDIS, which theoretically streamlines internal reporting whilst also ensuring compliance with the UN’s highest standards of disability inclusion.

1.2 Purpose, objectives and scope of the evaluation

Purpose

The purpose of this evaluation is to review **the extent to which disability inclusion is effectively implemented across all three levels of WHO** – Headquarters’, Regional and Country office levels covering operations and programmatic work. This is in line with the WHO Policy on Disability, which stipulates that: “The WHO Evaluation Office will conduct an independent evaluation of the WHO Policy on Disability, informing its review every five years, as part of the Organization’s strategic planning processes and the Global Programme of Work” (WHO, 2021).

The evaluation is **formative and forward-looking** and draws out lessons learnt and **examples of good practice** to inform the future direction of WHO’s UNDIS work.

Objectives

The evaluation has three objectives as outlined in the terms of reference (Annex 1):

- To assess to what extent **WHO has implemented its Disability Policy and Action Plan** in alignment with UNDIS objectives and with a focus on the achievement of results, including in each of the four core areas and at overall strategic level;
- To identify **factors that hinder or support the ability of the organization to meaningfully integrate disability inclusion** in the four core areas of the Action Plan; and
- To formulate **findings, conclusions and recommendations** that will inform implementation of the WHO's Policy on Disability and future reviews. Furthermore, the evaluation will identify ways to strengthen WHO's organizational leadership to protect and advance the rights of persons with disabilities.

Scope

The evaluation covers the period from 2019 (when the Secretary General launched the UNDIS strategy) to the present date (mid-2024). Whilst the evaluation focuses on the implementation of the WHO Policy on Disability, launched in 2020 and published in 2021, it explores the changes over the last five years as a result of the UNDIS and WHO's subsequent response.

It examines WHO's implementation of the Policy on Disability (at Headquarters', regional and country levels) across the six WHO regions, focusing on data collection at these levels to identify current capacity, leadership, examples of good practice and promising approaches for further exploration.

Evaluation audience

The key audiences for this evaluation include primary internal WHO stakeholders:

- UNDIS Steering Committee
- UNDIS Secretariat
- UNDIS working groups
- WHO departments, regional and countries offices
- WHO staff, consultants, interns and volunteers with disabilities, and workforce members with dependents with disabilities, and allies (Embracing Disability Affinity Group)
- WHO Executive Board.

Evaluation findings will be shared with all WHO programmes and operations teams who are working to mainstream disability inclusion, including among others the Gender Equality, Human Rights and Health Equity who have experienced or might experience similar mainstreaming challenges.

1.3 Object of the evaluation

The object of this evaluation is the WHO Policy on Disability, developed in 2020 and the governance and the costed action plan through which it is operationalized. WHO has been implementing its efforts on disability inclusion through the action plan, which is drawn from the 15 indicators identified in the UNDIS framework.

1.4 Evaluation criteria and questions

Evaluation matrix

A summary of the evaluation questions and sub-questions, including the Organisation for Economic Co-operation and Development (**OECD**) / Development Assistance Committee (**DAC)** criteria to which they relate, is presented in Table 1. The evaluation covers the OECD / DAC criteria of relevance, effectiveness, efficiency and sustainability. The full evaluation matrix is included as an annex to this report (Annex 3).

Table 1. Evaluation questions and corresponding DAC criteria

Evaluation Question	OECD / DAC criteria
Evaluation Question 1: To what extent is disability inclusion effectively implemented across all three levels of WHO?	**Effectiveness**
Sub-question 1.1: To what extent does the WHO Policy on disability bring coherence to the operational and programmatic efforts to mainstream disability inclusion?	**Coherence**
Sub-question 1.2: What are the relevant mechanisms for operationalizing the WHO Policy on Disability at all three levels? In what ways do they incentivize / catalyse action or not?	**Relevance**
Sub-question 1.3: To what extent are resources allocated through the flexible fund to ensure the efficient use and prioritization of the costed workplan?	**Efficiency**
Sub-question 1.4: To what extent do WHO staff feel that actions taken are relevant and effective to creating an inclusive entity?	**Relevance**
Evaluation Question 2: To what extent are specific disability inclusion measures in place at each level of the organization– and what examples of good practice are there?	**Effectiveness**
Sub-question 2.1: What interventions exist to mainstream disability inclusion and what good practice examples are there of specific disability inclusion measures at Headquarters', regional and country levels?	**Effectiveness**
Sub-question 2.2: What are the challenges to implementing interventions to mainstream disability inclusion and disability-specific measures at Headquarters', regional and country levels?	**Effectiveness**
Evaluation Question 3: To what extent has WHO created a sustainable foundation on which to continue to deliver on the policy after 2024?	**Sustainability**

Conceptual framework for the evaluation

As there was no existing Theory of Change for the UNDIS or the WHO Policy Disability, the evaluation team developed a conceptual framework during the inception phase to guide the evaluation. This was informed by document review and key informant interviews during this initial phase. The conceptual framework sets out the evaluation's understanding of the ambition for the WHO Policy on Disability and the outcomes and assumptions that will be tested during the evaluation.

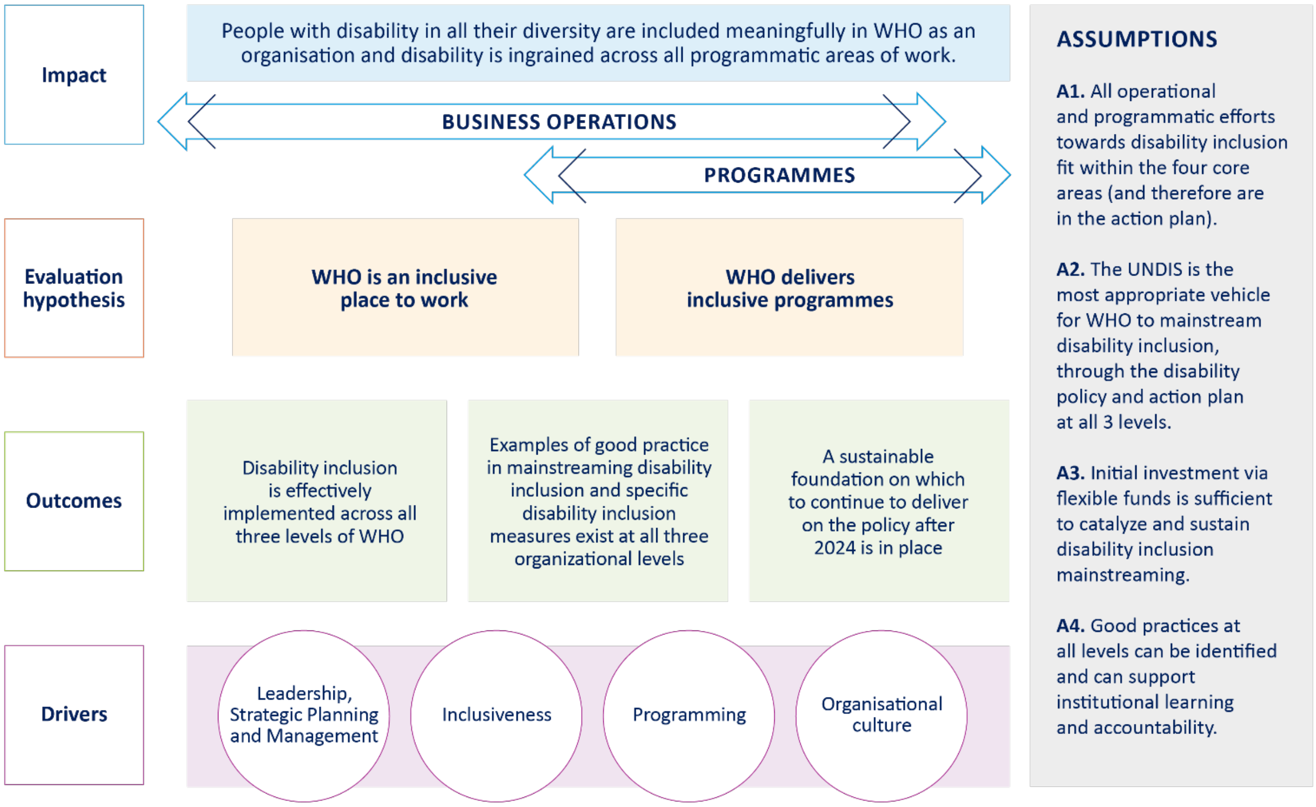
The evaluation explores to **what extent the WHO is both a disability-inclusive place to work and delivers disability inclusive programs**, at all three levels of operation. In particular, it looked at the following outcomes:

1. The effective implementation of disability inclusion across all three levels of WHO;
2. The existence of good practice examples in mainstreaming disability inclusion and specific disability inclusion measures; and
3. The existence of a sustainable foundation on which to continue to deliver on the policy after 2024.

Evaluation questions explore these outcomes at the different levels, through the lens of the four core areas of the WHO Disability Policy – namely Leadership, Strategic Planning and Management; Inclusiveness; Programming; and Organizational culture.

The conceptual framework has been validated with the Evaluation Office, the UNDIS Secretariat and the Evaluation Reference Group prior to the finalisation of the inception report (Figure 1). The full conceptual framework is included as Annex 2.

Figure 1. Conceptual framework for the evaluation



A1. All operational and programmatic efforts towards disability inclusion fit within the four core areas (and therefore are in the action plan).

A2. The UNDIS is the most appropriate vehicle for WHO to mainstream disability inclusion, through the disability policy and action plan at all 3 levels.

A3. Initial investment via flexible funds is sufficient to catalyze and sustain disability inclusion mainstreaming.

A4. Good practices at all levels can be identified and can support institutional learning and accountability.

II. Methodology

2.1 Approach

This non-experimental, mixed-methods evaluation is both formative in nature and utilisation-focused, with an emphasis on ensuring the findings are relevant, actionable and accessible to stakeholders. It combines both a strong participatory and human rights-based approach with a theory-based approach, grounded in the conceptual framework (or theory of change illustrated above) to explore how WHO's Policy on Disability is driving effective implementation of disability inclusion.

Central to this approach is the meaningful participation of rights-holders in the evaluation process – primarily in this case for the business operations dimension – that is the WHO workforce, to ensure their voices and perspectives and experiences are central (see section on consultation and participation below for further details).

An adapted outcome harvesting approach was selected for this evaluation as it is a particularly useful approach for looking at complex and dynamic systems of social change. This focus on harvesting and linking stories of change and challenges through a triangulated analysis of document review and stakeholder engagement allowed the clear identification of what worked and why, and what lessons could be drawn.

The evaluation has been guided by the following principles:

- It is utilization-focused, so that the findings and process can inform decision-making and improve operations and programming with a view to benefiting the entire organization, particularly people with disabilities in all their diversity, and to strengthening the systemic integration of disability inclusion within WHO. The evaluation is forward-looking with a strong focus on lesson learning.
- Participation and co-ownership: The evaluators worked closely with the Evaluation Office and UNDIS Secretariat at WHO, taking a collaborative stakeholder engagement approach to ensure meaningful participation. This included convening dialogue with (business operations and programming) staff across all levels, custodian Departments and the Embracing Disability Affinity-Resource Group, and contributing to the development of the recommendations.
- Focus on feminist research principles, intersectionality and gender equality, disability and social inclusion (GEDSI) as a core part of the human rights-based approach: GEDSI is central to the evaluation, with its principles considered at each stage of the evaluation. This ensured the inclusion of diverse stakeholders and rights-holders, and that data is disaggregated by gender, and disability status, where appropriate.
- UN Evaluation Group (UNEG) principles of integrity, accountability, respect, and beneficence, which support systematic consideration of ethics to help balance the goals of evaluations with the rights and interests of diverse participants and their communities.

Consultation and participation

Given the formative nature of this evaluation, the evaluators aimed to collaborate extensively with WHO stakeholders across levels and representing diverse elements. The evaluation team used various methods to enable active participation, ensuring information directly informed findings and recommendations. These qualitative methods (see section on tools below) guided areas of research while allowing informants to respond freely about harvested change. To ensure accessibility and participation in general, the evaluation team prepared questions and briefing notes in advance and sent them to key informants before interviews. Key validation mechanisms included regular check-ins with the UNDIS Secretariat, the ERG, and periodic attendance at UNDIS Focal Point meetings to discuss emerging findings.

A series of consultations were held with different stakeholder groups throughout the evaluation, including the **Embracing Disability Affinity Resource Group, the UNDIS focal point network, the UNDIS Disability Resource Group**, and the **Evaluation Reference Group**. The Embracing Disability Affinity Resource Group, a 300-member collective representing staff with disabilities, dependents with disabilities, and allies, was a significant stakeholder group with which the evaluation team engaged. Members of the Embracing Disability Affinity Group[4] were invited to meet on two occasions to reflect on the implementation of the Policy on Disability and gather direct input on WHO culture and leadership values related to disability inclusion and to offer support in triangulation and sensemaking of the data.

The evaluation team periodically attended the monthly meetings with the **UNDIS Disability Resource Groups**[5] during the period of data collection, which gave an insight into the work of these different departments and enabled it to explore any questions that arose.

The Evaluation Reference Group was also a key group supporting stakeholder consultation, as outlined below.

---

[4] The Embracing Disability Affinity group is open to any WHO employee who experiences any form of disability (visible and non-visible), colleagues with dependant family members with disabilities, and those interested in the work of disability, and/or support the work towards disability inclusion in WHO.

[5] The UNDIS Disability Resource group is a group created by and for UNDIS Focal Points and open to any WHO employee. It aims to build capacity on disability inclusion in WHO and develop a network of WHO workforce members to drive disability inclusion in business operations and programming.

2.2 Data collection methods

This evaluation entailed three data collection methods (Figure 2):

Figure 2. Data collection methods

40+
DOCUMENTS REVIEWED

16 KIIS AND 14 FGDS AND 90+ RESPONDENTS

2
CONSULTATIONS WITH STAKEHOLDERS

Desk review (documents and data)

The evaluation team reviewed more than 40 documents during the evaluation and sourced documents through the UNDIS Secretariat, UNDIS Disability Inclusion Strategy Information Hub, the Evaluation Manager, through key informants at Headquarters, regional and country level, and through internet searches. Annex 7 includes the list of documents covered at Headquarters', regional and country levels, including UNDIS reporting.

Key informant interviews and focus group discussions

A series of key informant interviews (KIIs) and focus group discussions (FGDs) were conducted with a range of WHO workforce members at the three levels of the organization. This included staff from both the Operations and Programme divisions of the organization to understand how the Policy on Disability is understood and being implemented (WHO, 2021). Annex 4 includes a list of interviews conducted.

Details of the number of interviews and people consulted by the stakeholder group are provided (Table 2).

Table 2. Stakeholder groups for KIIs

Location / level	Stakeholder Group	Method	Number of respondents
Headquarters	Custodian department leads	9 KIIs and group interviews	9 women, 3 men and 1 non-binary (13 total)
Regional offices (six regions)	Technical programme staff and Business operations staff	3 KIIs and 6 FGDs	15 women and 7 men (22 total)
Country offices (12 total)	Technical programme staff and Business operations staff	3 KIIs and 8 FGDs	20 women, 17 men, 4 unknown (41 total)
Persons with disabilities or persons with family members or allies with disabilities	Disability Affinity group members	2 group consultation meetings for validation and sensemaking during the data collection and analysis	18 people (gender disaggregation not known) *Some of these individuals were included in other interviews and discussions
Persons with disabilities or persons with family members or allies with disabilities	Organizations of persons with disabilities	1 KII	1 woman
TOTAL		**16 KIIs / group interviews and 14 FDGs and 2 group consultations**	**95 people**

The evaluators requested the following demographic data from each respondent and have ensured information is kept confidentially and anonymously as per the evaluator's data protection policy (see Annex 6):

- Job title
- Location
- Woman / Man / non-binary / prefer not to say
- Do you self-identify as a person with a disability? (optional)

Not all respondents provided this information, but for those who did the percentages of respondents by gender and disability are given in pie-chart form (Figure 3 and Figure 4).

Figure 3. Percentage of interviewees by gender

Percentage of respondents by gender

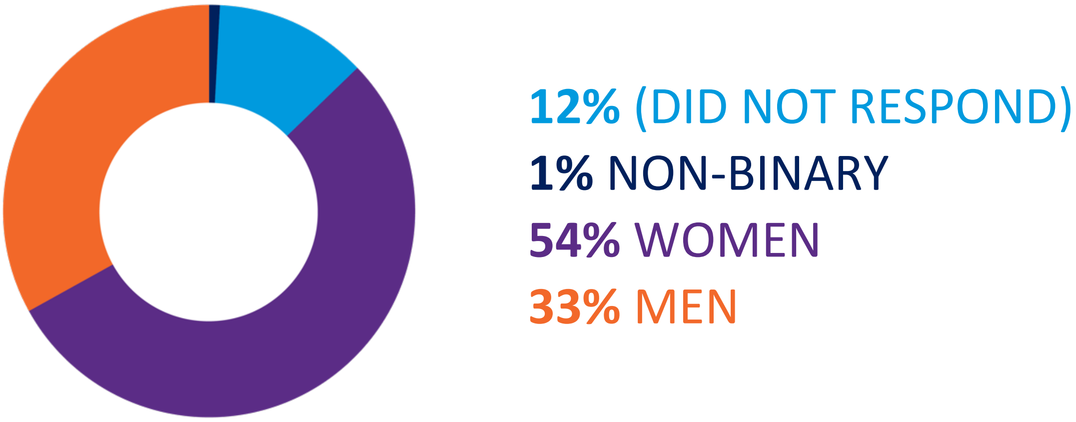
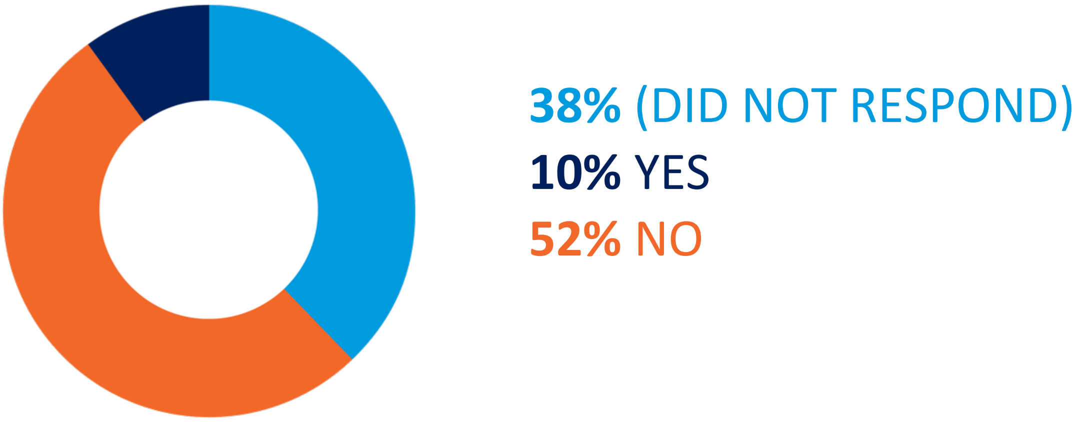


Figure 4. Percentage of interviewees who identify as a person with disabilities

Percentage of respondents who identify as a person with disabilities



Sampling strategy

During the inception phase the evaluators developed criteria, discussed and validated with the ERG, to identify a sample of countries across all six regions to focus our interviews and document review. They used an **appreciative inquiry approach** to identify country offices with positive examples of what has been working well to improve disability inclusion within operations and programmes.

- **AFRO:** Tanzania, Cote d'Ivoire
- **EMRO:** Bahrain, Saudi Arabia
- **SEARO:** Nepal, India
- **WPRO:** Laos, Solomon Islands
- **EURO:** Montenegro, Moldova, Georgia
- **PAHO:** Bahamas

Validation and analysis

The evaluation's analysis and synthesis included the following phases:
(1) initial coding of interviews and document review; and
(2) overall synthesis of the findings from these sources,
followed by triangulation and validation meetings.

The evaluation team used a thematic analysis approach to analyse qualitative data from KIIs and FGDs, identifying key trends and patterns across evaluation questions. The document review used a similar coding framework in Excel to extract evidence and findings related to the evaluation questions. The coding framework was designed in alignment with the evaluation questions and assumptions outlined in the theory of change matrix.

Data was triangulated between these coded interviews and the document review, which involved comparing and integrating findings across these different data sets. The interviews were coded using thematic analysis to identifying emerging themes which were then cross-referenced with findings from the document review.

The evaluators also drew on the evaluation teams' extensive sectoral knowledge of evidence and good practice with regards disability inclusive programming, and gender mainstreaming.

Internal evaluation team analysis workshops were held to explore and analyse trends in the data prior to drafting the preliminary findings, conclusions and recommendations.

The Embracing Disability Affinity Group members and the ERG have played a crucial role in sensemaking, validating findings, and recommendations, along with the UNDIS Secretariat and evaluation manager.

Evaluation governance mechanism

The independent evaluation team worked closely with the WHO Evaluation Office, which supported the reviewing and quality assurance of key documents submitted and collaborated closely with the WHO UNDIS Secretariat.

The Evaluation Reference Group (ERG) provided advisory technical support to the evaluation. Their role specifically included:

- Reviewing the draft inception report, with focus on evaluation questions.
- Reviewing the draft and final reports to ensure the technical soundness of the findings and adequacy of recommendations.
- Act as a source of knowledge for the evaluation.
- Support the dissemination of findings as relevant.

2.3 Ethical considerations

This evaluation is informed by ethical and safety standards, guided by the UN Evaluation Group (UNEG) and WHO Evaluation Office Ethical Guidelines *(8)* as well as the evaluators' Ethical Policy and Child Protection and Vulnerable Adults Safeguarding Policy, setting the commitment, values and principles to create a positive and safe environment for children and vulnerable adults. All consultants were required to read and confirm their commitment to these policies and have received an induction on these policies. Both the WHO Evaluation Office and an Ethical Committee internal to the evaluators advised on ethical issues, and the potential risks of all research and evaluation work.

Participants to the evaluation took part **voluntarily, based on free and informed consent**, with their agency respected, including their wishes to answer specific questions or remain anonymous.

All participants were asked if they required any accommodations to be able to participate and commit to providing any **reasonable adjustments** to facilitate their engagement.

Personal information was treated **confidentially**, and the **privacy** and **anonymity** of participants preserved. No personal or identifying information was recorded or used in the final report. Quotes and examples used were anonymized. A Unique ID system was used throughout the evaluation to anonymously link demographic information with responses.

2.4 Limitations of the evaluation

Since access to data collected as part of this evaluation was restricted to members of the evaluation team only, this limited the evaluation (Table 3).

Table 3. Limitations of the evaluation

Limitations	Mitigations
There were a limited number of documents related to programmes and evaluations available for the evaluation team to consider as part of the document review and triangulation.	The evaluation is qualitative in design largely drawing on key informant interviews. During interviews and consultations, the evaluation team requested relevant documentation and sought to validate the views shared at validation sessions to fill gaps and identify additional documentation.
The organizational culture survey, identified as a key source of data in the ToRs, was not implemented during the timeframe, due to factors outside the evaluation's control. The evaluation therefore did not have access to additional quantitative data	Targeted interviews and focus groups were conducted to gather qualitative insights and anecdotes on lived experiences related to organizational culture, with proxy coding as a part of the analysis to cross-tabulate staff sentiment/ perceptions captured in responses

to support the triangulation and validation of the workforce perceptions gleaned through in-depth interviews.	to other questions but relevant to cultural shifts within WHO.
Initial stakeholder list was selected by UNDIS Secretariat and Evaluation Office (based on organizational roles of potential respondents), but some stakeholders were not available to participate within the timeline of the evaluation, which may have led to some areas being less well represented than others.	The evaluation team broadened the stakeholder consultation pool based on recommendations from initial interviews and a limited number of additional recommendations from headquarters' staff and those interviewed.
A voluntary question was asked of all respondents related to their disability status. Some didn’t answer this, leading to incomplete demographic data across our stakeholder list.	Where this data was available it was used as a trend indicator rather than an absolute number to get a sense of staff with disabilities and their perspectives. Respondents’ disability status was anonymized in data analysis and reporting.
The small sample size and scale of this evaluation has limited the extent to which trends are able to be generalized across the three levels of the organization, particularly at country level.	The evaluation ensured balanced representation by engaging diverse departments and regions across the three levels. It endeavoured to engage stakeholders in both programmes and operations. Analysis was conducted at each level, then cross-tabulated across Headquarters, regional, and country levels to identify trends, differences, and contextual anomalies.

