World Health Organization

EXECUTIVE BOARD
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Programme budget 2020–2021

WHO results framework: an update

Report by the Director-General

1. In resolution WHA72.1 of 24 May 2019, the Seventy-second World Health Assembly approved the Programme budget 2020–2021 and requested the Director-General, inter alia, to continue developing the results framework of the Thirteenth General Programme of Work, 2019–2023 (GPW 13), in consultation with Member States, including through the regional committees, and to present the results framework to the Executive Board at its 146th session.

2. The GPW 13 focuses on measurable impacts on people's health at the country level. In order to implement this measurement system, a results framework is required to regularly track the joint efforts of the Secretariat, Member States and partners to meet GPW 13 targets and achieve the Sustainable Development Goals (SDGs), as well as to measure the Secretariat's contribution to that process. In addition, the 2017–2018 assessment of WHO by the Multilateral Organisation Performance Assessment Network, in keeping with the increased impact- and outcome-focused approach of the GPW 13, stated that an accurate and reasonable measurement of WHO's contribution is needed, and that there needs to be clarity on what is being tracked and measured.[1]

3. The results framework presented in this document (see Annex 1) is accompanied by a system for measuring impact – the GPW 13 WHO Impact Framework;[2] a scorecard for output measurement (see Annex 5); and qualitative case studies. Together, they provide a holistic view of WHO's overall impact. WHO' GPW 13 impact measurement structure (see Annex 2) consists of the top-level indicator of healthy life expectancy (HALE); the triple billion targets and related indices (see Annex 3); and 46 outcome indicators (see Annex 4).

4. The time frame for the results framework is 2019–2023 and spans three separate programme budget periods: the end of the biennium 2018–2019, the biennium 2020–2021 (for which the programme budget was approved in May 2019) and the biennium 2022–2023.

5. Pursuant to resolution WHA72.1, this document summarizes the plans for the elaboration of the methods for calculating the outcome indicators, the triple billion indices and HALE, which will be subsequently issued as a methods report, as well as plans for the finalization of the Output Scorecard. The updated process has incorporated Member States' feedback through the six regional committee

[1] Multilateral Organisation Performance Assessment Network (MOPAN). MOPAN 2017-18 assessments: World Health Organization (WHO). April 2019 (http://www.mopanonline.org/assessments/who2017-18/, accessed 18 November 2019).

[2] See document A72/5.

meetings. In addition, a technical consultation, including experts from Member States and academia, has provided inputs to refine the methods of impact measurement.

Outcome indicators

6. The outcome indicators are intended to provide a flexible approach in which Member States select their own priorities. Countries will therefore be able to target their efforts according to their specific local health needs. Countries will track progress using the associated outcome indicators.

7. Annex 4 provides a full list of the proposed 46 outcome indicators, 39 of which are SDG indicators; the seven non-SDG indicators, which were approved in World Health Assembly resolutions and have been selected for GPW 13, cover antimicrobial resistance (antibiotic consumption); polio; risk factors for noncommunicable diseases (obesity; blood pressure; trans-fatty acids); and emergency-related factors (vaccination for emergencies, essential health services for vulnerable populations).

Universal health coverage index

8. A combined measure of health service coverage and related financial hardship will be used to monitor progress towards the GPW 13 milestones. Health service coverage will continue to be measured using the service coverage index that has been approved by the Inter-agency and Expert Group on SDG indicators (IAEG-SDGs). The methodology to create the index, related to indicator 3.8.1 of the SDGs, is well documented and involves a simple aggregation method.[1]

9. Financial hardship due to spending on health occurs when a household has to pay a very large share of its disposable income on health services (catastrophic payments) or when the costs of health services push a household below the poverty line (impoverishing payments). The methodology to estimate financial hardship related to indicator 3.8.2 of the SDGs is also approved by the IAEG-SDGs and documented.[1]

10. Member States, the Secretariat, United Nations partners and the IAEG-SDGs all recognize that the current measure of health service coverage focuses on "crude" coverage and does not capture "effective" coverage, that is, whether people who need health services are receiving services of sufficient quality to produce the desired health gain. The Secretariat has begun work on an updated index that categorizes tracer indicators by type of care (promotion, prevention, treatment, rehabilitation and palliation) and by age group (life course). The Secretariat has convened a meeting of representatives of Member States, experts and United Nations partners to finalize the methodological work related to the updated index.

Health emergencies protection index

11. The health emergencies protection index consists of three tracer indicators, derived from the outcome indicators, that capture activities to prepare for, prevent, and detect and respond to health emergencies. This index is the mean value of the indicators of the capacity to prepare, prevent, and detect and respond.

[1] See the metadata repository of the United Nations Statistics Division (https://unstats.un.org/sdgs/metadata/files/Metadata-03-08-01.pdf, accessed 18 November 2019).

Healthier population index

12. The healthier population index focuses on measuring the impact of multisectoral interventions that are influenced by policy, advocacy and regulatory approaches stewarded by the health sector. The priority indicators for use in this index are in the process of being selected from the outcome indicators.

Healthy life expectancy

13. HALE is a comprehensive summary measure of population health that combines the measurement of lifespan and health span. It is the mean number of years that a person is expected to live in good health, accounting for years lived in less than full health due to disease or injury. WHO regularly reports on HALE through its global health estimates, using an accepted standard methodology.

Methods

14. A methodology document that is regularly updated has been made available online, along with baselines and targets for the triple billion indices and the outcome indicators. The methodology document also includes suggested approaches to data disaggregation for the outcome indicators and the triple billion indices in order to enable inequality monitoring so as to determine who is being left behind.

15. Refinements to the methodology and steps to improve data availability for the health emergencies protection index, especially for the detect and respond indicator, were made over the course of 2019. Member States were consulted in the process of finalizing the methodology.

16. The method for the calculation of the healthier population 1 billion target was developed by a working group in the Secretariat, which discussed and addressed methodological issues. The proposed methodology was reviewed in a consultation with representatives of Member States and experts held in October 2019.

17. Other public health priorities for which additional milestones and indicators are being considered include service coverage for severe mental disorders, care dependency in older adults, cervical cancer screening and palliative care. The Secretariat will continue to engage with Member States and experts over the course of 2019–2021 in defining the indicators for these areas, exploring ways of strengthening data sources and finalizing methodology through a series of technical consultations. Baselines and milestones will be established once these steps have been completed. The indicators that are agreed on will then be presented to the Executive Board for inclusion in the proposed programme budget for 2022–2023.

Output measurement

18. The Secretariat is making a significant shift in its approach to measuring its accountability for results, from a top-down aggregate approach to one that measures the Secretariat's impact at the country level. The Secretariat will measure the delivery of outputs as a way of demonstrating its contribution to the achievement of outcomes and to the impact in each country. The integrated nature of the results framework – in particular of the outputs – calls for an innovative way of measuring the outputs to promote accountability and a more meaningful measurement of Secretariat delivery. To this end, the Secretariat is proposing a new approach to measuring the outputs: it will no longer identify a large number of output indicators, since that approach has proved to be insufficient to ensure transparency and accountability and the indicators have succeeded in measuring only part of the results achieved by the outputs.

19. The new approach to output measurement adopts a scorecard approach (see Annex 5). The new approach is an important step forward to strengthen how performance is measured in WHO. The aim is to introduce an output assessment system which is more:

- **meaningful:** by being focused more directly on strategic priorities and the work that the Secretariat is actually doing;
- **accountable:** by providing clear linkages to what is expected under each output and from each budget centre;
- **holistic:** by covering different aspects of performance rather than the current unidimensional approach using multiple indicators.

20. The new approach draws on experience elsewhere, including the use of balanced scorecards for strategic management and performance assessment in large organizations. By adopting this approach, the Secretariat is proposing to measure the depth and breadth of each output using six assessment parameters or dimensions, which have been chosen to relate directly to what is strategically important for WHO across all of its work.

21. The first three dimensions assess the strategic shifts intended in GPW 13 that define WHO's effective delivery: (a) how well the Secretariat has performed its leadership function at all levels; (b) the extent to which the Secretariat has delivered the priority global goods that are critical to achieving the output; and (c) the extent to which the Secretariat has delivered technical support to achieve impacts in countries.

22. The assessment of the fourth and fifth dimensions demonstrates WHO's commitment to mainstream interventions that achieve outputs while integrating gender, equity and human rights and to deliver interventions that provide value for money.

23. The sixth dimension – achieving results in ways leading to impacts – ensures the proper tracking of the influence of WHO's work to ensure the achievement of outcomes and impacts in countries. By tracking the early indications of success (leading indicators), the Secretariat will be able to demonstrate accountability not only for delivering outputs but also for contributing to the outcomes and impacts that matter most.

The elements of the Output Scorecard

24. The Output Scorecard structures the assessment of performance holistically, using three steps.

- Performance is defined and structured around six key dimensions of performance that reflect what is strategically important for WHO.
- Performance is assessed for each dimension with a set of performance attributes that lay out clear expectations for delivery by the Secretariat (e.g. "Is the Secretariat providing strategic and authoritative advice on health matters?" or "Is the Secretariat delivering the global public health goods that are critical to delivering the outputs?"). These attributes define clearly exactly what is being measured under each dimension.
- Each attribute is scored using a 4-point scale, using a common set of criteria across the outputs. A scale with a detailed explanation of the range of ratings is provided to ensure a more objective

measurement of the attribute. The average score of the attributes under each dimension defines the score for that dimension.

25. The Output Scorecard, with the full set of six dimensions with its attributes, criteria and scoring scale, is presented in Annex 5. Annex 5 also elaborates on the leading indicators by which the "Results in ways leading to impact" dimension will be measured.

26. The approach to selecting leading indicators also represents a change in the way in which the indicators will be used to measure performance. The output delivery teams, an internal platform for collaboration across departments and programmes, have been developing a logic model, or theory of change, for each output. The purpose is to analyse how the Secretariat's work leads to the delivery of the outputs, and then how the delivery of outputs influences the achievement of outcomes and impacts. From this, a set of the most critical leading indicators that allow the Secretariat to track its influence to outcomes and impacts will be selected.

27. This first iteration of the leading indicators will be tested and developed further as part of the pre-testing for the entire Output Scorecard during early 2020. Further work will be done to assess whether these suggested indicators meet the criteria outlined above and where additional development and testing work is needed, and alternatives will be explored. Logic models will be tested and determination made as to whether the indicators represent the influence of WHO across the three levels to achieving outcomes/impacts. Some of these indicators may be refined or replaced before full roll-out of the Output Scorecard.

Method of assessment and validation

28. The assessment will be initiated by teams at all levels of the Organization. They will rate their performance against the attributes under each dimension for each output using a set of criteria with the scoring scale. Certain dimensions may be assessed through internal peer validation.

29. The self-assessment ratings will be validated by a three-level mechanism described as follows:

(a) Internal moderation of ratings – line managers check for quality and consistency of ratings across different entities. Output delivery teams from every major office, and the global output delivery teams, will also review the ratings under their respective outputs.

(b) Internal peer review combined with sample expert check of rating – mechanisms such as validating the high self-assessment ratings (ratings of 4). This process will be led by a small group of staff who have expertise in the specific dimension.

(c) Periodic validation check – using independent validation or spot checking, for example through the programmatic audits of WHO's Internal Oversight Services or periodic evaluations.

Consultations and finalization of the Output Scorecard

30. The Output Scorecard methodology represents an important change in WHO that will require understanding and the buy-in of the staff who will apply the Output Scorecard.

31. The work on the presentation of the concept of the Output Scorecard to WHO has centred on testing the idea and developing the measurement instrument to make sure that it is robust and credible yet simple enough to be put into practice immediately in the 2020–2021 biennium.

32. Several internal consultations with staff across the three levels of the Organization have been conducted, while the inputs of staff members at all three levels of the Organization have shaped the measurement instrument in a way that is relevant to measuring their work.

33. The Output Scorecard has been refined based on consultations and initial pilot testing at headquarters, regional offices and country offices. Further pilot testing is under way and could lead to further refinements of the proposed attributes, criteria, scale and indicators. Opportunities to observe the pilot testing will be made available to Member States in order to enhance their understanding of the methodology and plans for implementation of the Output Scorecard.

Reporting results

34. The reporting of results by the Organization will also change significantly in order to strengthen its accountability for delivering results.

35. The change will start in the process of generating and monitoring data and information across the Organization. The objective is to strengthen the linkages between country offices, regional offices and headquarters so that the information generated from monitoring not only informs reporting globally but also ensures learning and provides feedback to the implementation process, ensuring a clearer focus on the delivery of outcomes and the triple billion targets across the Organization.

36. This new approach will require better linkages within the major offices and coordination across the three levels of the Organization. The Secretariat will use its newly established networks and teams for joint delivery and monitoring across the Organization.[1]

37. The reporting will also change by harmonizing previously fragmented data, such as WHO statistics, WHO observatory reports, programme review reports, country reports and corporate results reporting. The aim is to strengthen the coherence of the reports by using the same data and sources and aligning them with the new measurement system for GPW 13.