III. Evaluation Findings

Evaluation Question 1: *To what extent is disability inclusion effectively implemented across all three levels of WHO?*

The focus of this evaluation question was to explore the extent to which the WHO Policy on Disability has increased the workforce's understanding of disability inclusion, and how this is impacting the ways in which people are pursing mainstreaming activities within their areas of work and responsibilities. This includes consideration of both operations (how disability inclusive WHO is as an employer) and programming (the extent to which WHO considers disability inclusion within its programming). There is of course considerable overlap between these two strands of work since a disability inclusive culture will permeate through operational and programmatic decision-making processes. This question tests the first and second assumption (A1 and A2) in the conceptual framework that *all operational and programmatic efforts towards disability inclusion fit within the four core areas and are therefore in the action plan* and *the UNDIS is the most appropriate vehicle for WHO to mainstream disability inclusion, through the disability policy and action plan at all 3 levels.*

Overall, this evaluation found that the WHO Policy on Disability and in general the concept of disability inclusion are well supported across the organization, in part due to its close mirroring of the UNDIS. The Policy and the UNDIS provide a solid mandate for integrating disability inclusion into all aspects of programmatic work and business operations. Disability inclusion mainstreaming also benefits from being underpinned by the UN-wide commitment to the Leave no one behind principle, which includes a strong focus on persons with disabilities, and with which staff are very familiar.

Evaluation Sub-Question 1.1: *To what extent does the WHO Policy on disability bring coherence to the operational and programmatic efforts to mainstream disability inclusion?*

Summary: The WHO Policy on Disability together with the UNDIS has provided a strong mandate for integrating disability into all aspects of programmatic work and business operations. Disability inclusion mainstreaming also benefits from the underpinning of the UN-wide commitment to the 'Leave no one behind' principle, and the WHO commitment to 'Health for All', which include a strong focus on persons with disabilities, and with which staff are very familiar and personally committed to. Coherence is mostly identifiable at Headquarters' level, which is expected given that this work is at an early stage and initiated in the context of COVID-19. Disability inclusion is considered a cross-cutting issue relevant to both programme technical work and business operations. However, further efforts are needed to enhance its implementation across the organization and ensure clearer alignment with other cross-cutting initiatives to emphasize disability inclusion as a priority issue.

Finding 1. From an initial absence of an organization-wide approach to disability inclusion, the WHO Policy on Disability has begun a step-change towards greater coherence for disability inclusion. At this early stage the coherence is mostly identifiable at Headquarters' level. The overlap between the Policy and UNDIS has left lines of accountability and responsibility less clear and requiring a stronger, strategic focus on disability inclusion to increase coherence through to regional and country levels.

The WHO Policy on Disability is operationalized by a costed action plan, developed in 2021 using the 15 UNDIS indicators that are tracked and reported on via custodian departments. Most of this work happens at Headquarters' level and, given the short time it has been operational it is less familiar to colleagues at regional and country level. Stakeholders interviewed for this evaluation who are not directly part of custodian departments had limited awareness of either the action plan or the WHO Policy on Disability. They were, however, more aware of the UNDIS as an UN-wide priority initiative.

In this respect, key informants noted that the UNDIS has been helpful in prompting them to consider disability inclusion at operational level, in human resources for example, but it is far less influential in affecting change at all levels of programmatic work, highlighting the incremental phasing of this work, starting at HQ operational level, before being picked up at other levels through the organization, as illustrated by this respondent from Headquarters: "change is happening but we attribute that to the work we have been doing, not as a result of UNDIS or the Policy on Disability. We haven't really noticed anything changing significantly as a result of UNDIS – not from a technical perspective at least."

There is recognition that the WHO Policy on Disability, whilst important, is not yet adequately known for it to provide coherence to WHO's disability inclusion work at Regional and Country Office levels. In many respects, since it so closely resembles the UNDIS it is not fully aligned to the decentralised way in which WHO is set up and works.

Part of the coherence that is currently missing, at least in respect to those staff teams not embedded in the UNDIS structure, is the lack of measurable and reportable disability inclusion targets, whether that is in relation to operations or programmes. Numerous respondents commented on the importance of indicators and accountability measures that give teams a clear mandate to prioritize issues like disability inclusion and to implement plans that ensure they are covered. These sentiments were expressed by regional and country level colleagues: *"If we are not measuring it, it won't be done"* and another similar comment, *"what gets measured gets done."*

At the moment, WHO does not mandate the collection of disability disaggregated data from within its operations or programming at any level, which means that it cannot objectively describe the extent to which it has increased or improved its ability to reach persons with disabilities. Currently it must rely on the proxy indicators created by UNDIS which are not tailored to the way WHO operates, nor are detailed enough to provide sufficient direction for individual teams dealing with the issue of how to mainstream disability inclusion. Disability inclusion is aggregated into reporting on gender, equality and human rights through the Output scorecard (Dimension 4 on Impactful integration of gender, equity, human rights and disability (GERD), however disaggregation of data by disability is not a requirement. This means that GERD results do not yet accurately reflect work happening on disability inclusion and therefore it is not possible to follow up or learn from experiences. Concerns were also raised that the lack of attention to disaggregation of disability data was leaving staff with little confidence in knowing what progress looks like in relation to disability inclusion. Respondents also noted that people are more likely to focus on issues within the GERD space that are measured, and the lack of disability data disaggregation leave staff less motivated to follow up on this issue. Without fully disaggregated data it is very difficult for WHO to track the extent to which the Policy on Disability is providing guidance for programme and operations work and therefore its overall effect on coherence is difficult to determine.

The need for a stronger, strategic focus on disability inclusion is illustrated by examples of the way in which broader organization-wide processes have not yet taken up disability inclusion. For example, disability inclusion in technical programmes is not explicitly captured in the GERD roadmap, which was produced after adoption of the Policy on Disability and UNDIS.

So, whilst the Policy on Disability and UNDIS indicators have provided a focus for attention on disability inclusion, especially at Headquarters' level, there remains a need for stronger, more sustained messaging on the implications for different teams in their work and more detailed mechanisms for tracking progress across programming and operations.

Finding 2. The Policy on Disability is well supported by WHO's general commitment and understanding of the human rights approach to addressing health equity. The focus on 'Health for All' and 'Leave no one behind' is underpinned by strong personal passion which has the potential to be harnessed in pursuit of greater disability inclusion. However, the lack of specific technical expertise and confidence in discussing disability means there is still progress to be made on effective implementation of inclusive actions across the organization.

There is a strong culture across the organization of recognising health inequities and the role that stigma, discrimination and denial of human rights plays in creating those inequalities. This has made it relatively easy to talk about disability inclusion, whether people are working directly on disability-related issues or not. All key informants had a solid understanding of disability inclusion from a health equity perspective and agreed that this was central to the DNA of WHO's 'Health for All' mandate[6]. The principles underpinning WHO's disability inclusion agenda are generally well understood, and many people referenced WHO's global mandate, and the UN-wide principle of 'Leave no one behind' (LNOB).

---

[6] It is important to note that the evaluation used purposive sampling, and an appreciative enquiry approach so it was to be expected that most of the people the evaluators spoke with would have a good understanding of disability inclusion as some aspect of their role and responsibilities included this area of work.

The LNOB principle is well understood at all three levels of the organization and is a strong driver for programmatic work at country level, especially at the UN Country Team level where there are a number of joint-UN initiatives working on this.

Whilst there is widespread acceptance of the theoretical policy position, there is still a lack of confidence and technical expertise when it comes to practical application. Individuals, and teams often expressed how unsure they were about practicing these principles in their work. Moreover, this is especially challenging in the context of perceived competing priorities and overstretched workloads.

Currently, WHO relies on the role of focal persons to take this work forward across the regions and countries. For a large agency at an early stage of disability inclusion, focal points can be an effective way of promoting a coordinated approach. In fact, many people interviewed for this evaluation referenced the existence of these roles at Headquarters', regional and country level. This structure is well recognized as an approach, endorsed by UNDIS and the WHO Policy on Disability. Moreover, the Policy is well supported at the highest level of the organization with strong leadership commitment. The senior-level mandate and the focal point structure is valuable, and identifying people to lead and champion this work is a good approach to dealing with the fact that disability inclusion is still new to most WHO staff. However, effectiveness requires that those with focal point responsibility are confident in applying a disability inclusive approach, have the knowledge to support colleagues, the time allocated within their job descriptions and are supported to deliver.

The evaluation heard from respondents that many people who were given the role of disability inclusion focal point had either not known this was part of their role or had agreed to it out of a personal passion and commitment to the issue, often because of personal, lived experience.

“I am the) focal point because it sits within my portfolio of violence and injury prevention. Four or five years ago when I joined there wasn’t active engagement with disability inclusion. (This change) reflects developments at global level. When I was recruited, disability inclusion wasn’t included in my job description. You assume those responsibilities”, said one respondent from a country office.

A further challenge identified was the tendency for some individuals to end up with multiple focal point roles. Some key informants described having to sit on so many working groups and represent such a diverse range of issues that they found it very difficult to be effective. In many cases, people expressed their neglect of disability inclusion work, mostly because of a lack of experience and confidence in this area of work.

The reliance on focal persons presents a challenge to the systematic and strategic positioning of this work. Over the longer term this strategy risks consigning disability inclusion to the delegated work of a small number of individuals and may ultimately limit the agency's ability overall to mainstream disability inclusion. Currently the approach is contributing to a more ad-hoc application of disability inclusion rather than as an organization-wide strategy.

This risk is well illustrated by an example shared by one interviewee who described how the disability focal person in the office set up an initiative in their region establishing work experience placements with a further education institution for persons with disabilities. In the short term, this had the positive effect of raising awareness on how to work alongside colleagues with different impairments and contributed towards a more open and inclusive culture in the office. However, this was a short-lived initiative that was not monitored with a view to establishing more inclusive recruitment and retention practices. It had been an idea generated through personal connections by the focal person, which ended once the staff member left their position.

Finding 3. At a programmatic or technical level, disability is predominately viewed from a biomedical approach and understood as a health condition or impairment by some of the technical units outside of the disability programme.

Until UNDIS was launched, disability work was mostly included within rehabilitation, and even now many of the focal persons for disability inclusion have ‘disability and rehabilitation’, or ‘violence and injury prevention’ in their job title. This positioning is likely due to the historical focus of the organization and the largely medically trained workforce’s understanding of disability as a medical problem that can be prevented or treated. There is need to shift mindset and awareness of disability inclusion as a health equity issue. The view that disability is something that can be prevented or ‘fixed’ (biomedical approach) rather than as a rights and equity of access issue (human rights’ model), continues to challenge this work. This latter understanding is well documented in the Disability Inclusion Core Concepts Guidance developed in 2022 (WHO, 2022) which outlines a definition and understanding of disability from WHO’s perspective and is grounded in the WHO classification of Functioning, Disability and Health (ICF). This is clear in explaining that disability results from the interaction between health conditions and /or impairments and a range of contextual factors:

> *‘Disability is not the same as a health condition or impairment. For example, depression, cerebral palsy, or retinopathy are not disabilities: they are health conditions which contribute to disability if the surrounding environment negatively impacts the person’s life.... Regardless of the health condition or impairment, persons with disabilities can enjoy healthy lives by realizing their aspirations, satisfying their needs, if the barriers in their surrounding environments are removed.’*

Despite this general guidance however, the biomedical approach still predominates across the range of stakeholders interviewed. Many interviewees simultaneously understood that disability inclusion is important to ensure health equity and universal health coverage but were unsure how this would relate to inclusion in their own work area because they still see disability as an individual, biomedical issue. This is further illustrated by a respondent from regional office who explained, *"There's often a lack of understanding within healthcare and providers regarding even those initial basic needs for services for assistive products for rehabilitation (which) are not considered essential health care. One of the fundamental barriers is there is often a very biomedical approach to doctors and health workers, they simply don't think about the person as a whole, their functioning and their life. This very narrow way of thinking about people's health doesn't convert to how they live their life, how they do their daily activities, how they can then participate, go to school, go back to work."*

Furthermore, people cite having to deal with multiple, seemingly conflicting rights issues to the extent that they must then prioritize. This understanding of the priority attached to disability inclusion can vary significantly between departments. Programme staff, including NCD staff who work on preventing the health conditions that can contribute to disability, are more likely to view their work on disability as related to alleviating a chronic condition rather than also as an inclusion issue. For those working around the social determinants of health, the priority is more likely to be equity of health outcomes for persons with disabilities. This suggests that more specific and targeted messaging, awareness raising and training may be required across the organization to address variations in understanding how to implement disability inclusive actions. The tuberculosis (TB) programme is a positive example of where progress has been made in dealing with both the medical and the social issues inherent in a lot of disability work. TB is a complex disease with biomedical, social and co-morbidity issues (some of which can contribute to disability). It was described to the evaluation team as the 'hallmark of social exclusion' given that there can be high levels of stigma attached to having the disease. The TB Unit has been championing a broader inclusion strategy, challenging issues around access to treatment and wider support for persons with disabilities, also in relation to access to social protection. Whilst it has been doing this for some time, they believe that their holistic approach has not gained traction across the wider organizational structure and fear this could be lost if the approach is deprioritized in future.

There was self-reflection among some country programmes that their own capacity and understanding of disability inclusion needed to be improved. Many are concerned that they may say or do the wrong thing since they feel that this is an ever-evolving area of work (reflecting their relatively recent entry into disability inclusive work). Many do not yet have the language or confidence of understanding to be able to plan proactively for disability inclusion, especially in relation to the technical programming where support and examples are less easy to access.

At the operations level when asked about the impact of the Policy on Disability on disability inclusion, many people were confident in talking about how it prompts the need for reasonable accommodation, accessible infrastructure and software, or IT systems, alongside issues of fair and equal recruitment. However, the extent to which these initiatives were being implemented varied depending on whether the respondent was at Headquarters, RO or CO. At CO level, for example, respondents most often talked about physical accessibility, the need for wheelchair accessible offices or venues for meetings. Some mentioned examples of where sign language interpreters had been hired to facilitate access for Deaf participants at events but very few mentioned, without prompting, measures to support people with invisible disabilities. Generally, from an operational perspective, disability inclusion was mostly described in terms of an individual accommodation made for a specific type of impairment rather than as a need to plan for, and address, barriers in the workplace (attitudinal, institutional *and* environmental).

It was good to note that among key informants there was awareness and understanding that poor mental health can lead to social, emotional and physical impairments, which may constitute a disability. Recent webinars arranged by the Embracing Disability Affinity Group specifically addressing this issue were conducted to promote mental health awareness week and have increased visibility of persons with disabilities having an underlying mental health condition and the challenges they face, as well as raising awareness of how poor mental health may require specific accommodations and adjustments.

Providing tools, guidance and resources without ongoing support tends to be insufficient in disability inclusion because many people are unaware of their lack of understanding, and many will assume they already understand disability. Given that many respondents have already acknowledged they lack capacity and have become aware of their ignorance, there is a growing target group for such training.

Finding 4. Disability inclusion is considered a cross-cutting issue relevant to both programme technical work and business operations. In this regard it fits well within other cross-cutting initiatives including gender equality, human rights and health equity (GRE) and diversity, equity and inclusion (DEI). However, there could be more explicit alignment with such initiatives to clarify messaging on disability inclusion as a priority issue.

As noted previously, conceptually disability inclusion is welcomed across WHO and many are making the link between GRE, DEI and disability inclusion. However, the messaging around disability inclusion has become somewhat confused because processes into which disability inclusion would seem to fit have not always adequately articulated this or have not emphasized disability inclusion as a critical aspect of these areas.

This is illustrated by the way in which neither GRE roadmap nor the DEI strategy explicitly align with, or link to, the Policy on Disability or the UNDIS indicators. Several key informants noted this as being problematic, especially since both these initiatives were developed after UNDIS and the Policy on Disability came into effect. This creates a level of disconnect between the Policy and other strategies and initiatives which leads to some insecurity amongst staff around the importance of disability inclusion. Concern was expressed by some respondents that this lack of synergy could mean that disability inclusion faced axing if senior leadership stopped promoting it. In a similar way, other respondents expressed how they felt overwhelmed by the pressures of introducing numerous initiatives and strategies addressing cross-cutting issues which, in the absence of support and follow-up, led them to de-prioritize areas like disability inclusion, which were neither explicit nor obviously aligned.

Respondents at all levels of the organization suggested that the learning from mainstreaming gender could usefully be applied to efforts to integrate disability inclusion. The structural sustainability of disability inclusion requires a much greater level of visibility and coherence across systems and processes than is currently evident. The Policy on Disability and the UNDIS indicators are still relatively new, but for progress to be made there needs to be greater levels of oversight of and synergy with organizational initiatives that could help promote disability inclusion. There are opportunities to build stronger linkages and collaboration between UNDIS and the GRE department to better align messaging, share lessons, and maximise synergies.

***Evaluation Sub-Question 1.2:** What are the relevant mechanisms for operationalizing the WHO Policy on Disability at all three levels? In what ways do they incentivize / catalyse action or not?*

Summary: A number of mechanisms are supporting disability inclusion across the organization, including UNDIS Structures (Steering Committee, Secretariat and Working Group) and the Action Plan, all of which are backed by strong leadership commitment. Staff groups have been helpful in raising awareness and driving conversations. To effect the organizational change that is required for disability inclusion to become fully embedded within WHO a review of these structures, including the focal point structure and resources available would be beneficial. Country offices are seeking more practical guidance, tools, and training to mainstream disability inclusion in their work. While global planning and reporting frameworks could improve accountability, their effectiveness is mixed, and there are no mandatory disability-specific indicators in place.

This evaluation sub-question examines various organizational mechanisms to operationalize the WHO Policy on Disability at all three levels, including the UNDIS governance structures and action plan, staff groups, resourcing, country level stakeholders and influencers, capacity building initiatives and global planning a reporting framework.

Finding 5. UNDIS structures and the Action Plan backed by strong leadership commitment have supported disability inclusion across operations and, to some extent, programming. However, the current reliance on UNDIS structures and resources, including the focal point structure, for implementation of the Policy on Disability are not sufficient for effecting the organizational change process that is required for disability inclusion to become fully embedded within WHO.

The primary mechanism through which the WHO Policy on Disability has been operationalised is the UNDIS Action Plan. The Policy's intention is to make WHO a disability inclusive organization and it utilises the core focus areas outlined by the UNDIS of leadership, planning and management; inclusiveness; programming; and organizational culture as its own focus for actions. As noted previously, the Policy's Costed Action Plan uses the 15 UNDIS indicators to track and report on progress. In addition, the internal governance structure mandated by UNDIS has been adopted by WHO as the mechanism through which to implement and monitor the Policy. Within WHO, this includes the WHO **UNDIS Steering Committee**, which provides senior level leadership and oversight; the WHO **UNDIS Working Group,** which includes focal points from custodian departments and which provides more general support to the implementation and monitoring of the Action Plan; and the WHO **UNDIS Secretariat** currently consisting of three members of staff representing programmes and business operations with responsibility for convening and coordinating the Steering Group and the Working Group and all the reports and plans associated with implementation. The intention is to establish comparable structures at regional level.

Staff at Headquarters' level credit UNDIS with galvanizing action towards achieving a more disability-inclusive organization and for providing the Policy with a powerful UN mandate for action. Another positive point is that the UNDIS governance structure is backed by a strong leadership commitment to disability inclusion as evidenced by senior management membership of the Steering Committee and senior members of staff in the UNDIS Secretariat highlighted by this respondent from Headquarters,

> *"UNDIS has been a game changer for the organization,*
> *giving it concrete actions to drive change."*

WHO have been able to report good year-on-year progress against the 15 UNDIS indicators at headquarter level since their 2019 baseline. Whereas in 2019 WHO reported 14 indicators as either missing or approaching (with one exceeding) by 2023 they reported four exceeding, 10 meeting or approaching and just one missing. Most of the achievements have been in operations with three of the key programme targets staying at approaching level (with one exceeding). In recent months, more progress around programme targets has started to emerge because of a concerted effort to push implementation beyond Headquarters.

In 2023 membership of the UNDIS Steering Committee was extended to include regional office senior management and country representatives on an annual rotational basis to strengthen UNDIS implementation at all levels of the organization. Capacity-building visits to regional offices by the UNDIS Secretariat have also helped to prompt progress on UNDIS, including on Indicator 9 (programming), which has been at approach level since 2020. The establishment of regional steering committees has to date been dependent on the capacity of the UNDIS Secretariat to visit regions, conduct awareness-raising activities and support their development. Where this has happened there has been positive feedback on progress. In the Regional Office for Africa (AFRO), for example, notable strides have been made since the UNDIS regional steering committee was launched this year following extensive consultation and a visit by the UNDIS Secretariat in February 2024 to raise awareness of UNDIS and identify entry points for implementation, such as including UNDIS as a standing agenda item in meetings with WHO country representatives. Similar progress was noted in the Regional Office for the Western Pacific (WPRO) following a visit from the UNDIS Secretariat.

A primary challenge facing WHO currently is the extent to which UNDIS and its associated governance, planning and monitoring structure is adequate for the task of fully implementing the Policy on Disability and to mainstream disability inclusion across the organization. This relates to concerns around the levels of resourcing of the UNDIS Secretariat as well as issues related to roles, responsibilities and integrated ways of working.

Under the current operating model, there is one staff from Business Operations and two Disability Programme staff within the UNDIS Secretariat who have effective responsibility for driving and supporting disability inclusion mainstreaming across the organization, alongside their other duties not related to the UNDIS Secretariat. The Disability Programme itself is a small team, but since adoption of the Policy on Disability their role within the WHO has assumed considerably more importance since there is an organization-wide need to draw on their expertise. As much of WHO's programmatic work is devolved to regional and country offices, technical resourcing is required at all levels of the organization. The resources required for a Secretariat that is primarily tasked with coordinating meetings and UNDIS activities, collating information, and providing technical support across the three levels of the Organization is considerably different to one that has the whole responsibility for driving and effecting an organizational change process. There needs to be discussions at senior level around the expectations of the role of the UNDIS Secretariat in relation to implementation of the Policy on Disability and its ambition to make WHO a disability-inclusive organization. Whilst the UNDIS Secretariat's role and resourcing are clear in relation to UNDIS, it seems as though the expectations that this group will be able to achieve transformational change on disability inclusion across the organization are too ambitious. The fact that the UNDIS structure has not provided WHO with appropriate mechanism for assigning the roles, responsibilities and integrated ways of working required for an organizational change process is also relevant to this.

Whilst the UNDIS has clear roles and responsibilities for the four focus areas and the 15 indicators, there is disability inclusion work which falls outside of the scope of the action plan. There is a need for stronger collaboration and alignment with other WHO stakeholders working in areas related to disability inclusion, especially if the organization wants **to shift the attitudes of a predominantly medical workforce from a medical model of disability focused on impairments to a rights-based approach**. Among these stakeholders, the Gender, Human Rights, and Health Equity (GRE) department for example has a mandate to promote health equity and inclusion through its GRE Roadmap activities, making it a valuable ally in mainstreaming disability inclusion in technical programming. Stakeholders from different groups have flagged the need for closer coordination and greater clarity to enhance the efficiency and effectiveness of their respective efforts to make WHO an inclusive organization, recognising that they don't always have the technical expertise on disability inclusion to support this awareness-raising and capacity-strengthening work.

Disability mainstreaming is an organizational change process affecting all staff in all teams, from communications to vaccination programmes. The current UNDIS structure and particularly the reliance on the disability programme expertise within the Secretariat is insufficient for supporting the organization-wide change process promoted in the Policy on Disability.