38. The results report to Member States will be prepared annually, based on the GPW 13 results framework, which will progressively include all aspects of the new reporting structure, including reporting on the Output Scorecard, the outcomes and the triple billion targets. The results report for the biennium 2020–2021 will contain a scorecard for each of the outputs and the performance of output delivery at each of the levels of the Organization. It will include both quantitative reports on the indicators and indices and qualitative reports that explain progress, risks, challenges and lessons learned, as well as case studies that illustrate the impacts resulting from WHO's work in countries and from its normative functions.

39. At the end of the GPW 13 period, the Secretariat will prepare a comprehensive report summarizing progress made towards the GPW 13 2023 targets, the triple billion targets and the Secretariat's contribution as measured through the Output Scorecard and the qualitative case studies over the 2019–2023 period.

40. Selective country case studies will showcase the Organization's impact by sharing experiences on successes and lessons learned, including failures, strengthening its role as a learning organization.

[1] WHO has established output delivery teams, outcome networks and strategic priority networks to ensure coherence in planning, monitoring and reporting, and joint delivery of the Secretariat's work in line with the integrated results framework. The aim is to work in a coordinated way to achieve the triple billion targets. See Annex 5 for further details.

Case studies at the country, regional or global levels may be included and clear country results will be demonstrated, as well as the impact of WHO's work on the lives of people.

Next steps

41. The Secretariat will continue to work with Member States, national statistical offices and other partners in order to empower countries to analyse, interpret and track progress and thus make maximal use of their data as they advance towards meeting the pledge of the 2030 Agenda for Sustainable Development to leave no one behind.

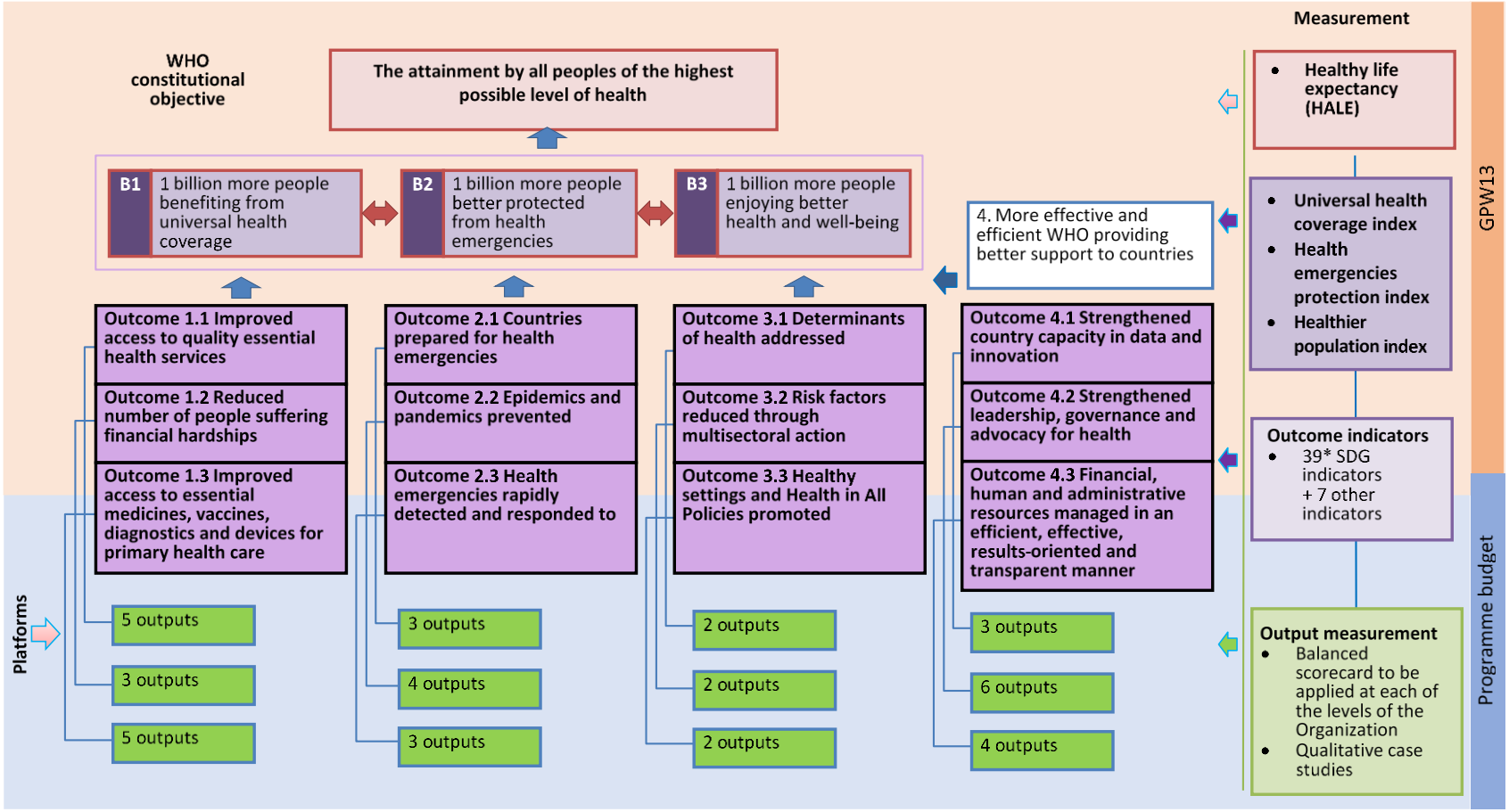
42. The Secretariat will work with all its offices to refine further the Output Scorecard instrument in order to ensure a balance between robustness and credibility on the one hand and simplicity and feasibility of application on the other. Member States will be consulted before its finalization and presentation to the World Health Assembly.

ACTION BY THE EXECUTIVE BOARD

43. The Executive Board is invited to note the report and comment and provide strategic advice on the finalization of the measurement of the results framework. This will inform the text of the document that will be submitted for consideration by the Seventy-third World Health Assembly.

ANNEX 1

THIRTEENTH GENERAL PROGRAMME OF WORK, 2019–2023: RESULTS FRAMEWORK

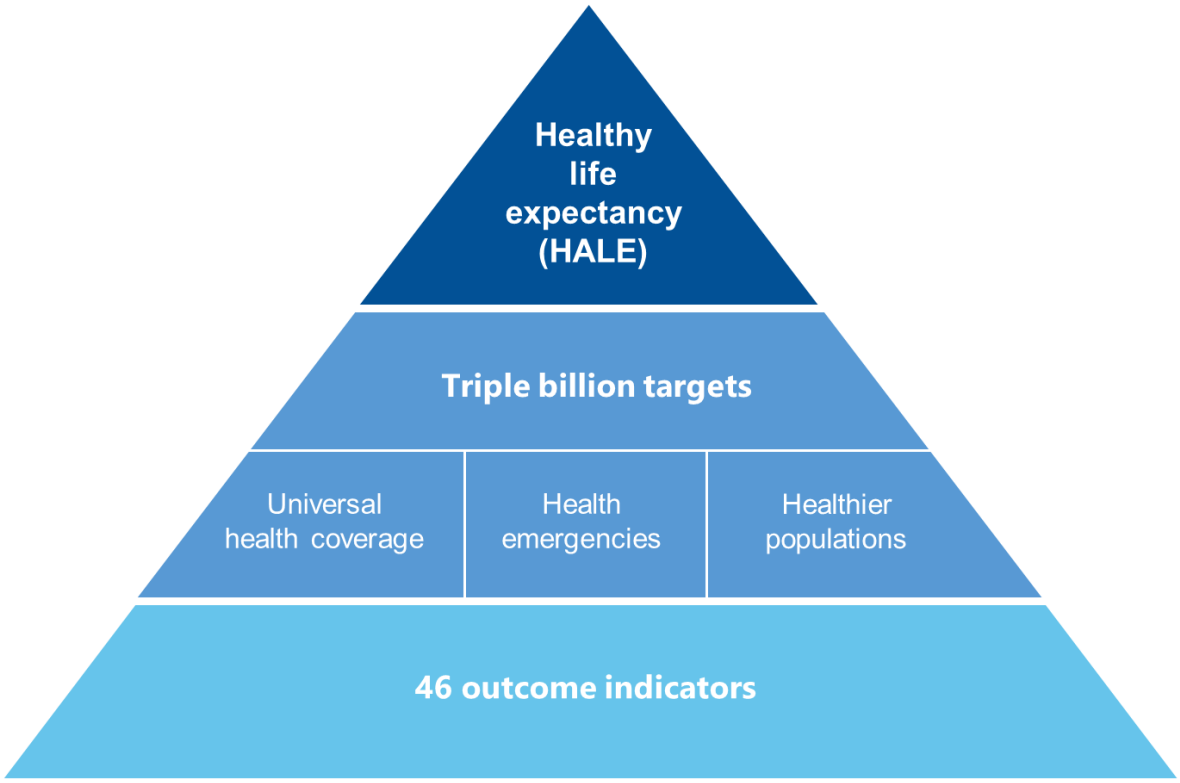


* Changed from 38 to 39 as the antimicrobial resistance indicator will be formally included in SDG list of indicators following the 2020 Comprehensive Review.

GPW 13: Thirteenth General Programme of Work, 2019–2023; SDG: Sustainable Development Goal.