Finding 6. Staff groups, such as the Embracing Disability Affinity Group, have provided a crucial space and platform to drive conversations and awareness raising.

In addition to the formal UNDIS structures mentioned previously, the Embracing Disability Affinity Resource Group brings together WHO employees who experience disability (visible and non-visible), colleagues with dependant family members with disability, and those interested in the work of disability, and/or supporting the work towards disability inclusion in WHO. The group started before the launch of the Policy on Disability as a forum for staff with disabilities and allies to connect and share information and support. UNDIS funding has increased the Affinity Group's visibility and reach, for example, through awareness-raising activities focused on organizational cultural change and internal advocacy that have provided informal opportunities to change ableist attitudes within WHO, as highlighted by this Headquarters respondent,

> *"You have highly educated people here who sometimes don't like to be seen to make a mistake or say the wrong thing. So, they might rather just stay away or not say anything. But when we invite people like this (in a more informal way) we are saying, it's okay to ask a question and to be in a more humble position to acknowledge that […]. The group aims to provide a space where people feel they can be honest - to ask questions and even to talk about their own impairments in ways that they would not have the confidence to do otherwise."*

The UNDIS focal point network and UNDIS Disability Resource Group also play important roles in advocating for disability inclusion and disseminating knowledge across all levels and regions of WHO. Staff at all three levels also highlight the role of DEI initiatives, such as the DEI network and respectful workplace training, that have helped start conversations on how to create an inclusive and enabling environment for staff, in part through the recent consultations on the strategy. Disability inclusion for WHO's workforce/workplace is one of the five priority areas within WHO's DEI strategy[7].

Finding 7. Dedicated expertise, communication and resourcing at all levels of the organization is critical to systematically integrate disability inclusion into WHO's operational processes and programmatic work and to avoid overburdening multiple-faceted focal points.

---

[7] Draft DEI strategy, July 2024, awaiting sign off

The Steering Committee, which has an oversight function, has membership from regions aiming to proactively advocate for UNDIS in their respective networks (DPMs and Directors of Administration and Finance (DAFs) and WHO Representatives (WRs).

Dedicated resourcing and expertise at regional level is key as regions play an intermediary role supporting country offices to implement policies and guidance from Headquarters, as well as facilitating learning between WHO Member States and regions. This is acknowledged at different levels as highlighted by the comment of one regional respondent,

> *"You need dedicated resource to drive the work. In some regions disability inclusion is carried along with five other areas."*

Progress has varied in implementing disability inclusion in different regional offices. For example, EURO had dedicated disability inclusion expertise to develop a regional framework for action to achieve the highest attainable standard of health for persons with disabilities. However, in 2022, progress was slower in PAHO/AMRO due to a two-year vacancy in the technical expert on disability role.

In many regional and county offices consulted during the evaluation, specific disability inclusion expertise was insufficiently resourced, and staff were assigned the role of disability focal point or nominated to join a working group in addition to their existing responsibilities. This challenge is not unique to disability inclusion. In one regional office, a technical officer noted membership of 12 working groups, including the disability working group, and due to lack of time and capacity, prioritizing disability inclusion work was not possible. In addition, it was flagged that the group had only met twice in the past two years.

In technical roles, designated disability focal points often specialise in a disability-related field such as rehabilitation and assistive technology. However, this can contribute to a siloed approach and make it more challenging to enable a disability-inclusive lens to be mainstreamed across all areas of programming. Conversely, in smaller offices the nominated disability focal point may not have a background in disability inclusion and would thus lack the capacity or confidence to manage disability mainstreaming among several competing priorities.[8] While many disability inclusion focal points interviewed demonstrate strong commitment to the agenda, some cautioned that an over-reliance on individuals is not sufficient for the systematic mainstreaming of disability inclusion required for organizational change of this scale. Staff members interviewed expressed their concerns that without more formalized resourcing the sustainability of the disability inclusion work could be at risk if priorities or leadership change.

Several key informants made comparisons with other organizational change initiatives, such as gender equality and preventing, and responding to, sexual misconduct, and noted that these areas have benefited from more sustained levels of communication and resourcing over a longer period within WHO. Thus, there is a much deeper and more consistent level of understanding across the workforce of how to apply a gender lens to all areas of work, and there is greater consensus that safeguarding against sexual exploitation, abuse and

---

[8] In smaller WHO country offices this is usual practice for WHO (see recommendation for further discussion)

harassment (applying a zero-tolerance approach across the organization) is the responsibility of every individual. Disability inclusion, on the other hand, is still regarded by many as the work of specialist departments/units and/or as an optional extra. It will take a lot more time with sustained levels of communication and technical support for disability inclusion to become a uniformly well-embedded approach within WHO.

Finding 8. At the country level, UN country teams, local context and national stakeholders, including governments, are key influencers of country offices' disability inclusion work, more so than the WHO Policy on Disability.

Due to the parallel reporting structures, country office respondents interviewed were often more familiar with the UN country team (UNCT) accountability scorecard on disability inclusion - the UNDIS reporting process coordinated by the UNCT - than with WHO's Policy on Disability and Action Plan. Further awareness-raising and education on how UNDIS applies to WHO would help country office staff to apply a disability-inclusive lens to their work more consistently (and would reduce the tendency to regard UNDIS as a 'tick-box' reporting process).

At the country level, WHO work is governed by local context and the priorities of stakeholders such as the Ministry of Health and donors. Collaboration with other UN agencies via the UNCT is a key mechanism to advocate for disability inclusion with governments and donors. UNCT coordination additionally supports cross-sectoral partnership on disability inclusion within countries, which several country respondents noted was an important avenue to collaborate with key partners beyond the health sector, such as ministries of social development.

A focus group with programme representatives at WPRO described how the health equity for persons with disabilities agenda was helping them to progress work on disability-focused actions at country level. In particular, they have been using the Disability Guide for Action as a national planning tool in Malaysia and Cambodia, alongside the Disability Inclusive Health toolkit, developed in the region, for work at health-facility level. Interestingly the drive for this did not come directly from the Disability Action Plan, or UNDIS reporting. Much of the motivation came directly from country priorities, gaps identified by the data or through development partners. To some extent, the organizational focus on inclusion has given them opportunities to talk about the need for awareness on disability but much of the push has been contextual.

The Moldova team, for example, has become an advocate for inclusion and is working to promote this when talking with the Ministry of Health about the construction of accessible premises, or disability-inclusive health worker training. As in WPRO, they find it challenging to talk about disability inclusive approaches when working with medical personnel, and their efforts are mainly focused on assistive technology provision and rehabilitation (although these are services for the whole population and not specifically for persons with disabilities who should have access to ALL health services). These interventions need to be used with caution as they can reinforce the biomedical understanding to the detriment of the whole population health system strengthening approach, which WHO is promoting, and supporting countries and technical teams to adopt this. Experience from Montenegro cautions that it can be particularly difficult for small country offices to prioritize specific issues, and agendas can easily become politicized. They noted that populism tends to lead to increasing numbers of politicians who may be happy to appear in selfies with persons with disabilities, but who quickly move away from doing anything meaningful when confronted with the complexity of the tasks.

Meaningful consultation with organizations of persons with disabilities (OPDs) is another mechanism to support disability inclusion at country level. While efforts to include persons with disabilities in consultations and policy discussions are increasing, these initiatives are still at preliminary stages and are not systematically integrated across the work. At Headquarters, and in some regions, partnerships with OPDs have been established, trying to respect the meaningful participation principle of “nothing about us without us”. This is less consistent at country level, although there are some positive emerging examples. WHO India has been working with the Blind Relief Association to develop Information, Education and Communication materials and signage that are accessible for people with different vision impairments. Other country teams shared examples of how they too are linking with persons with disabilities. The Solomon Islands programme is working on a workplace culture and inclusivity programme, including focusing on mental health and evidencing the creation of quarterly consultative spaces driving inclusion within WHO offices. The Tanzania office is also partnering with an OPD, although the partnership awaits formalization with an MoU. Partnerships with OPDs, while underway, are still largely informal, and there is a need for greater accountability and formalization of these relationships to ensure sustained progress.

Finding 9. There is strong demand from country offices for more practical, accessible how-to guidance, standard operating procedures, tools and training to mainstream disability inclusion across all areas of work.

In interviews, country office staff highlight strong support coming from regional offices and Headquarters in guiding their disability inclusion work across both operations and programmes. Several practical guidance documents have been developed to support country offices, and the UNDIS Information Hub has been developed to house all these documents in one place.[9]

The EURO region, for example, noted definite progress, but siloed working (teams very focused on their technical areas) can make general inclusion hard because programmes operate separately from each other. There was considerable motivation at the regional office level when the Policy on Disability was launched but they felt that it took too long for

---

[9] See for example the Disability Inclusion Core Concepts; the WHO Manual on Disability; the Disability Guide for Action currently being piloted in a number of countries; and the WHO European Framework for Action, which outlines how Member States can operationalize the global resolution on the highest attainable standard of health for persons with disabilities.

structured guidance to be made available. There can be a feeling that disability is a programme issue and an expectation that technical teams will have the expertise to deliver the disability work. From their perspective, disability inclusion is not systematic or organized yet. One country office respondent said,

> *"I would find it difficult to understand how to integrate this into my field of work; so, the main thing is first we have to orient our minds to think in terms of disability, before moving on to any new programme."*

Despite being highly motivated by WHO's 'Health for All' mandate to be disability inclusive, many informants said they needed more practical guidance as they lacked the confidence to incorporate this into their day-to-day work. Evidently, disability inclusion is not systematic or automatic for everyone. Respondents across the organization note that more awareness-raising is needed to ensure all staff consistently apply a disability inclusion lens to their work and have a basic understanding of, or know where to access, clear guidance on minimum standards.

UNDIS indicator reporting shows that operational standards and processes have been rolled out successfully since actions are within WHO control and can be tracked. However, WHO Headquarters has little oversight of the implementation of corporate standards at country office level due to the decentralized structure of WHO. It is therefore important that guidance is not only developed but properly rolled out and socialized with on-going capacity-building, especially at the country level.

In Nepal, for example, the office noted that considerations regarding improving physical access are now more common although not yet mainstreamed. COVID-19 highlighted the need for accommodations such as this when so much of the work went online, but the Nepal office has been motivated to continue beyond the COVID-19 period. This was also mentioned by Tanzania, Lao (to a lesser extent) and at regional level where EURO for example noted that the policy impacted areas such as human resources, conferences and meetings. One key informant shared that in their region sign language interpretation had been provided routinely during webinars but was then questioned by the finance team who wanted to know how many people benefited, and it was later withdrawn as a routine offer. But it is worth noting that this was not a common finding.

Technical focal points also flagged the need for operational support of their work. This is particularly the case when consulting with OPDs whose representatives may have accessibility requirements that have not been included in budgets. A country office respondent recalled having to justify to their finance team the higher cost of selecting a physically accessible venue to host meetings with OPD representatives.

Finding 10. Global planning and reporting frameworks have potential to strengthen accountability, but current findings on utility and uptake are mixed, and there are no mandatory disability-specific indicators.

Reporting and measurement frameworks can play an important role in incentivizing action and strengthening accountability to WHO's commitments, especially at country office level where priorities are dictated by local considerations. In line with UNDIS Indicator 2 on Strategic Planning, WHO has tried to integrate disability inclusion into the WHO General Programme of Work, Programme Budget and Results Frameworks.

The 13th General Programme of Work (GPW13) mentions persons with disabilities in relation to the push for universal healthcare (UHC), recognizing that marginalization and stigma makes access difficult. It includes one outcome designed to measure equity of access to UHC by gender, age, income and disability, which has been helpful in driving some of the focus, especially from a programme's perspective at regional and country level. Moreover, the 'Leave no one behind' (LNOB) agenda continues to provide WHO with an international mandate to make disability inclusion an implicit factor of success. The 14th General Programme of Work (GPW14) builds on this momentum to some extent, referencing the need to be inclusive of persons with disabilities explicitly throughout the strategic document, although there are no outcomes, indicators or disaggregation markers that explicitly reference disability inclusion, as these are mainly linked to SDGs.

There is a sense from across the regions and countries, consulted with as part of the evaluation, that there are considerable variations in the extent to which reporting and accountability mechanisms are used. Both PAHO/AMRO and the Regional Office for South-East Asia (SEARO) noted that the systems are more familiar and embedded at Headquarters' level compared to regions and country offices where there is far less confidence. PAHO/AMRO noted for example that whilst disability work would fit within their health equity framework, there is currently no disability work for them to report on. Similarly, SEARO mentioned that they had no awareness of the UNDIS Action Plan and were not guided in their work by any disability framework. In EURO the WHO European Framework for Action has provided country offices with a very significant mandate to advocate for disability inclusion. A consultative process was used with Member States and OPDs and includes targets and actions to guide its implementation. The fact that it is has an operational focus has been a key factor in its successful take up because it enables Member States to see what is required from a practical perspective.

The **output scorecard** is the mechanism that integrates disability inclusion into WHO's results framework, tracking results against the thirteenth General Programme of Work (2019-2025), specifically related to 'Leave no one behind'. First piloted in 2020-2021, the output scorecard was designed and revised to enable progress on disability inclusion to be assessed across both technical and enabling functions and at all three levels of WHO. Respondents are asked to provide information to support their scoring for GRED – adherence to this varies.

In interviews, very few staff cited the output scorecard when asked about mechanisms that help to enable WHO's disability inclusion work. This may be due to the scorecard being a relatively new reporting mechanism, or it may be that evaluation informants are not involved in the reporting process. However, two participants described the scorecard's explicit measurement of disability as a cross-cutting dimension as a "wake up call," highlighting that many colleagues "weren't doing anything on this agenda" and that "it allowed us to reflect as a team across every function on what action we're taking." This is further highlighted by a respondent from Headquarters who said,

> *"These corporate processes have triggered increased attention and conversations in house around inclusion of disability, alongside the work that [the UNDIS Secretariat] are doing to promote this area of work."*

While the output scorecard has triggered internal reflection on progress regarding disability inclusion, a major shortcoming is the recent change in the scorecard that led to the aggregation of disability inclusion with gender, equity and human rights. This means progress on disability inclusion specifically cannot be tracked as it is hidden within the broader category. For instance, the end of biennium assessment for 2022-23 shows that 90% of outputs scored at least 3 out of 4 on "Impactful integration of gender, equity, human rights and disability", in the output scorecard, an increase from 31% during the end of biennium assessment for 2020-21. However, it is not possible to determine whether there has been any progress on disability inclusion integration, or whether the increase was driven by work on gender equality and human rights. In addition, as reported in one country focus group discussion, self-assessment processes are a challenge when there is a lack of consistent understanding of what disability inclusion work looks like and where there is a lack of confidence around what baselines and standards should be.

The Disability Inclusion Marker (DIM) is a new planning tool developed in line with the gender and human rights' markers that were rolled out this year *(9)*. Products and services are scored on a four-point scale. The intention is to support WHO teams to be more intentional about disability inclusion and to use the scores to estimate the proportion of the budget that can be attributed to disability inclusion. For example, a score of 0 = 0% of expenditure; 1= 15%; 2= 30%; and 3= 80%. The score criteria and corresponding expenditure percentages are based on UN best practice on the integration of markers throughout UN agencies, such as the Gender Equality Marker scale, as communicated by UN Women. However, there is currently no consensus as to whether WHO will mandate reporting on disability through the Disability Inclusion Marker. Only two country offices mentioned using a disability inclusion marker in joint work planning with UN agencies and government partners in country. A compendium of key performance indicators has been developed for AFRO, which includes an additional Key Performance Indicator (KPI) on disability, which is an important step in measuring disability inclusion work at country and regional level[10].

There is a significant data gap at national level in relation to disability disaggregation within the Health Information Management Systems (HMIS) which makes it challenging for WHO

---

[10] KPI added: "Number of countries supported by WHO that have integrated disability inclusion into national health programmes and strategies to address health equity for persons with disabilities." (source: information shared by key informant)

to monitor the extent to which health equity is being achieved, at least in relation to access to basic health services. Having this information readily available would likely help promote the integration of disability into country-level programme work. WHO could take a greater role in promoting the adoption and uptake of an HMIS that allows for disability disaggregation.

Evaluation Sub-Question 1.3: *To what extent are resources allocated through the flexible fund so that the costed workplan is efficiently used and prioritized?*

Summary: The flexible funding allocated to support the UNDIS Action Plan has been crucial in resourcing and implementing key disability inclusion initiatives. These funds have helped integrate disability inclusion into core processes, while also supporting stand-alone activities. This funding mechanism highlights the importance of flexible resources in starting and mainstreaming priority areas like disability inclusion. However, resource gaps still exist, which should be addressed to ensure the continued implementation of the Action Plan and the sustainable embedding of disability inclusion across all operational and programmatic levels.

This sub-question sets out to explore the allocation and use of the flexible fund mechanism and tests the third assumption (A3) in the conceptual framework that this initial investment via the flexible funds is sufficient to catalyse and sustain disability inclusion mainstreaming. The findings below explore this in more detail.

This seed funding was allocated as a catalytic funding to support UNDIS implementation and was distributed to UNDIS Custodian Units. When UNDIS was launched, there was no specific funding available to departments to implement the requirements set out in the UNDIS 15 indicators, so the Director General allocated flexible funding in 2021. The UNDIS funding was available until end 2024, after which time each department, region, or country was expected to include disability inclusion in their own budget.

In 2020, following the launch of the UNDIS and the development of WHO's Policy on Disability, a governance structure was established which included the Steering Committee, the UNDIS Secretariat, and the Working Groups, made up of Custodian Departments[11]. This group developed a costed Action Plan outlining what was required to deliver on the UNDIS and WHO Policy on Disability. The Action Plan is aligned to and feeds into UNDIS reporting. The biennial budget cycle had already begun when this process was initiated, so the costed workplan had to be submitted to the Steering Committee for approval, and then to the Director-General for consideration of flexible funding. This was duly approved.

The objectives of the Action Plan are to ensure that:

- The needs of people with disabilities are addressed in all efforts to improve the health, functioning and well-being of all people, including through targeted actions;

---

[11] WHO Custodian Departments are responsible for the implementation of the different areas and sub-areas of the Action Plan.

- The rights of people with disabilities are realized through the human rights-based approach of the organization, guided by the Convention on the Rights of Persons with Disabilities (CRPD);
- People with disabilities in all their diversity are meaningfully participating in all levels of the Organization's workforce; and
- Disability is recognized as a natural part of the human condition and disability is an integral part of all programmatic areas of work and the six core functions of WHO.

The total amount allocated to the Action Plan for the period 2021 – 2024, and subsequently extended to 2025, is approximately US$ 2.5 million.[12] At the time of this evaluation, not all funds had been spent and the unspent balance is to be allocated for additional activities identified in the UNDIS Action Plan into 2025. The current tracking and reporting system for expenditure presents some challenges in terms of clarity and comprehensiveness, which makes it difficult for the evaluation to fully assess the efficiency of resource utilization. [13]

Finding 11. The flexible funds allocated to support the implementation of the UNDIS Action Plan have been instrumental in ensuring that key initiatives were resourced and implemented appropriately. Some examples of disability inclusion work becoming embedded in core processes as a result of this funding were found, along with other examples of funds that were allocated to stand-alone activities. This mechanism has demonstrated the vital importance of ensuring a flexible resourcing approach to kickstart the work on embedding and mainstreaming a priority area of work such as disability inclusion.

The UNDIS flexible funds were used to support numerous initiatives, which had been prioritized and deemed crucial for the delivery of disability inclusion at both programmatic and technical levels as well as the internal, corporate functioning of the organization. These initiatives included, for example:

- The redesign and re-branding of the website to improve its accessibility;
- An assessment of the accessibility of WHO Headquarters and regional offices and infrastructure to identify and prioritize gaps;[14]
- A central fund to support individual requests for reasonable accommodation;
- Capacity strengthening of regional offices, provided through in-person visits conducted by the UNDIS Secretariat team;
- Development of technical guidance notes to support the implementation of the Policy on Disability;
- The update of the e-learning platform for greater accessibility;

---

[12] As cited in UNDIS Action Plan 2021-2024, shared on 16th August 2024 (Activity funding)

[13] There is no evidence of major visible inefficiencies in how UNDIS resources are used, although it is difficult to fully ascertain this since current allocations are to be spent over the next two years (2024 and 2025).

[14] Reviewer commented that this is also currently being done at country level, although the evaluation team has been unable to verify or comment on this as it was not raised during data collection.

- Health system policy dialogues at the country level to support ministries of health to advance health equity for persons with disabilities;
- Awareness raising and campaigns initiated by the Disability Affinity Group for the wider WHO workforce, including funding sign language interpreters and inviting guest speakers; and
- This same formative evaluation of the WHO Disability Policy.

Many of the activities identified in the Action Plan were related to institutional set-up, and either did not require specific additional funding, such as updating and developing policies and guidance, or represented one-off investments, such as the website redesign or the Secretariat's awareness-raising visits to the regional offices. The expectation regarding other initiatives that may require regular resourcing was that these ongoing costs would be allocated through the routine budget setting process by Budget Centre Managers once the costs value of these activities had been confirmed. The extent to which this has been achieved is mixed, with some custodian departments more positive about this than others.

Departments in receipt of this funding were generally aware that this funding was temporary and therefore would be better used for consultancies, assessments, or other one-off activities. This has been very useful, has certainly helped raise awareness, and kickstart some of the work on disability inclusion, but there is a risk that the outcomes are likely to be less sustainable or impactful in the long term.

There are examples of where this initial flexible funding has been integrated into routine costs, for example the reasonable accommodation fund, initially funded from the flexible funds but from 2024 this has been included as a core part of the Human Resources and Talent Management (HRT) budget, which is a significant achievement. Other areas that would benefit from ongoing core resourcing include the UNDIS Secretariat's activities to increase awareness and strengthen capacity.

Finding 12. Resource gaps remain and need to be addressed to ensure that the UNDIS Action Plan continues to be implemented, with disability inclusion sustainably embedded across all three levels of the Organization, both operationally and programmatically.

The flexible funds have provided support to initiatives that require a sustainable source of funding to ensure the momentum that has been built is not lost, due to resource constraints. The work of the UNDIS Secretariat is a prime example of that. The flexible funding was used by the UNDIS Secretariat to fund the capacity building and awareness raising visits to the regions. The UNDIS Secretariat is essential to maintain a consistent and persistent focus on disability inclusion across the organization and provide capacity strengthening support and advice, which will require staffing and financial support.

Another aspect of disability inclusion work that requires additional investment is technological advances that may require investment for the organization to remain up to date and compliant as this field of work advances. Whilst the initial investment to the website redesign and several Information Management and Technology (IMT) initiatives have been implemented to improve the accessibility of a range of IT platforms, there is a concern that without ongoing investment these will rapidly cease to be cutting edge.

A substantial allocation of funding had initially been made to support regional offices to implement the UNDIS Action Plan, however, no requests were submitted from Regional Offices to the Steering Committee. Key informants suggested that this might be due to limited awareness of UNDIS at those levels, and ROs being unaware of the available funding or what was needed to comply with the strategy and WHO Policy on Disability in particular. The UNDIS Steering Committee decided to redeploy the funds to Headquarters' Custodian units to manage, including to create a centralized fund for Reasonable Accommodation that can be accessed by regional and country offices and to support the Secretariat to deliver awareness raising and targeted capacity strengthening support to each Regional Office to build understanding and capacity around the UNDIS and requirements for disability mainstreaming. This experience highlights the importance of ensuring investment is made in establishing the infrastructure and processes needed to promote these new opportunities, including the staff time required to advertise and oversee the existence of these new funding opportunities.

Evaluation Sub-Question 1.4: *To what extent does the WHO workforce feel that actions being taken are relevant to, and effective in, creating an inclusive entity?*

Summary: Considerable progress has been made in fostering an inclusive culture within WHO. However, some barriers to disability inclusion appear to be systemic, with opportunities to raise awareness and improve the implementation of policies and guidance across all levels of the organization. Additionally, there is a perception that some of the challenges may stem from the current approach to disability inclusion which is viewed predominately from a biomedical approach and understood as a health condition by some of the technical units outside of the disability programme, suggesting a need for broader perspectives in programming.

This question draws heavily on perceptions of WHO workforce interviewed during the data collection at all three levels of the organization.

Finding 13. Significant efforts have been made to develop an inclusive culture within WHO, with strong, visible leadership supporting those efforts. The extent to which this is felt at all levels varies.

There is a shared understanding across the three levels of WHO that the visibility of, and focus on, disability inclusion has increased, signalling a shift in the organizational culture and approach to disability. Headquarters' staff recognize that WHO is making tangible strides towards becoming a more inclusive organization. It is UNDIS, rather than the Policy of Disability, which is seen as an important driver for these changes, encouraging integration of disability inclusion into technical areas and policy-making processes. The leadership of this area of work at Headquarters is highly valued, although respondents acknowledged that WHO is at still at an early stage in its journey towards disability inclusion, and there needs to be a prioritisation of resources to sustain momentum. The principle of ‘Leave no one behind’ and the focus on equity are embedded in WHO culture and staff motivations, but there is work yet to be done to ensure disability inclusion is integrated in a systematic way, as explained by this Headquarters respondent,

> *“WHO is making progress. Instead of saying it’s an inclusive organization, I'd say it’s no longer a neglectful organization."*

At regional level, there is a strong acknowledgment of the positive direction set by WHO Headquarters. Some regions have made significant efforts to mainstream disability inclusion in their programmatic work. For example, in the WHO Regional Office for Europe (EURO), staff viewed disability as a core focus of their programmatic work. The European Regional Framework for Action and resolutions between Member States for achieving the highest attainable standard of health for people with disabilities are perceived as key enablers that well position EURO to report on the UNDIS and drive disability inclusion work (*10*).

Other regions are at an earlier stage of integrating disability inclusion, with some efforts feeling symbolic rather than sustainable, despite the staff enthusiasm that was evident in many interviews. Respondents from across stakeholder groups at the regional level, frequently cited a lack of resources as well as limited awareness and confidence as key factors hindering the integration and mainstreaming of disability. Regional respondents mentioned the need for further support to effectively translate disability policies and frameworks into actionable priorities. However, there was frequent acknowledgement from regional and country level respondents that they ‘don’t know enough’ about disability inclusive practices and approaches, and their openness to admit this and explore their limited confidence suggests a positive organizational culture of willingness to learn and improve. When asked how they would rate the extent to which WHO can be seen as an inclusive organization one regional respondent said,

> *“I would rate it 5 or 6 out of 10 – in terms of inclusive organization. We are nascent, showing good signs of the commitment and we need to do more - examples I gave are limited and mostly in Headquarters… We need to see it filter through across all levels.”*

Country-level respondents demonstrated commitment to the Policy on Disability and noted a shift in language and understanding of disability inclusion in the post-COVID 19 pandemic period. However, progress is hindered by limited resources, existing building and infrastructure, and contextual challenges. A respondent from a county office reflected on the challenge of changing culturally ingrained language or ‘a set of words’ that they grew up with for referring to persons with disabilities, which are now no longer acceptable. This is changing, but similar reflections across countries have highlighted the need for continued sensitisation for staff on how “the personal becomes political” in matters of equity and how this translates into the workplace.

Many respondents at the country level felt that disability inclusion is not yet fully integrated into business operations.

The gap between policy and implementation is evident, as county offices try to move beyond addressing smaller, easier-to-achieve infrastructure changes (like access ramps) to thinking more about the deeper systemic issues that must be tackled to become a truly inclusive organization (such as tackling ableist language and behaviour). To tackle such systemic issues, a clear plan detailing the ways in which disability inclusive practices can be promoted and supported is needed. Having policies and written guidance in place is not enough without ongoing training and staff in place to provide advice and support on the effective implementation of these policies.

The WHO staff health insurance scheme is not without implementation challenges in relation to disability issues. Respondents with experience of this reported that it fell short in meeting their needs fully, and the guidance and advice provided to access it was not always as supportive as it might have been.

Finding 14. There is a perception that some of the barriers to disability inclusion at WHO are systemic, related to limited awareness of disability inclusion and inherent challenges to implement policies and guidance effectively across all levels of the organization.

Across WHO, there is widespread agreement on the importance of disability inclusion, with little direct opposition in principle. Staff members generally feel that disability inclusion is the right thing to do and is supported across the Organization. However, this support often does not translate into planned or proactive action, revealing systemic and capacity barriers.

Structurally, respondents were broadly aware that the UNDIS Secretariat coordinated and cohered the work on disability inclusion. Other structures exist at Headquarters, which are also seen to be leading, or championing the disability inclusion agenda, including the Disability Programme, the Staff Embracing Disability Affinity Group, and the diversity, equity and inclusion work of the Gender Equality, Human Rights and Health Equity (GRE) department. Whilst integrating effective disability inclusion warrants the championing and implementation by everyone, these different structures have inadvertently created some confusion among the WHO workforce in terms of where to go for support and implementation advice, and this may be contributing to a strategic disconnect, or limited focus.

At the headquarters level, the Embracing Disability Affinity Group has been instrumental in driving organizational cultural change and fostering a more inclusive and safer environment, for learning, and sharing experiences about disability. As a group however, they noted that there is a long way to go before disability inclusion is mainstreamed or accepted as a core part of the work, in a way that is similar to WHO’s approach to gender equality. Some mentioned complex processes that can delay decision-making and require multiple levels of approval as one hindering factor.

Similar concerns from the Gender, Human Right and Health Equity (GRE) department highlighted some of the challenges they faced in managing significant workloads and a large remit among a small staff team and limited funding thus, “we fall under the same paradigm of...undervalued work”. The responsibility for diversity, equity and inclusion (DEI) sits partially in this team as well as with human resources, yet the alignment with UNDIS and the structures for collaboration are unclear.

At the regional level, while there is ready acceptance and approval from leadership that accessibility measures like wheelchair ramps should be in place, these actions are often reactive rather than proactive, typically occurring only after specific challenges, situations or disability inclusion requests arise. Regional respondents felt this reflected a broader issue of disability inclusion not yet being fully ingrained in routine operations or decision-making processes, unlike other priorities such as sexual exploitation and abuse (SEA), which are more systematically embedded. Staff in these offices expressed similar frustrations around the lack of control over the accessibility of rented or co-located premises, as well as the complex processes that may delay or complicate the implementation of disability-inclusive practices and procurement. The complicated, and sometimes slow-moving, WHO processes often require prompts to prioritize disability inclusion, making it seem more of an afterthought than an integral part of daily operations as shown by this statement from a regional respondent,

> *“I used to tell my colleagues we’re so vertical in our approach that when we speak of cross cutting – it is crossed, and it is cut!”*

Country office respondents recognize the importance of disability inclusion, but they face similar obstacles in making it an integral part of their operations. Respondents felt they lacked practical guidance and training on how to integrate disability inclusion in programmes and processes in the same way as the workforce are trained on safeguarding and gender sensitivity, for example.

Finding 15. There is a perception that some of the challenges to effective disability inclusion are related to the way disability is understood and approached through a predominantly medicalized approach to programming.

Numerous respondents at different levels reported that tensions existed between technical delivery driven by clinical and medical considerations, on the one hand, and a wider social understanding of structural marginalisation, barriers and lack of access to services and support, on the other. However, some departments, like the Noncommunicable Diseases, Rehabilitation and Disability and TB teams, have made substantial efforts to take a more disability inclusive and rights-based approach to their interventions. Much of this appears to be driven by personal passion and commitment rather than by strong institutional messaging or strategic direction, with one respondent from Headquarters suggesting,

> *“We need to support literacy to have the same understanding of the concepts because it’s not the same as medical terms. [It is] important to create a safe space where we can say language is political, so we need to unpack the clinical terms.”*

One issue that illustrates the difficulty for staff in approaching disability from a rights perspective was the way in which employment practices and workforce representation were discussed by respondents. Interviewees, especially at the country and regional levels, frequently cited WHO’s education and training requirements for professional employment as a key barrier to persons with disabilities applying for jobs with WHO. Whilst it may be that in some contexts people with disabilities are excluded from educational opportunities, beliefs like this are often driven by negative assumptions of what is achievable by persons with disabilities. These kinds of attitudes may suggest levels of unconscious bias that need addressing before more proactive work on inclusive recruitment, for example, can be undertaken. There may well be educational barriers, but it is important to recognize that there could be a whole range of institutional, attitudinal and environmental barriers that are excluding persons with disabilities from applying to WHO.

Some regions have been exploring different options for addressing barriers to participation in the workforce. In PAHO/AMRO, for example, WHO introduced a work experience programme to provide opportunities for young people with disabilities to work in the office. This trial intervention was a positive demonstration of inclusive hiring practices. However, the individual who set up the work experience programme left the Organization, and the programme was discontinued. Such interventions have the potential to become a sustainable way of working but are limited by structural and human resource constraints. Another example shared focused on how regions are seeking to improve disability inclusion within the workforce as a means of raising awareness and reducing unconscious bias or stigma against people with disabilities. In this example, WHO collaborated with UN Volunteers to recruit people who may not have the standard qualifications into positions with the organization. This was seen by one respondent as a positive approach to building diversity in the workforce, bypassing some of the usual educational pre-requisites for employment. Predominant attitudes among WHO’s technical and programme workforce, while sensitive to the importance of disability inclusion, tend to justify WHO’s practices as the ‘way it has to be’, as this regional respondent shared,

> *“A person hired for malaria [programming], only does malaria and nothing else. In our countries as well as my unit, we tend to look at medical documents, [we] look at things very clinically.”*

Country staff feel the absence of, and the critical need for, a common language to harmonize understanding and communication about disability inclusion across diverse cultural and linguistic backgrounds, as stated by this respondent from a regional office,

> *“We have been trained by medical school that ‘being healthy is normal’ [and] ‘being disabled is not healthy’. [that] change in mindset is essential. In terms of awareness lots more needs to be done.”*

Similarly, while Headquarters' mandates can guide operational practices for disability inclusion, programming work in countries is heavily driven by the capacities of country staff, availability of targeted disability funding, and other structural factors. Country programming staff find that technical cooperation is often narrowly defined by specific diseases or conditions, leaving little space for cross-cutting disability inclusion. They also feel that they lack the time and capacity to drive programming more inclusively, given the need to report against several Headquarters' priorities at any given point, leaving limited capacity/availability to pursue their programming goals (such as systemic disability inclusion) as actively as they would have liked. This is especially challenging in emergency programmes, where there is very little earmarked funding for disability inclusion.

In some countries, WHO Country Offices are co-located within inaccessible Ministries of Health, making it difficult to advocate for disability inclusion when the offices themselves are inaccessible. These basic infrastructure gaps remaining at the country level have raised concern among staff that WHO must 'walk the talk' better. For instance, as one country office respondent explained:

> *"From a programme's perspective, we talk of disability inclusion, but we haven't seen programmes doing disability inclusion in a cross-cutting and effective manner. For example, the maternal health programme - is it disability sensitive? We don't know – we have a lot to improve to implement this in a cross-cutting manner for the rest of the programmes."*

Our evidence suggests that staff at all levels would welcome effective measures for creating an inclusive organization, including the integration of accessibility considerations into meetings and key documents as well as giving priority to accessible infrastructure at events. The revamp of the WHO website to meet accessibility standards and the remodelling of the main building to include accessible bathrooms and fire doors were particularly appreciated by the workforce at Headquarters.

Respondents mentioned that the disability allowance for parents with children with disabilities had recently been increased, and this was seen as a significant step towards making WHO a more disability inclusive employer. Similarly, there was support across all levels of staff to encourage people with disabilities to apply for advertised vacancies.

Country staff noticed an absence of employees with visible disabilities, highlighting gaps in the recruitment practices, and staff across all levels of the Organization expressed concerns about the comprehensiveness of disability inclusive measures in hiring processes, particularly their relevance in a world where disability interacts with social and systemic barriers, as shown by this head office respondent:

> *"I [have worked at WHO for over 24 years and] have been involved in the recruitment process. Disability has never been featured as reason for not recruiting someone. However, the reality is that people with varying disabilities experience a lack of support. People with disabilities are less likely to access highly technical/training settings where they can get high qualifications."*

Although job adverts encourage a diversity of applicants to apply it is unclear how much of the application process is accessible and how much training or awareness recruitment panels have had to ensure that their hiring practices are accessible for the recruitment of persons with disabilities. Overall hiring practices – whether lived experience is taken into consideration, for example, or whether there are work experience opportunities offered for different roles - need to be scrutinized. Anecdotes from respondents at regional and country level indicate that the inclusion of persons with disabilities is easier to effect at Headquarters than at other levels, with the most challenges expressed by those working at the country level, as expressed by one respondent from a regional office,

> *"Coming here to this environment it is totally surprising that accessible ramps etc. don't exist here. My wife is disabled [and so] I'm sensitive to it."*

Additionally, there is a lack of data on staff diversity characteristics, including disability, at all levels of the organization, which hampers efforts to design appropriate interventions as well as to develop relevant institutional responses to staff, consultants, interns and volunteers' needs and reasonable adjustments. Persons with less visible disabilities are most often overlooked in communication materials and disability-inclusive actions.

Evaluation Question 2: *To what extent are specific disability inclusion measures in place at each level of the organization, and what examples of good practice are there?*

Summary: There is a range of examples of disability inclusion at all three levels of WHO, some that appear to be part of a more strategic approach and many standalone activities that may have limited sustainable or transformative impact. Common challenges identified include issues of centralized decision-making and insufficient data on disability, gaps in the communication and promotion of existing resources, and challenges in distinguishing disability-specific programming from disability inclusion.

This evaluation question sought to identify examples of disability inclusion initiatives implemented at Headquarters, regional and county levels in programmes, or operations. The evaluation's appreciative enquiry approach to country selection was developed to support the identification of promising practices, and where possible document review was used to triangulate these examples shared. As highlighted in the limitations section, documented evidence of these examples was limited. The following discussion highlights some of the examples and includes a reflection from the evaluation team on learning and adaptation for greater impact.

This question tests the fourth assumption (A4) in the conceptual framework that *good practice examples at all levels can be identified and can support institutional learning and accountability.*

Evaluation Sub-Question 2.1. *What interventions exist to mainstream disability inclusion and what good practice examples are there of specific disability inclusion measures at Headquarters', regional and country levels?*

Finding 16. While there is a range of examples of disability inclusion at all three levels of the WHO, some appear to be part of a more strategic, deliberate approach, but many are standalone activities that may have limited sustainable or transformative impact.

The following section provides notable examples of emerging or promising practice at different levels, such as Headquarters and regional offices supporting Member States to mainstream disability inclusion in programming through frameworks and toolkits; incorporating the lived experience of people with disabilities through hiring practices and meaningful consultation with OPDs; collaboration across the UN system; raising awareness through international days and conferences. These examples were shared through respondent interviews and in many cases the evaluation team has been unable to substantiate the examples due to the limited documentation available or shared.

Examples at Country Office

Country office implementation of the WHO Disability Guide for Action in consultation with OPDs

Over the last two years, WHO has been piloting the Disability Guide for Action *(11)* in several countries, including Tanzania, Cote d'Ivoire, Malaysia and Montenegro. The toolkit provides step-by-step technical and practical guidance to Member States on how to develop a comprehensive national action plan to advance health equity for persons with disabilities through integration of disability inclusion into existing health systems strengthening efforts. The guide sets out a planning process to support ministries of health to conduct a situational assessment and develop an action plan in consultation with key stakeholders including OPDs. Partnership is a key component of the process to ensure a comprehensive approach to mobilize local networks. In the words of one country office representative,

> *"If we are able to implement, I am optimistic Tanzania will be a leader on equity."*

Following the release of the *WHO Global report on health equity for persons with disabilities* in 2022 *(2)*, the Tanzania Ministry of Health requested technical assistance to implement the report's recommendations, demonstrating the value of WHO's global advocacy to generate political will at the national level. WHO Tanzania has supported the Ministry of Health to develop an action plan to advance health equity for persons with disabilities, using the WHO Disability Guide for Action process. A technical working group was formed featuring a wide range of health and disability stakeholders, including Ministry of Health departments, other ministries and government bodies, development partners and crucially, OPDs.

The Tanzania Federation of Disabled People's Organizations (SHIVYAWATA), which represents 12 OPDs including associations for the blind, the deaf, physical impairments, intellectual difficulties and albinism, is part of the Disability Guide for Action Working Group along with another OPD.

This umbrella organization credits WHO Tanzania for making efforts to consult people with a range of different disabilities to understand diverse needs and experiences in accessing health care in Tanzania. SHIVYAWATA hopes to formalize the positive cooperation with WHO Tanzania to continue to address the challenges of health inequity faced by people with disabilities through a memorandum of understanding**.**

In addition to providing invaluable insights into the lived experience of a range of people with disabilities, the process of partnering with OPDs has also been a rich learning experience for both programmatic and operations staff in the country office to understand practical aspects of facilitating an inclusive consultation, including hiring sign language interpreters, selecting accessible venues, and reforming inaccessible procurement practices. They have also partnered with disability specialist International NGOs, such as Sightsavers and CBM on programmatic (e.g., Monitoring and Evaluation framework) and operational (e.g., venue, transport) aspects of the action plan.

LESSONS LEARNED: Meaningful engagement of OPDs is not only key to meeting international commitments like the CRPD and UNDIS but data also shows that involving OPDs in the design of policies and programmes improves outcomes by ensuring they reflect the rights and needs of persons with disabilities *(12)*. To ensure this is meaningful, however, it is important to recognize that OPDs may be limited in capacity, both in terms of their availability for consultative processes and in their familiarity with the way in which agencies like WHO work.

Longer term investment in the capacity of OPDs to engage in the health sector is essential for building civil societies capable of holding governments to account for the provision of equitable health services, but this has long been a neglected area. Establishing longer term engagement strategies, which include funding, with OPDs (and/or with those supporting OPDs such as those developing in Tanzania and at EURO) will help to ensure equitable access to healthcare can become a reality.

WHO Bahrain catalysed disability inclusion mainstreaming through dedicated resourcing and inter-agency coordination

WHO Bahrain hired a Disability Inclusion Officer to lead the UN Country Team Disability Inclusion Task Force in 2023, coordinating UN agencies to collaborate on cross-sectoral efforts to strengthen disability inclusion and completing the annual UNCT accountability scorecard on disability inclusion. With support from EMRO and WHO Headquarters, WHO

Bahrain provided technical guidance on the Ministry of Social Development's National Strategy for the People with Disabilities, ensuring the integration of disability inclusive health components as well as coordinating UNCT support for the planned activities. WHO Bahrain volunteered to be the UNCT coordinator to demonstrate the added value of having a designated disability inclusion officer, and in this case, a person with lived experience of disability.

Although funding for the position was only available for just one year, the team understands that disability inclusion is an integrated component of every staff member's work - "a translation of the commitment to achieve the SDGs"- and a bridge to work with other ministries and stakeholders beyond the health sector. While the country office was established only three years ago and consists of a small team, WHO Bahrain has undertaken several disability inclusive initiatives in that time, including:

- Organizing community awareness campaigns with key partners and stakeholders such as a 'Public Spaces for All' event to mark International Day for Persons with Disabilities and a World Hearing Day event with Gulf University;
- Collaborating with UNICEF and UNESCO on a disability inclusion in education project;
- Using Disability Inclusion Markers during country prioritization work planning with the Ministry of Health to advocate for a mainstreamed approach;
- Producing social media posts with subtitled videos targeting the deaf community; and
- Ensuring accessible physical spaces for events - and establishing accessibility requirements from the outset.

LESSONS LEARNED: Utilizing technical expertise in disability inclusion is essential when these skills are not yet widely available within an organization. Disability inclusion is a recognized skill area within development and humanitarian assistance, and WHO would do well to consider how it could increase its access to technical expertise in this area. One off initiatives such as this can be catalytic but only if attention is paid to building internal capacity and providing ongoing support as staff build confidence. Seeking to hire people with disability inclusion skills as part of workforce development plans and establishing internal resource facilities (such as a Disability Inclusion Helpdesk) are practical ways in which organizations can build capacity over the longer term and reduce the need for external consultants and volunteers.

Examples at Regional level

European Regional Framework for Action outlines how to operationalize global resolution to achieve the highest attainable standards of health for persons with disabilities

In response to the World Health Assembly's adoption of resolution WHA74.8 in May 2021 on the highest attainable standard of health for persons with disabilities, WHO Europe and its 53 Member States took the initiative to develop the European Framework for Action to achieve the highest attainable standard of health for persons with disabilities 2022–2030, working in close collaboration with OPDs. The framework was adopted at the 72nd Regional Committee meeting in September 2022, committing all 53 Member States to work towards ensuring that people with disabilities are fully included in healthcare planning, delivery and leadership across the region by 2030.

The framework sets out four objectives with corresponding action areas, along with 13 targets and 20 indicators to measure progress and success:

- Ensure that all persons with disabilities receive quality health services on an equal basis with others;
- Promote the health and well-being of persons with disabilities;
- Ensure that all health policies and programming, as well as resilience-building and recovery plans during public health emergencies, are disability inclusive; and
- Build an evidence base on disability and health.

Led by seven Member States and enabled by dedicated technical expertise in the regional office, the process to develop the framework was highly consultative. A series of online consultations were held with both members states and OPDs from countries across the region to provide feedback and input into the framework's objectives, priorities, actions, and implementation and monitoring processes. To facilitate the meaningful participation of OPDs and persons with disabilities, the consultation process included:

- Sending documents in accessible format ahead of meetings;
- Longer and more frequent breaks and longer discussion time during meetings;
- Using accessible presentation formatting and presenting mode; and
- Making International Sign Language interpretation and live captioning available during meetings.

WHO Europe also increased engagement with the European Disability Forum for their own capacity- building on making communications and content more accessible, to reach more OPDs and individuals through their network, for professional sparring, and to provide feedback on technical products.

It was also important that the WHO Resolution documents were readily available in accessible PDF formats and as an Easy Read version, as they call for the engagement of OPDs in reaching objectives and with specific indicators they could contribute to achievement in collaboration with their governments. The Easy Read version was tested by a focus group to ensure both texts and images could be comprehended. This was the first time the regional office had produced Easy Read documents. An area of improvement identified was that when the Easy Read document was subsequently translated into the other working languages of the region, translators noted that validated Easy Read in their language would require another process and that direct translation does not provide the same easy-to-understand comprehension.

LESSONS LEARNED: This case study provides a good example of how to engage meaningfully with OPD representatives. Some highlights include planning sufficient time to enable the process to be inclusive allowing time for documents to be provided in accessible formats and for OPD representatives to familiarize themselves with the information. Ensuring access to meetings doesn't just require captions or sign interpreters it's also about allowing sufficient time for processing information and for communicating in different ways. A good consultative process will also build trust and the fact that OPD representatives were involved in the whole process and could see the changes that their participation effected helps that process. Finally, it is best practice to ensure that accessible products are available at the same time as the main documentation.

Examples at all levels

WHO effectively leveraged International Days for disability inclusion across all levels

WHO has effectively utilized international days to promote disability inclusion at all levels, responding to the growing need for awareness and action. These observances serve as strategic opportunities to engage both internal and external stakeholders, fostering an environment of inclusion and advocacy.

At the Headquarters' level, the communications team has effectively integrated disability inclusion into campaigns associated with international days like World Hearing Day and the International Day of Persons with Disabilities. These campaigns are coordinated with technical departments to ensure alignment with broader advocacy and policy goals. For instance, Mental Health Mondays, linked to World Mental Health Day, have involved WHO staff in webinars and seminars featuring experts on disability-related topics, thereby cultivating an inclusive workplace culture. Additionally, the Embracing Disability Affinity Group, supported by UNDIS funding, has spearheaded initiatives such as the 'Walk the Talk' event on the International Day of Persons with Disabilities, underscoring WHO's commitment to a disability-inclusive workplace.