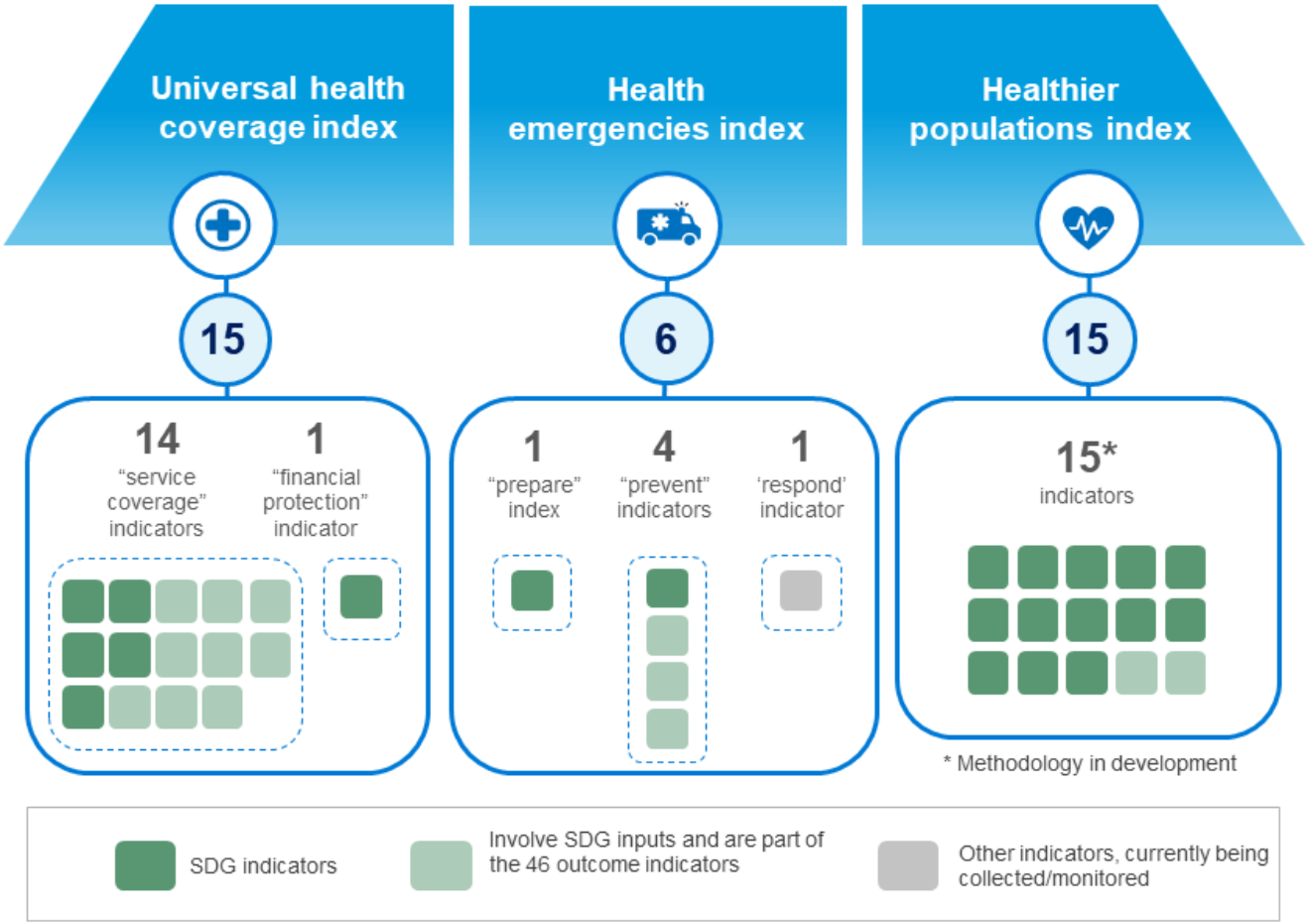
ANNEX 2

WHO'S GPW 13 IMPACT MEASUREMENT STRUCTURE



ANNEX 3

TRIPLE BILLION TARGETS AND RELATED INDICES: MAPPING WITH SDG INDICATORS



ANNEX 4

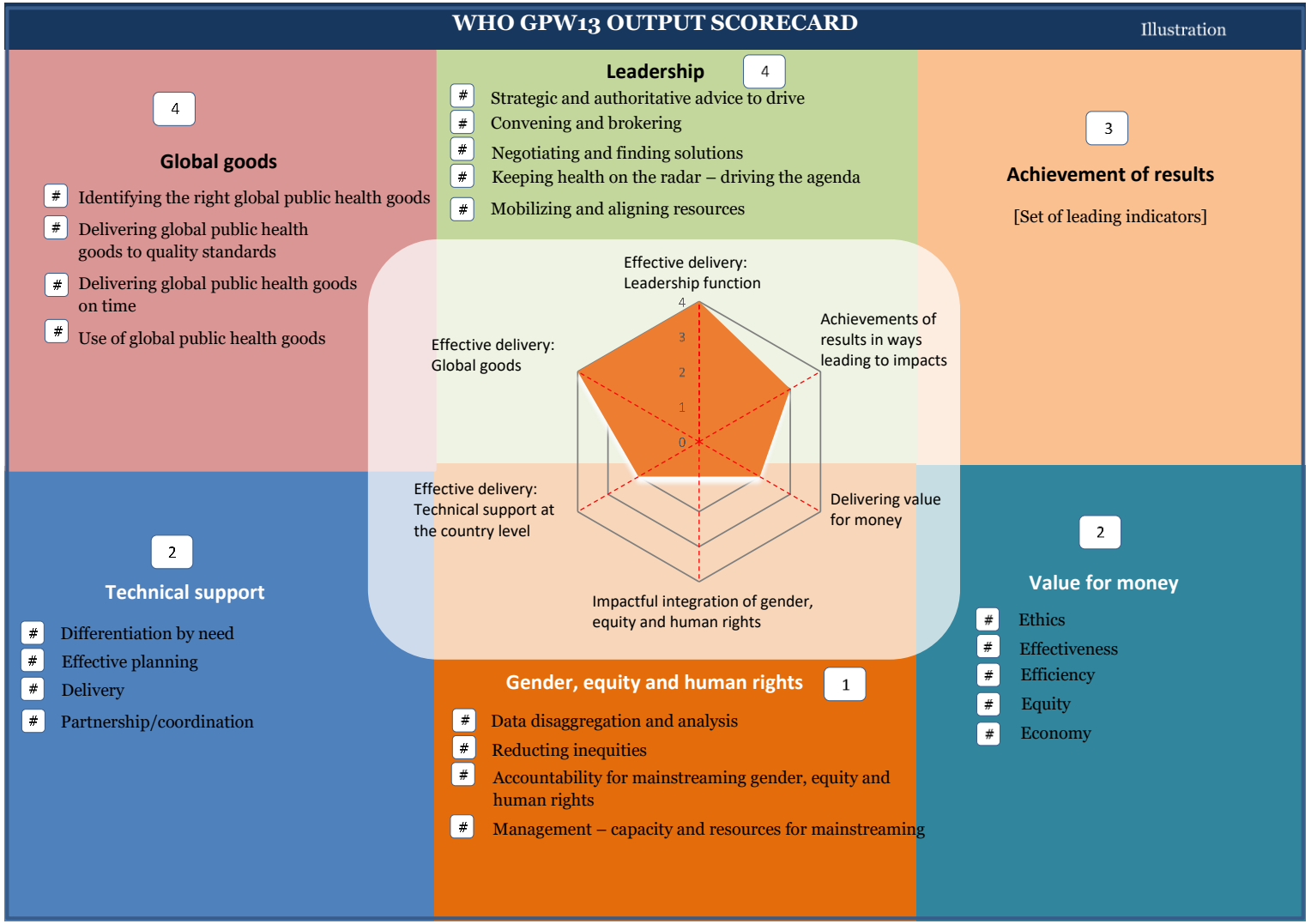
MAPPING GPW 13 TO SDG AND HEALTH ASSEMBLY INDICATORS

Number of SDG indicator/ Health Assembly resolution	**SDG/Health Assembly indicator**
SDG 1.5.1	Number of deaths, missing persons and directly affected persons attributed to disasters per 100 000 population
SDG 1.a.2	Proportion of total government spending on essential services (education, health and social protection)
SDG 2.2.1	Prevalence of stunting (height for age <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age
SDG 2.2.2	Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age (wasting)
SDG 2.2.2	Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age (overweight)
SDG 3.1.1	Maternal mortality ratio
SDG 3.1.2	Proportion of births attended by skilled health personnel
SDG 3.2.1	Under-5 mortality rate
SDG 3.2.2	Neonatal mortality rate
SDG 3.3.1	Number of new HIV infections per 1000 uninfected population, by sex, age and key populations
SDG 3.3.2	Tuberculosis incidence per 100 000 population
SDG 3.3.3	Malaria incidence per 1000 population
SDG 3.3.4	Hepatitis B incidence per 100 000 population
SDG 3.3.5	Number of people requiring interventions against neglected tropical diseases
SDG 3.4.1	Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease
SDG 3.4.2	Suicide mortality rate
SDG 3.5.1	Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders
SDG 3.5.2	Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol
SDG 3.6.1	Death rate due to road traffic injuries
SDG 3.7.1	Proportion of women of reproductive age (15–49 years) who have their need for family planning satisfied with modern methods
SDG 3.8.1	Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)
SDG 3.8.2	Proportion of population with large household expenditures on health as a share of total household expenditures or income
SDG 3.9.1	Mortality rate attributed to household and ambient air pollution

Number of SDG indicator/ Health Assembly resolution	**SDG/Health Assembly indicator**
SDG 3.9.2	Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)
SDG 3.9.3	Mortality rate attributed to unintentional poisoning
SDG 7.1.2	Proportion of population with primary reliance on clean fuels and technology
SDG 11.6.2	Annual mean levels of fine particulate matter (e.g. PM2.5 and PM10) in cities (population weighted)
SDG 3.a.1	Age-standardized prevalence of current tobacco use among persons aged 15 years and older
SDG 3.b.1	Proportion of the target population covered by all vaccines included in their national programme
SDG 3.b.3	Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis
SDG 3.c.1	Health worker density and distribution
SDG 3.d.1	International Health Regulations (IHR) capacity and health emergency preparedness
SDG 3.d.2	Percentage of bloodstream infections due to selected antimicrobial-resistant organisms
SDG 4.2.1	Proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being, by sex
SDG 5.2.1	Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age
SDG 5.6.1	Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care
SDG 6.1.1	Proportion of population using safely managed drinking water services
SDG 6.2.1	Proportion of population using (a) safely managed sanitation services and (b) a hand-washing facility with soap and water
SDG 16.2.1	Proportion of children aged 1–17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month
Health Assembly resolutions on health emergencies	Vaccine coverage of at-risk groups for epidemic or pandemic prone diseases
Health Assembly resolutions on health emergencies	Proportion of vulnerable people in fragile settings provided with essential health services
WHA68.3 (2015)	Number of cases of poliomyelitis caused by wild poliovirus
WHA68.7 (2015)	Patterns of antibiotic consumption at the national level
WHA66.10 (2013)	Age-standardized prevalence of raised blood pressure among persons aged 18+ years (defined as systolic blood pressure of >140 mmHg and/or diastolic blood pressure >90 mmHg) and mean systolic blood pressure
WHA66.10	Percentage of people protected by effective regulation on *trans*-fats
WHA66.10	Prevalence of obesity

ANNEX 5

A. Output scorecard dimensions and scoring scale for the technical outputs (outputs under outcomes 1.1 to 4.1)



Dimension 1: Effective delivery: Leadership functions		
Attribute	**Criteria**	**Scoring scale**
Strategic and authoritative advice to achieve impact	**Strategic approach:** Strategic thinking and advice aimed at driving long-term impact **Evidence-based advice:** Evidence-based advice, using latest data/best practice **Authoritative:** Regarded as authoritative by key external stakeholders **Influential:** Influential and well positioned with key decision-makers **Impactful:** Impactful in key areas targeted for this biennium	**Strong (4)** Consistently strategic and has already had significant impact in all the key targeted areas that are key to delivering the output.[1] Always informed by high-quality evidence. Ideally positioned and widely seen as authoritative by all external stakeholders. **Satisfactory (3)** Mainly strategic and well evidenced, seen as authoritative by some key stakeholders. Already well positioned to influence key decision-makers. Significant impact in two or three targeted areas that are key to delivering the output. **Developing (2)** Advice is becoming more strategic and is starting to be seen as authoritative, with impact likely in at least one key area. Good progress has been made in building and using the evidence base. **Emergent (1)** Mainly reactive/tactical. Positioning to reach decision-makers is at an early stage and is not yet seen as authoritative. Evidence base is being developed. Limited impact on key areas so far.
Convening and brokering	**Building partnerships and networks:** Plays a leading role to build and use effective and sustainable networks and partnerships **Brokering solutions:** Brokers solutions and bridges gaps in difficult areas **Leading successful events:** Supports and leads effective events which are well chaired, focused and timely	**Strong (4)** Highly effective use of sustainable networks and partnerships in all areas significant for the output delivery. Has helped to broker solutions in many difficult areas. Frequently leads major events with successful outcomes **Satisfactory (3)** Effective use of networks and partnerships in most areas significant for the output delivery. Regularly plays brokering role including in at least one difficult area. Has led at least two successful events. **Developing (2**) Has started to build some effective networks. Playing brokering role but not yet in the most challenging areas. Planning and leading events in one or two key areas. **Emergent (1)** At an early stage of building networks and partnerships. Not yet positioned for brokering role but developing a platform. Limited role in convening events so far, but building an approach.

[1] These targeted areas which are the most significant areas where WHO leadership is crucial. These are set by the Output Delivery Teams at the outset.

Dimension 1: Effective delivery: Leadership functions		
Attribute	**Criteria**	**Scoring scale**
Negotiating and finding solutions	**Understanding the players:** Understands the context and needs of the different players **Positioning:** Well positioned with key players on challenging issues **Evidence based approach:** Identifies solutions informed by the evidence and best practice **Finding practical solutions:** Identifies practical, sustainable and implementable solutions	**Strong (4)** Deep understanding of the key players and context. Leading role in negotiations on the most challenging issues. Regularly identifies practical, sustainable and evidenced solutions. **Satisfactory (3)** Solid understanding of most key players and context. Well positioned including on more challenging issues. Has identified practical, sustainable, evidenced solutions in two or three key areas. **Developing (2)** Becoming directly involved in discussions with the key players. Has helped to identify practical, sustainable and implementable solutions in at least one key area, informed by solid evidence. **Emergent (1)** In the early stages of mapping the stakeholders, understanding their needs and positioning to play a role. In the process of developing the required evidence base and platform for future work.
Keeping health on the radar – driving the agenda	**Strategic communication:** Use of advocacy and strategic communication tools to promote health **Targeting key events:** Targets and influences key events (e.g. global health summits, national events) **Influencing at key events:** demonstrates visible leadership and influence in discussions on health at key events **Setting direction:** Anticipates new/emerging issues to help set direction and develop a clear long-term vision	**Strong (4)** Best practice use of strategic communication has ensured health is high on the agenda for all the targeted events. Plays a leading role in discussions and setting direction on new and emerging issues. **Satisfactory (3)** Makes effective and regular use of strategic communication and advocacy tools, resulting in the placement of health high on the agenda in at least two targeted, important events. Is helping to set direction and set out a clear long-term vision. **Developing (2)** Has begun to use strategic communication and advocacy tools and is advocating for health on the agenda for at least one or two targeted events. Able to lead and influence in at least one or two key areas and starting to identify new and emerging issues. **Emergent (1)** Use of strategic communication and advocacy tools is at an early stage. In the process of building a targeting and influencing approach. Participates in key events but mainly reactive at this stage.