In the regions, WHO adapts its approach to suit local contexts. The Regional Office for the Eastern Mediterranean, for instance, has used international days to organize webinars and workshops that feature speakers with disabilities to promote visibility and give them a platform to share their experiences. One notable event during International Women's Day included a Pakistani woman with disabilities, active in the health sector, discussing her experiences in the health sector. These events not only raise awareness but also integrate the lived experiences of persons with disabilities into regional health initiatives.

Country offices worldwide have also harnessed international days to drive disability inclusion:

- In Bahrain, the WHO office organized a 'Walk the Talk' event on the International Day of Persons with Disabilities, engaging youth volunteers, UN agencies, and government ministries to emphasize accessibility in public spaces. A collaboration with Gulf University for World Hearing Day further highlighted the importance of inclusive health care;
- In the Bahamas, the WHO office utilized World Hearing Day and Universal Health Coverage Day to raise awareness through radio and TV interviews, social media, and accessible video content with sign language and subtitles; and
- In India, the WHO office used international days like the International Day of Persons with Disabilities to highlight positive role models and ensured respectful language in signage during events, such as a tennis match involving players in wheelchairs.

These efforts evidence how WHO effectively uses relevant international days to advance disability inclusion while ensuring alignment with broader strategies. Going forward, it is crucial to avoid tokenism and ensure these initiatives lead to lasting change.

LESSONS LEARNED: These examples show how leveraging international days can provide points in time when issues like disability can be highlighted. However, to make these more powerful and to promote a disability inclusive focus, WHO should consider ways to raise awareness during events which are not disability specific. For example, events like World Cancer Day (04 February); International Women's Day (08 March); World Health Day (07 April); and the International Day for the Elimination of Violence Against Women (25 November) all provide opportunities to raise awareness of the need for disability inclusive actions. Widening the focus will help to reduce the tendency for disability to be associated with specific impairments and lead to more inclusive ways of working. It is also important that international awareness days are not the only activities that are undertaken to raise awareness and integrate disability inclusion within WHO. They should only be used as one element of a comprehensive approach to raise awareness and promote disability inclusion.

***Evaluation Sub-Question 2.2:** What are the challenges to implementing interventions to mainstream disability inclusion and disability-specific measures at Headquarters', regional and country levels?*

Finding 17. The evaluation identified common challenges to implementing disability specific and mainstreaming measures across all levels including:

Centralized decision-making and insufficient data on disability: The centralized decision-making structure within some regions, while effective in promoting broad inclusion policies, can limit the capacity for context-specific and systemic change at the local level. A critical barrier to more localized efforts is the lack of disaggregated data on disability needs, the number of persons with disabilities, and the specific barriers they face. Without this data, regional and country offices struggle to tailor interventions that adequately address the needs and priorities of persons with disabilities, hampering efforts towards meaningful, systemic change.

Communication and awareness of existing resources: There are noticeable gaps in the communication and promotion of existing resources, such as the Reasonable Accommodation (RA) Fund, which limit their full utilization at country level. Additionally, there are challenges related to mindset, where accessibility may not always be fully integrated into planning processes. In some cases, staff requests for reasonable accommodations have been met with questions regarding their necessity, suggesting an opportunity to further cultivate an understanding of the importance of inclusivity from the outset.

Challenges in distinguishing health conditions/impairments-specific programming from disability inclusion: A key issue that needs to be addressed is the tendency to conflate disability-specific programming with broader disability inclusion, often influenced by strong biomedical perspectives or understanding held by staff. Disability is still frequently viewed through the lens of individual health conditions/impairments with a focus on rehabilitation/habilitation, medical interventions and/or provision of assistive technology. For example, the evaluation team was given an example of disability inclusion programming solely linked to impairment-specific work without any reference to inclusive health services. This highlights the ongoing challenge of ensuring that WHO differentiates health conditions/impairment-specific actions from its wider disability inclusion agenda and communicates this clearly and consistently. For staff and external stakeholders accustomed to engaging with disability as an impairment or health conditions there is a risk in making assumptions that any work on health conditions/impairments is working towards disability inclusion. Programming that is focused on rehabilitation /habilitation, medical interventions and/or provision of assistive technology is important to health-related work, but it is insufficient to achieve disability inclusion. Very nuanced, careful and deliberate messaging targeting staff and external stakeholders is necessary to avoid reinforcing medical approaches to disability that may impede WHO's broader goals of disability inclusion.

Evaluation Question 3: *To what extent has WHO created a sustainable foundation on which to continue to deliver on the policy after 2024?*

Summary: At the headquarters level, progress has been made in integrating disability inclusion into corporate and programme practices, along with improvements in reporting, governance, and accountability mechanisms. There has been a notable shift in how disability is discussed across all levels of the organization, with increased confidence in using rights-based language and acknowledging lack of confidence in discussing the issues. Partnerships, particularly with OPDs, are recognized as crucial for driving sustainability and embedding disability inclusion, although these collaborations are still in their early stages.

This evaluation question sets out to explore the extent to which the interventions and mechanisms established by WHO under the UNDIS are likely to continue after the current policy period, particularly in the context of the flexible funds ending in 2024.

Finding 18. There are positive foundations in place to support disability-inclusive practices and mechanisms, which are especially evident at headquarter level.

This evaluation considers that there are positive foundations in place to support disability-inclusive practices, which are especially evident at Headquarters' level. There is also explicit recognition from key informants that the corporate level focus on disability inclusion has provided some regional offices with the impetus to develop their own focus.

The Department of Planning, Resource Coordination and Performance Monitoring (PRP), for example, clearly stated that disability inclusion processes are now institutionalized within WHO. Their reasoning rests with the fact that disability is referred to within statements in the results framework and it is now possible to tag disability (although on a voluntary basis) within operational planning.

Staff in the Information Management Technology (IMT) articulated strongly that UNDIS specifically directed their work to improve the accessibility of the WHO website. Their main concern was that with only limited funding the digital team could soon start to fall behind again as the speed of technological developments increased along with broadening potentials for inclusion. Currently, they are reliant on a good community of practice (from Headquarters to country office level) to try and keep ahead, but they do not have the capacity to audit communications on a regular basis, so the extent to which they are keeping up to date is uncertain. Nonetheless, the norms and standards they have agreed within the Community of Practice (CoP) that focus on disability inclusion do not encounter push-back. Rather there is considerable agreement that there is little point creating content that is not going to reach key target groups. Corporate processes have helped to trigger increased attention, alongside regular communications from the UNDIS Secretariat.

The fact that the Policy on Disability aligns with the UNDIS means WHO has been able to create structures with the potential to ensure disability inclusion becomes embedded. The fact that UNDIS requires focal points motivated regions like AFRO and SEARO to set up their steering committees and prioritize work on disability inclusion. UN coordination groups on disability (such as that in the SEARO region) have enabled the regional offices to focus more on supporting countries to include disability. For example, SEARO used the two-year country office strategy process to encourage offices to develop four to five strategic priorities to help develop their disability inclusion approach. In Nepal for instance, they identified some priority UNDIS indicators to give them the mandate to work on disability, which they then report on as part of the UNCT and as the WHO office.

The main finding in relation to the sustainability of disability inclusive practices and mechanisms was that the key driver for inclusion is mostly regarded to have come from UNDIS, driven by individuals with personal commitment and motivations, and to some extent by the Universal Healthcare agenda, rather than as the result of sustainable structures or strategic approaches, or the Disability Policy itself. So, whilst the Policy on Disability is not necessarily the primary driving factor in promoting disability inclusion, it is nevertheless currently benefiting from the structures and processes that UNDIS provides.

Finding 19. Some progress has been made to integrate disability inclusion into corporate and programme practices and ensure that reporting, governance and accountability mechanisms are established and enshrined in process.

Whilst efforts have been made to integrate disability inclusion into corporate and programme practices there is much variability amongst the workforce at different levels in terms of capacity and understanding.

Alongside the fact that UNDIS mandates disability inclusion as an UN-wide priority, it also requires WHO to implement and monitor an organization-wide policy on disability inclusion. WHO fulfilled this quite rapidly when in 2020 it launched its Policy on Disability (in line with UNDIS Indicator 3). UNDIS also required an Action Plan with custodian departments at Headquarters' level to manage delivery. WHO is using the UNDIS mandated structure to ensure that the objectives of UNDIS and the WHO Policy on Disability are realized. It is responsible for the leadership and implementation of both UNDIS and the WHO Policy on Disability, which are implemented by respective WHO departments and Offices, and overseen by the WHO UNDIS Steering Committee, currently chaired by Assistant Director General, Business Operations (ADG BOS) made up of WHO senior managers including representatives from regional and country offices. As discussed in Finding 5, the UNDIS Working Group and UNDIS Secretariat have key roles to play in this structure and internal governance arrangements.

The intention is to establish comparable structures at regional level with regional steering committees and focal point persons who would continue the process of embedding disability inclusion at regional and country levels. Establishment of regional steering committees is dependent currently on the capacity of the Secretariat to visit regions, conduct awareness-raising activities and support their development. The focal person system, as discussed above, while useful, needs to be evaluated for effectiveness. People in these roles frequently ‘wear multiple hats’ and have been identified because of their technical focus, and often because they also support gender mainstreaming and / or Diversity, Equity and Inclusion. Whilst some of these focal points have a background in disability, and most have some awareness of disability inclusion, they are not always technical experts and yet they find themselves in significant demand. The current resourcing of this structure appears to be insufficient given the task facing WHO.

It has been possible to succeed relatively quickly against UNDIS indicators in some areas, especially in relation to corporate changes such as the focus on improving physical access to buildings and meetings alongside a greater awareness of the need to provide captioning and sign language interpretation, although more work is needed to ensure the indicator for this is met.

Key informants raised the crucial issue to achieving a sustainable disability-inclusive approach, the strongly biomedical approach to disability which health professionals bring to the issue, and the rights and inclusion part of the work needs far more awareness and training. This is reflected in the fact that actions focused on the provision of services such as rehabilitation and assistive technology (these are services for the whole population and not specifically for persons with disabilities) are the focus of country office work on disability inclusion, while persons with disabilities require access to ALL health services. One region respondent felt that this was one of the biggest challenges facing the organization,

> *“The WHO is a titanic! The biomedical point – I’m glad I wasn't the only one who picked up on the biomedical thing... I think that that is the biggest area we face. It's just simply that we work mostly with doctors, health professionals who still think about diseases and organs. They don't think about the whole person....”*

The internal governance structure, while it is comprehensive, could be mandated to play a stronger role in driving forward an organizational-wide change agenda in relation to the sustainability of disability inclusion. The UNDIS Secretariat is well appreciated, with co-leads representing Business Operations (BOS) and Programmes enabling an organization-wide perspective to be taken. The leadership is well briefed and in alignment with the importance of disability inclusion. The regions too are well-represented, and the Steering Committee and focal point structure does provide a good framework within which to structure disability inclusion. WHO therefore aligns well with UNDIS, but it is not then clear what role these structures play in promoting or monitoring the Policy on Disability.

WHO Flexible Funds allocated for the UNDIS managed by the custodian departments are disconnected from other streams of funding for disability work. In addition, the funding allocated under the UNDIS Flexible Funding mechanism is not systematically tracked. The co-leads within the UNDIS Secretariat, and the Steering Committee, are key drivers in this process in that they can promote disability inclusion alongside the planning and reporting processes. To ensure disability inclusion continues to be supported and prioritized across the organization, sustained advocacy with the custodian departments and budget centre managers is required to ensure time and resources are invested to maintain the momentum that has started. Building on this, there may also be legitimate concerns about sustainability because the ongoing work of the UNDIS Secretariat itself, the body which currently has the technical expertise and the ability to convene the various stakeholders across the organization, is not fully funded. To date, funding for a third member of the Secretariat has been provided from the Disability Programme budget but from 2025 this will no longer be made available. Overall, there is a question of how the UNDIS Secretariat's functioning will be maintained.

Finally, in order to sustainably embed disability inclusion into corporate and programming processes an organization-wide change effort is needed. However, disability inclusion is not currently addressed by WHO using a corporate change management approach (in the way that gender equity has been, for example).

The organization planning and budgeting for disability inclusion is largely driven by the UNDIS indicators without accounting for WHO operating model. The recommended structures and the accompanying indicators for disability inclusion have been generated by the wider UN system, but not by WHO specifically. They do not take account of the way WHO functions as a significantly decentralized agency, with many of the indicators focused on processes (such as policy adoption or the establishment of frameworks) at the organization level. This means WHO has made, and can make, relatively rapid progress at the Headquarters' level against many of the UNDIS indicators but tracking how this translates into progress at regional and country level is not obvious.

This dependence on the UNDIS framework leaves WHO exposed to general criticisms of the value of the UNDIS indicators, including: the lack of participation by persons with disabilities in their design and monitoring; the overly generalised nature of the indicators (too broad to measure specific progress within agencies); the focus on process rather than outcomes (policy adoption rather than improvements at the output/outcome level); the lack of qualitative metrics which would indicate the effectiveness and quality of actions; and the reductionist nature of the 15 indicators, which means they focus on actions that can easily be quantified, missing the complex and intersectional nature of effective disability inclusion. As noted previously, this evaluation found that whilst the Policy on Disability is supportive of disability-inclusive work it is not the main driver for this in the regions or countries.

Finding 20. There has been a notable change in the way people talk about disability across the organization at all levels, with people having much more confidence to use rights-based language or to admit to feeling uncertain about discussing some of these issues.

Across the interviews and focus group discussions participants said that over the past three to four years the language spoken concerning disability was generally rights-based and inclusive, and many people felt confident to talk about inclusion. There was a strong sense that even if people lacked confidence or technical expertise, there was no question that disability inclusion was an important agenda item for WHO, as confirmed by this Headquarters' respondent, who explained,

> *"There has been a dramatic change on the visibility on our area of work compared to pre- COVID19 pandemic. Disability in WHO before the pandemic was not mentioned at all."*

Respondents noted that the 'Leave no one behind' and Health Equity agendas were enabling disability inclusion to become part of the WHO's DNA. Corporate processes have helped raise the profile, and the UNDIS Secretariat has been instrumental in enabling that to happen especially at Headquarters' level and increasingly at regional and country office levels. Regions that had been visited by the UNDIS Secretariat noted in particular that it was instrumental in helping them establish the structures and vision for their work on disability inclusion. A key point to note here is that - according to key informant interview (KII)s, the sensitivity of senior leadership to the issue of disability inclusion and their willingness to talk internally and externally about its importance has been a significant motivation for staff who have wanted to talk about inclusion. The launch of the Policy on Disability provided momentum for people to work with but there is a technical skills' gap in relation to disability inclusive programming and operations that requires ongoing messaging and support.

Finding 21. WHO works with a range of partners at all levels, and this is seen as key to driving sustainability and embedding disability inclusion. Partnerships with OPDs are recognized as key to the sustainability agenda but are still nascent.

WHO regions and country offices develop partnerships with a range of different stakeholders from Ministries of Health, other UN agencies (as in the case of Partnership on the Rights of Persons with Disabilities work) and with development agencies working on specific projects. The Tanzania country office for instance has made significant progress on the development of partnerships both with government and the disability movement locally. Over the past four to five years the focus on disability and the number of stakeholders engaged has grown. The Tanzania office for instance is developing a Memorandum of Understanding (MoU) with the main disability network (SHIVYAWATA), with which it has established a good relationship as part of the work with the MoH on the new health sector strategy. Overall, the relationships this office has created with the MoH, international organizations working in this space, such as Sightsavers and CBM, and OPDs like SHIVYAWATA, have been stimulated by both the skills and drive of the focal point and the mandate provided by frameworks such as UNDIS. In Moldova, for instance, the Ministry of Social and Labour has been a significant champion for WHO on social equity issues, and there is an active engagement of ministers with the WHO office for disability identification work. Recent work with the UN Partnerships on the Rights of Persons with Disabilities (UNPRPD) programme in Georgia (to deliver a study on the status of refugees with disabilities) is developing recommendations for working with persons with disabilities and refugees in Georgia itself. PAHO/AMRO developed a partnership with the Special Olympics programme which is helping them to see the benefits of creating relationships that go beyond a focus on government.

In general, whilst there are a small number of working partnerships with OPDs and other stakeholders in the sector beyond governments, these partnerships are less frequent and more nascent. There does not seem to be an organizational process or approach to working with OPDs. Thus, there is an opportunity in future to build on the foundational examples cited above and strengthen a systemic and enabling WHO approach to meaningful engagement with OPDs.

Credit: WHO / Mwesuwa Ramsey

IV. Conclusions

During the inception phase of the evaluation, four assumptions linked to the evaluation question that set out to test and validate were identified and the subsequent conclusions are also based upon these assumptions, as shown below.

Assumption 1: All operational and programmatic efforts towards disability inclusion fit within the four core areas (and therefore are in the action plan).	The evaluation identified initiatives at country and regional level which conceptually fitted within the action plan but were not consistently captured and reported on through those mechanisms (recommendation 1 & 6).
Assumption 2: The UNDIS is the most appropriate vehicle for WHO to mainstream disability inclusion, through the disability policy and action plan at all three levels.	The evaluation suggests that WHO's Policy on Disability is a WHO-specific operational context (recommendation 1).
Assumption 3: Initial investment via flexible funds is sufficient to catalyse and sustain disability inclusion mainstreaming.	The flexible funds mechanism has supported, and kickstarted, a number of important initiatives to mainstream disability inclusion. Continued resourcing may be required to ensure sustainability of some of these initiatives (recommendation 8).
Assumption 4: Good practices at all levels can be identified and can support institutional learning and accountability.	The evaluation identifies some examples of good practice, but suggested improved monitoring, evaluation and reporting is required to build on knowledge and information available (recommendation 6).

Conclusion 1. Alignment of the WHO Policy on Disability and UNDIS has raised the profile of disability inclusion across the Organization and contributed to meeting UN-wide commitments. Stronger contextualisation and tailoring to WHO's unique operational framework would further strengthening alignment.

The alignment of the WHO Policy on Disability to the UNDIS has brought considerable value with regards to raising the profile of disability inclusion across the organization and meeting UN-wide commitments and has given WHO a strong mandate to promote disability inclusion across the organization and its programmes. There is an opportunity for WHO to adapt and contextualize the UNDIS specifically for WHO, tailoring it to better align with the organization's unique operational framework. This would enhance the organization's strategic and sustainable impact for the future. Currently, the guidance provided does not fully capture WHO's processes and priorities, creating a need for clearer, practical directives that identify measurable changes. Addressing this gap could shift the focus from stand-alone actions within the current plan towards more integrated, evidence-based interventions, embedding disability inclusion more deeply into WHO's core strategies and fostering greater collaboration and long-term impact across its initiatives.

LINK TO FINDINGS: 1, 9, 18

Conclusion 2. Alignment and leadership of disability-inclusion work through the UNDIS Steering Committee and UNDIS Secretariat has supported the organization's achievements on disability inclusion. The Policy on Disability and the UNDIS indicators are still relatively new and different departments, and offices, across WHO have a role to play in ensuring disability inclusion is integrated across the work of the organization, both in programmes and operations, due to the cross-cutting nature of this work.

The leadership and clear framework established for overseeing UNDIS commitments - particularly through the composition of the UNDIS Steering Committee, which includes senior management, and the UNDIS Secretariat - have been instrumental in the organization's achievements to date in advancing this agenda. This comprehensive governance structure presents an opportunity to enhance the sustainability of disability inclusion as an organization-wide change agenda. As the focus for driving implementation of the Policy on Disability and the UNDIS indicators sits with the UNDIS Secretariat and the Disability Programme they would seem to have a role in supporting greater synergies across different initiatives. To strengthen commitment to this agenda, it is important to address the current reliance on UNDIS structures and resources for implementation of the Policy on Disability which are not sufficient to effect the organizational change process that is required for disability inclusion to become fully embedded within WHO.

Fostering stronger alignment and collaboration across all departments working on disability inclusion as part of a health equity approach (including among others those working on gender, human rights, and diversity, equity, and inclusion) with the UNDIS Secretariat's efforts (and the disability programme's efforts) in disability-inclusion mainstreaming is essential for achieving strategic coherence. Given the cross-cutting nature of disability inclusion, raising awareness of the roles and points of contact for staff seeking guidance will be beneficial. This will help create a more cohesive approach and ensure that all initiatives are effectively aligned towards the common goal of fostering an inclusive environment.

LINK TO FINDINGS: 4, 5, 6, 12, 13

Conclusion 3. The focal point structure is an effective way to promote a coordinated approach to integrating disability inclusion across programmes and operations and is a well-established approach used by WHO, and the UN system more broadly, but the responsibilities, identification and resourcing of the role requires greater clarity.

The focal person system requires further resourcing to ensure individuals allocated to these roles have the necessary expertise and experience in disability inclusion to provide the leadership, advice and guidance needed. This requires adequate resources and training to effectively champion disability inclusion within the organization. This approach will help reinforce the message that disability inclusion is a priority and a vital area requiring specialized skills.

To achieve the systematic inclusion of disability necessary for impactful organizational change, it's essential to create a more robust and well-supported focal point structure. By investing in this framework, WHO can cultivate a strong network of advocates who can drive meaningful progress and foster an inclusive culture throughout the organization.

LINK TO FINDINGS: 5, 7, 18

Conclusion 4. The strong commitment to human rights and the 'Leave no one behind' agenda, along with WHO staff's personal dedication to the 'Health for All' mandate, provides a solid foundation for further embedding disability inclusion work across the organization. However, more widespread awareness-raising and clarifying definitions is needed to ensure this becomes embedded.

The commitment to the human rights and the 'Leave no one behind' agenda, combined with strong personal dedication and wide acceptance, provides a valuable foundation for further embedding disability inclusion work across the organization. While these elements are essential, enhancing the impact of WHO's disability inclusion efforts will require additional widespread messaging and consistent awareness-raising initiatives.

To empower staff to effectively plan and deliver disability-inclusive programs, it is important to provide the necessary language and tools. The UNDIS Secretariat and Disability Programme have an important role to play in strengthening capacity and fostering a culture of inclusivity across the organization to ensure that disability inclusion becomes a core value, rather than being perceived merely as a reporting obligation under UNDIS.

LINK TO FINDINGS: 2, 3, 9, 15, 18, 20

Conclusion 5. What gets measured gets done. Accountability and reporting requirements are useful to track what is being done with regards disability inclusion. However, the evaluation revealed gaps in the organization’s ability to effectively monitor and evaluate disability-specific activities, as well as inconsistencies in collecting and reporting data related to persons with disabilities.

County offices seem more aware of the accountability requirements under the UNDIS reporting processes coordinated by the UNCTs than they are with any WHO specific requirements related to the WHO Policy on Disability and accompanying Action Plan. The absence of a mandatory reporting system (specific for disability) for WHO programmes and operations to provide information and data makes it difficult to identify examples of evidence-based good practice to support institutional learning and accountability. The WHO Results Framework is not detailed enough to help WHO assess its progress against the Policy on Disability, and neither is the Output Scorecard. There is no tracking of inclusion of persons with disabilities and the impact of that inclusion.

A greater understanding of who is accessing services as well as who is employed is crucial to ensure that WHO is an inclusive place to work and that it delivers inclusive programmes. Disability data is useful for the organization to collect to ensure it is meeting the needs of a diverse workforce, but it must be handled with strict confidentiality. Without fully disaggregated data, it is very difficult for WHO to track the extent to which the Policy on Disability is providing guidance for programme and operations work, and thus its overall effect on coherence is difficult to determine.

LINK TO FINDINGS: 10, 19

Conclusion 6. The Flexible funds mechanism has provided crucial resources and support to kickstart a number of initiatives at Headquarters to ensure disability inclusion. While there have been challenges with the funding allocation and spending processes, which have primarily impacted the distribution of resources to regional and country offices, there remains a significant opportunity to enhance the impact of this mechanism and catalyse efforts towards greater disability inclusion for the remaining period these funds are available.

To maximize the catalytic impact and sustain the momentum on disability inclusion, dedicated human resources and a supportive infrastructure are needed to strengthen the overall resourcing and capacity needed to deliver on this ambitious agenda.

LINK TO FINDINGS: 7, 11, 12

Conclusion 7. Operational guidance and training have been developed to support the implementation of the UNDIS and the WHO Policy on Disability. This has yet to be fully rolled out and operationalized at regional and country levels, unsurprising given the timeframe available for implementation, but now requires prioritization.

The UNDIS action plan has, in the five years since the policy has been in place, successfully identified several practical actions to support the delivery of the strategy, primarily at Headquarters' level. While policies and guidance have been developed, the evaluation highlights an opportunity for further implementation at the regional and country levels. To ensure that disability inclusion practices are effectively promoted and enacted, it is essential to provide practical training for the workforce on how to deliver on WHO's disability-inclusive commitments and to empower them to support others in adopting a disability-inclusive approach. Ongoing and targeted disability awareness training and support will help people in all teams to transition from biomedical thinking to the human rights' approach to disability. This should be done openly, across teams (operations and programmes) allowing people to explore how their own biases towards disability may be affecting the ways in which they approach their work. A number of good practices are already in place, including a centralised Reasonable Accommodation fund and the Staff Affinity Group, which provides a platform for networking and sharing of lived experiences across the organization, which should be supported to continue.

To enhance the action plan and strengthen the delivery of the strategy, developing a communication and outreach plan to support the promotion of disability inclusion practices, allocating sufficient human resources for ongoing support could be beneficial. There is also a need to provide training for interview panels and hiring committees to ensure that disability inclusion and accessible practices are well understood, enabling team members to confidently implement related policies and guidance.

LINK TO FINDINGS: 9, 14, 16, 18

Conclusion 8. Strong collaboration with OPDs is necessary to ensure that persons with disabilities are meaningfully engaged in advocacy and accountability efforts. OPDs play a critical role in representing the voices of persons with disabilities and advocating for their rights. However, their ability to hold governments accountable for delivering equitable services is often limited by resource constraints and capacity gaps.

The evaluation has identified promising examples of partnerships with OPDs and networks, along with efforts to integrate guidance on consulting with these groups into WHO programmes. While these collaborations are currently limited in number, they represent a valuable starting point for enhancing engagement with OPDs. Meaningful involvement of OPDs is not only essential for fulfilling international commitments under the CRPD and UNDIS, but it also plays a crucial role in enhancing programme outcomes.

To build on these initial successes, investment is required to support the capacity strengthening of OPDs to engage in the health sector, recognizing the challenges they may face in terms of availability and familiarity with WHO's operational processes. Developing a comprehensive, organization-wide WHO OPD engagement strategy will be key. This strategy should include long-term investments in capacity building, as well as funding dedicated to supporting both organizational growth and programming initiatives. By fostering stronger, more sustainable partnerships with OPDs, WHO can enhance its efforts towards inclusivity and ensure that the voices of persons with disabilities are integral to its work.

LINK TO FINDINGS: 8, 16, 21

V. Recommendations

The evaluation has identified the following recommendations which have emerged from the findings and conclusions for WHO to consider. The recommendations are set out under three headings: Strategic, Operational and Programme and Resourcing.

They have been validated at a meeting with the Evaluation Reference Group and through several discussions with the UNDIS Secretariat and presentation to the UNDIS Steering Committee.

Strategic recommendations

Recommendation 1

Update the WHO Policy on Disability in the next phase of implementation to better reflect the unique operational situation of WHO, in particular its decentralized structure. This should include a clearer specification of roles and responsibilities for all disability inclusion work and the following actions:

External:

- Organize a consultation process with UN peers to understand how others have utilised UNDIS in their organizational policies and reporting systems.

Internal:

- Organize a consultative process to ensure that different parts of WHO gain buy-in for the Policy on Disability;
- Establish a process for adapting and tailor the Policy setting out clear timeframe, resourcing, monitoring and oversight;
- Conduct a comprehensive mapping of how disability inclusion is integrated across a range of departments and programmes working on health equity issues.

LINK TO CONCLUSIONS 1, 2

Priority: High

Level: Headquarters (UNDIS Steering Committee) to lead,
but to include Regional Offices and Country Offices for mapping

By whom: UNDIS Secretariat and focal points

Recommendation 2

Enhance engagement with different departments around the UNDIS indicators, to support greater integration of disability inclusion across WHO both in programmes and operations. This could be done through supporting greater synergies across different initiatives and clarifying the scope of work of individual teams and oversight of organizational initiatives to promote disability inclusion:

- Strengthen the linkages between different departments and teams working on disability inclusion to ensure these initiatives can be more aligned, including the collaboration between GRE and UNDIS Secretariat and Disability Programme;
- Develop a clear strategy for how to utilise collaboration and synergies with other cross-cutting initiatives to make disability inclusion more visible and more effective;
- Establish clear roles and responsibilities across the different departments working on aspects of integrating disability inclusion into their work to improve collaboration, streamline workflows and ensure staff understand how to apply disability inclusion practically.

LINK TO CONCLUSION 2

Priority: High

Level: Headquarters, and cascaded to other teams at other levels

By whom: UNDIS Steering Committee and UNDIS Secretariat

Recommendation 3

Strengthen the focal point structure established to promote a coordinated approach to integrating disability inclusion by articulating the roles and responsibilities of focal persons who steer offices, teams and departments towards mainstreaming disability inclusion in the longer term:

- Ensure there is a clear expectation and dedicated time within the job descriptions of those with focal point responsibilities and that they have the technical knowledge to support colleagues in implementing inclusive actions;
- Ensure Terms of Reference are updated and shared with all focal points;
- Identify clear time commitments for focal points to fulfil these requirements;
- Encourage individuals to not take on too many focal point responsibilities to avoid them spreading themselves too thinly;

- Ensure focal persons receive regular mandatory learning and development opportunities so that they can keep abreast of current good practice and WHO developments in disability inclusion mainstreaming;
- Consider developing a succession plan to manage turnover among focal persons at different levels.

LINK TO CONCLUSION 3

Priority: High

Level: Headquarters to lead, but to include ROs and COs for consultation and implementation

By whom: UNDIS Steering Committee supported by Secretariat, and UNDIS Working Group

Operational recommendations

Recommendation 4

Strengthen awareness and understanding of disability inclusion and implement a comprehensive, organization-wide capacity-building initiative that includes targeted training and practical technical guidance and advice in order to enhance skills across the workforce and foster a culture of continuous learning and self-reflection:

- Ensure the technical guidance notes that have been developed under UNDIS are widely circulated and promoted across the organization;
- Continue to develop, finalize and share widely simple, practical, best practice guidance on how to mainstream disability inclusion, that is adapted for WHO's specific context;
- Develop a clear training strategy, supported by inclusion champions who have the confidence to nudge people away from biomedical thinking;
- Support the Disability Programme to provide a more flexible, on-demand internal 'Helpdesk-type' approach to provide capacity strengthening support across the workforce, including access to evidence-based research, information and guidance tailored to their specific needs;
- Integrate disability inclusion into the mandatory 2-3 day induction training at the regional office level for new staff delivered every quarter which currently includes Prevention of and Response to Sexual Misconduct (PRS) as a core topic for induction;

- Encourage consultants employed by WHO on long-term contracts to participate in the induction training as a requirement for their contract;
- Continue to offer the programme of webinars and awareness raising events to raise the profile of disability inclusion across the Organization, and improve socialisation of the issues, and ensuring that advice remains relevant and up to date; and
- Establish peer learning opportunities to explore how disability inclusion is being considered and taken forward in these areas.

LINK TO CONCLUSIONS 4, 7

Priority: High

Level: All levels with a focus on country offices

By whom: UNDIS Secretariat, UNDIS Working group and custodian departments, and ROs and COs for consultation and implementation

Recommendation 5

Sustain and enhance efforts to become a disability-inclusive employer with a proactive and structured approach to inclusive hiring practices and ensuring that barriers to employment for persons with disabilities are identified and removed to address underrepresentation of persons with disabilities in the workforce:

- Provide mandatory training for hiring managers and HR personnel on disability awareness, unconscious bias, and inclusive hiring practices;
- Ensure reasonable accommodations are clearly offered and communicated during the hiring process, not just once in post;
- Offer flexible application and interview arrangements, including accepting alternative application formats, virtual interviews etc.;
- Monitor recruitment data, retention rates and employee satisfaction to evaluate the success of inclusive hiring practices and make adjustments based on real-time data;
- Conduct a review of reasonable accommodations and compensation packages available across the workforce to ensure they adequately address the needs of employees and consultants with disabilities.

LINK TO CONCLUSION 7

Priority: Medium

Level: All three levels

By whom: HRT at all levels

Recommendation 6

Strengthen the Organization’s monitoring, evaluation and reporting systems to systematically track and report disability-specific activities, outcomes, and expenditure with an emphasis on improving data collection related to persons with disabilities:

- Develop a Theory of Change and results framework to articulate results for the WHO Policy on Disability Inclusion;
- Collect data on disability that is relevant to each of its own organizational priorities. The measurement process should reflect the policy area (team priorities) rather than being entirely analogous to UNDIS. WHO should consider separating the reporting system from UNDIS reporting requirements and making it internal to WHO;
- Explore the requirements to make reporting against the Disability Inclusion Marker mandatory, and similar to reporting against the Gender Equality Marker and UN system-wide Action Plan (UN-SWAP) indicators;
- Develop an enhanced system for tracking how resources are used for disability inclusion efforts specifically, ensuring spending and programmatic outputs are monitored on an ongoing basis. This will help improve the prioritisation of resource allocation;
- Implement a confidential system for collecting data on the disability status of the workforce to support inclusive practices. This could be an annual survey or an optional equality and diversity monitoring form, in which confidentiality and voluntary participation is assured;
- Conduct organizational-wide awareness raising to encourage voluntary disclosures among the workforce to ensure accessibility and accommodation needs are addressed;
- Ensure guidance on how to collect disaggregated data safely and appropriately at strategic planning and population level is made widely available and communicated to staff at country level in particular;
- Document good practice examples from country offices who are already working with national governments to strengthen health systems and health management information systems, so as to capture this information and thereby share learning widely across the Organization.

LINK TO CONCLUSION 5

Priority: Medium

Level: All three levels: Headquarters, Regional Offices, Country Offices

By whom: DG/ ADG, UNDIS Steering Committee, Secretariat, and custodian departments, including HRT, PRP, NCD

Partnerships and resourcing recommendations

Recommendation 7

Strengthen partnerships with organizations of persons with disabilities (OPDs), developing Memoranda of Understanding where appropriate, and prioritize supporting their long-term capacity to strengthen their ability to influence health-related policy, monitor health service provision, and ensure that governments meet their obligations under disability rights frameworks:

- Emphasize to donors the need to invest in strengthening the capacity of OPDs to better engage in the health sector, in particular committing to long-term, sustainable funding arrangements to enable OPDs to focus on advocacy work and deliver for their members without being hindered by short-term, activity-based funding cycles;
- Build on nascent examples of good practice working with OPDs at country and regional level to develop and formalise an organizational process for working with OPDs to strengthen systemic engagement;
- Maximize the opportunities for Regional Offices and Country Offices to ensure that persons with disabilities are able to participate and engage in mainstream programmes, for example ensuring they are involved in evaluation processes and programme advisory groups etc.;
- Explore opportunities for developing Memorandums of Understanding with OPDs to formalize partnerships to strengthen the meaningful engagement of persons with disabilities across WHO's work.

LINK TO CONCLUSION 8

Priority: High

Level: All three levels: Headquarters, Regional Offices, Country Offices

By whom: Disability programme and focal persons,
programmes at all levels

Recommendation 8

Prioritize resources for spending on disability inclusion to sustain the momentum and strong progress achieved to date:

- Encourage programmes to add one disability inclusion action in their workplans over the next three years;
- Continue to ensure that disability inclusion is embedded in the Organization's operational budget planning and resource allocation processes, so it becomes a core

consideration across all funding decisions, through ongoing advocacy with custodian departments and budget centre managers;

- Advise donors of the need to ensure disability inclusion is built into all projects/programmes and not just to fund standalone disability projects; make this a requirement for all requests for proposals, in the same way that gender and safeguarding are now included.

LINK TO, AND BASED ON, CONCLUSIONS 2, 6

Priority: High

Level: Headquarters

By whom: ADG and UNDIS Steering Committee

VI. References

1. Wilson-Grau R, Britt H. Outcome Harvesting. Ford Foundation. May 2012. (https://www.betterevaluation.org/tools-resources/outcome-harvesting-0, 15 October 2024).

2. World Health Organization. Global report on health equity for persons with disabilities. 02 December 2022. (https://www.who.int/publications/i/item/9789240063600).

3. World Health Organization. Global report on health equity for persons with disabilities. 02 December 2022. (https://www.who.int/publications/i/item/9789240063600).

4. Danos, C., Heydt, P., Kuper, H., Burbach, M., Rotenburg, S., Seghers, F., 2022. Reimagining health systems, Missing Billion Report. Missing Billion Initiative & Clinton Health Access Initiative. (2022 MB report — Missing Billion Initiative)

5. Gréaux, M., Moro, M.F., Kamenov, K., Russell, A.M., Barrett, D., Cieza, A., 2023. Health equity for persons with disabilities: a global scoping review on barriers and interventions in healthcare services. Int J Equity Health 22, 236. (https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-023-02035-w).

6. World Health Organization. Towards a Common Language for Functioning, Disability and Health: ICF. 2002. (https://www.who.int/docs/default-source/classification/icf/icfbeginnersguide.pdf?sfvrsn=eead63d3_4);

7. World Health Organization. WHO Policy on Disability. 2021. (https://www.who.int/publications/i/item/9789240020627).

8. United Nations Evaluation Group (UNEG). 2020. UNEG Ethical Guidelines for Evaluation. (https://www.unevaluation.org/document/detail/2866).

9. UNCT. Gender Equality Marker Guidance Note. 2024. (https://unsdg.un.org/resources/unct-gender-equality-marker-guidance-note-2024)

10. The WHO European Framework for action to achieve the highest attainable standard of health for persons with disabilities 2022–2030. (https://www.who.int/europe/publications/i/item/WHO-EURO-2022-6751-46517-67449).

11. Health Equity for Persons with Disability. Guide for Action. 2024 (http://www.who.int/activities/supporting-countries-to-advance-health-equity-for-persons-with-disabilities)

12. IDA, NORAD. Promoting engagement of Organisations of Persons with Disabilities (OPDs) in development and humanitarian action. 2022. (https://www.internationaldisabilityalliance.org/sites/default/files/opd-engagement-paper-2022-ok1.pdf).

VII. Annexes

Contents

Annex 1: Terms of Reference

Evaluation of the WHO Policy on Disability Terms of Reference

I Background

According to the United Nations Convention on the Rights of Persons with Disabilities, persons with disabilities are “persons who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various attitudinal and environmental barriers, hinder their full and effective participation in society on an equal basis with others”.[15] Today, an estimated 1.3 billion people – about 16% of the global population – experience significant disability: 80% live in developing countries and are over-represented in poorer sections of the population.[16] This number is increasing due in part to population ageing and a rise in the prevalence of noncommunicable diseases.

Health for All is at the core of WHO’s mandate. The WHO Constitution (1946) explicitly highlights the right of all people to the highest attainable standard of health, thus grounding the Organization’s work in a human rights-based approach. WHO’s principles of health equity are also aligned with internationals norms and instruments including, *inter alia,* 1978 Declaration of Alma-Ata, the Declaration of Astana emanating from the Global Conference on Primary Health Care in October 2018, as well as the core principles enshrined in the United Nations Convention on the Rights of Persons with Disabilities (CRPD, 2006).[17] WHO’s work is also committed to the principle of “leaving no one behind” reaffirmed in the 2030 Agenda for Sustainable Development and the United Nations flagship “Disability and development report: realizing the Sustainable Development Goals by, for and with persons with disabilities” (2018).[18]

Disability inclusion is at the core of resolution WHA74.8 (2021) on the highest attainable standards of health for persons with disability.[19] It is also in line with the 13th General Programme of Work, which reaffirms WHO’s leadership on health equity within the transformative agenda of the SDGs and achieving Health for All. Disability inclusion is critical to achieving the Sustainable Development Goals and global health priorities of universal health coverage, protection in health emergencies and healthier populations.[20]

---

[15] See: UNenable: www.un.org/esa/socdev/enable/faqs.htm

[16] WHO Health Topics. Disability. Ibid

[17] See Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. Global Conference on Primary Health Care: From Alma-Ata towards universal health coverage and the Sustainable Development Goals, Astana, Kazakhstan, 25 and 26 October 2018. For the full text of the CRPD, including principles, definitions and state parties’ obligations see: *Convention on the Rights of Persons with Disabilities*, 24 January 2007. United Nations General Assembly resolution 61/106 (2007) https://social.desa.un.org/issues/disability/crpd/convention-on-the-rights-of-persons-with-disabilities-crpd

[18] UN DESA (2018). *Disability and development report: realizing the Sustainable Development Goals by, for and with persons with disabilities*. New York: United Nations

[19] WHA74.8 The highest attainable standards for persons with disability. Retrieved at: https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_R8-en.pdf

[20] See: WHO. 13th General Programme of Work 3019-2023. Geneva: World Health Organization at: https://apps.who.int/iris/bitstream/handle/10665/324775/WHO-PRP-18.1-eng.pdf

According to the WHO Global Report on Health Equity for Persons with Disabilities[21]: "disability is part of being human and integral to the human experience. It results from the interaction between health conditions and/or impairments that a person experiences, such as dementia, blindness or spinal cord injury, and a range of contextual factors related to different environmental and personal factors including societal attitudes, access to infrastructure, discriminatory policies, age, and gender". This understanding of disability is grounded in the WHO International Classification of Functioning, Disability and Health (ICF), published in 2001.[22] The ICF, adopted by WHO Member States, was the first document to set a new understanding of disability, based on the biopsychosocial model, and defining disability not only by the underlying health condition or impairment of a person, but also by the fundamental effect of their environment".

The WHO Policy on Disability

On 11 June 2019, the UN Secretary-General launched the United Nations Disability Inclusion Strategy (UNDIS) to mainstream disability inclusion in all areas of the UN's work, both inside and outside the Organization.[23] Subsequently, in 2020 WHO developed a WHO Policy on Disability at the request of the Director-General (DG), in consultation with the programmatic and operational departments of the Organization, staff with disability and Regional Disability Leads. With this policy, WHO commits to becoming "an organization which is inclusive of people with disability in all their diversity and systematically integrates disability in all programme areas, contributing to the practical implementation of the globally agreed commitments contained in the United Nations treaties, conferences and summits and their follow-up".[24]

The policy expands on other organizational policies, such as the updated Policy on Employment of Persons with Disability (2022), which commits the Organization to providing equal access to employment, advancement and retention to ensure a diverse and skilled workforce representing all people in society. It builds on the existing focus on strengthening data collection on disability through initiatives like the Model Disability Survey, which provides comprehensive information about disability distribution in a country or region and the WHO Disability Assessment Schedule 2.0 (WHODAS 2.0), a standardised method to measure health and disability across cultures.[25] The Policy synergises with WHO work on Health Equity, Gender Equality and Human Rights. As described in the Thirteenth general programme of work 2019−2023, "WHO commits, at all levels of engagement, to the implementation of gender equality, equity and rights-based approaches to health that enhance participation, build resilience, and empower communities".[26]

The WHO Policy on Disability is operationalized through a costed Action Plan (2021-2024), that is intended as a living document. The objectives of the Action Plan are to ensure that: 1)

---

[21] Page 3 of the Report, accessible at : https://www.who.int/teams/noncommunicable-diseases/sensory-functions-disability-and-rehabilitation/global-report-on-health-equity-for-persons-with-disabilities

[22] https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health

[23] United Nations (2019). UN Disability Inclusion Strategy at: https://www.un.org/en/content/disabilitystrategy/

[24] WHO Policy on Disability. Geneva: World Health Organization; 2021. Licence: CC BY-NC-SA 3.0 IGO at: https://apps.who.int/iris/rest/bitstreams/1344492/retrieve

[25] See the link to Databases and Tools at this page: https://www.who.int/health-topics/disability#tab=tab_1

[26] WHO/PRP/18.1. The Thirteenth General Programme of Work, 2019–2023, was approved by the Seventy-first World Health Assembly in resolution WHA71.1 on 25 May 2018.

the needs of people with disabilities are addressed in all efforts to improve the health, functioning and well-being of all people, including through targeted actions; 2) the rights of people with disabilities are realized through the human rights-based approach of the Organization; 3) people with disabilities in all their diversity are meaningfully participating in all levels of the Organization's workforce; and 4) disability is recognized as a natural part of the human condition and disability is an integral part of all programmatic areas of work and the six core functions of WHO.

The Policy and the Plan are aligned with and feed into the Organization's monitoring and reporting on implementation of the UNDIS through all levels of the organization, according to 15 indicators covering four core areas of responsibility: leadership, strategic planning and management; inclusiveness; programming; and organizational culture. Reports are twice annually - once to the UN Secretariat and once to the WHO EB.

The Action Plan identifies Custodian Departments (see Figure 1) responsible for each indicator and it sets baselines and targets against which to track progress, in line with the UNDIS. The Action Plan is a plan for the whole organization, developed and implemented in collaboration with regions and countries.

Between 2020 and 2023 about US$ 2.86m were allocated to catalyse implementation efforts on disability inclusion. The budget documents provide details of funding by year and by indicator as allocated to each responsible department. Data on implementation rate by indicator are available from the WHO UNDIS Secretariat.

The WHO Policy on Disability – programmatic and governance aspects

WHO has set in place a UNDIS Steering Committee (currently chaired by ADG BOS and consisting of the Chef de Cabinet, ADG UHC/Communicable and Noncommunicable Diseases (UCN), Executive Director Health Emergencies (WHE) and ADG Business Operations (BOS)), and more recently DPM EURO, DAF PAHO/AMRO, WR Mongolia and WR Indonesia to champion and oversee progress in the uptake and implementation of the policy at senior management at all levels in the Organization. A WHO UNDIS Working Group, comprised of focal points in Custodian Departments and soon regional teams, supports implementation of specific activities in the Action Plan. A WHO UNDIS Secretariat, led by two representatives from BOS and UCN/NCD, coordinates meetings between the SC and the WG and prepares the annual report with inputs from the Working Group and Regional Offices.

A participatory approach is necessary to build trust between WHO and the communities served by the Organization's work and ensure the ownership and commitment of all the stakeholders involved in WHO's programmatic and business operations. This applies also to persons with disabilities and their representative organizations. The Embracing Disability Affinity-Resource Group is a voluntary, employee-led group that fosters a diverse, inclusive, and supportive workplace aligned with WHO values, with disability inclusion at the forefront. The group also includes parents of children with disabilities and allies. They provide feedback on actions to promote an enabling environment for WHO staff.[27]

The table below shows the WHO Custodian Departments responsible for implementation of the different areas and sub-areas of the Action Plan, as well as responsibilities of regional offices.

WHO Policy on Disability and Action Plan: Areas of responsibility, sub-areas and custodian departments

Action Plan Sub-area	**Custodian department / Regions**
CORE AREA 1: Leadership, strategic planning and management	
Leadership	Director-General's Office
Strategic planning	Department of Planning, Resource Coordination and Performance Monitoring
Disability-specific policy / strategy	Director-General's Office
Institutional setup	Disability Programme at NCDs Department
CORE AREA 2: Inclusiveness	
Consultation with persons with disabilities	Disability Programme at NCDs Department
Accessibility Conferences and events and Infrastructure and premises IMT Communications	Department of Operational Support and Services Department of Operational Support and Services Department of Information Management and Technology Department of Quality Assurance of Norms and Standards
Reasonable accommodation	Department of Human Resources
Procurement	Department of Supplies
CORE AREA 3: Programming	
Programmes and projects	Disability Programme at NCDs Department Department of Planning, Resource Coordination and Performance Monitoring
Evaluation	Department of Evaluation
Country programme documents	Department of Country Strategy and Support Disability Programme at NCDs Department
Joint initiatives	Disability Programme at NCDs Department
CORE AREA 4: Organizational culture	
Employment	Department of Human Resources

---

[27] WHO Disability Inclusion Toolkit - Core Concepts for Disability Inclusion in WHO and UNDIS Guidelines on Consulting with Persons with Disabilities.