Dimension 1: Effective delivery: Leadership functions		
Attribute	**Criteria**	**Scoring scale**
Mobilizing and aligning resources	**Resource planning:** Plans ahead on resource requirements informed by strategic priorities and sound analysis of needs and costs **Strategic communication for resource mobilization:** Uses appropriate communication tools to support resource mobilization and develop new funding sources **Deployment and alignment of resources:** Deploys resources effectively to align with key priorities within available earmarked and flexible resources **Capacity-building:** Balances immediate needs with longer term capacity-building and skills development	**Strong (4)** Plans and uses resources flexibly to align with long-term strategic priorities related to the output and contribute to achieving impacts. Is highly strategic in communicating and advocating for resources and has identified new funding sources. Strategic approach to building capacity and skills is already implemented. **Satisfactory (3)** Plans and uses resources effectively based on sound analysis. Mobilizes available resources effectively drawing on existing channels. Allocates human and financial resources effectively in line with priorities and need, taking account of capacity-building and skills. **Developing (2)** Resource mobilization and alignment approach includes elements of strategic planning, sound analysis, capacity-building and advocacy but is still “work in progress”. **Emergent (1)** Approach to resource mobilization and allocation is based mainly on responding to needs as they arise. A more strategic approach is being considered but is at an early stage.

Dimension 2: Effective delivery: Global public health goods		
Attribute	**Criteria**	**Scoring scale**
Prioritizing of global public health goods for impact	Global public health goods delivered are identified and prioritized to achieve GPW 13 impact	*[Placeholder: To be used for the assessment at the end of 2022 and beyond]* **Strong (4)** All global public health goods planned passed through an established rigorous three-level prioritization process, based on evidence of impact at the country level. Three-level technical input is evident. **Satisfactory (3)** Most global public health goods planned passed through an established rigorous three-level prioritization process. **Developing (2)** Some global public health goods planned passed through an established rigorous three-level prioritization process. **Emergent (1)** No global public health goods planned passed through an established rigorous three-level prioritization process. A list of greenlighted global public health goods is available to all three levels of the Organization.
Delivering the prioritized global public health goods		*[Self-assessment with validation]* **Strong (4)** All prioritized global public health goods are completed. **Satisfactory (3)** Most prioritized global public health goods are completed. **Developing (2)** Some prioritized global public health goods are completed. **Emergent (1)** No prioritized global public health goods are completed.
Delivering global public health goods to **quality standards**	Global public health goods are developed according to quality-assured processes as defined by the Science Division or Data Analytics and Delivery for Impact (headquarters)	*[Assessment by Science Division or Data Analytics and Delivery for Impact (headquarters)]* **Strong (4)** All completed global public health goods meet all quality assurance steps. **Satisfactory (3)** Most completed global public health goods meet all quality assurance steps. **Developing (2)** Some completed global public health goods meet all quality assurance steps. **Emergent (1)** No completed global public health goods meet all quality assurance steps.

Dimension 2: Effective delivery: Global public health goods		
Attribute	**Criteria**	**Scoring scale**
Use of global public health goods	Global public health goods are available and accessible for use by countries Global public health goods are taken up by countries and contribute to GPW 13 impact	*[Assessment by Regional Office Output Delivery Team; the scorecard may be complemented with case studies of the use of global public health goods]* *To be used for the assessment at the end of 2022 and beyond*

Dimension 3: Effective delivery: Technical support at the country level		
Attribute	**Criteria**	**Scoring scale**
Differentiation by country need	**Differentiated technical assistance:** Deploys an appropriate mix of modalities (policy dialogue, strategic support, technical assistance, service delivery) to meet emerging country needs[1] **Understanding of country needs:** Decisions are based on a strategic understanding of country needs that is informed by in-depth analysis of country priorities, capacities, vulnerabilities and opportunities **Responsive to changes in needs:** As country needs evolve, makes appropriate and timely changes in the mix of technical support	**Strong (4)** Technical support and mix of technical assistance modalities are highly tailored to country needs and informed by in-depth strategic analysis of priorities, capacities, vulnerabilities and opportunities. Highly agile[2] and responsive to changes in country need. **Satisfactory (3)** Technical support is reasonably tailored to country needs and based on a sound and up-to-date analysis of country priorities, capacities, vulnerabilities and opportunities. As country needs change, support is adapted within a reasonable timescale. **Developing (2)** Technical support is gradually adapting to fit country needs with some further changes required to achieve a good fit. Analysis is being updated/improved. Could be more agile/responsive. **Emergent (1)** Technical support is yet to be well tailored and responsive. The analysis and understanding of country needs is yet to be developed sufficiently and the mix of instruments will need to be adapted significantly.
Effective planning of country support	**Country support planning:** **A structured, evidence-based and bottom-up process** with engagement of three levels **An effective dialogue** with a wide range of country stakeholders including civil society **An impact-oriented approach** underpinned by results measurement	**Strong (4)** A country support plan focused on priorities is in place based on country capacities, needs and vulnerabilities. Results are measured and fed back into decisions to support an impact-oriented approach. The country cooperation work of WHO at the country level and its country support plan are based on a consultative dialogue with a wide range of partners at the country level and across the three levels. **Satisfactory (3)** Country support plan is based on a solid analysis of country needs and is in line with the country priorities. The engagement of three levels and dialogue with core partners are adequate.

[1] In line with WHO's approach to achieving strategic shifts, i.e. driving public health impact in every country with a differentiated approach based on capacity and vulnerability, as set out in GPW 13.

[2] In this context, "Agile" means that changes in needs and priorities are quickly (e.g. within one month) identified and discussed with government, at different levels within WHO as required, and with partners and country stakeholders; WHO support, including resources, staffing and types of support are then rapidly (e.g. within three months) adapted and realigned as required, to ensure ongoing relevance, targeting of impact and quality.

Dimension 3: Effective delivery: Technical support at the country level		
Attribute	**Criteria**	**Scoring scale**
		Developing (2) The planning process for country support under for this output is somewhat structured and improving, including the engagement of three levels of the Organization. The country cooperation work is mainly focused on WHO up to now, but there has been some dialogue with partners. **Emergent (1)** The planning process is at an early stage and/or the country support plan is being developed. A dialogue with stakeholders is starting. There is inadequate engagement of three levels of the Organization in country support planning.
Effective delivery	**Country support delivered according to plan and objectives are met:** Delivery adheres to agreed plan across the three levels. The objectives of the support are met. **Increased resources and capacity for technical support at regional and country office levels:** **Timely:** Country support is timely, in line with agreed milestones **Quality:** Country support achieves required standards of quality	**Strong (4)** All country support delivered is according to agreed country support plan across the three levels. It consistently delivers all the agreed objectives. There is evidence of increased resources for country support and technical capacity at country office level. Technical support is delivered based on agreed timescales, to a high standard of quality. **Satisfactory (3)** Most of the agreed country support plan is delivered to a satisfactory level of quality. Any gaps are being addressed through prompt actions. Sufficient efforts to improve technical support capacity at regional and country office levels. **Developing (2)** Country support is partly delivering what is required although there are delays and/or are gaps and/or quality is inconsistent. Limited improvements in capacity for technical support at regional and country office levels. **Emergent (1)** There is evidence that country support delivered is mostly unplanned and not coordinated with the country office. Objectives are significantly off track and not likely to be met – due to quality, timeliness or financing issues.

Dimension 3: Effective delivery: Technical support at the country level		
Attribute	**Criteria**	**Scoring scale**
Partnership	**Shared approach:** Shared approach to coordination and partnership, based on shared goals (Sustainable Development Goals) and planning mechanisms (e.g. United Nations Development Assistance Framework) **Relationships and trust:** Strong relationships and high levels of trust with relevant partners, based on regular and effective communication and dialogue **Division of labour:** Shared agreement with partners on comparative advantage and division of labour **Leveraging change:** Delivery of shared goals with and through partners	**Strong (4)** WHO delivers its technical support through a shared approach to partnership based on strong relationships and trust. Has leveraged partnerships to deliver transformational change and significant impact of technical support. **Satisfactory (3)** A shared approach to partnership is in place and relationships are good in the delivery of technical support to countries. Is regularly working with partners to deliver benefits, both at strategic level and on specific projects and initiatives. **Developing (2)** Approach to partnership is still developing, relationships are being built and some successful examples exist of working together on specific technical support related to the output. **Emergent (1**) Approach is mainly internally focused in the delivery of technical support, working through WHO and government rather than with partners, although starting to identify opportunities to partner and develop relationships.
Institutional capacity-building	**Capacity assessment and analysis:** Capacity[1] analysis is used effectively to plan approaches for sustainable capacity-building **Country ownership:** Ensuring country ownership is built into the approach to country support **Monitoring:** Regular monitoring of capacity strengthening is built into the approach	**Strong (4)** Capacity-building is based on robust capacity analysis and monitoring to achieve results. Already achieving sustainability through skills transfer, financial sustainability and a high degree of country involvement and ownership. Includes capacity-building at different levels (people, institutional, system) and achieves intended results. **Satisfactory (3)** Capacity-building includes capacity analysis and regular monitoring. Sustainability (i.e. skills transfer, financial sustainability, country ownership) is purposefully built into the approach. Capacity is built at different levels in at least one of the areas, i.e. people, institutional, system.

[1] Capacity includes human resources, governance, systems, regulation, service provision, and training needs.

Dimension 3: Effective delivery: Technical support at the country level		
Attribute	**Criteria**	**Scoring scale**
	Institutional strengthening: Clear evidence[1] that institutional strengthening and skills transfer are being achieved	**Developing (2)** Capacity analysis is starting to be used to inform an approach to capacity-building, and country ownership is being built. Monitoring evidence is starting to be used to adjust approach. An approach to measuring results achieved for capacity-building is work in progress. **Emergent (1)** Capacity-building is not yet built into the approach and needs to be considered further.

[1] Indicators are needed to give evidence.

Dimension 4: Impactful integration of gender, equity and human rights		
Attribute	**Criteria**	**Scoring scale**
Data disaggregation and analysis	**Data:** Collection, analysis and reporting of data disaggregated by sex, age and other dimensions **Health differences:** Identification of health differences that may be unfair and avoidable **Identification of linkages** between gender inequalities and other forms of discrimination **Analysis:** Analysis of quantitative and qualitative data, policies and/or laws to identify populations experiencing disadvantage or discrimination, including barriers and gender-based discrimination	**Strong (4)** • Data are disaggregated by sex[1] and by at least two other inequality dimensions (e.g. age, disability, economic status, education, place of residence (urban/rural) or subnational geography). • These data are analysed regularly and used in planning, reporting and/or evaluation. • Populations experiencing disadvantage or discrimination and processes leading to exclusion are identified. • Analysis of policies and laws include a gender, equity and rights analysis of the evidence. **Satisfactory (3)** • Data are disaggregated by sex[1] and by at least two other inequality dimensions (e.g. age, disability, economic status, education, place of residence (urban/rural) or subnational geography). • These data are analysed regularly and used in planning, reporting and/or evaluation. • Populations experiencing disadvantage or discrimination and processes leading to exclusion are identified. **Developing (2)** • Data are disaggregated by sex[1] and by at least two other inequality dimensions (e.g. age, disability, economic status, education, place of residence (urban/rural) or subnational geography). • Populations experiencing disadvantage or discrimination and processes leading to exclusion are identified. **Emergent (1)** • Disaggregation and analysis are not yet being considered and/or thinking is at a very early stage; or disaggregated data are not available.

[1] If not applicable by sex, an explanation should be provided as this is a mandate from WHA60.25 Strategy for Integrating Gender Analysis and Actions into the Work of WHO.

Dimension 4: Impactful integration of gender, equity and human rights		
Attribute	**Criteria**	**Scoring scale**
Reducing inequities	**Strategy/policy actions:** Actions aimed at reducing gender inequalities and health inequities in programmes and policies are in place **Technical assistance:** Technical assistance to reduce inequities is provided, including a participatory approach and a human rights-based approach **Engagement:** Engagement, through various forms of meaningful participation of stakeholders at global, regional national or community level (as relevant) is promoted, implemented and reported on	**Strong (4)** • Strategic programmatic documents include reducing gender inequalities, health inequities and discrimination in the proposed actions/interventions. • Country support plans and implementation always includes actions to reduce and monitor gender inequalities, health inequities and discrimination. • Meaningful participation of stakeholders has been ensured in the design, implementation and evaluation of actions to reduce health inequities. **Satisfactory (3)** • Strategic programmatic documents include reference to gender inequalities, health inequities and discrimination. • Country support plans mostly include actions to reduce gender inequalities, health inequities and discrimination. • Meaningful participation of stakeholders has been promoted in the design, implementation and evaluation of actions to reduce gender inequalities, health inequities and discrimination. **Developing (2)** • Strategic programmatic documents include reference to gender inequalities, health inequities and discrimination. • Technical assistance includes identification of gender inequalities, health inequities and discrimination. **Emergent (1)** • Strategic programmatic documents include reference to gender inequalities, health inequities and discrimination.

Dimension 4: Impactful integration of gender, equity and human rights		
Attribute	**Criteria**	**Scoring scale**
Management for capacity-building and resource allocation	**Capacity-building**: Capacity-building[1] on mainstreaming gender, equity and human rights is planned, implemented and reported on **Resource allocation:** Resources are allocated in workplans[2] to appropriately sustain capacity-building on mainstreaming gender, equity and human rights **Awareness raising:** Raising awareness on and advocating for mainstreaming gender, equity and human in the achievement of outputs is conducted	**Strong (4)** • At least two activities have been conducted to build or strengthen staff's capacities for mainstreaming gender, equity and human rights. • Resources allocated in the Output Delivery Team to appropriately sustain capacity-building for mainstreaming gender, equity and human rights are least 5% of the total funding of the output for country support. **Satisfactory (3)** • At least two activities have been conducted to build or strengthen staff capacities for mainstreaming gender, equity and human rights. • Resources allocated in the Output Delivery Team to appropriately sustain capacity-building for mainstreaming gender, equity and human rights are less than 5% of the total funding of the output for country support. **Developing (2)** • At least one activity has been conducted to build or strengthen staff capacities for mainstreaming gender, equity and human rights. • Resources allocated in the Output Delivery Team to appropriately sustain capacity-building for mainstreaming gender, equity and human rights are less than 5% of the total funding of the output for country support. **Emergent (1)** • Activities to build or strengthen staff capacities for mainstreaming gender, equity and human rights have been planned or partially implemented.

[1] Capacity-building can take many forms, including technical assistance, collaborations or through training (e.g. training on mainstreaming gender, equity and human rights; training on health inequality monitoring and data disaggregation; training on how to do a gender analysis; training on how to conduct a barriers assessment in health services; training on how to conduct a health programme review with Innov8; the "I know Gender" course from the United Nations; training on the Sustainable Development Goals and the leaving no one behind approach).

[2] Either in activity workplans or salary workplans, which could allocate dedicated staff or staff's time to support the mainstreaming of gender, equity and human rights into the budget centres, programmes, division, unit, office, etc.

Dimension 4: Impactful integration of gender, equity and human rights		
Attribute	**Criteria**	**Scoring scale**
Accountability and organizational change	**Change in institutions:** Promoting and institutionalizing an organizational change to actionable mainstreaming of gender, equity and human rights is part of the culture of WHO **Organizational change:** Actions promoting organizational change should include mainstreaming gender, equity and human rights **Accountability:** Accountability for gender, equity and human rights should be clear and enforced by managers,[1] including in budget centres' workplans and managers' objectives in the performance management and development system	**Strong (4)** • An equity, gender and human rights mainstreaming plan for the budget centres has been developed and monitored. • Mainstreaming gender, equity and human rights is included in one of the objectives in the performance management and development system for Senior Management (starting at P5 level). • Preparation and development of governing bodies' documentation address gender, equity and human rights. **Satisfactory (3)** • An equity, gender and human rights mainstreaming plan for the budget centres has been developed and monitored. • Mainstreaming gender, equity and human rights is included in one of the objectives in the performance management and development system for Senior Management (starting at P5 level). **Developing (2)** • An equity, gender and human rights mainstreaming plan for the budget centres has been developed and monitored. **Emergent (1)** • Discussions for developing an equity, gender and human rights mainstreaming plan for the budget centres have started.

[1] Including Directors, Regional Advisers, Coordinators, WHO Representatives.

Dimension 5: Delivering value for money		
Attribute	**Criteria**	**Scoring scale**
Effectiveness	**Outputs are on track** to achieve the intended outcomes **Monitoring systems are in place and being used to track progress** Where outputs are off track, **remedial actions are taken** **Evaluation is being used to support learning and innovation** **Credible Theory of Change**	**Strong (4)** WHO output is fully on track to deliver the intended outcome(s), supporting sustainability.[1] Quality is at the highest possible level. Monitoring and evaluation systems are feeding into management decision-making and learning for this output. There is a clear understanding about how impacts will be achieved. **Satisfactory (3)** WHO output is broadly on track to deliver the intended outcomes. Quality of delivery is at a satisfactory level. Monitoring and evaluation systems are feeding into management decision-making and learning for this output. **Developing (2)** Interventions under the output are partially on track to achieve intended outcomes, and measures are being taken to accelerate progress. Sustainability is being considered but is not yet fully developed. Monitoring and evaluation is developing. **Emergent (1)** Interventions under the output are off track to achieve their outcomes and/or sustainability is either not likely or not tested. Monitoring and evaluation systems are not yet in place or do not yet feed into decision-making.

[1] Sustainability is a function of Government and not of WHO. However, WHO can advocate for it, to convince decision-makers and treat sustainability as priority in its work. At government level, sustainability is reached if there is strong political commitment on both financial and non-financial plans, (human resources staffing, budgeting, multisectoral resources).

Dimension 5: Delivering value for money		
Attribute	**Criteria**	**Scoring scale**
Ethics	**Awareness** Have ethical standards and principles relevant to the output been clearly identified and understood? For example: (a) WHO's Code of ethics and Professional conduct[1] (b) Specific ethical standards (where relevant) that apply for this output area[2] **Compliance** Have WHO's agreed ethical standards been fully integrated, and are they being applied?	**Strong (4)** Relevant ethical standards and principles are fully understood and integrated into programme design and implementation relevant to the output, resulting in full compliance with no exceptions. **Satisfactory (3)** Relevant ethical standards and principles are considered in programme design and implementation relevant to the output, with high levels of compliance. Any exceptions are relatively minor and have been addressed. **Developing (2)** Relevant ethical principles and standards are being considered but are not yet consistently followed through in decisions and implementation. **Emergent (1)** Programme design and implementation relevant to the output do not yet fully take into account relevant ethical principles and standards and/or there are major gaps in competence around ethics and/or compliance, leading to significant reputational risk.

[1] WHO's Code of Ethics and Professional Conduct (2017) sets out the following ethical principles: integrity; accountability; independence and impartiality; respect for the dignity, worth, equality, diversity and privacy of all persons; professional commitment. The code also contains specific guidance on how these principles apply in practice for individual staff, managers and at organizational level. For example, commitments at organizational level cover areas such as: ensuring a fair and respectful workplace, preventing sexual exploitation and abuse, child protection, human rights, gender, equity and human rights and fair and transparent procurement, etc. At individual level, the code covers areas such as respecting national laws, conflict of interests, violence in the workplace, etc. Other areas covered by the guide include relations with non-State actors, use of information, reporting wrongdoing (whistleblowing and protection against retaliation), etc.

[2] In individual areas of WHO's work, specific ethical standards and guidance apply e.g. "WHO Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies"; "International ethical guidelines for biomedical research involving human subjects"; "UNEG ethical guidelines for evaluators", etc. Although an exhaustive list cannot be provided here, output network leads are expected to be able to identify and reference specific ethical standards that have been formally adopted by WHO for their own areas.

Dimension 5: Delivering value for money		
Attribute	**Criteria**	**Scoring scale**
Equity[1]	**Resource allocation** includes criteria to ensure that the expected benefits are distributed fairly and/or reach the most vulnerable When **the most vulnerable** are not reached, an analysis and plan should be developed to identify what resources or management decisions need to be made to correct this situation **Reporting on output achievement** includes analysis on how resources were allocated to fairly distribute benefits to the most vulnerable **Evaluation** is used to support learning and innovation on equity-oriented resource allocation and reporting	**Strong (4)** • Explicit criteria (e.g. rules, norms, standards, etc.) are used to allocate resources with a view to distribute benefits fairly and/or to reach the most vulnerable. • Reporting on output achievement includes analysis on how resources were allocated to fairly distribute benefits to the most vulnerable. • Equity-oriented resource allocation capacity and reporting are built or strengthened. **Satisfactory (3)** • Explicit criteria (e.g. rules, norms, standards, etc.) are used to allocate resources with a view to distribute benefits fairly and/or to reach the most vulnerable. • Reporting on output achievement includes analysis on how resources were allocated to fairly distribute benefits to the most vulnerable. **Developing (2)** • Explicit criteria (e.g. rules, norms, standards, etc.) are defined for promoting the allocation of resources with a view to distribute benefits fairly and/or to reach the most vulnerable, but are not used consistently. **Emergent (1)** • Equity-oriented resource allocation and reporting is promoted but without clear criteria (e.g. rules, norms, standards, etc.).

[1] Scoring in this attribution should be done in conjunction with, and consistent with the gender, equity and human rights dimension. For example, the gender, equity and human rights attribute on management capacity and resources should be scored consistently with the criterion in value for money equity on “strategies capacities and skills”.

Dimension 5: Delivering value for money		
Attribute	**Criteria**	**Scoring scale**
Efficiency	**Management has taken strategic decisions** to address system[1] weaknesses and to deliver efficiency gains where possible **Available financial and human resources** are optimally used during the planning period **Delivery is timely** **Financial and risk management processes** meet relevant standards and are implemented appropriately	**Strong (4)** Strategic decisions have already led to clear efficiency gains in several areas. Delivery is consistently timely and financial and human resources are used optimally. Financial management and risk management processes are fully implemented. **Satisfactory (3)** Strategic decisions have led to efficiency gains in at least one area. Delivery is timely. Financial management and risk management processes are fully implemented. **Developing (2)** Efficiency gains are being targeted but implementation is "work in progress". Delivery is usually timely but with some delays or use of no-cost extensions. Resources are not always optimally used. Financial management and risk management processes are improving/under development. **Emergent (1)** Efficiency gains have not yet been targeted. No-cost extensions to deadlines have been repeatedly required and/or resources have not been fully used. Financial and risk management processes are in need of significant strengthening.
Economy	**Compliant use of benchmarking comparisons,** vis a vis adequate quality and costs including reference to WHO and United Nations system-wide standards	**Strong (4)** Input costs are consistently better than relevant benchmarks, while maintaining quality. Regular reference to market benchmarks is built in and actions are already fully implemented to achieve best buy. **Satisfactory (3)** Input costs are broadly in line with relevant benchmarks, while maintaining quality. At least one benchmarking comparison has been made and follow-up action is under way to achieve best buy. **Developing (2)** Input costs are higher than relevant benchmarks in some areas, although work has been done to understand the reasons and actions are being considered to achieve best buy. **Emergent (1)** Input costs are consistently higher than expected and/or limited if any analysis to identify the reasons and consider benchmarks. Limited progress on actions to ensure best buy.

[1] This includes standard operating procedures and policies.

Note: Economy is not to be scored if effectiveness is rated as 1 or 2.

Dimension 6: Results in ways leading to impacts

This dimension:

- helps answer the "so what" question, providing an early indication of the extent to which the work of the WHO Secretariat (five other dimensions) influences the outcomes and drives impact; and

- helps monitor whether the Secretariat is making a significant contribution to or influence to achieving impact to people's health through the delivery of its work as measured by the other five dimensions of the Output Scorecard (global public health goods, technical support, leadership, value for money, and gender, equity and human rights).

The following are the steps for establishing the measure of this dimension.

1. Develop a logic model or each output that shows how the achievement of the output leads to outcomes/impacts. See the logic model example for output 1.1.1 in the Figure.

2. Identify leading indicators, which provide early indication that the outcomes/impacts are likely to be achieved, especially where overall outcomes data are reported too infrequently to be able to track progress and make adjustment to activities in light of whether the desired impacts are being achieved. Leading indicators should be:

   (a) **Moveable** by WHO: does the metric capture something that WHO can influence, so that there is a reasonable chance of success and the contribution of WHO on results is captured?

   (b) **Measurable:** are these data already being collected or if not do the resources and commitment exist at all levels to capture them in the future? Can metadata be clearly defined (e.g. what is the numerator, denominator, computation)?

   (c) **Meaningful:** is there a clear link between a change in the metric and outcomes that makes a significant difference in the health of populations, and can setting a goal around the metric inspire partners, stakeholders and the public to drive action?

3. Work will be done to map progress on the metric to the 4-point scale so that it can be incorporated into the Output Scorecard, and the results will be reported in a consistent way using the spider diagram.

This first iteration of these indicators will be tested and developed further as part of the pre-testing for the entire Output Scorecard during early 2020. Further work will be done to assess whether these proposed indicators (below) meet the criteria outlined above and where additional development and testing work is needed and alternatives explored. Logic models will be tested and determination made as to whether the indicators represent the influence of WHO across the three levels to achieving outcomes/impacts. Some of these indicators may be refined or replaced before full rollout of the Output Scorecard.