Capacity development for staff	UNDIS Secretariat Department of Human Resources
Communication	Department of Communications

II Purpose and objectives of the evaluation

WHO closely monitors the implementation of the UNDIS Action Plan; nevertheless, there has been no specific external evaluation conducted by WHO regarding this area of work so far.[28] The policy states that "The WHO Evaluation Office will conduct an independent evaluation of the WHO Policy on Disability, informing its review every five years, as part of the Organization's strategic planning processes and the Global Programme of Work". This requisite is aligned with Indicator 10 of the UNDIS entity accountability framework, that requires WHO to conduct a "meta-analysis of evaluation findings, conclusions and recommendations relating to disability inclusion […] at least every five years". WHO started to implement UNDIS in 2019, so the five years evaluation is required in 2024. The evaluation of the Policy on Disability is also part of the WHO evaluation office bi-annual workplan 2022-2023. As the design of the GWP14 is currently underway, this evaluation comes timely to ensure that any recommendation be included in WHO core processes going forward.

Evaluation purpose

The purpose of the evaluation is to review the extent to which disability inclusion is effectively implemented across all three levels of WHO. This will also help WHO to promote institutional learning and accountability, contributing to implementation of the UNIDIS, of the Convention on the Rights of Persons with Disabilities (CRPD) and the achievement of the Sustainable Development Goals (SDGs), including the core commitment to leave no one behind.

Findings and lessons learned will feed into the annual report to the UN Secretariat and the WHO Executive Board (e.g., Member States). Recommendations from the evaluation will inform the Leadership (e.g., DG, WHO UNDIS Steering Committee, Regional Directors), UNDIS custodian departments and regional and country offices on how to make progress on their UNDIS work.

The evaluation will be primarily **formative and forward-looking** with a view to facilitate strategic decision-making for WHO to better integrate disability inclusion throughout the Organization. Findings and lessons learned from this evaluation will suggest how to overcome barriers and effectively improve UNDIS implementation at HQ, regional and country offices. The evaluation should identify ways to improve the WHO UNDIS Action Plan.

Evaluation objectives

The objectives of the evaluation are:

---

[28] A UN Joint Inspection Unit Review on Enhancing Accessibility for Persons with Disabilities to Conferences and Meetings of the United Nations System was conducted in 2018 (JIU/REP/2018/6 February 2019), and that includes WHO.

- To assess to what extent WHO has implemented its Disability Policy and Action Plan in alignment with UNDIS objectives and with a focus on the achievement of results, including in each of the four core areas and at overall strategic level;
- To identify factors that hinder or support the ability of the Organization to meaningfully integrate disability inclusion in the four core areas of the Action Plan;
- To formulate findings, conclusions and recommendations which will inform implementation of the WHO's Policy on Disability and future reviews. Furthermore, it will identify ways to strengthen WHO's organizational leadership to protect and advance the rights of persons with disabilities.

III Evaluation scope

Evaluation scope

Period covered

The evaluation will cover actions from the Policy on Disability rollout in 2019 to date.

Geographical coverage

The WHO Policy on Disability is relevant for all levels of the WHO workforce, operations and programme. The evaluation will encompass implementation at headquarters, regional offices and country offices. All six regions will be covered.

Content areas

The evaluation will assess the progress made, gaps, and challenges in implementing UNDIS at HQ, regional and country offices level. Assessment of progress covers each of the 15 UNDIS Indicators (including the 4 sub-indicators under Indicator 6 on accessibility)[29] and the implementation of the activities included in the WHO UNDIS Action Plan.

The evaluation will cover work on inclusive measures for staff with disabilities and mainstreaming of disability inclusion into WHO programmes and business operations (all programmatic and business operations at HQ, regional and country offices). The way WHO recruits, hires, trains, procures, communicates, develops norms and standards, implements public health interventions, and executes its core functions are important components of the policy and will be subject to evaluation.

Given the constrained timeline and budget, the evaluation will not encompass the WHO NCD disability programme's specific mandate and activities at the global, regional, or country levels[30], except for those closely related to the WHO Policy on Disability Action Plan.

---

[29] For progress on indicators, please refer to the criteria to "approach, meet, and exceed requirements" in the UNDIS Entity Accountability Framework technical notes.

[30] Among other, reference to WHA 74.8 - The highest attainable standard of health for persons with disabilities (https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_R8-en.pdf)

IV Evaluation criteria and questions

Evaluation criteria and questions

The evaluation will seek answers to a maximum of 10 prioritised evaluation questions. Evaluation questions will be discussed and refined (re-prioritised as needed) at the inception phase of the evaluation. Potential evaluation questions are provided below.

The evaluation will use the OECD/DAC criteria of relevance (*is the intervention doing the right things?*), coherence (*how well does the intervention fit*), effectiveness (*is the intervention achieving its objectives*), efficiency (*how well are resources being used?*), and sustainability (*will the benefits last*)[5]. Evaluation questions are organized by these OECD/DAC criteria.

A theory of change will be reconstructed at the inception phase to help clarify what the inputs and expected outputs of the work of the Policy on Disability and Action Plan are and prioritise evaluation questions.

Potential evaluation questions and relevant OECD criteria

Evaluation questions	Reference to OECD/DAC criteria
Q1: How is the Action Plan strengthening internal and external coherence?	**COHERENCE**
Q2: To what extent are the Action Plan activities relevant to and aligned with the ambition of the WHO Policy on Disability? **Q3:** To what extent is disability, disability inclusion and associated responsibilities among management and staff at all three organizational levels appropriately understood (e.g., disability versus health conditions/impairments, understanding of UNDIS and its commitments)? **Q4:** What is the level of satisfaction among staff, consultants, interns, and volunteers with disabilities with the type of actions included in the WHO UNDIS Action Plan (- *the what*)?	**RELEVANCE**
Q5: To what extent is UNDIS achieving its objectives? What are the current challenges, particularly at the regional and country levels, and what strategies can be employed to improve its implementation? To what extent is prioritization necessary and if so, how should it be done? **Q6:** What are the most effective practices in mainstreaming disability inclusion and specific disability inclusion measures at all three organizational levels? How can these be shared to facilitate knowledge and learning? **Q7:** To what extent has the Output Scorecard (Gender, Equity, Human Rights & Disability dimension) proven effective to the integration of disability issues into technical programmes and at the business operations level? **Q8:** What is the level of satisfaction among staff, consultants, interns, and volunteers with disabilities regarding the implementation of UNDIS	**EFFECTIVENESS**

(*- the how*) (e.g., accessibility, health insurance, and provision of Assistive Technology)? *Please note that information about satisfaction on reasonable accommodation will be collected with a staff survey end 2023.*	
Q9: To what extent are allocated resources to implement the costed action plan being efficiently used and prioritized?	**EFFICIENCY**
Q10: To what extent will the benefits last beyond 2024 (when flexible funds are meant to stop)? Are custodian departments and regional offices prepared for the post-2024 period? *Please note that unlike most initiatives / programmes, UNDIS received flexible funds to kick start.*	**SUSTAINABILITY**

V Evaluation approach and methods

Overall approach and methods

The evaluation will be conducted in line with the WHO Evaluation Policy.[31] The evaluation will follow the principles set forth in the WHO Evaluation Practice Handbook[32], the United Nations Evaluation Group Norms and Standards for Evaluation (2016) and its Ethical Guidelines.[33] It will also respect the UNEG Guidance on integrating Human Rights and Gender Equality in Evaluation (2014), the Guidance on Integrating Disability Inclusion in Evaluations and Reporting on the UNDIS Entity Accountability Framework Evaluation Indicator (2022)[34] and the WHO Guidance note on Integrating Health Equity, Gender Equality, Disability Inclusion and Human Rights in WHO Evaluations (2023).[35]

This section provides brief preliminary guidance on the methodological approach foreseen for this evaluation. The approach will be adapted and detailed at the inception phase for the evaluation. The evaluators will assess options and describe in detail the suitable methods to meet the purpose, objectives and scope of this evaluation, including an appropriate sampling strategy (purposive sampling) for key informants and an evaluation matrix with a description of data sources, as well as methodological limitations and mitigation measures.

The design of the evaluation should be non-experimental, and theory based, with a utilization focused approach. To identify good practices, an outcome harvesting approach may be considered.

The methodology is expected to be innovative, participatory – engaging with users of the evaluation and focusing on use of the findings and recommendations by all key stakeholders – and enable rigorous and systematic data collection and analysis. Findings should be based on triangulated evidence, and conclusions and recommendations should derive from

---

[31] WHO Evaluation Policy (2018) Geneva: World Health Organization; 2018.

[32] WHO Evaluation Practice Handbook. Geneva: World Health Organization; 2013.

[33] Norms and Standards for Evaluation. New York: United Nations Evaluation Group, 2016 (http://www.unevaluation.org/document/detail/1914) and UNEG Ethical Guidelines for Evaluation, 2020 (https://www.unevaluation.org/document/detail/2866).

[34] 2014 (http://www.unevaluation.org/document/download/2107) and 2022 (https://www.un.org/sites/un2.un.org/files/2022/06/uneg_guidance_on_integrating_disability_inclusion_in_evaluation_0.pdf).

[35] https://www.who.int/publications/m/item/guidance-note-on-integrating-health-equity--gender-equality--disability-inclusion-and-human-rights-in-who-evaluations

findings. Multiple sources should be used and triangulated to ensure that findings can be generalized and do not result from single sources or views.

The evaluation will be conducted using a mix methods approach combining qualitative and quantitative data, to be further refined during the inception phase. Evaluation tools (questionnaire for KIIs) should be developed with the participation of staff with disabilities and other members of the Affinity Group. Countries for data collection will be selected as purposive samples to analyse good practices (or specific challenges) and facilitating overall learning.

Methods should include:

- **Document review.** This will include a wide range of key strategic documents, including but not limited to: GPW13; Policy on Disability and Action Plan including RBM system and budgets 2020-2023; disability inclusions programming and related annual programme reports and budgets; equity and inclusion policies including relating to human resources practices.
- **Quantitative data** from the UNDIS/WHO monitoring system to assess progress against key indicators for all 15 indicators.
- **Quantitative and qualitative data** from the Disability Inclusion questions included in the **organization-wide culture survey**. The culture survey is being carried out end-2023 (led by the WHO Human Resources Department), and it covers the entire WHO workforce (staff, volunteers, consultants, interns) for an estimated number of about 17,000 potential respondents. The disability inclusion questions focus on reasonable accommodation. Findings from the survey should provide understanding of potential issues to explore further and analyse through KIIs and focus groups. As of note, the survey does not include accessibility issues, questions around the process leading to reasonable accommodation, and attitudes/stigma. Given that KIIs may tend to favour individuals who have previously been engaged in disability inclusion work, rather than providing a comprehensive cross-section of WHO staff, the use of the Culture survey can serve as a valuable tool to mitigate this bias by ensuring a more diverse and inclusive representation.
- **Qualitative data/Key informant interviews and focus group discussions**.

- Interviews with internal stakeholders at HQ (UNDIS Steering Committee, Secretariat, and Custodian departments members, regional level disability focal points), regional offices (disability focal points and where they do not exist, GER focal points) and a selection of country offices, identified through discussion with regional offices (people at country level responsible for coordinating implementation of UNDIS with UN country teams).
- WHO staff, consultants, interns, volunteers with disabilities across all three levels of the Organization, the Embracing Disability Affinity Resource Group members (in particular the subgroup of people with disabilities), the Staff Union and members of organizations of persons with disabilities in official relation with WHO – ensuring engagement with the full diversity of people with disabilities/ by sex, impairment (and not the most visible/vocal only).
- The Staff Health & Wellbeing/Medical service for staff.

- KIIs with external stakeholders that might include ministry of health officials and officials of other relevant governmental institutions; relevant research institutes, agencies, and academia; UN agencies; other relevant multilateral organizations; donor agencies; other relevant partners; organizations of people with disabilities (OPDs) and civil society.

Reasonable accommodation should be considered during data collection to allow full participation of persons with disabilities.

- **Identification of good practices/Lessons learned**. In the context of a formative evaluation, identification (through KIs, other) of examples of good practices across the organizations (and possible cases that were unsuccessful if they provide useful learning for the way forward) – including in regions and at the country level (in the broader context of UN Country Teams/UNCTs implementation of UNDIS). Good practices should cover examples of mainstreaming (e.g., COVID-19 programming, Emergencies) as well as measures for strengthening inclusion. The sampling for good practices will be purposive, with technical units, regions or specific countries for good practices/lessons identified through exploratory interviews with staff at the UNDIS Secretariat/Disability Programme and regional offices and snowball sampling.

Human rights, equity and gender equality. With reference to the UNEG guidance on Integrating Human Rights and Gender Equality in Evaluation and the corresponding 2023 WHO guidance[36], the evaluation is expected to integrate human rights, equity and gender equality (intersection between gender and disability) considerations in its design, data collection, analysis and reporting, including an analysis to the extent to which actions and interventions contribute to addressing inequities and 'leave no-one behind'. The evaluation will use a gender equality and human rights approach. Data concerning key informants will be disaggregated by gender to ensure equitable representation and evaluate potential variations in responses/intersectionality.

Ethical **considerations.** The evaluation will be expected to follow 2020 UNEG Ethical Guidelines. The inception report will outline how the evaluation team will adhere to ethical considerations including: confidentiality and anonymity, do no-harm approaches, use of the appropriate ethical protocols in the administration of qualitative methods with respondents, data management and storage, and integration of appropriate cultural/language considerations.

Users of the evaluation stakeholders

With a strong focus on ownership and utilization, the approach of the evaluation will concentrate on engaging with users of the evaluation findings and recommendations. The evaluation team is expected to create opportunities for discussions with stakeholders and iterative feedback loops throughout the evaluation. The methodology should demonstrate

---

[36] http://www.unevaluation.org/document/download/2107 and https://www.who.int/publications/m/item/guidance-note-on-integrating-health-equity--gender-equality--disability-inclusion-and-human-rights-in-who-evaluations

impartiality and lack of bias by relying on a cross-section of information sources (from various stakeholder groups).

Internal users of the evaluation are the UNDIS Steering Committee, the Working Group, the UNDIS Secretariat, the WHO departments and regional offices who are custodians for the implementation of the Policy and Action Plan (Operational departments (e.g., Business Operations (BOS), Operational Support and Services, Human resources …) and NCD/Disability Programme). Key users are also WHO staff, consultants, interns, volunteers with disabilities (relevant networks, staff association, Embracing Disability Affinity Resource Group members and other staff with disabilities). The programme for Gender Equality, Human Rights and Health Equity (GRE), whose work involves mainstreaming gender, equity and human rights across the three levels of WHO and in the Organization's programmatic and operational work will contribute and benefit from the evaluation. Other internal users are Regional and Country Offices, in their effort to customise and implement the Policy and Action Plan.

Member States will also benefit from an external assessment of progress in implementation of the Policy and learning for the future. Users include the UN SG UNDIS Secretariat, organizations of people with disabilities in official relation with WHO (e.g., World Blind Union), Donors and National Governments who, as recipients of WHO's technical assistance, have an interest in the partnership and how a restructured WHO might strengthen in-country support and technical assistance for better health outcomes.

VI Evaluation management

WHO Evaluation Office

WHO Evaluation Office (EVL) will act as **Evaluation Manager**. EVL will work in collaboration with the UNDIS WHO Secretariat. The full scope of the evaluation will be defined jointly. Since this is an independent evaluation, EVL will have final sign-off of evaluation products.

The role of evaluation manager will involve reviewing and quality assuring key documents (drafting/reviewing ToR, inception report and the draft and final reports), identification and access of stakeholders within and outside WHO (in collaboration with the UNDIS Secretariat), supporting evaluators with data collection, dissemination of evaluation deliverables for comments, and organization of meetings and stakeholder workshop.

From the WHO Evaluation Office, the Director and/or the Chief Evaluation Officer is responsible for the sign-off of deliverables.

Evaluation Reference Group

The Evaluation Manager will be supported by an advisory technical Evaluation Reference Group (ERG). The ERG will:

- Review the draft inception report, with focus on evaluation questions;

- Review the draft and final reports to ensure the technical soundness of the findings and adequacy of recommendations;
- Act as a source of knowledge for the evaluation;
- Support the dissemination of findings as relevant.

Evaluation Team

The evaluation will be conducted by an **external independent evaluation team (two experts)**, selected competitively. The evaluation team should have strong technical understanding, appropriate evaluation skills mix and evaluation methodologies. In addition to evaluation expertise the team must have content knowledge/ experience on public health/health equity and disability-inclusive approaches and strong disability inclusion skills. It is desirable that the team has relevant experience in performing similar complex evaluations and understanding of WHO and the United Nations system.

In coordination with the WHO evaluation office, the evaluation team will be responsible for:

- Designing, planning and implementing the evaluation, drafting the evaluation report, using the approach to be agreed in the inception report, and for delivering in accordance with the ToRs specifications and timeline.
- Consulting and liaising, as required, with the Evaluation Manager, and to ensure satisfactory delivery of all deliverables.
- Scheduling and conducting all meetings, interviews, focus group discussions and final workshop with stakeholders.

The evaluation team is expected to carry out the evaluation with a high degree of independence and manage their own travel and other administrative arrangements as relevant.

The level of effort is estimated at around 150 person days (two-member team) over a period of six months. Two trips to Geneva may be considered at inception phase and/or at the time of the stakeholder workshop.

VII Evaluation deliverables and timeline

Deliverable 1: Inception report and Power Point presentation

The inception phase will start with a review of key documents and briefings with HQ and ROs and a selection of country offices key stakeholders. The evaluation team will assess the current Action Plan and reconstruct a theory of change for the Policy on Disability. During this phase the team will examine key corporate functions, as aligned to the UNDIS mechanism, to assess the extent to which disability inclusion had been mainstreamed across key areas of WHO. The team will also develop a sampling strategy to identify documents from across the regions and selected country offices to analyse any evidence of disability inclusion integration, including evidence of the three approaches and the four core areas. The inception phase will involve active participation and inclusivity through exploratory interviews with stakeholders, working collaboratively with the ERG to refine evaluation questions, develop a stakeholders' mapping and address other methodological aspects.

The inception report and a Power Point summary will close this phase. The inception report will be prepared following the Evaluation Office template and will focus on methodological and planning elements. Considering data availability and the evaluation questions, it will present a detailed evaluation framework, including limitations, and an evaluation matrix, with clarity on methods and data sources by evaluation question. Data collection tools will be drafted as part of the inception report, alongside consent forms and ethical protocols. The draft inception report will be reviewed by the Evaluation Manager and the ERG and will be finalized by the evaluation team taking into account comments received.

Deliverable 2: Draft evaluation report and Power Point presentation

The evaluation team will submit a draft evaluation report to the Evaluation Manager and present the draft report either online or in person to the ERG with a summary Power Point presentation. The draft report will be finalized following discussions with key stakeholders, and taking due consideration of comments received including from the ERG. The draft final report will contain findings, conclusions, and recommendations.

Deliverable 3: Stakeholder workshop

Prior to the finalization of the recommendations, the evaluation team will organize a workshop with the main counterparts across all levels of the Organization to discuss main findings, conclusions and co-create recommendations. The stakeholders' workshop will be held either online or in person.

Deliverable 4: Final evaluation report, brief and PowerPoint presentation

The evaluation team will submit a final evaluation report, including findings, conclusions and recommendations, to the Evaluation Manager after due consideration of comments received. The report will include an executive summary. The report will be disseminated internally and posted on the WHO Evaluation Office website (www.who.int/about/evaluation/en/).

The final report will be delivered together with a brief highlighting main findings/conclusions and recommendations and a power point presentation. The evaluation report and brief will provide an assessment of the results according to the evaluation questions and methodology. It will include conclusions based on the evidence generated in the findings and draw actionable prioritised recommendations.

NOTE that the revisions of any of the deliverables produced by the evaluation team will be accompanied by feedback on each comment provided. This feedback will succinctly summarize if and how comments were addressed and if they were not, it will justify why. Evaluators should use standard WHO evaluation templates for the various products. All graphs and figures etc. should also be provided in editable format. Briefs and summaries should be available in an accessible format (e.g., easy read screen readers friendly format etc).

The evaluation team may collaborate with the WHO evaluation office/Communication expert to explore and contribute to additional communication products such as infographics, visual summaries or video interviews/clips with key staff and stakeholders involved in the evaluation.

Timeline

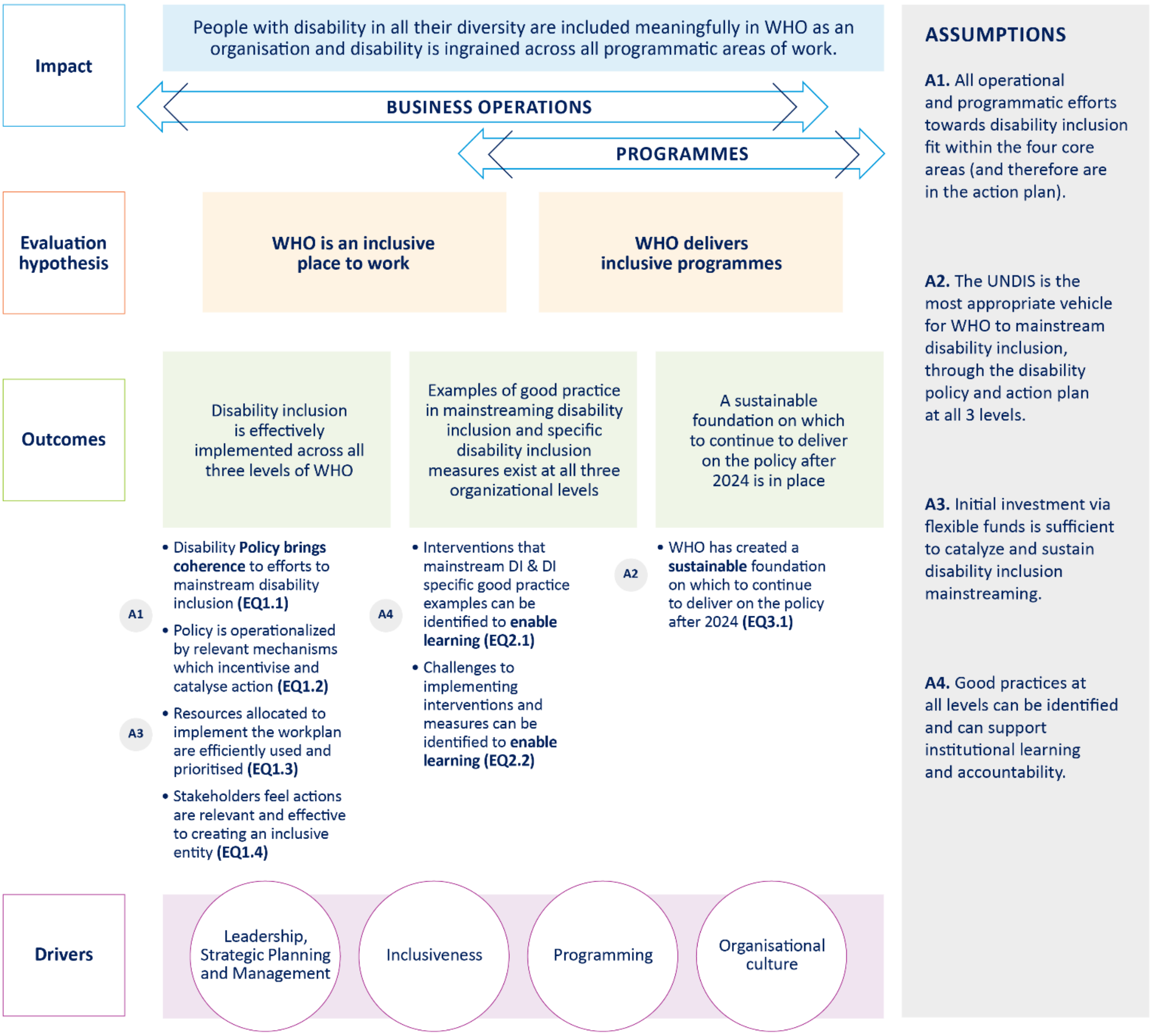
Key milestones envisaged for the evaluation are provided below. The evaluation will last six months and will be home-based with potential travel to Geneva HQ. *The evaluation findings are needed latest by October 2024 (to be presented in the UNDIS reports to UN and EB).*

Evaluation timeline (tentative)

Milestones	Dates
Finalisation of the TORs	October 2023
Recruitment of evaluation team	November 2023
Inception Report	January 2023
Data collection	December-April 2024
Draft report	April 2024
Final report	June 2024
Dissemination	From June 2024

Annex 2: Conceptual framework

Conceptual framework for the evaluation



Impact

People with disability in all their diversity are included meaningfully in WHO as an organisation and disability is ingrained across all programmatic areas of work.