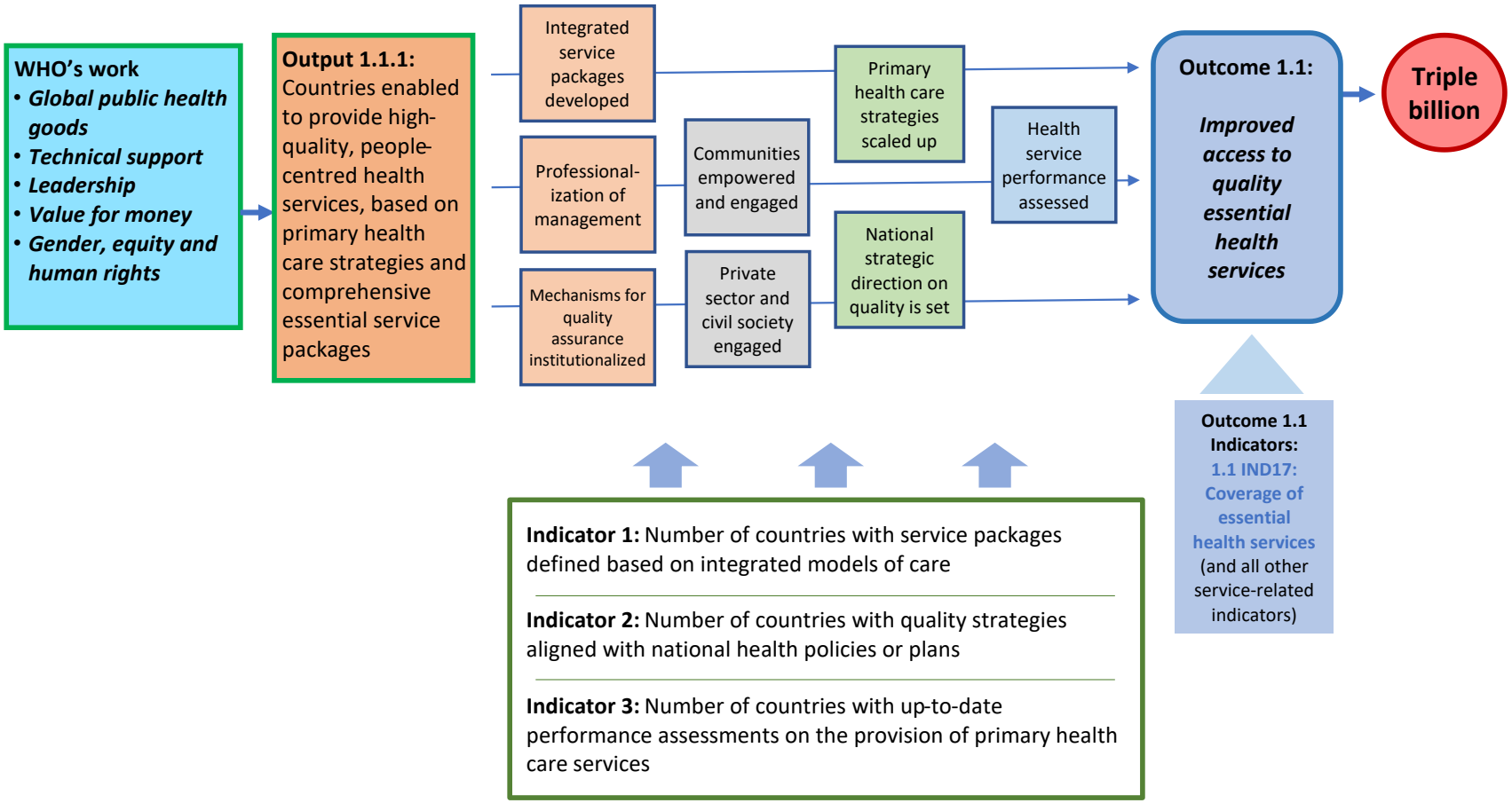
Output #	Proposed leading indicators
1.1.1	Number of countries with service packages defined based on integrated models of care
	Number of countries with quality strategies aligned with national health policies or plans
	Number of countries with up-to-date performance assessments on the provision of primary health
1.1.2	Number of countries where burden of disease assessments are done at the national level to identify their respective high burden diseases and conditions
	Number of countries implementing integrated disease guidance addressing the highest burden health conditions for their specific country
	Number of countries receiving joint support for delivering integrated disease services that address the diseases and health conditions most relevant for the respective country
1.1.3	Number of additional countries that have used WHO guidance on adolescent health services barriers assessment to develop their national plans and strategies
	Number of countries that have developed multisectoral programmes for early childhood development
	Number of additional countries transitioning out of support from Gavi, the Vaccine Alliance, that have increased their allocation to vaccine procurement compared to 2019 allocation
	Number of additional countries that have introduced human papillomavirus DNA tests for cervical screening
1.1.4	Number of countries with a comprehensive national health sector policy/strategy/plan with goals and targets updated within the past five years
1.1.5	Number of countries implementing national health workforce accounts
	Number of countries reporting on migrant health workers (as measured by foreign-born/ foreign-trained health workers)
1.2.1	Number of countries supported showing evidence of progress in their health financing arrangements
1.2.2	Increased number of countries producing country-specific health accounts using classifications from *A System of Health Accounts*, 2011 edition
	Increased number of countries that have completed or updated an analysis of financial protection since 2015
1.2.3	Increased number of countries systematically incorporating economic evidence when developing new products (e.g. packages of essential services and investment cases) or improving decision-making processes (e.g. health technology assessments) with the intent to increase efficiency
1.3.1	Global public health goods self-assessed and independently assessed
1.3.2	Number of countries regularly reporting prices of medicines via international platforms
1.3.3	Number of countries with: • improved regulatory systems • stable, well-functioning regulatory status (National Regulatory Authority maturity level 3) • a risk-based approach for regulating in vitro diagnostic medical devices • improved regulatory preparedness for public health emergencies

Output #	Proposed leading indicators
1.3.4	Gaps in the antimicrobial resistance landscape identified, and potential products to fill these gaps identified
	Priorities for paediatric formulations (e.g. HIV, tuberculosis) identified, and promotion and advocacy for research and development to deliver them conducted
1.3.5	Functional antimicrobial resistance multisectoral coordination groups established in >=60% of Member States with national action plans to address antimicrobial resistance (medium term – end 2023).
	Participation in Global Antimicrobial Resistance Surveillance System (GLASS): >=50% of Member States participating in GLASS (short term – end 2021) >=50% of Member States have national antimicrobial resistance surveillance systems and are providing data on the SDG3 antimicrobial resistance indicator (medium term- end 2023)
	Systems for monitoring consumption and rational use of antimicrobials in human health established in 60% of Member States (medium term – end 2023)
	National infection prevention and control programmes being implemented nationwide in 40% of Member States (medium term – end 2023)
2.1.1	Number of countries that submitted State Party self-assessment annual reports on IHR implementation
	Number of countries that have used findings from the IHR monitoring and evaluation framework to develop or update their national action plans
2.1.2	Number of countries with national strategies or plans to strengthen all-hazards country capacities to reduce health risks and consequences of emergencies and disasters
	Number of global strategies developed by WHO to address key and emerging areas for strengthening country capacities to reduce health risks and consequences of emergencies and disasters
	Number of global strategies in WHO technical programmes that include development of capacities to reduce health risks and consequences of emergencies and disasters
2.1.3	Number of countries having developed public health risk profile
	Number of countries at risk of imminent public health events operationally ready to detect and respond quickly and effectively
2.2.1	Number of target product profiles for product and medical countermeasures developed for high threat pathogens
	Number of policy advice materials (expert advisory panel or committee recommendations, guidelines, public health research, policy brief) developed for high threat pathogens and high impact events
2.2.2	Number of countries with fully funded multisectoral cholera control plans aligned to the global road map
	Number of countries incorporating influenza programmes into national action plans that include strategies for nonpharmaceutical interventions, vaccines and antiviral medicines
	Number of countries developing, updating, implementing and exercising pandemic plans
	Proportion of countries with a budgeted meningitis preparedness and response plan
	Proportion of countries with implementation plans to eliminate yellow fever epidemics or comprehensive multi-year strategic plans detailing yellow fever routine immunization introduction or improvement activities and reporting coverage in joint reporting forms

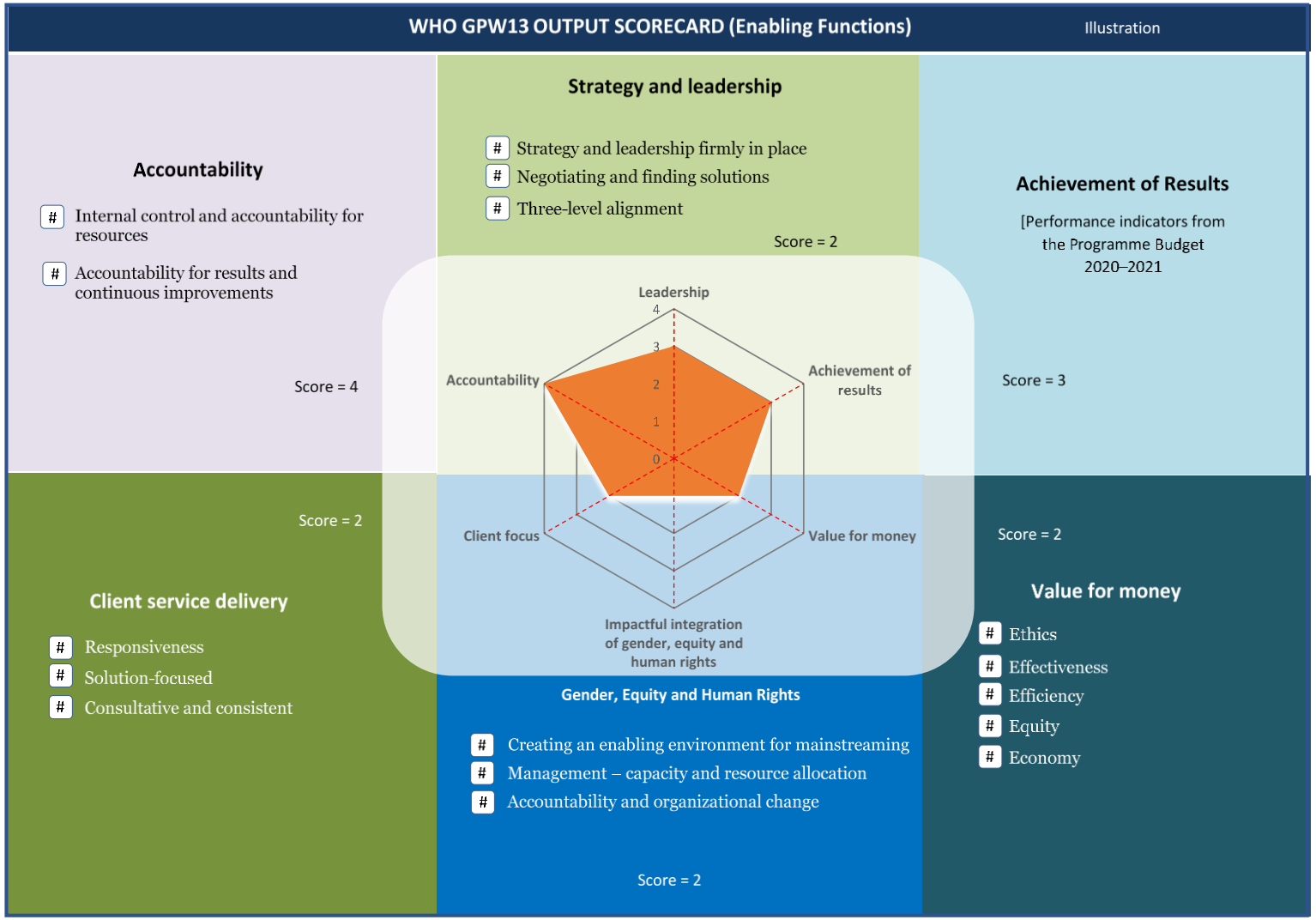
Output #	Proposed leading indicators
2.2.3	Increased number of hot spots that have been supported to develop risk mitigation strategies for high threat pathogens and reduce vulnerability to emergence and spread
	Increased number of countries with mitigation measures of emergence/re-emergence of high threat pathogens incorporated into national programmes
	Number of outbreak/epidemics of high threat pathogens prevented or minimized (e.g. no onward human-to-human transmission) through disease preparedness and early detection activities
2.2.4	Awaiting submission
2.3.1	Percentage of acute public health events for which a risk assessment is completed within one week
2.3.2	Percentage of all graded emergencies which activated an incident management system at country level within 72 hours
	Percentage of all graded emergencies for which a first WHO situation report was issued within 24–72 hours
	Percentage of all graded emergencies for which a request for resources from the Contingency Fund for Emergencies and/or regional fund have been submitted within 24–72 hours
2.3.3	Percentage of fragile, conflict-affected and vulnerable settings that have a humanitarian response plan (or equivalent) that includes a health sector component
	Percentage of fragile, conflict-affected and vulnerable settings with known attacks on health care that report to the surveillance system for attacks on health care (SSA)
	Percentage of country health clusters with a dedicated, full-time health cluster coordinator
3.1.1	Support provided to at least xx countries on implementation of evidence-based programmes on violence against children (no baseline until 2022)
	Percentage of countries with road safety laws that meet best practice (data available 2022)
	Percentage of countries with policies addressing maternal, infant and young child nutrition
	Support provided to five countries on mainstreaming gender, equity and human rights
	Countries with improved response on the stigma index
3.1.2	Number of countries with water safety planning policies
	Number of countries that have developed health adaptation plans for climate change
	Number of countries that have included public health considerations in relation to mitigation within their nationally determined contributions to implementation of the Paris Agreement
	Number of countries that have included public health considerations in their national chemical management plans
	Number of countries that have developed national policies on occupational health