BUSINESS OPERATIONS

PROGRAMMES

Evaluation hypothesis

WHO is an inclusive place to work

WHO delivers inclusive programmes

Outcomes

Disability inclusion is effectively implemented across all three levels of WHO

- Disability **Policy brings coherence** to efforts to mainstream disability inclusion **(EQ1.1)**
- Policy is operationalized by relevant mechanisms which incentivise and catalyse action **(EQ1.2)**
- Resources allocated to implement the workplan are efficiently used and prioritised **(EQ1.3)**
- Stakeholders feel actions are relevant and effective to creating an inclusive entity **(EQ1.4)**

Examples of good practice in mainstreaming disability inclusion and specific disability inclusion measures exist at all three organizational levels

- Interventions that mainstream DI & DI specific good practice examples can be identified to **enable learning (EQ2.1)**
- Challenges to implementing interventions and measures can be identified to **enable learning (EQ2.2)**

A sustainable foundation on which to continue to deliver on the policy after 2024 is in place

- WHO has created a **sustainable** foundation on which to continue to deliver on the policy after 2024 **(EQ3.1)**

Drivers

Leadership, Strategic Planning and Management

Inclusiveness

Programming

Organisational culture

ASSUMPTIONS

A1. All operational and programmatic efforts towards disability inclusion fit within the four core areas (and therefore are in the action plan).

A2. The UNDIS is the most appropriate vehicle for WHO to mainstream disability inclusion, through the disability policy and action plan at all 3 levels.

A3. Initial investment via flexible funds is sufficient to catalyze and sustain disability inclusion mainstreaming.

A4. Good practices at all levels can be identified and can support institutional learning and accountability.

Annex 3: Evaluation matrix

EQ1. To what extent is disability inclusion effectively implemented across all three levels of WHO? (effectiveness)	
SUB QUESTIONS **EQ1.1** To what extent does the WHO Policy on disability bring coherence to the operational and programmatic efforts to mainstream disability inclusion? (*coherence)* Staff understanding of disability inclusion and related concepts Staff understanding of their role in mainstreaming disability inclusion	
INDICATORS Staff understand disability inclusion and their roles and responsibilities in relation to the disability policy	**DATA SOURCES** WHO Disability Policy KIIs and FGDs with selected Operations and Programme staff in all regions and selected country offices, and headquarters
INDICATORS Disability policy is reflected in operational and programmatic documents, such as guidance, plans, budgets, reports, etc.	**DATA SOURCES** Comparative analysis of Disability Policy and documents (guidance, plans, budgets, reports, etc.)
EQ1.2 What are the relevant mechanisms for operationalizing the WHO Policy on Disability at all three levels? In what ways do they incentivize / catalyze action or not? (relevance/ efficiency)	
INDICATORS Action plans in place, utilized and reported against at country, regional at headquarter levels	**DATA SOURCES** Action plans, budgets, reports against action plans at HQ, RO, selected COs
INDICATORS Operational and technical guidance (e.g., output scorecard, disability marker) in place, utilized and reported against at country, regional at headquarter levels	**DATA SOURCES** Operational guidance (e.g., reasonable accommodation SoP) Technical guidance (e.g., output scorecard, disability marker, MoH technical guidance) Evidence of use in relevant plans/reports
INDICATORS Staff understand how to and are motivated to implement the disability action plan and guidance	**DATA SOURCES** KIIs and FGDs with selected Operations and Programme staff in all regions and selected country offices, and headquarters
INDICATORS Staff perceive mechanisms (including action plan and related guidance) are useful and inform their work to mainstream disability	**DATA SOURCES** KIIs and FGDs with selected Operations and Programme staff in all regions and selected country offices, and headquarters
INDICATORS Staff understand and are motivated to implement the disability action plan and guidance	**DATA SOURCES** KIIs and FGDs with selected Operations and Programme staff in all regions and selected country offices, and headquarters Performance appraisal framework
EQ1.3. To what extent are resources allocated through the flexible fund to implement the costed workplan being efficiently used and prioritized? (efficiency)	
INDICATORS Evidence of implementation of flexible funds	**DATA SOURCES** Costed workplan/budgets Applications to flexible fund Reporting against UNDIS

INDICATORS Process to access flexible funds is understood and accessible to all	**DATA SOURCES** Application guidance
INDICATORS Staff are satisfied with process and implementation of flexible fund	**DATA SOURCES** KIIs/FGDs with selected Operations and Programme staff in all regions and selected country offices, and headquarters
INDICATORS Flexible funds have been used to catalyze and embed disability inclusion within the organizational culture and processes	**DATA SOURCES** Reporting against UNDIS Evidence of change (or not) in terms of disability inclusion at different levels (pre-post) Expert judgement
EQ1.4. To what extent do WHO staff and consultants feel that actions being taken are relevant and effective to creating an inclusive entity? (effectiveness)	
INDICATORS Staff perceive that the following are conducive to creating an inclusive entity: operational processes and actions programmatic processes and actions organizational culture and leadership behaviours	**DATA SOURCES** KIIs/FGDs with selected Operations and Programme staff in all regions and selected country offices, and headquarters (including Affinity Group) Group Consultation discussions with staff across the entity
EQ2. What interventions exist to mainstream disability inclusion and what good practice examples are there of specific disability inclusion measures at each level of the organization?	
SUB QUESTIONS: **EQ2.1** What interventions exist to mainstream disability inclusion and what good practice examples are there of specific disability inclusion measures at headquarters, regional and country levels? **EQ2.2** What are the challenges to implementing interventions to mainstream disability inclusion and disability-specific measures at headquarters, regional and country levels?	
INDICATORS Examples of interventions to mainstream disability inclusion at headquarters, regional and country levels Good practice examples of specific disability inclusion measures at headquarters, regional and country levels Common challenges in mainstreaming disability inclusion at headquarters, regional and country levels Common challenges in implementing disability inclusion specific measures at headquarters, regional and country levels	**DATA SOURCES** KIIs/FGDs with selected Operations and Programme staff in all regions and selected country offices, and headquarters Reports Cross referencing with (international) good practice
EQ3. To what extent has WHO created a sustainable foundation on which to continue to deliver on the policy after 2024? (sustainable)	
INDICATORS Evidence of disability inclusive practices and mechanisms at HQ, RO and CO, integrated into future plans with custodian departments	**DATA SOURCES** KIIs/FGDs with selected Operations/Planning and Programme staff in all regions and selected country offices, and headquarters Plans and budgets (including GPW14)

	Guidance
INDICATORS Reporting, accountability and governance mechanisms (e.g., secretariat, steering committee) continuing	**DATA SOURCES** KIIs/FGDs with selected Operations and Programme staff in all regions and selected country offices, and headquarters Policies and related guidance which enshrine reporting / accountability /governance mechanisms
INDICATORS Staff perceive there is a sustainable foundation to continue to deliver on the policy after 2024	**DATA SOURCES** KIIs/FGDs with selected Operations and Programme staff in all regions and selected country offices, and headquarters
INDICATORS WHO has strong partnerships with relevant stakeholders (e.g., OPDs and Ministries of Health) to continue integrating disability inclusion in operations and programs after 2024	**DATA SOURCES** KIIs/FGDs with selected Operations and Programme staff in all regions and selected country offices, and headquarters KIIs, group discussions with networks of people with disabilities
INDICATORS Examples / evidence of prioritisation in the action plan	**DATA SOURCES** KIIs/FGDs with selected Operations and Programme staff in all regions and selected country offices, and headquarters KIIs, group discussions with networks of people with disabilities Policies, workplans and budgets

Annex 4: Interview question guide

Evaluation of the WHO Policy on Disability

(multiple stakeholders – please note that questions were adapted based on type of respondent)

Location	HQ / Regional / Country	
Stakeholder Group	WHO staff / Operations / Programs	
Method	KII / FDG /Consultation	
Participant Number	#01, 02,	

CONSENT:

Your participation is completely voluntary. You have the right not to answer any question and you can end the interview early without consequence.	
Data will be kept confidential and will not be stored any longer than required for the evaluation. We may want to use quotes and findings in the final report, but they will be presented in a way that they cannot be traced to you individually. Are you happy for us to do that anonymously or would you *like to be named with some quotes in the report and in any other publication that comes from this report? If not, we will include you as anonymous, type of respondent, gender and disability status in the list of key informants.*	
Are you happy for the information you provide to be used in the published assessment report or related products? Do you consent to your data being used this way?	
We would like to record the discussion – **are you happy with the discussion being recorded?** The recording will be securely stored and only available to the evaluation team and will be permanently deleted once the evaluation is completed.	

Do you have any questions about the assessment or how your information will be used before we begin, or **are you happy to proceed with the interview?** If you have questions about how your data is being used or would like to withdraw your participation, you are free to contact me at any time.	

Section 1: Demographic information

1. Please confirm:

- Name
- Job title
- Location
- Woman / man / non-binary / prefer not to say
- Do you self-identify as a person with a disability?

Section 2:

2(a) Considering your role within WHO, what does disability inclusion mean for the work that you do? (*general overview of what they think it means to work inclusively*)

2(b) Do you have a specific role in delivering any of the activities included in the Disability Action Plan? If so, can you briefly outline what activities you are carrying out that are directly related to the Action Plan.

Section 3:

3(a) On a scale of 1 to 5 how much confidence do you have in being able to implement your Disability Action Plan activities: (*this could be in relation to skills, capacity, funding or overall culture etc*)

Totally unsure **1**	Generally unsure **2**	Neither confident nor unsure **3**	Generally confident **4**	Fully Confident **5**

3(b) Given your response, what mechanisms are in place which have been helpful in providing you with the skills / confidence to deliver? **AND/OR** what mechanisms should be in place to help provide you with the skills / confidence to deliver?

3(c) What have been some of the most motivating factors for you in implementing disability inclusive activities?

3(d) What have been some of the challenges you have faced in implementing these disability inclusive activities?

Section 4:

4(a) Has your work (or activities) been funded through the 'flexible funding mechanism'? If yes, how critical has this been for stimulating and sustaining your disability inclusion work? (*Would things have happened anyway or did the funds enable you to try out new things; were they catalytic? etc*.)

4(b) To what extent do you believe that WHO is a disability inclusive Organization in relation to the work that it does?

4(c) To what extent do you believe that WHO is a disability inclusive Organization as a place to work *(for example in relation to culture, diversity of workforce, awareness of disability issues, people feeling free to speak out, accessibility issues, reasonable accommodation service, etc.)?*

Section 5:

Gathering examples of good practice (this could be used during FGDs)

We would now like you to reflect on any examples of where disability mainstreaming, or disability specific actions have been implemented since the adoption of the Disability Policy in 2021.

5(a) Do you have any examples of where you (your team) have implemented an intervention / actions or programme that has been deliberately designed to promote the *mainstreaming of disability* and / or of where you (your team) have implemented an intervention / action or programme which has been *disability specific*? (*Ensure there is enough detail in the description of the action to be able to write it up; make sure they are clear as to whether the action promotes mainstream inclusion or is disability specific*)

5(b) Reflecting on the response to the previous question, please outline what, if any, challenges you faced in relation to implementing the actions – sometimes it's helpful to think in terms of 'what would I do next time around if I were starting this again?' (*Again, ensure there is enough detail provided and make sure it is clear whether the action is mainstream or disability specific*)

Section 6:

6(a) On a scale of 1 to 4 to what extent do you believe that disability has been sufficiently integrated into the day-to-day business of WHO that it has now become a permanent way of working for WHO:

Not integrated into any key processes **1**	Integrated into relatively few key processes **2**	Integrated into most key processes **3**	Fully integrated into all key processes **4**

6(b) Given your response, can you explain where you see there has been the most progress and the least progress made? *(Prompt for details of practices and mechanisms [including funding] which have been put in place, or which are missing completely; how confident are they that disability will remain an issue against which activities / programmes will be planned and reported on?)*

6(c) What mechanisms do you use to report on progress against the disability policy action plan (and any associated activities)?

6(d) How is progress on the disability action plan disseminated to you?

6(e) Given that UNDIS specific funding will be coming to an end in 2024 what does the funding situation look like for this work in future? Has this been successful integrated into budgets from 2025, or included in ongoing work?

END OF INTERVIEW

Annex 5: List of people consulted

Global level

Category	Number	Gender distribution
WHO	13	9 women, 3 men and 1 non-binary
Disability Affinity Group	6	N/A

Sub-total: 19

Regional level

Category	Number	Gender distribution
AFRO	1	1 women
EMRO	4	4 women
EURO	3	1 women, 2 man
SEARO	2	1 women, 1 man
WPRO	8	6 women, 2 men
PAHO/AMRO	4	2 women, 2 men

Sub-total: 22

Country level

Category	Number	Gender distribution
Cote d’Ivoire CO	4	N/A
Tanzania CO	1	1 woman
Tanzania OPD	1	1 woman
Bahrain CO	6	5 women, 1 man
Saudi Arabia CO	4	1 women, 3 men
Moldova, Georgia, Montenegro CO	4	3 women, 1 man
India CO	15	10 men, 5 women,
Nepal CO	1	1 man
Solomon Islands CO	1	1 woman
Lao CO	2	2 women
Bahamas CO	3	2 women, 1 man

Sub-total: 42

Annex 6: Data security and protection protocol

Access to data collected as part of this evaluation will be restricted to members of the evaluation team, on a “need to know basis”, so teams can share general access to a locked folder, or restricted access, while access to identified data is limited to a specific subset of the team.

As a rule, personally identifiable information (PII) and sensitive data unless strictly needed for the evaluation will not be collected or stored. Each evaluation team member has the responsibility to keep primary data (i.e., notes, audio recordings, chat conversations, transcriptions, survey responses, informed consent forms) safe on their electronic devices and hard copies, if any, will be stored in safe places.

Electronic data will be saved in the evaluator’s SharePoint folders that are only accessible to the evaluation team. Any copies and notes stored on individuals’ devices will be password-protected and have auto-lock settings active. Files containing primary data will not by shared by email or using shared computer drives. Hard copies of data including video, photos and audio files and notes related to the evaluation will be kept safe, never left unattended, and their transportation will be limited. No identifiable data will be collected without consent. Hard copy data will be destroyed safely as soon as it is transferred into soft copy.

Where primary data including PIIs is collected for analysis, data will be separated from the PIIs, so it is fully anonymised.

Personal or sensitive data (e.g., non-anonymised databases, registration lists) will not be shared with third parties, such as WHO RO and COs, governments, or others.

After the evaluation report has been finalized and approved by WHO, all primary data will be destroyed. All members of the evaluation will review and adhere by the ethical principles of this evaluation and will sign a data confidentiality agreement stating that they agree to the appropriate use, confidentiality, and protections for sharing, and storage of data collected for this evaluation.

Privacy Notice for participants:

The data we use

We use the information you provide to us in order to carry out or inform our research. Throughout the process we will endeavour to protect your identity, however there may be times when we combine or analyse your data in a way that means you could be identified.

We do not share this data with anyone unless the law says we must (a legal obligation), for example to carry out checks under our due diligence policy or for audit purposes.

Under data protection law, certain types of personal information are recognized as ‘sensitive’, including health information and information regarding race, religious beliefs, and political opinions. If you have agreed, we may collect such special category information34 during our interviews if the purpose of our research needs it. You can withdraw your consent for us to use this data at any time. Unless you have agreed to be identified, we remove any personally identifiable information from our data sets, notes, and reports to make sure you cannot be identified from the research and reporting we do. Any information you provide will remain confidential during our research and reporting.

Third party sharing and storage

We use third party providers to store your data on our systems and may include servers hosted in the United States. We do not transfer your data to a third country unless that country provides sufficient and adequate security measures to protect your data.

Where necessary, we share data with partners providing services to us or that we work in partnership with, for example other research partners or humanitarian agencies.

We will keep your information no longer than reasonably necessary for the purposes for which we hold it, and we will store and delete it securely in accordance with our internal policies.

Your rights

You have a number of rights with regard to your personal data, including:

- the right to request access and obtain a copy of your data – this means everything we hold that relates to you,
- the right to request correction or erasure of your personal data,
- the right to restrict or object to processing.

To exercise any of these rights or, if you have would like more information or have any concerns as to how your data is processed, you can contact our Data Protection Officer at dataprotectionofficer@sddirect.org.uk. If you are under 18, your parents or guardian may need to help with this.

If you are not happy with how we have handled your request or complaint, you can also contact the UK Government Information Commissioner’s Office, which oversees the protection of personal data in the United Kingdom, by visiting their website (ico.org.uk) or using their help line +44 303 123 1113.

Annex 7: Documents reviewed

Banks, L.M., Kuper, H., Polack, S., 2017. Poverty and disability in low- and middle-income countries: A systematic review. PLoS ONE 12, e0189996.

Danos, C., Heydt, P., Kuper, H., Burbach, M., Rotenburg, S., Seghers, F., 2022. Reimagining health systems, Missing Billion Report. Missing Billion Initiative & Clinton Health Access Initiative.

Duff, J.H., Liu, A., Saavedra, J., Batycki, J.N., Morancy, K., Stocking, B., Gostin, L.O., Galea, S., Bertozzi, S., Zuniga, J.M., Alberto-Banatin, C., Dansua, A.S., Del Rio, C., Kulzhanov, M., Lee, K., Scaglia, G., Shahpar, C., Ullmann, A.J., Hoffman, S.J., Weinstein, M., Szapocznik, J., 2021. A global public health convention for the 21st century. The Lancet Public Health 6, e428–e433.

Gréaux, M., Moro, M.F., Kamenov, K., Russell, A.M., Barrett, D., Cieza, A., 2023. Health equity for persons with disabilities: a global scoping review on barriers and interventions in healthcare services. Int J Equity Health 22, 236.

Mitra, M., Long-Bellil, L., Moura, I., Miles, A., Kaye, H.S., 2022. Advancing Health Equity And Reducing Health Disparities For People With Disabilities In The United States: Study examines health equity and health disparities for people with disabilities in the United States. Health Affairs 41, 1379–1386. https://doi.org/10.1377/hlthaff.2022.00499

Mishra, S., Rotarou, E., Peterson, C., Sakellariou, D., 2023. The WHO European framework for action to achieve the highest attainable standard of health for persons with disabilities 2022–2030. The Lancet Regional Health – Europe, Volume 25, 100555

Moon, S., Kickbusch, I., 2021. A pandemic treaty for a fragmented global polity. The Lancet Public Health 6, e355–e356. https://doi.org/10.1016/S2468-2667(21)00103-1

Swenor, B.K., 2021. Including disability in all health equity efforts: an urgent call to action. The Lancet Public Health 6, e359–e360. https://doi.org/10.1016/S2468-2667(21)00115-8

The Lancet Public Health, 2021. Disability—a neglected issue in public health. The Lancet Public Health 6, e346. https://doi.org/10.1016/S2468-2667(21)00109-2

United Nations Disability Inclusion Strategy. UN Country Team (UNCT) Accountability Scorecard on Disability Inclusion.

United Nations Department of Economic and Social Affairs, 2023. The Sustainable Development Goals Report 2023: Special Edition, The Sustainable Development Goals Report. United Nations. https://doi.org/10.18356/9789210024914

UN Women. World Health Organization UN-SWAP 2.0 Performance 2022.

United Republic of Tanzania, Ministry of Health, 2024. Health Equity for Persons with Disabilities Action Plan 2024-2026 [DRAFT].

World Health Organization, 2002. Towards a Common Language for Functioning, Disability and Health ICF, 2002.

World Health Organization, 2015. WHO global disability action plan 2014-2021: better health for all people with disability.

World Health Organization, 2019. WHO Thirteenth General Programme of Work 2019-2023.

World Health Organization, 2021. WHO Policy on Disability. https://iris.who.int/bitstream/handle/10665/341079/9789240020627-eng.pdf

World Health Organization, 2021. The highest attainable standard of health for persons with disabilities, 2021. Seventy-fourth World Health Assembly Agenda item 26.4. https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_R8-en.pdf

World Health Organization, 2021. WHO Manual. III.4.9 Employment of Persons with Disabilities.

World Health Organization, 2021. WHO Programme Budget 2022-2023.

World Health Organization Evaluation Office, 2021. Evaluation of the integration of gender, equity and human rights in the work of the World Health Organization. Volume 1: Report. September 2021

World Health Organization, 2022. Disability Inclusion Toolkit: Core Concepts for Disability Inclusion in WHO.

World Health Organization, 2022. WHO eManual. III.4.9 Processing and reviewing reasonable accommodation requests. Standard Operating Procedure effective 1 December 2022.

World Health Organization, 2022. Global report on health equity for persons with disabilities.

World Health Organization, 2022. WHO Output Scorecard 2.0: For Technical Outputs and Leadership and Enabling Outputs - version 2

World Health Organization Bahrain, 2022. Maximizing Impact: The work of WHO in Bahrain. Annual report 2022.

World Health Organization Regional Office for Europe, 2022. The WHO European Framework for action to achieve the highest attainable standard of health for persons with disabilities 2022–2030.

World Health Organization, 2023. Guidance note on integrating health equity, gender equality, disability inclusion and human rights in WHO evaluations.

World Health Organization, 2023. Disability Inclusion Marker – Guidance on the application of the marker's criteria.

World Health Organization, 2023. Roadmap of the WHO Secretariat to advance gender equality, human rights and health equity, 2023-2030

World Health Organization, 2023. 2024 Annual Evaluation Report (EB154/31): update and proposed workplan for 2024–2025. Geneva.

World Health Organization Evaluation Office, 2023. Independent Evaluation of WHO's Results-Based Management Framework: Final Report WHO Evaluation Office – January 2023. https://cdn.who.int/media/docs/default-source/evaluation-office/rbm-final-evaluation-report.pdf

World Health Organization Bahrain, 2023. Biannual Newsletter: WHO Bahrain Country Office. Issue 2: July-December 2023.

World Health Organization, 2024. Draft fourteenth general programme of work. 4th Consultation Document. Pre-World Health Assembly.

World Health Organization, 2024. Health equity for persons with disabilities: a guide for action. Information sheet.

World Health Organization Regional Office for the Western Pacific, 2020. Disability-inclusive health services toolkit: A Resource for Health Facilities in the Western Pacific Region. Manila: World Health Organization Regional Office for the Western Pacific

World Health Organization, 2024. WHO HQ UNDIS Working Group Draft Terms of Reference.

World Health Organization, 2024. WHO Results Framework: Delivering a measurable Impact in countries. Fourteenth General Programme of Work. Technical Paper.

World Health Organization, 2024. Draft WHO Diversity, Equity and Inclusion (DEI) Strategy, 2025-2027

World Health Organization. UNDIS Reports to UN, 2020

World Health Organization. UNDIS Reports to UN, 2021

World Health Organization. UNDIS Reports to UN, 2022

World Health Organization. UNDIS Reports to UN, 2023

Any enquiries about this evaluation should be addressed to:
Evaluation Office, World Health Organization
Email: evaluation@who.int
Website: Evaluation (who.int)