Output #	Proposed leading indicators
3.2.1	Population covered by effective taxation on tobacco, alcohol and sugar-sweetened beverages (a) Population covered by effective taxes on tobacco products (b) Population covered by effective excise taxes on alcohol and other pricing policies (c) Population covered by effective taxes on sugar-sweetened beverages
	Population covered by legislative/regulatory measures (a) Population covered by comprehensive drink-driving countermeasures (b) Population covered by bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion (c) Population covered by policies to reduce industrially produced trans fatty acids in the food supply
	Level of Codex Member State participation in the Codex process
3.2.2	Population covered by measures WHO agreed with the private sector on the reduction of noncommunicable disease risk factors
	Number of countries having health literacy and community empowerment strategies
	Number of countries having transparent national accountability mechanisms that foster the prevention and control of noncommunicable diseases
3.3.1	Number of countries having passed laws, regulations and policies that foster healthy and enabling environments where people live, work and age
	Population covered by improved institutional capacities, mechanisms and mandates of relevant authorities to reduce environmental and societal health risks and foster healthy investments
3.3.2	Population covered by better coordinated and aligned global action to address noncommunicable disease risk factors
	Population covered by healthy investments based on WHO advice

Fig. Output 1.1.1 – Logic model/theory of change (illustrative example, simplified version)



B. Output scorecard dimensions and scoring scale for outputs under outcomes 4.2 and 4.3



Dimension 1: Effective delivery: Strategic direction and leadership		
Attribute	**Criteria**	**Scoring scale**
Leadership and clear strategic direction in place (All criteria applicable to all 4.2 outputs; some criteria applicable to 4.3 outputs)	• Existence of a clear strategic direction for the work under the output • The extent of stability of a clear leadership function in place • The extent of Secretariat capacity to deliver • The level of strategic and corporate risk management	**Strong (4)** A clear strategic direction is in place and the Secretariat has adequate capacity to deliver on its strategy; WHO is well positioned and seen as driving the agenda at global/regional/country context; a clear and stable leadership in the area of work covered by the enabling output is in place for the entire biennium (24 months); strategic and corporate risks towards achieving the output are addressed. **Satisfactory (3)** A clear strategic direction is in place and the Secretariat has adequate capacity to deliver on its strategy; WHO is seen as driving the agenda at global/regional/country context in relation to the areas of work under the output; a clear and stable leadership function is in place for at least one year of the biennium. **Developing (2)** A clear strategy is in place and the Secretariat has some capacity to deliver on its strategy. A stable leadership function is in place for less than one year of the biennium. **Emergent (1)** A strategic direction is in place; capacity to deliver uncertain; leadership function is not in place for most of the biennium.
Negotiating and finding solutions (When assessing this, it needs to be contextualized on specific challenging issues identified to be constraining the achievement of the output)	• Understands the context and needs of the different players • Well positioned with key players on challenging issues • Identifies solutions informed by the evidence and best practice • Identifies practical, sustainable and implementable solutions	**Strong (4)** The key players are identified and engaged. The context of issues and needs of players are well laid out and understood by the key players. A leading role in negotiations is established on the most challenging issues. Can demonstrate strong evidence that a sustainable/practical solution has been identified and applied on the most challenging issues related to the output. **Satisfactory (3)** The key players are identified and engaged; the context of issues and needs are well laid out and understood by key players. A leading role in negotiations is established on more challenging issues. Has identified practical, sustainable, evidenced solutions in two or three challenging areas under the output. **Developing (2)** Becoming directly involved in discussions with the key players. Has helped to identify practical, sustainable and implementable solutions in at least one key area, informed by solid evidence.

Dimension 1: Effective delivery: Strategic direction and leadership		
Attribute	**Criteria**	**Scoring scale**
		Emergent (1) In the early stages of mapping the stakeholders, understanding their needs and positioning to play a role. In the process of developing the required evidence base and platform for future work.
Three-level alignment	• The extent through which the roles and responsibilities (including delegation of authority) are laid out and respected • The level of resources at the country level (% of budget funded for the output) • The extent of the functioning of issue/conflict resolution mechanism between the levels for the output • The extent of involvement of country offices in high-level decision-making in relation to the output	**Strong (4)** Roles and responsibilities (including delegation of authority) between headquarters, regional offices and country offices are clearly laid out based and respected; at least 80% country offices are well-resourced to deliver; a well-functioning platform exists to resolve issues and conflicts between the levels; policies and policy implementation are aligned across three levels. There is proactive involvement of country offices in high-level decision-making. **Satisfactory (3)** Roles and responsibilities clearly laid out and respected; between 50% and 80% of country offices are well-resourced to deliver; a well-functioning platform exists to resolve issues and conflicts between the levels; there is no evidence of country office involvement in high-level decision-making. **Developing (2)** Roles and responsibilities clearly laid out but application is still evolving. A platform for discussion of roles and responsibilities exists but no regular interaction; most country offices are not involved in high-level decision-making. **Emergent (1)** Roles and responsibilities not clearly laid out. No regular interaction between the three levels. Country offices are not involved in decision-making.

Dimension 2: Accountability		
Attribute*	**Criteria**	**Scoring scale**
Internal control and accountability for resources	• Score from the existing assessment for the Internal Control Framework (ICF)	**Strong:** ICF score is 4. **Satisfactory:** ICF score is 3. **Developing:** ICF score is 2. **Emergent:** ICF score is 1.
Accountability for results and continuous improvement	• The extent to which the findings of performance assessments, reviews and audits are driving operational actions and decisions of managers under this output • The extent to which managers are taking corrective actions to address underperformance and incorporate lessons learned into strategy revision, planning, implementation	**Strong (4)** There is strong evidence that operational actions and decisions, and performance management in the areas under this output are driven by results of performance monitoring in line with the assessment of results dimension (dimension 6) (validated by the Office of Internal Oversight Services); all of the recommendations in the last audits have been addressed/implemented (as relevant). **Satisfactory (3)** The is clear concrete evidence that operational actions and decisions and performance management in the areas under this output are driven by results of performance monitoring in line with the assessment of results dimension (dimension 6); at least 70% of the recommendations in the last audits have been addressed/implemented (as relevant). **Developing (2)** Findings from the results dimension of the Scorecard have been considered but are not shaping future activities and policies, not always driving operational actions and decisions in the areas under the output. Less than 70% of the last audit recommendations have been addressed (as relevant). **Emergent (1)** Results dimension is not reported on, none of the findings are affecting policies, operational actions and decisions. Less than 50% of recommendations in the last audits are addressed.

* *These are in line with the functional elements of WHO's accountability framework (2015).*

Dimension 3: Effective delivery: Client service delivery		
Attribute	**Criteria**	**Scoring scale**
Responsiveness *Respond to clients'(partners) needs in a timely manner*	• **Understanding of client needs:** gathers feedback systematically to understand client needs and organizational requirements • **Responsiveness:** delivers quality services and products which meet the needs of the organisation and client groups • **Timeliness:** delivers consistently within agreed timescales, renegotiating flexibly as priorities and needs change	**Strong (4)** Exceeds expectations of a highly responsive and timely service delivery in all key areas relevant to the output which meets the needs of the Organization at different levels, as evidenced by systematic client feedback. Excellent understanding of client needs and uses this to balance the needs of different parts of the Organization. **Satisfactory (3)** Meets the expectations of a responsive and timely service in most key areas, as shown by client feedback. Delivery is achieving a reasonable balance between the responding to the needs of immediate clients and the wider Organizational need. **Developing (2)** Client responsiveness and timeliness is improving, with successes in at least one key area and work in progress in others. Delivery is mainly focused on the most immediate and urgent client needs but is starting to develop a wider perspective on the three levels. **Emergent (1)** Data are being gathered to develop a better understanding of client needs and approaches are being developed to improve responsiveness and timeliness, but this is currently work in progress.

Dimension 3: Effective delivery: Client service delivery		
Attribute	**Criteria**	**Scoring scale**
Solutions focus *Finds solutions to clients' needs within the existing regulatory framework*	• **Focus on innovative solutions:** Identifies, tests and delivers flexible solutions to meet client needs within relevant regulatory frameworks in line with organizational priorities • **Innovation:** Seeks innovative solutions to achieve desired outcomes, learning from best practice in other settings	**Strong (4)** Effective solutions identified and delivered in all the agreed areas, which flexibly respond to client needs. Has made excellent use of innovative approaches, learning from best practice in other settings. **Satisfactory (3)** Effective solutions identified in several key areas and being delivered in most of the agreed areas. Innovative solutions are being investigated with a view to learning from best practice in other settings. **Developing (2)** Is in the process of developing effective solutions with implementation under way in at least one area. **Emergent (1)** A solutions focus is being developed, with further work required to scope/design/test before implementation is possible.

Dimension 3: Effective delivery: Client service delivery		
Attribute	**Criteria**	**Scoring scale**
Consultative and consistent *Integrates the perspectives of all three levels of the Organization in the development policy/business processes*	• **Obtaining senior level support:** has effective strategies for consulting with senior management to ensure buy-in • **Consultative approach:** follows an effective consultative approach when developing policy and systems • **Understanding of perspectives across the Organization:** good understanding of wider WHO needs and perspectives, at different levels	**Strong (4)** Meets the expectations of the consultative and participatory process. Client surveys demonstrate evidence that they are engaged in policy development, finding innovative solutions and monitoring the implementation. There is evidence of a well-functioning championing group to advance activities of the areas under the output. Regularly tracks the engagement of clients on process, policy improvements and client satisfaction. [A score of 4 is only possible here if there is strong evidence by client surveys.] **Satisfactory (3)** Meets the expectations of the consultative and participatory process. Client surveys demonstrate evidence that they are engaged in policy development, finding innovative solutions and monitoring the implementation. Mechanisms in place to track client engagement or satisfaction. **Developing (2)** Approach is already more consultative and there are processes for seeking feedback and integrating perspectives of clients. Client engagement and satisfaction are not tracked in a structured way. **Emergent (1)** Mainly inward-looking at present, although a more consultative approach is starting to be considered/designed.

Dimension 4: Impactful integration of gender, equity and human rights		
Attribute	**Criteria**	**Scoring scale**
Creating an enabling environment for mainstreaming	**Data collection and analysis:** Support the Organization's efforts to collect, analyse and report disaggregated data **Analysis:** Analysis of corporate quantitative and qualitative data to identify bottlenecks for implementation of gender, equity and human rights mainstreaming **Identification of entry points** for strengthening human rights-based approaches and gender-responsiveness in WHO, including for supporting gender equality in the Organization	**Strong (4)** • Enabling functions data are disaggregated whenever by sex, age group, location and other relevant dimensions (e.g. country data produced with support from WHO; staff structure; consultancies; delegations' composition; external suppliers' data; Bulletin of WHO; advisory committees). • Policies and operational processes explicitly **indicate and promote** alignment with a "leave no one behind" approach based on gender, equity and human rights mainstreaming and are applied consistently. • There is evidence of leadership and management actions proactive in supporting human rights-based approaches and gender-responsiveness in all WHO's work, including for supporting gender equality in the Organization. **Satisfactory (3)** • Enabling data are disaggregated (as relevant) by sex, age group, location and other relevant dimensions (e.g. country data produced with support from WHO; staff structure; consultancies; delegations' composition; external suppliers' data; Bulletin of WHO; advisory committees). • Policies and operational processes at least **refer to** the "leave no one behind" approach based on gender, equity and human rights mainstreaming; leadership and management actions allow human rights-based approaches and gender responsiveness and track gender equality in the Organization. **Developing (2)** • Some data are disaggregated (as relevant) by sex, age group, location and other relevant dimensions (e.g. country data produced with support from WHO; staff structure; consultancies; delegations' composition; external suppliers' data; Bulletin of WHO; advisory committees). Reference to the "leave no one behind" approach based on gender, equity and human rights mainstreaming in policies and operational guidelines not yet consistent. **Emergent (1)** • Inclusion of human rights-based approaches and gender-responsiveness, including for supporting gender equality in the standard operating procedures and plans in the enabling units contributing to the output, is not always consistent.

Dimension 4: Impactful integration of gender, equity and human rights		
Attribute	**Criteria**	**Scoring scale**
Management for capacity-building and resource allocation	**Capacity-building**: Capacity-building[1] on mainstreaming gender, equity and human rights is planned, implemented and reported on **Resource allocation:** Resources are allocated in workplans[2] to appropriately sustain capacity-building on mainstreaming gender, equity and human rights **Awareness raising:** Raising awareness on and advocating for mainstreaming gender, equity and human in the achievement of outputs is conducted	**Strong (4)** • At least two activities have been conducted to build or strengthen staff's capacities for mainstreaming gender, equity and human rights. • Resources allocated in the Output Delivery Team to appropriately sustain capacity-building for mainstreaming gender, equity and human rights are least 5% of the total funding of the output. **Satisfactory (3)** • At least two activities have been conducted to build or strengthen staff's capacities for mainstreaming gender, equity and human rights. • Resources allocated in the Output Delivery Team to appropriately sustain capacity-building for mainstreaming gender, equity and human rights are less than 5% of the total funding of the output. **Developing (2)** • At least one activity has been conducted to build or strengthen staff's capacities for mainstreaming gender, equity and human rights. • Resources allocated in the Output Delivery Team to appropriately sustain capacity-building for mainstreaming gender, equity and human rights are less than 5% of the total funding of the output. **Emergent (1)** • Activities to build or strengthen staff's capacities for mainstreaming gender, equity and human rights have been planned or partially implemented.

[1] Capacity-building can take many forms, including technical assistance, collaborations or through training (e.g. training on mainstreaming gender, equity and human rights; training on health inequality monitoring and data disaggregation; training on how to do a gender analysis; training on how to conduct a barriers assessment in health services; training on how to conduct a health programme review with Innov8; the "I know Gender" course from the United Nations; training on Sustainable Development Goals and the leaving no one behind approach).

[2] Either in activity workplans or salary workplans, which could allocate dedicated staff or staff's time to support the mainstreaming of gender, equity and human rights into the budget centres, programmes, division, unit, office, etc.

Dimension 4: Impactful integration of gender, equity and human rights		
Attribute	**Criteria**	**Scoring scale**
Accountability and organizational change	**Change in institutions:** Promoting and institutionalizing an organizational change to actionable mainstreaming of gender, equity and human rights is part of the culture of WHO **Organizational change:** Actions promoting organizational change should include mainstreaming gender, equity and human rights **Accountability:** Accountability for gender, equity and human rights should be clear and enforced by managers,[1] including in budget centres' workplans and managers' objectives in the performance management and development system	**Strong (4)** • An equity, gender and human rights mainstreaming plan for the budget centres contributing to the output has been developed and monitored. • Mainstreaming gender, equity and human rights is included in one of the objectives of Senior Management (starting at P5 level) in the performance management and development system. • Preparation and development of governing bodies' documentation address gender, equity and human rights. **Satisfactory (3)** • An equity, gender and human rights mainstreaming plan for the budget centres contributing to the output has been developed and monitored. • Mainstreaming gender, equity and human rights is included in one of the objectives of Senior Management (starting at P5 level) in the performance management and development system. **Developing (2)** • An equity, gender and human rights mainstreaming plan for the budget centres contributing to the output has been developed and monitored. **Emergent (1)** • Discussions for developing an equity, gender and human rights mainstreaming plan for the budget centres contributing to the output have started.

[1] Including Directors, Regional Advisers, Coordinators, WHO Representatives.

Dimension 5: Delivering value for money		
Attribute	**Criteria**	**Scoring scale**
Effectiveness	**Output are on track** to achieve the intended outcomes	**Strong (4)** All key performance indicators (in results dimension) are on track or fully achieved. **Satisfactory (3)** At least 70% of the key performance indicators (in results dimension) are on track or fully achieved. **Developing (2)** At least 50% of the key performance indicators (in results dimension) are on track or fully achieved. **Emergent (1)** Less than 50% of the key performance indicators (in results dimension) are on track or fully achieved.
Ethics	Capacity-building to enhance awareness: Have relevant ethical standards and principles relevant to the output have been clearly identified and understood? For example: (a) WHO's Code of ethics and Professional conduct[1] (b) Specific ethical standards (where relevant) that apply for this output area[2]	**Strong (4)** Relevant ethical standards and principles have been fully understood and integrated into policy/process design and implementation resulting in full compliance with no exceptions. **Satisfactory (3)** Relevant ethical standards and principles have been considered in programme design and implementation relevant to the output, with high levels of compliance. Any exceptions are relatively minor and have been addressed. **Developing (2)** Relevant ethical principles and standards are being considered but are not yet consistently followed through in decisions and implementation.

[1] **WHO's Code of Ethics and Professional Conduct (2017)** sets out the following ethical principles: integrity; accountability; independence and impartiality; respect for the dignity, worth, equality, diversity and privacy of all persons; professional commitment. The code also contains specific guidance on how these principles apply in practice for individual staff, managers and at organizational level. For example, commitments at organizational level cover areas such as: ensuring a fair and respectful workplace, preventing sexual exploitation and abuse, child protection, human rights, gender, equity and human rights and fair and transparent procurement, etc. At individual level, the code covers areas such as respecting national laws, conflict of interests, violence in the workplace, etc. Other areas covered by the guide include relations with non-State actors, use of information, reporting wrongdoing (whistle-blowing and protection against retaliation).

[2] In individual areas of WHO's work, specific ethical standards and guidance apply e.g. "WHO Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies"; "International ethical guidelines for biomedical research involving human subjects"; "UNEG ethical guidelines for evaluators", etc. Although an exhaustive list cannot be provided here, output network leads are expected to be able to identify and reference specific ethical standards that have been formally adopted by WHO for their own areas.

Dimension 5: Delivering value for money		
Attribute	**Criteria**	**Scoring scale**
	Monitoring of compliance of ethical standards – Have WHO's agreed ethical standards been fully integrated, and are they being applied?	**Emergent (1)** Policy/process design and implementation relevant to the output do not yet fully take into account relevant ethical principles and standards and/or there are major gaps in competence around ethics and/or compliance, leading to significant reputational risk.
Equity[1]	**Resource allocation** includes criteria to ensure that the expected benefits are distributed fairly and/or are reaching the most vulnerable When **reaching the most vulnerable** is not achieved, an analysis and plan should be developed to identify what decisions on resources or management have to be made to revert this situation **Reporting on output achievement** includes an analysis on how resources were allocated to fairly distribute benefits to the most vulnerable **Evaluation** is being used to support learning and innovation on equity-oriented resource allocation and reporting	**Strong (4)** • There are explicit criteria (e.g. rules, norms, standards) for promoting the allocation of resources for the output with a view to distribute benefits fairly and/or to reach the most vulnerable. • Reporting on output achievement include analysis on how resources were allocated to fairly distribute benefits to the most vulnerable. • Capacities are built or strengthened on equity-oriented resource allocation and reporting. **Satisfactory (3)** • There are explicit criteria (e.g. rules, norms, standards) for promoting the allocation of resources with a view to distribute benefits fairly and/or to reach the most vulnerable. • Reporting on output achievement include analysis on how resources were allocated to fairly distribute benefits to the most vulnerable. **Developing (2)** • There are explicit criteria (e.g. rules, norms, standards) for promoting the allocation of resources with a view to distribute benefits fairly and/or to reach the most vulnerable. **Emergent (1)** • Equity-oriented resource allocation and reporting is promoted but without clear and criteria (e.g. rules, norms, standards).

[1] Scoring in this attribution should be done in conjunction with, and consistent with the gender, equity and human rights dimension. For example, the gender, equity and human rights attribute on management capacity and resources should be scored consistently with the criterion in value for money equity on "strategies capacities and skills".

Dimension 5: Delivering value for money		
Attribute	**Criteria**	**Scoring scale**
Efficiency	**Management has taken strategic decisions** to address system[1] weaknesses and deliver efficiency gains where possible **Available financial and human resources** are used strategically and flexibly to achieve results **Delivery is timely** **Financial and administrative management processes** meet relevant standards and are implemented	**Strong (4)** Strong evidence exists that strategic decisions have already led to significant efficiency gains in several areas. Options for delivery of products/services are laid out, documented, evaluated and decisions are taken with consideration of optimizing delivery. Delivery is consistently timely and financial and human resources are fully used. Efficiency gains are measured and reported. [A score of 4 here should be validated by an independent mechanism.] **Satisfactory (3)** Strategic decisions have led to efficiency gains in at least one area. Options for delivery of products/services are laid out, documented, evaluated and decisions are taken with consideration of optimizing delivery. Delivery is timely. Efficiency gains can be explained. **Developing (2)** Efficiency gains are being targeted but implementation is "work in progress". Delivery is usually timely with some use of no-cost extensions. Resources are not always fully used. **Emergent (1)** Efficiency gains have not yet been targeted. No-cost extensions to deadlines have been repeatedly required and/or resources have not been fully used.
Economy	The extent through which goods and services procured are purchased at the best price given the quality required, following WHO procurement policies and standard operating procedures Adherence to periodic market benchmarking and other exercises ensure that the prices at which WHO purchased goods and services are competitive Extent of awareness and adherence of staff making procurement and human resources	**Strong (4)** After establishing efficiency, additional measures are taken to minimize cost with regular reference to market benchmarks. Regular reference to is built in and actions already fully implemented. WHO procurement policies and standard operating procedures are understood by staff including management and they are strictly adhered to in all procurement and human resources decisions. [A score of 4 can only be given here if efficiency is 3 or 4.] **Satisfactory (3)** At least one benchmarking comparison has been made and follow-up action is under way to procure with the best price given the quality required. Options are laid out and documented for making informed choices. WHO procurement and human resources policies are understood and adhered to by staff making procurement and human resources decisions under the output.

[1] This includes standard operating procedures and policies.

Dimension 5: Delivering value for money		
Attribute	**Criteria**	**Scoring scale**
	decisions on WHO procurement and human resources policies and standard operating procedures	**Developing (2)** Input costs are higher than relevant benchmarks in some areas, although work has been done to understand the reasons and actions are being considered to achieve best buy. Staff making decisions on procurement and human resources are sensitized to WHO procurement and human resources policies and standard operating procedures but full understanding of all processes is still work in progress. **Emergent (1)** Input costs are frequently higher than expected and/or limited if any analysis to identify the reasons and consider benchmarks. WHO procurement and human resources policies and standard operating procedures are not fully understood nor applied by staff who are making procurement and human resources decisions. Work is in progress to fully train staff in their application.

Dimension 6: Achievement of results in ways leading to impacts

These indicators provide a more quantitative and early indication as to how the enabling functions are contributing to the achievement of results in the other strategic priorities. These performance indicators have been taken from the Programme budget 2020–2021. They will be aligned with the key performance indicators that are currently being developed as part of the delegation of the authority in relation to management and administration.

Output #	Proposed leading indicators
4.2.1	Leading indicators to be determined
4.2.2	Percentage of critical risks with a mitigation plan
	Percentage of audit observations responded to in a timely manner, with an emphasis on addressing systemic issues
	Percentage of recommendations in corporate and decentralized evaluations implemented within agreed time frames
	[Indicator on effective and timely response by the Secretariat to allegations of sexual exploitation and abuse]
4.2.3	[Indicator to measure progress of successful outcomes from WHO advocacy with Member States to mobilize additional, flexible and more predictable funds needed beyond assessed contributions]
	Increased donor and partner visibility on contributions made to support the work of WHO, through innovative and effective communications channels and platforms
4.2.4	Proportion of priority outcomes at the country level with at least 75% funding by the end of the first quarter of the biennium
	Percentage of technical expertise required at the country level agreed in budgeted and funded country support plans
	Percentage of priority global goods with detailed plans, including resource requirements
4.3.1	An unmodified audit opinion that the financial statements are presented in accordance with International Public Sector Accounting Standards (Yes/No)
	Issuance of an annual statement of internal control that addresses the effectiveness of internal controls and identifies any significant risks (Yes/No)
	[Indicator on improvements to the quality and timeliness of direct financial cooperation reporting, with overdue reports constituting less than 3% of the total number of reports issued in the previous biennium]
	Extent of compliance of global imprest accounts with imprest reconciliations requirements and attainment of an A rating
4.3.2	Increase in the number of international staff members moving between major offices
	Improvements in the overall male/female ratio of international professional staff
	Percentage of international professional staff from unrepresented and underrepresented countries
	Reduction in the average duration of the selection process from the date of publication of a vacancy notice to the issuance of a letter of offer to the successful candidate

Output #	Proposed leading indicators
4.3.3	Number of IT services repurposed and delivered as shared, global services
	Number of new platforms and services introduced in support of innovation
	[Indicator on productivity time lost due to security incidents]
	Updates to the Organization's business continuity plan (Yes/No)
4.3.4	Rate of compliance with mandatory security training
	Rate of compliance with United Nations Minimum Operating Security Standards
	[Indicator on progress of implementation of sound inventory control and warehouse management systems]
	[Indicator on efficient delivery of goods to country operations, as measured by the time from the creation of a purchase order to the delivery of the product to the country warehouse]
	[Indicator on transparency and fairness of the procurement process, as assessed by the number of formal complaints received from vendors through the established mechanism, against the baseline in 2019]

Note. Indicators under development and pretesting are shown in square brackets.

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